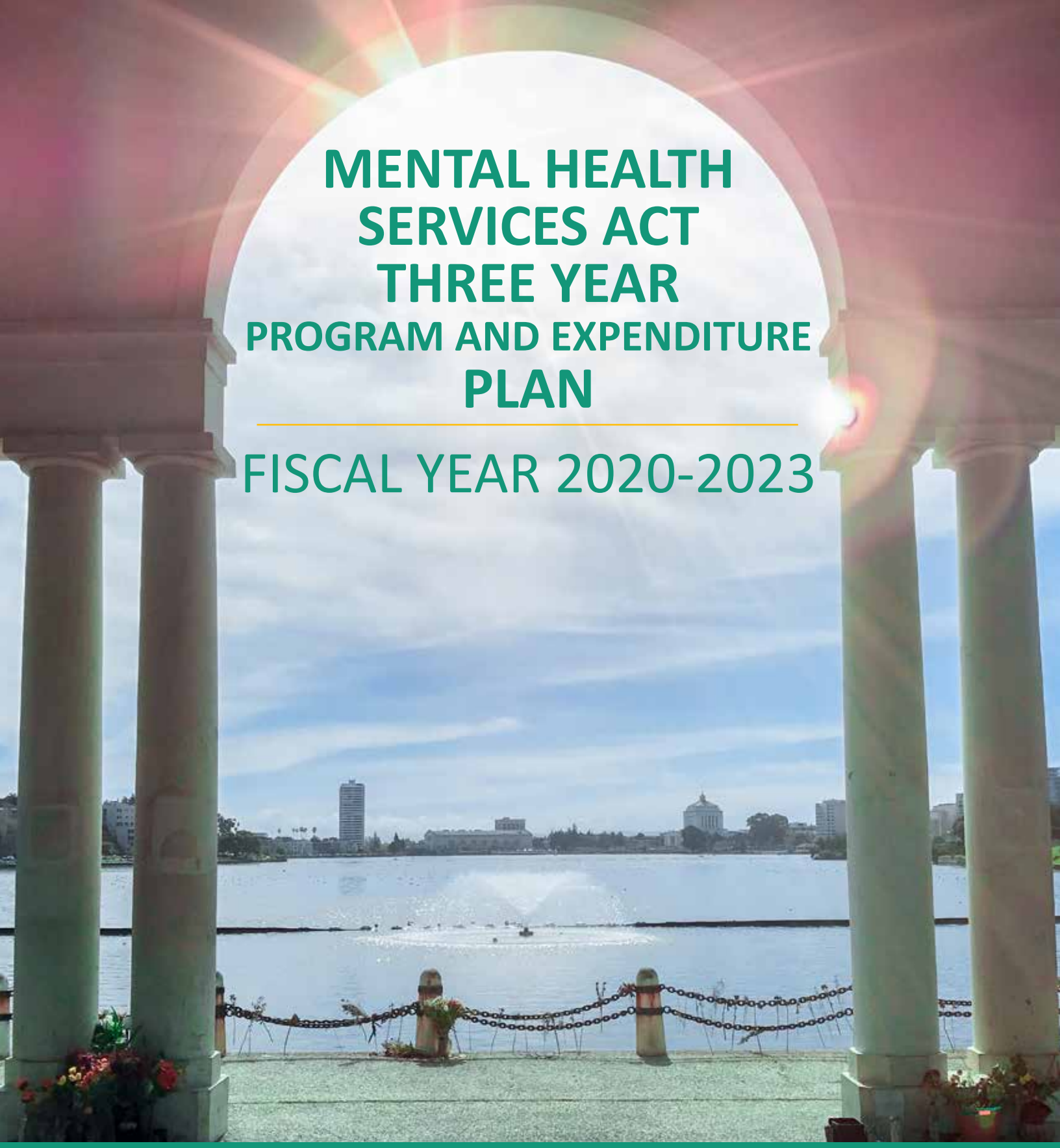


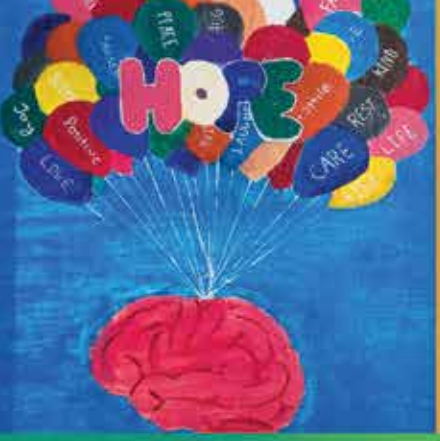
# MENTAL HEALTH SERVICES ACT THREE YEAR PROGRAM AND EXPENDITURE PLAN

## FISCAL YEAR 2020-2023

MENTAL HEALTH SERVICES ACT (MHSA) DIVISION | ALAMEDA COUNTY BEHAVIORAL HEALTH DEPARTMENT
RELEASED FOR PUBLIC COMMENT: AUGUST 21, 2020-SEPTEMBER 21, 2020

MENTAL HEALTH ADVISORY BOARD MEETING – PUBLIC HEARING
MONDAY, SEPTEMBER 21, 2020 | 5:00 PM
HTTPS://GLOBAL.GOTOMEETING.COM/JOIN/663301309
UNITED STATES (TOLL FREE): 1 877 309 2073 | ACCESS CODE: 663-301-309

alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES


HOPE




POWER
Strength
FRIENDS
THERAPY
SELF LOVE
MEDS
PATIENCE
GROWTH
ACCEPTANCE
TRUST
FAMILY
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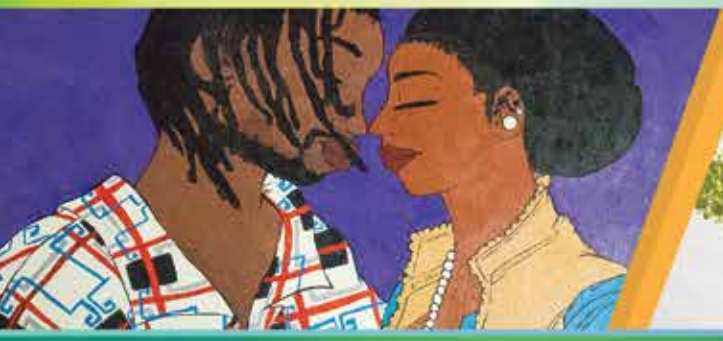
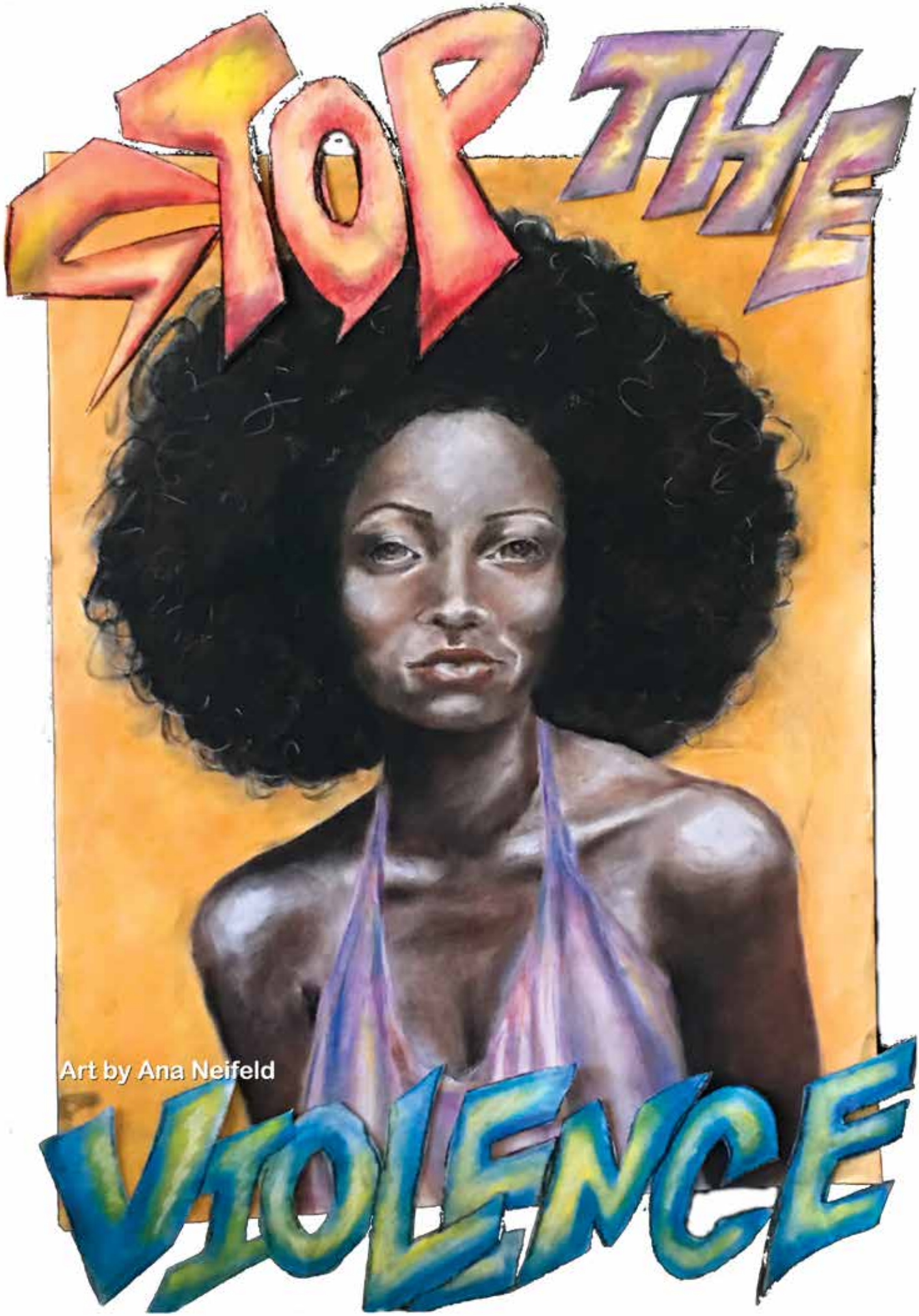
BALANCE



# MENTAL HEALTH SERVICES ACT
# FY20-23 THREE YEAR PLAN
## Table of Contents

## MHSA PLAN UPDATE PUBLIC COMMENTS

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


STOP THE
Art by Ana Neifeld
VIOLENCE

# Message From the Director

***Welcome*** to Alameda County Behavioral Health Care Services (ACBH) Department's Fiscal Year (FY) 2020-23 Mental Health Services Act (MHSA) Three-Year Program and Expenditure Plan (Three-Year Plan) for fiscal years 2020-2021 through 2022-2023.

Fiscal year 2020-2021 marks the start of our new Three-Year Plan which has been guided by the many heartfelt community voices that gave of their time, effort and energy to participate in our Community Program Planning Process (CPPP).

As the Director of Alameda County Behavioral Health, I am excited about this new Three-Year Plan as well as the opportunity to continue to engage more with our consumer and family member community, local nonprofit stakeholders, the Mental Health Advisory Board and our public systems. This continued engagement will assist us in serving our most vulnerable communities utilizing a cultural and racial/ethnic equity lens as well as the principles of trauma informed care.

Thank you to everyone who participated this Spring in our CPPP process, all the while being in the middle of the COVID-19 pandemic and the myriad of social issues that have affected our county and a nation as a whole. Your input has been invaluable and helped us to shape a Plan the incorporates the many voices we heard across the county. Please see the community input section for details.

As we weather economic uncertainty, the health implications from COVID-19 and the racial and ethnic injustices we've experienced has informed my own vision of how our department may be poised to be of service to our Community. This national change has also helped to serve as a guiding direction through these three departmental priorities during this next Three-Year MHSA Plan:

- Non-traditional community organizations supporting system wellness (such as faith-based and culturally relevant agencies and programs);
- Care coordination and community outreach, and
- Stigma and social Isolation reduction – (particularly due to COVID-19).

Although we are all living through unprecedented times ACBH is here to support our clients and family members while holding the spirit and core values of MHSA: Community Collaboration, Cultural Responsiveness, Consumer and Family Driven, Wellness Recovery and Resiliency, and Integrated services.

***Together we can make a difference. Together we have hope.***

Sincerely,

Karyn Tribble, PsyD, LCSW, Director
Alameda County Behavioral Health Care Services

# Alameda County Behavioral Health Mission and Vision

## MISSION

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

## VISION

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

**ACCESS** we value collaborative partnerships with consumers, families, service providers, agencies and communities, where every door is the right door for welcoming people with complex needs and assisting them toward wellness, recovery and resiliency.

**CONSUMER & FAMILY EMPOWERMENT** we value, support and encourage consumers and their families to exercise their authority to make decisions, choose from a range of available options, and to develop their full capacity to think speak and act effectively in their own interest and on behalf of the others that the represent.

**BEST PRACTICES** we value clinical excellence through the use of best practices, evidence-based practices, and effective outcomes, include prevention and early intervention strategies top promote well being and optimal quality of life. We value business excellence and responsible stewardship through revenue maximization and the wise and cost-effective use of public resources.

**HEALTH & WELLESS** we value the integration of emotional, spiritual and physical health care to promote the wellness and resilience of individuals recovering from the biological, social and psychological effects of mental illness and substance use disorders.

**CULTURALLY RESPONSIVE** we honor the voices, strengths, leadership, languages and life experiences of ethnically and culturally diverse consumers and their families across the lifespan. We value operationalizing these experiences in our service setting, treatment options, and in the processes we sue to engage our communities.

**SOCIALLY INCLUSIVE** we value advocacy and education to eliminate stigma, discrimination, isolation and misunderstanding of person experiencing mental illness and substance use disorders. We support social inclusion and the full participation of consumers and family members to achieve full lives in communities of their choices, where they can live, learn, love, work, play and pray in safety and acceptance.

# MHSA GUIDING PRINCIPLES

There are 5 principles which guide all MHSA planning and implementation activities:

**Cultural Competence**
Services should reflect the values, customs, beliefs, and languages of the populations served and eliminate disparities in service access.

**Community Collaboration**
Services should strengthen partnerships with diverse sectors to help create opportunities for employment, housing, and education.

**Client, Consumer, and Family Involvement**
Services should engage clients, consumers, and families in all aspects of the mental health system, including planning, policy development, service delivery and evaluation.

**Integrated Service Delivery**
Services should reinforce coordinated agency efforts to create a seamless experience for clients, consumers and families.

**Wellness and Recovery**
Services should promote recovery and resiliency by allowing clients and consumers to participate in defining their own goals so they can live fulfilling and productive lives.

# Executive Summary

Alameda County Behavioral Health (ACBH) is pleased to present the Mental Health Services Act (MHSA) Three-Year Program and Expenditure Plan (Three-Year Plan) for fiscal years 2020-23. This Three-Year Plan begins July 1, 2020, and will be updated annually in fiscal years 2021-22 and 2022-23.

The Three-Year Plan describes MHSA funded programs including; the program purpose, the monies allocated to fund these programs, and the measures taken to evaluate plan effectiveness and ensure that the programs meet the Mental Health Services Act requirements. The Three-Year Plan is comprised of five components: Community Services and Supports (CSS), Prevention and Early Intervention (PEI), Innovation (INN), Workforce Education and Training (WET), and Capital Facilities & Technology (CFTN).

## California's Mental Health Services Act

MHSA is funded by levying a one percent tax on personal annual incomes that exceed one million dollars. The MHSA, known as Proposition 63, was passed by California voters in 2004 and provides increased funding to support mental health services through five components for individuals with mental illness and inadequate access to the traditional public mental health system.

## Mental Health Services Act Expenditures

The importance of MHSA support is well known to our department, as a proportion of overall mental health funding in Alameda County has grown over time. For State Fiscal Year (FY) 20/21, ACBH set aside up to $136,071,268 million in budget authority, which is an approximate 55% increase over the previous Three-Year Plan budget (starting in FY 17/18). This increase in budget authority has primarily been driven by the need for additional homelessness and housing supports, new crisis programming, increased capacity in our Full-Service Partnership (FSP) programming, additional school-based supports and increased culturally responsive services.

Within the past few years all counties in California have experienced high MHSA allocations due to the success of the California economy. However, it should be noted that as a result of the Novel Coronavirus (COVID-19), it is anticipated that in future years, beginning in FY 21/22, ACBH's MHSA allocation will be reduced and potential contract right sizing or reduction strategies may be initiated. At this time, the actual fiscal impacts or potential reductions associated with COVID-19 are unknown. Nonetheless, in order to be proactive and safeguard against significant impact on the Alameda County community, fiscal planning to evaluate and strategize surrounding a future change in our financial landscape will be initiated this Fall. Additional information on these reductions will be included within the FY 21/22 MHSA Plan Update.

## MHSA Community Program Planning & Stakeholder Engagement Process

Exhibit 1 provides an overview of Alameda County's ongoing Community Program Planning Process (CPPP). Alameda County utilizes five MHSA principles to guide planning and implementation activities and employs a range of strategies to engage stakeholders at all levels of planning and implementation. Our CPPP provides a number of opportunities for a 14-member stakeholder group and other representatives to participate in the development of our Three-Year Plans and Annual Updates and stay informed of our progress in implementing MHSA-funded programs. During FY 19/20, MHSA increased the membership of

Despite health factors precluding our department from convening large in-person forums due to COVID-19, ACBH has been committed to identifying creative ways in which to engage the community and various stakeholders over the course of our planning efforts. Launched on April 27, 2020 through May 31, 2020, our CPPP consisted of more than 14,069 community input invitations via a social justice public relations firm, social media, e-mail requests, and creation of a new Community Input webpage with 2,145 new users. A community input survey was translated into 7 threshold languages with 627 unduplicated completions, which was a 14% increase from the previous CPPP survey completion rate in FY 17/18.

The MHSA team coordinated 12 focus groups with more than 198 group participants, each representing an important cross section of Alameda County populations. Some reoccurring themes from focus groups and surveys included: requests for housing and homelessness programs, school-based wellness programs, long-term mental health care and substance abuse treatment programs to combat depression and suicide, digital kinship villages, subacute and acute beds, increased license board and care facilities, and requests to target services for underserved and unserved communities- specifically African-Americans, transitional-age youth, persons experiencing homelessness and immigrants & refugees.

**Exhibit 1: Major components of the MHSA Community Program Planning Process (CPPP)**


**Cross-Component findings**:

- *Factors Related to Expenditures*: Expenditures to support an enhanced behavioral system of care through Community Services and Supports comprises 76 cents out of every Mental Health Services Act dollar. This proportion is in keeping with Welfare and Institutions Code Section 5892, which specifies the percentage of Mental Health Services Act monies to be expended on each component.
- *Local Trends Impact Report*: COVID-19 and unemployment and homelessness rates represent indicators of the overall economic health of Alameda County that are related to an increased need for public mental health services. Examination of the impacts of the shelter-in-place policy on

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- Financially supporting the Alameda County Loan Repayment Program (ACLRP) to provide up to $10,000 awards to mental health professionals that share the same ethnic, cultural and language backgrounds of the underserved and unserved communities that ACBH serves.

**General System Improvement Efforts**

Performance indicators for the County's FSP Programs and Prevention and Early Intervention component have been updated for FY 19/20 based on FY18/19 data, and include performance measurements and outcomes. In addition, a new Performance Management section contains a summary of quality assurance and improvement strategies. Appendices C, I and J contain individual program profiles of MHSA programs and plan elements.

**Closing**

In summary, ACBH has aggressively approached its CPPP process in a manner designed to eliminate as many barriers as possible to promote inclusive outreach and engagement. Our resulting MHSA Three-Year Plan for fiscal years 2020-23 are reflective of a Departmental recalibration and attempt to regard our valuable stakeholder feedback with a commitment towards Alignment, Communication, and Organizational Structure. Our goals are to create a basis for future efforts that represent a variety of stakeholder and community needs such as culturally-relevant, clinically pragmatic, and community-centered support and care. We are pleased to present our process, plans, and commitment to the future of our county with you at this time.

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

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

**I. COMMUNITY SERVICES AND SUPPORTS**

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

**II. PREVENTION AND EARLY INTERVENTION (PEI)**

a. PEI Programs focused on the Middle Eastern Community, UELP Program

**III. INNOVATIONS**

a. Approved INN Programs being Implemented in FY 19/20
b. New INN Programs under Development

**IV. WORKFORCE, EDUCATION, AND TRAINING (WET)**

a. Alameda County Loan Repayment Program
b. Navigator Training Program

**V. CAPITAL FACILITIES AND TECHNOLOGICAL (CFTN) NEEDS**

a. African American Wellness Hub Complex
b. MHSA Technology Project

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

### Full-Service Partnership (FSP) Program Slots Update

Alameda County currently has 890 on-going FSP slots distributed across 11 programs and 100 additional (time-limited) partner slots (50 per homeless focused FSP), for a total of 990 FSP slots. The 100 time-limited slots target individuals who are homeless and struggling with severe mental illness and co-occurring physical health and/or substance use disorders. These 100 additional slots are being piloted for three years (FY 19/20- 21/22) to determine their effect on the homelessness crisis in Alameda County. Connected to these 100 slots will be housing subsidies in order to rapidly house the FSP clients. Below are the FSP programs and the partner slots:

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

### FSP Outcome Metrics Being Developed

ACBH currently uses a web-based data and outcome reporting system called YellowFin. MHSA staff have partnered with System of Care staff and the ACBH Data Services team to develop new FSP outcome and impact metrics that when complete will be highlighted in the FY 21/22 MHSA Plan Update.

The newly created reporting dashboard will cover hospitalizations, housing, incarcerations, primary care linkage, employment, education, cost, and data quality. Below is an example of one of the draft metrics the team is designing.

**Outcome Question:** Do the number of incarcerations decrease for FSP partners in the years that they are in an FSP, when compared to the year prior to FSP admission?

| | |
|---|---|
| All FSP Episodes* | 807 |
| Pre-Year: FSP Episodes with At Least 1 Incarceration | 327 |
| Year 1: Eligible Episodes** | 132 |
| Year 1: Episodes with Decrease in Incarcerations | 85 |
| Year 1: % of Episodes with Decrease | 64% |
| Year 2: Eligible Episodes | 20 |
| Year 2: Episodes with Decrease in Incarcerations | 17 |
| Year 2: % of Episodes with Decrease | 85% |
| Year 3+: Eligible Episodes*** | 4 |
| Year 3+: Episodes with Decrease in Incarcerations | 3 |
| Year 3+: % of Episodes with Decrease | 75% |

*Total number of FSP episodes considered for the metric. Due to limitation of historic incarceration data availability, this report is limited to FSP episodes that began on or after 1/1/2017.

**Eligible Episodes - FSP episodes who had at least one incarceration in the 12 months prior to their FSP admission, and remained in the FSP for at least the number of years indicated (1, 2, or 3)

***Year 3 columns contain data for the most recent 12 month period of an FSP episode, for FSP episodes that have lasted at least three full years.

(Data Source: ACBH/ITD/AC Sheriff's Department)

It's the goal that ACBH staff continue to more deeply evaluate the FSP programs to determine additional impact metrics as well as potential cost benefit/cost savings analysis.

In addition to this new metric dashboard, the FSPs already have a dashboard that tracks a number of metrics around provider follow-up and engagement. These metrics are included in the FSP section and have specific benchmarks that when reached allow the provider to receive an incentive payment. This process is to move ACBH more towards payment for quality of care. All of these dashboards will be used by FSPs for program improvements and yearly reports.

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

### Successful Startup of the New Crisis Residential/Crisis Stabilization Program: Amber House

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

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

Towards the end of FY 19/20 209 individuals had been served in the CRT and 353 individuals in the CSU.

Both the CRT and CSU will be available to the Community Assessment & Transport Team (CATT) when it begins running in early FY 20/21.

This program is listed as OESD # 11.

### COVID-19 Outreach and Engagement

The global COVID-19 pandemic has had severe and significant physical and mental health impacts that are not only ongoing today, but will have substantial impacts well into the future. It's also important to note that communities of color and cultural groups have been disproportionality impacted as we can see from our zip code data through the Alameda County Public Health Department.[2]

To combat this and provide health information in a culturally responsive manner the ACBH Ethnic Services Unit created educational posters and bus shelter ads that are currently being displayed in zip code hotspots. See Appendix B-3 for the ads.

In addition to these efforts a second wave of information and education will take place this summer in the form of large-scale murals depicting our diverse communities, which will have translated messages about wearing a mask and risks of COVID-19. Like the bus shelter ads these will be placed in zip codes that have been disproportionally affected by COVID-19.

## II. PREVENTION AND EARLY INTERVENTION (PEI)

The Underserved Ethnic and Language Program (UELP) contractor, Diversity in Health Training Institute (DHTI), began providing services to the Middle Eastern Community in FY 19/20. Their program is called, The Sidra Community Wellness Program, and focuses on wellness among Middle Eastern and North African communities in Alameda County.

The program offers culturally responsive services for immigrants facing challenges with adapting to life in the United States. They provide outreach and educational services, preventive counseling, consultations to organizations and community leaders, and referrals to available resources and social supports that are designed to create ease in the lives of immigrants. The intention of the program is to promote and support social and psychological wellness and healing among Middle Eastern and North African immigrant

[2] https://achcsa.maps.arcgis.com/apps/opsdashboard/index.html#/332a092bbc3641bd9ec8373e7c7b5b3d

communities settling down in Alameda County. Click on the link for more information www.Sidramena.org

This program will be listed in future MHSA Plans under PEI # 9.

## III. INNOVATION (INN)

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

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

The Community Assessment & Treatment Team (CATT) was approved by the MHSOAC on October 25th 2018 and after an in-depth planning process CATT is scheduled for a soft launch on July 20, 2020 with a team in Oakland, San Leandro and Hayward, respectively. An additional team will be launched in Fremont later in 2020. When at full capacity, CATT will have a total of 12 teams in the field 7 days a week from 7am to 11pm. These teams are in addition to the current Mobile Crisis /Mobile Evaluation Teams, (MCT/MET) currently providing mobile crisis services in Alameda County.

CATT is an innovative pilot program created in collaboration with Alameda County Behavioral Health, Alameda County Care Connect, Alameda County Emergency Medical Services, Bonita House Inc. and Falck.

CATT pairs a clinician with an EMT to respond, in a modified Chevy Tahoe, to individuals who are experiencing a crisis due to mental health and or substance use. CATT will provide mental health assessment, crisis intervention, medical assessment, information, referral and transportation to a variety of voluntary settings including, but not limited to, Amber House voluntary Crisis Stabilization Unit/Crisis Residential Treatment (CSU/CRT) facility, Cherry Hill Detox and Sobering Center, Wellness Centers and ACBH Urgent Medication Clinics.

Whenever possible, CATT hopes to divert individuals who are not in need of involuntary hospitalization or an emergency department; however, CATT will be designated to write involuntary psychiatric holds (5150/5585) and transport to emergency departments as necessary.

### b. New INN Programs under Development

ACBH is currently exploring multiple new INN ideas based on the Community Program Planning Process (CPPP) that took place this past spring.

The themes recurring most often include: •Youth/TAY services for addressing trauma, anti-bullying, and violence; • Outreach/Engagement to individuals in social isolation; • Nutrition and mental health; • Housing/homelessness; • Telehealth; • Homecare visits, especially for physically disabled individuals; • Grief and trauma navigation post Covid-19; • Non-traditional led services: faith-based, culturally inclusive, peer led; • Music, dance, arts therapy, and • Asian Pacific Islander (API) and Underserved Ethnic and Language Populations (UELP) programs.

Based on budget and funding, ACBH will be looking to embark on new INN programs in the next year that will provide opportunities to engage more with consumer and family members, local nonprofit stakeholders and our diverse communities here in Alameda County. At the same time, it is important to acknowledge the effects of the pandemic, the extensive unemployment and current social movements. The pandemic has created a new landscape for service delivery with potentially new opportunities for innovation within these identified themes. Telehealth for example has been on the rise since the shelter-in-place order began in March, 2020. INN programming in this area has promise and potential.

## IV. WORKFORCE, EDUCATION, AND TRAINING (WET)

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

### a. Alameda County Loan Repayment Program

The WET unit is excited to be bringing back the Alameda County Loan Repayment Program (ACLRP). This was unfortunately phased out in FY 17/18 when funding from the Office of Statewide Health Planning and Development (OSHPD) was cut. ACBH recognizes the need and importance of this type of financial incentive as a strategy to retain mental health professionals in ACBH who reflect Alameda County's diverse population and share the same ethnic, cultural and language backgrounds of the underserved and unserved communities that ACBH serves.

Awardees may receive up to $10,000 after a twelve (12) month service obligation. Payment will be made directly to the lender(s). This program will be administered through the California Mental Health Services Authority (CalMHSA), and will be launch in July 2020.

### b. Navigator Training Program

Based on the success of the Mental/Behavioral Student Advocacy Training Pilot Program administered through Ohlone College (OC) the ACBH WET unit is continuing to partner with OC to expand this program. The expansion program will be called the Navigator Training Program and will be a one-year pilot initiative inviting participation from all seven community colleges in the county.
Two students will be recruited from each campus to serve as navigators to their peers who would benefit from receiving ongoing care after reaching their maximum number of campus-based sessions, or students who would benefit from a direct referral to a community-based agency because of complex or specialized care needs. Students will engage in an eight-module training program that will equip them with the knowledge, skills, and level of self-efficacy necessary to serve as navigators for their peers to facilitate continuity of care.

## V. CAPITAL FACILITIES AND TECHNOLOGICAL NEEDS (CFTN)

### a. African American Wellness Hub Complex

ACBH is excited to begin work on the development of an African American Wellness Hub Complex. This Complex will be developed over the next three years and will be a beacon of hope and energy for the African American community in Alameda County. Currently ACBH has budgeted $2 million/year for

three years for a total of $6 million dollars. ACBH staff are working closely with community consultants and the Alameda County General Services Agency department.

More information will be available on the progress of the land purchase or building purchase/renovation as it becomes available and will be posted on the MHSA website and in the FY 21/22 MHSA Plan Update.

### b. MHSA Technology Project

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

The request for proposal (RFP) for the *billing section* of the EHR will post on August 3rd. More information will be shared with the community when available.

# Funding Summary

County: Alameda

Date: 8/7/20

| | MHSA Funding | | | | | |
|---|---|---|---|---|---|---|
| | A | B | C | D | E | F |
| | Community Services and Supports | Prevention and Early Intervention | Innovation | Workforce Education and Training | Capital Facilities and Technological Needs | Prudent Reserve |
| **A. Estimated FY 2020/21 Funding** | | | | | | |
| 1. Estimated Unspent Funds from Prior Fiscal Years | 52,584,318 | 600,852 | 14,051,382 | 0 | 1,624,120 | |
| 2. Estimated New FY2020/21 Funding | 62,168,462 | 15,542,116 | 4,090,030 | | | |
| 3. Transfer in FY2020/21[a/] | (12,446,140) | | | 3,185,448 | 9,260,692 | |
| 4. Access Local Prudent Reserve in FY2020/21 | | | | | | 0 |
| 5. Estimated Available Funding for FY2020/21 | 102,306,640 | 16,142,968 | 18,141,413 | 3,185,448 | 10,884,812 | |
| **B. Estimated FY2020/21 MHSA Expenditures** | 93,786,736 | 16,004,524 | 5,618,550 | 3,185,448 | 10,884,812 | |
| **C. Estimated FY2021/22 Funding** | | | | | | |
| 1. Estimated Unspent Funds from Prior Fiscal Years | 8,519,905 | 138,443 | 12,522,862 | (0) | (0) | |
| 2. Estimated New FY2021/22 Funding | 56,470,720 | 14,117,680 | 3,715,179 | | | |
| 3. Transfer in FY2021/22[a/] | (3,409,229) | | | 1,395,059 | 2,014,170 | |
| 4. Access Local Prudent Reserve in FY2021/22 | | | | | | 0 |
| 5. Estimated Available Funding for FY2021/22 | 61,581,396 | 14,256,123 | 16,238,042 | 1,395,059 | 2,014,170 | |
| **D. Estimated FY2021/22 Expenditures** | 59,705,128 | 14,088,884 | 5,218,550 | 1,395,059 | 2,014,170 | |
| **E. Estimated FY2022/23 Funding** | | | | | | |
| 1. Estimated Unspent Funds from Prior Fiscal Years | 1,876,268 | 167,239 | 11,019,491 | (0) | 0 | |
| 2. Estimated New FY2022/23 Funding | 42,339,619 | 10,584,905 | 2,785,501 | | | |
| 3. Transfer in FY2022/23[a/] | (2,351,843) | | | 1,095,059 | 1,256,784 | |
| 4. Access Local Prudent Reserve in FY2022/23 | | | | | | 0 |
| 5. Estimated Available Funding for FY2022/23 | 41,864,044 | 10,752,144 | 13,804,993 | 1,095,059 | 1,256,784 | |
| **F. Estimated FY2022/23 Expenditures** | 41,327,352 | 10,621,259 | 4,980,550 | 1,095,059 | 1,256,784 | |
| **G. Estimated FY2022/23 Unspent Fund Balance** | 536,691 | 130,884 | 8,824,442 | (0) | 0 | |

| **H. Estimated Local Prudent Reserve Balance** | |
|---|---|
| 1. Estimated Local Prudent Reserve Balance on June 30, 2020 | 14,593,038 |
| 2. Contributions to the Local Prudent Reserve in FY 2020/21 | 0 |
| 3. Distributions from the Local Prudent Reserve in FY 2020/21 | 0 |
| 4. Estimated Local Prudent Reserve Balance on June 30, 2021 | 14,593,038 |
| 5. Contributions to the Local Prudent Reserve in FY 2021/22 | 0 |
| 6. Distributions from the Local Prudent Reserve in FY 2021/22 | 0 |
| 7. Estimated Local Prudent Reserve Balance on June 30, 2022 | 14,593,038 |
| 8. Contributions to the Local Prudent Reserve in FY 2022/23 | 0 |
| 9. Distributions from the Local Prudent Reserve in FY 2022/23 | 0 |
| 10. Estimated Local Prudent Reserve Balance on June 30, 2023 | 14,593,038 |

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

# Community Services and Supports (CSS) Component Worksheet

County: Alameda Date: 8/7/20

| | | Fiscal Year 2020/21 | | | | | |
|---|---|---|---|---|---|---|---|
| | | A | B | C | D | E | F |
| | | Estimated Total Mental Health Expenditures | Estimated CSS Funding | Estimated Medi-Cal FFP | Estimated 1991 Realignment | Estimated Behavioral Health Subaccount | Estimated Other Funding |
| **FSP Programs** | | | | | | | |
| FSP 3 | Support Housing for TAY (STAY) | 2,969,073 | 1,643,085 | 1,325,988 | | | |
| FSP 4 | Greater Hope Project | 4,398,759 | 2,434,273 | 1,964,486 | | | |
| FSP 7 | SSI Advocacy & Support Services | 2,492,225 | 1,989,218 | 503,007 | | | |
| FSP 10 | Housing Services | 13,801,188 | 12,981,991 | 819,197 | | | |
| FSP 11 | Community Conservatorship | 1,191,636 | 774,563 | 417,073 | | | |
| FSP 12 | Assisted Outpatient Treatment | 123,450 | 80,243 | 43,208 | | | |
| FSP 13 | CHANGES | 2,974,107 | 2,974,107 | 0 | | | |
| FSP 14 | STRIDES - Adult FSP | 2,974,105 | 2,974,105 | 0 | | | |
| FSP 16 | Connections 0-8 | 734,580 | 734,580 | 0 | | | |
| FSP 17 | East Bay Wrap 8-18 | 735,585 | 478,130 | 257,455 | | | |
| FSP 18 | Homeless Engagement Action Team (HEAT) | 4,398,760 | 4,398,760 | 0 | | | |
| FSP 19 | No. Co. Senior Homeless | 2,905,008 | 2,905,008 | 0 | | | |
| FSP 20 | Lasting Independence Forensic Team (LIFT) | 2,969,072 | 2,969,072 | 0 | | | |
| FSP 21 | Prevention, Advocacy, Innovation, Growth, and Empowerment (PAIGE) | 1,484,534 | 1,484,534 | 0 | | | |
| FSP 22 | Justice and Mental Health Recovery (JMHR) | 4,257,760 | 3,841,620 | 416,140 | | | |
| **Non-FSP Programs** | | | | | | | |
| OESD 4a | Mobile Integrated Assess Team for Seniors | 647,453 | 387,112 | 260,341 | | | |
| OESD 5a | Crisis Response Program - Capacity for Valley and Tri-City | 2,935,937 | 1,577,151 | 1,358,787 | | | |
| OESD 7 | MH Court Specialist Program | 510,391 | 264,383 | 246,008 | | | |
| OESD 8 | Juvenile Justice Transformation of Guidance Clinic | 492,235 | 254,978 | 237,257 | | | |
| OESD 9 | Multisystemic Therapy | 878,823 | 539,597 | 339,226 | | | |
| OESD 11 | Crisis Stabilization Service | 9,842,446 | 6,397,590 | 3,444,856 | | | |
| OESD 14 | Staffing to Asian Population | 2,188,896 | 1,659,404 | 529,492 | | | |
| OESD 15 | Staffing to Latino Population | 828,277 | 625,086 | 203,191 | | | |
| OESD 17 | Residential Treatment for Co-occurring Disorders | 950,176 | 356,316 | 593,860 | | | |
| OESD 18 | Wellness Center | 6,920,044 | 5,731,123 | 1,188,921 | | | |
| OESD 19 | Medication Support Services | 3,747,409 | 1,834,067 | 1,913,342 | | | |
| OESD 20 | Individual Placement Services | 3,866,353 | 2,131,311 | 1,735,042 | | | |
| OESD 22 | Planning African American Wellness Hub Complex | 313,253 | 313,253 | 0 | | | |
| OESD 23 | Crisis Residential Svc | 1,642,071 | 1,582,688 | 59,382 | | | |
| OESD 24 | Schreiber Center | 408,914 | 408,914 | 0 | | | |
| OESD 25 | BH-Primary Care Integration Project | 6,312,229 | 6,024,453 | 287,775 | | | |
| OESD 26A | Culturally Responsive Treatment programs for the African American Community, Medication Training | 334,581 | 334,581 | 0 | | | |
| OESD 26B | African American Reentry MH | 386,481 | 386,481 | 0 | | | |
| OESD 27 | In-Home Outreach Team | 2,908,629 | 2,643,484 | 265,145 | | | |
| OESD 28 | SAGE Case & Care Management | 2,569,040 | 1,669,876 | 899,164 | | | |
| OESD 29 | Older Adult Service Team | 1,063,845 | 1,063,845 | 0 | | | |
| OESD 30 | Peer Respite | 1,023,101 | 1,023,101 | 0 | | | |
| OESD 31 | 1st Onset | 1,340,001 | 868,589 | 471,412 | | | |
| OESD 32 | Suicide Prevention Crisis Line | 275,165 | 275,165 | 0 | | | |
| OESD 33 | Deaf Community Counseling Services | 297,752 | 193,539 | 104,213 | | | |
| OESD 34 | School-Based Behavioral Health | 1,359,621 | 1,234,081 | 125,540 | | | |
| OESD 35 | Community-Based Mental Health Outreach & Consultation | 1,856,779 | 1,819,737 | 37,042 | | | |
| OESD 36 | Presumptive Transfer Project | 762,973 | 762,973 | 0 | | | |
| **CSS Administration** | | 12,456,998 | 8,760,567 | 3,696,430 | | | |
| **CSS MHSA Housing Program Assigned Funds** | | 0 | | | | | |
| **Total CSS Program Estimated Expenditures** | | 117,529,714 | 93,786,736 | 23,742,978 | 0 | 0 | 0 |
| **FSP Programs as Percent of Total** | | 51.6% | 85,026,168 | | | | |

# Community Services and Supports (CSS) Component Worksheet (contd.)

County: Alameda Date: 8/7/20

| | | Fiscal Year 2021/22 | | | | | |
|---|---|---|---|---|---|---|---|
| | | A | B | C | D | E | F |
| | | Estimated Total Mental Health Expenditures | Estimated CSS Funding | Estimated Medi-Cal FFP | Estimated 1991 Realignment | Estimated Behavioral Health Subaccount | Estimated Other Funding |
| **FSP Programs** | | | | | | | |
| FSP 3 | Support Housing for TAY (STAY) | 1,469,073 | 768,085 | 700,988 | | | |
| FSP 4 | Greater Hope Project | 2,398,759 | 1,434,273 | 964,486 | | | |
| FSP 7 | SSI Advocacy & Support Services | 2,492,225 | 1,959,666 | 532,559 | | | |
| FSP 10 | Housing Services | 9,117,906 | 8,299,374 | 818,532 | | | |
| FSP 11 | Community Conservatorship | 1,191,636 | 774,563 | 417,073 | | | |
| FSP 12 | Assisted Outpatient Treatment | 123,450 | 80,243 | 43,208 | | | |
| FSP 13 | CHANGES | 1,474,107 | 1,474,107 | 0 | | | |
| FSP 14 | STRIDES - Adult FSP | 1,474,105 | 1,474,105 | 0 | | | |
| FSP 16 | Connections 0-8 | 734,580 | 734,580 | 0 | | | |
| FSP 17 | East Bay Wrap 8-18 | 735,585 | 478,130 | 257,455 | | | |
| FSP 18 | Homeless Engagement Action Team (HEAT) | 2,398,760 | 2,398,760 | 0 | | | |
| FSP 19 | No. Co. Senior Homeless | 1,405,008 | 1,405,008 | 0 | | | |
| FSP 20 | Lasting Independence Forensic Team (LIFT) | 1,469,072 | 1,469,072 | 0 | | | |
| FSP 21 | Prevention, Advocacy, Innovation, Growth, and Empowerment (PAIGE) | 1,184,534 | 1,184,534 | 0 | | | |
| FSP 22 | Justice and Mental Health Recovery (JMHR) | 2,757,760 | 2,280,020 | 477,740 | | | |
| **Non-FSP Programs** | | | | | | | |
| OESD 4a | Mobile Integrated Assess Team for Seniors | 647,453 | 387,112 | 260,341 | | | |
| OESD 5a | Crisis Response Program - Capacity for Valley and Tri-City | 1,435,937 | 802,151 | 633,787 | | | |
| OESD 7 | MH Court Specialist Program | 510,391 | 264,383 | 246,008 | | | |
| OESD 8 | Juvenile Justice Transformation of Guidance Clinic | 492,235 | 254,978 | 237,257 | | | |
| OESD 9 | Multisystemic Therapy | 878,823 | 539,597 | 339,226 | | | |
| OESD 11 | Crisis Stabilization Service | 3,342,446 | 2,172,590 | 1,169,856 | | | |
| OESD 14 | Staffing to Asian Population | 2,126,542 | 1,597,050 | 529,492 | | | |
| OESD 15 | Staffing to Latino Population | 828,277 | 625,086 | 203,191 | | | |
| OESD 17 | Residential Treatment for Co-occurring Disorders | 950,176 | 567,445 | 382,731 | | | |
| OESD 18 | Wellness Center | 6,174,080 | 4,478,755 | 1,695,325 | | | |
| OESD 19 | Medication Support Services | 2,379,543 | 1,505,692 | 873,851 | | | |
| OESD 20 | Individual Placement Services | 1,366,353 | 772,950 | 593,403 | | | |
| OESD 23 | Crisis Residential Svc | 1,142,071 | 1,082,688 | 59,382 | | | |
| OESD 24 | Schreiber Center | 408,914 | 408,914 | 0 | | | |
| OESD 25 | BH-Primary Care Integration Project | 4,021,738 | 3,733,962 | 287,775 | | | |
| OESD 26A | Culturally Responsive Treatment programs for the African American Community, Medication Training | 334,581 | 334,581 | 0 | | | |
| OESD 26B | African American Reentry MH | 386,481 | 386,481 | 0 | | | |
| OESD 27 | In-Home Outreach Team | 2,908,629 | 2,643,484 | 265,145 | | | |
| OESD 28 | SAGE Case & Care Management | 468,854 | 304,755 | 164,099 | | | |
| OESD 29 | Older Adult Service Team | 763,845 | 763,845 | 0 | | | |
| OESD 30 | Peer Respite | 723,101 | 723,101 | 0 | | | |
| OESD 31 | 1st Onset | 840,001 | 543,589 | 296,412 | | | |
| OESD 34 | School-Based Behavioral Health | 1,359,621 | 1,234,081 | 125,540 | | | |
| OESD 35 | Community-Based Mental Health Outreach & Consultation | 1,106,779 | 1,069,737 | 37,042 | | | |
| **CSS Administration** | | 9,065,922 | 6,293,599 | 2,772,323 | | | |
| **CSS MHSA Housing Program Assigned Funds** | | 0 | | | | | |
| **Total CSS Program Estimated Expenditures** | | 75,089,352 | 59,705,128 | 15,384,224 | 0 | 0 | 0 |
| **FSP Programs as Percent of Total** | | 51.0% | | | | | |

# Community Services and Supports (CSS) Component Worksheet (contd.)

County: Alameda Date: 8/7/20

| | | Fiscal Year 2022/23 | | | | | |
|---|---|---|---|---|---|---|---|
| | | A | B | C | D | E | F |
| | | Estimated Total Mental Health Expenditures | Estimated CSS Funding | Estimated Medi-Cal FFP | Estimated 1991 Realignment | Estimated Behavioral Health Subaccount | Estimated Other Funding |
| **FSP Programs** | | | | | | | |
| FSP 3 | Support Housing for TAY (STAY) | 969,073 | 493,085 | 475,988 | | | |
| FSP 4 | Greater Hope Project | 2,298,759 | 1,269,273 | 1,029,486 | | | |
| FSP 7 | SSI Advocacy & Support Services | 2,492,225 | 1,959,666 | 532,559 | | | |
| FSP 10 | Housing Services | 7,457,124 | 6,638,592 | 818,532 | | | |
| FSP 11 | Community Conservatorship | 1,191,636 | 774,563 | 417,073 | | | |
| FSP 12 | Assisted Outpatient Treatment | 123,450 | 80,243 | 43,208 | | | |
| FSP 13 | CHANGES | 974,107 | 974,107 | 0 | | | |
| FSP 14 | STRIDES - Adult FSP | 974,105 | 974,105 | 0 | | | |
| FSP 16 | Connections 0-8 | 734,580 | 734,580 | 0 | | | |
| FSP 17 | East Bay Wrap 8-18 | 735,585 | 478,130 | 257,455 | | | |
| FSP 18 | Homeless Engagement Action Team (HEAT) | 1,398,760 | 1,398,760 | 0 | | | |
| FSP 19 | No. Co. Senior Homeless | 905,008 | 905,008 | 0 | | | |
| FSP 20 | Lasting Independence Forensic Team (LIFT) | 969,072 | 969,072 | 0 | | | |
| FSP 21 | Prevention, Advocacy, Innovation, Growth, and Empowerment (PAIGE) | 684,534 | 684,534 | 0 | | | |
| FSP 22 | Justice and Mental Health Recovery (JMHR) | 1,957,760 | 1,585,020 | 372,740 | | | |
| **Non-FSP Programs** | | | | | | | |
| OESD 4a | Mobile Integrated Assess Team for Seniors | 447,453 | 257,112 | 190,341 | | | |
| OESD 5a | Crisis Response Program - Capacity for Valley and Tri-City | 1,269,059 | 452,773 | 816,287 | | | |
| OESD 7 | MH Court Specialist Program | 310,391 | 201,754 | 108,637 | | | |
| OESD 8 | Juvenile Justice Transformation of Guidance Clinic | 392,235 | 254,953 | 137,282 | | | |
| OESD 9 | Multisystemic Therapy | 578,823 | 344,597 | 234,226 | | | |
| OESD 11 | Crisis Stabilization Service | 3,242,446 | 2,107,590 | 1,134,856 | | | |
| OESD 17 | Residential Treatment for Co-occurring Disorders | 650,176 | 372,445 | 277,731 | | | |
| OESD 18 | Wellness Center | 4,868,646 | 3,575,821 | 1,292,825 | | | |
| OESD 19 | Medication Support Services | 1,929,543 | 1,254,203 | 675,340 | | | |
| OESD 20 | Individual Placement Services | 1,266,353 | 707,950 | 558,403 | | | |
| OESD 23 | Crisis Residential Svc | 1,142,071 | 1,082,688 | 59,382 | | | |
| OESD 24 | Schreiber Center | 408,914 | 408,914 | 0 | | | |
| OESD 25 | BH-Primary Care Integration Project | 2,860,910 | 2,673,134 | 187,775 | | | |
| OESD 26A | Culturally Responsive Treatment programs for the African American Community, Medication Training | 234,581 | 234,581 | 0 | | | |
| OESD 26B | African American Reentry MH | 286,481 | 286,481 | 0 | | | |
| OESD 27 | In-Home Outreach Team | 1,958,629 | 1,763,484 | 195,145 | | | |
| OESD 28 | SAGE Case & Care Management | 368,854 | 239,755 | 129,099 | | | |
| OESD 29 | Older Adult Service Team | 563,845 | 563,845 | 0 | | | |
| OESD 30 | Peer Respite | 523,101 | 523,101 | 0 | | | |
| OESD 31 | 1st Onset | 540,001 | 348,589 | 191,412 | | | |
| OESD 35 | Community-Based Mental Health Outreach & Consultation | 958,687 | 923,113 | 35,574 | | | |
| **CSS Administration** | | 4,356,507 | 2,831,730 | 1,524,778 | | | |
| **CSS MHSA Housing Program Assigned Funds** | | 0 | | | | | |
| **Total CSS Program Estimated Expenditures** | | 53,023,483 | 41,327,352 | 11,696,131 | 0 | 0 | 0 |
| **FSP Programs as Percent of Total** | | 57.7% | | | | | |

# Prevention and Early Intervention (PEI) Component Worksheet

County: Alameda Date:

| | | Fiscal Year 2020/21 | | | | |
|---|---|---|---|---|---|---|
| | | A | B | C | D | E |
| | | Estimated Total Mental Health Expenditures | Estimated PEI Funding | Estimated Medi-Cal FFP | Estimated 1991 Realignment | Estimated Behavioral Health Subaccount |
| **PEI Programs - Prevention** | | | | | | |
| PEI 1A | School-Based Mental Health Consultation in Preschools | 914,449 | 795,685 | 118,764 | | |
| PEI 1B | School-Based MH Access & Linkage in Elementary, Middle, & H | 1,095,155 | 1,095,155 | 0 | | |
| PEI 1C | Early Childhood Mental Health Outreach & Consultation | 380,047 | 300,000 | 80,047 | | |
| PEI 1D | Unaccompanied Immigrant Youth Outreach | 749,901 | 678,510 | 71,391 | | |
| PEI 4 | Stigma & Discrimination Reduction Campaign | 1,420,492 | 1,408,215 | 12,277 | | |
| PEI 5 | Outreach, Education & Consultation for Latino Community | 1,321,958 | 1,026,527 | 295,431 | | |
| PEI 6 | Outreach, Education & Consultation for Asian Pacific Islander | 1,800,869 | 1,572,464 | 228,405 | | |
| PEI 7 | Outreach, Education & Consultation for South Asian/Afghan ( | 1,500,750 | 1,392,726 | 108,024 | | |
| PEI 8 | Outreach, Education & Consultation for Native American Cor | 300,150 | 219,410 | 80,740 | | |
| PEI 9 | Outreach, Education & Consultation for Middle Eastern Comr | 300,150 | 260,530 | 39,620 | | |
| PEI 10 | Outreach, Education & Consultation for African Community | 300,048 | 260,442 | 39,606 | | |
| PEI 12 | Suicide Prevention/Trauma Informed Care | 1,650,406 | 1,604,195 | 46,211 | | |
| PEI 19 | Older Adult Peer Support | 289,515 | 289,515 | 0 | | |
| PEI 20A-E | Culturally Responsive PEI programs for the African American ( | 880,530 | 878,868 | 1,662 | | |
| PEI 22 | LGBT Support Services | 335,821 | 335,821 | 0 | | |
| PEI 24 | Sobrante Park Comm Proj | 350,000 | 350,000 | 0 | | |
| PEI 25 | Trauma Informed Services | 49,850 | 49,850 | 0 | | |
| **PEI Programs - Early Intervention** | | | | | | |
| PEI 3 | Mental Health for Older Adults, Geriatric Assessment & Respo | 971,127 | 525,155 | 445,972 | | |
| PEI 17A-B | TAY Resource Center | 1,015,572 | 1,015,572 | 0 | | |
| | | 0 | | | | |
| | | 0 | | | | |
| | | 0 | | | | |
| | | 0 | | | | |
| | | 0 | | | | |
| | | 0 | | | | |
| | | 0 | | | | |
| | | 0 | | | | |
| | | 0 | | | | |
| | | 0 | | | | |
| | | 0 | | | | |
| **PEI Administration** | | 2,326,687 | 1,945,884 | 380,803 | | |
| **PEI Assigned Funds** | | 0 | | | | |
| **Total PEI Program Estimated Expenditures** | | 17,953,477 | 16,004,524 | 1,948,953 | 0 | 0 |

# Prevention and Early Intervention (PEI) Component Worksheet (contd.)

County: Alameda Date:

| | | Fiscal Year 2021/22 | | | | |
|---|---|---|---|---|---|---|
| | | A | B | C | D | E |
| | | Estimated Total Mental Health Expenditures | Estimated PEI Funding | Estimated Medi-Cal FFP | Estimated 1991 Realignment | Estimated Behavioral Health Subaccount |
| **PEI Programs - Prevention** | | | | | | |
| PEI 1A | School-Based Mental Health Consultation in Preschools | 914,449 | 795,685 | 118,764 | | |
| PEI 1B | School-Based MH Access & Linkage in Elementary, Middle, & | 1,095,155 | 1,095,155 | 0 | | |
| PEI 1C | Early Childhood Mental Health Outreach & Consultation | 380,047 | 299,999 | 80,048 | | |
| PEI 1D | Unaccompanied Immigrant Youth Outreach | 749,901 | 678,510 | 71,391 | | |
| PEI 4 | Stigma & Discrimination Reduction Campaign | 834,405 | 822,128 | 12,277 | | |
| PEI 5 | Outreach, Education & Consultation for Latino Community | 821,958 | 526,527 | 295,431 | | |
| PEI 6 | Outreach, Education & Consultation for Asian Pacific Islande | 1,800,869 | 1,572,464 | 228,405 | | |
| PEI 7 | Outreach, Education & Consultation for South Asian/Afghan | 1,500,750 | 1,392,726 | 108,024 | | |
| PEI 8 | Outreach, Education & Consultation for Native American Cor | 300,150 | 219,410 | 80,740 | | |
| PEI 9 | Outreach, Education & Consultation for Middle Eastern Com | 300,150 | 260,530 | 39,620 | | |
| PEI 10 | Outreach, Education & Consultation for African Community | 300,048 | 260,442 | 39,606 | | |
| PEI 12 | Suicide Prevention/Trauma Informed Care | 1,350,406 | 1,304,195 | 46,211 | | |
| PEI 19 | Older Adult Peer Support | 289,515 | 289,515 | 0 | | |
| PEI 20A-E | Culturally Responsive PEI programs for the African American | 880,530 | 878,868 | 1,662 | | |
| PEI 22 | LGBT Support Services | 335,821 | 335,821 | 0 | | |
| PEI 24 | Sobrante Park Comm Proj | 350,000 | 350,000 | 0 | | |
| **PEI Programs - Early Intervention** | | | | | | |
| PEI 3 | Mental Health for Older Adults, Geriatric Assessment & Respo | 971,127 | 525,155 | 445,972 | | |
| PEI 17A-B | TAY Resource Center | 915,572 | 915,572 | 0 | | |
| | | 0 | | | | |
| | | 0 | | | | |
| | | 0 | | | | |
| | | 0 | | | | |
| | | 0 | | | | |
| | | 0 | | | | |
| | | 0 | | | | |
| | | 0 | | | | |
| | | 0 | | | | |
| | | 0 | | | | |
| | | 0 | | | | |
| | | 0 | | | | |
| **PEI Administration** | | 1,870,823 | 1,566,182 | 304,641 | | |
| **PEI Assigned Funds** | | 0 | | | | |
| **Total PEI Program Estimated Expenditures** | | 15,961,676 | 14,088,884 | 1,872,792 | 0 | 0 |

# Innovations (INN) Component Worksheet

County: Alameda Date: 8/7/20

| | Fiscal Year 2020/21 | | | | | |
|---|---|---|---|---|---|---|
| | A | B | C | D | E | F |
| | Estimated Total Mental Health Expenditures | Estimated INN Funding | Estimated Medi-Cal FFP | Estimated 1991 Realignment | Estimated Behavioral Health Subaccount | Estimated Other Funding |
| **INN Programs** | | | | | | |
| INN 2 Community Assessment & Transport Team | 3,057,358 | 3,057,358 | 0 | | | |
| INN 4 Land Trust | 500,000 | 500,000 | 0 | | | |
| INN 5 Technology Project | 1,794,925 | 1,794,925 | 0 | | | |
| INN 6 INN CPPP Expansion | 178,873 | 116,267 | 62,605 | | | |
| | 0 | | | | | |
| | 0 | | | | | |
| | 0 | | | | | |
| | 0 | | | | | |
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| | 0 | | | | | |
| | 0 | | | | | |
| | 0 | | | | | |
| **INN Administration** | 150,000 | 150,000 | 0 | | | |
| **Total INN Program Estimated Expenditures** | 5,681,156 | 5,618,550 | 62,605 | 0 | 0 | 0 |

County: Alameda Date: 8/7/20

| | Fiscal Year 2021/22 | | | | | |
|---|---|---|---|---|---|---|
| | A | B | C | D | E | F |
| | Estimated Total Mental Health Expenditures | Estimated INN Funding | Estimated Medi-Cal FFP | Estimated 1991 Realignment | Estimated Behavioral Health Subaccount | Estimated Other Funding |
| **INN Programs** | | | | | | |
| INN 2 Community Assessment & Transport Team | 3,057,358 | 3,057,358 | | | | |
| INN 4 Land Trust | 1,000,000 | 1,000,000 | | | | |
| INN 5 Technology Project | 894,925 | 894,925 | | | | |
| INN 6 INN CPPP Expansion | 178,873 | 116,267 | 62,605 | | | |
| | 0 | | | | | |
| | 0 | | | | | |
| | 0 | | | | | |
| | 0 | | | | | |
| | 0 | | | | | |
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| | 0 | | | | | |
| | 0 | | | | | |
| | 0 | | | | | |
| **INN Administration** | 150,000 | 150,000 | 0 | | | |
| **Total INN Program Estimated Expenditures** | 5,281,156 | 5,218,550 | 62,605 | 0 | 0 | 0 |

# Innovations (INN) Component Worksheet (contd.)

County: Alameda

Date: 8/7/20

| | Fiscal Year 2022/23 | | | | | |
|---|---|---|---|---|---|---|
| | A | B | C | D | E | F |
| | Estimated Total Mental Health Expenditures | Estimated INN Funding | Estimated Medi-Cal FFP | Estimated 1991 Realignment | Estimated Behavioral Health Subaccount | Estimated Other Funding |
| **INN Programs** | | | | | | |
| INN 2 Community Assessment & Transport Team | 3,057,358 | 3,057,358 | | | | |
| INN 4 Land Trust | 1,500,000 | 1,500,000 | | | | |
| INN 5 Technology Project | 156,925 | 156,925 | | | | |
| INN 6 INN CPPP Expansion | 178,873 | 116,267 | 62,605 | | | |
| | 0 | | | | | |
| | 0 | | | | | |
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| | 0 | | | | | |
| | 0 | | | | | |
| **INN Administration** | 150,000 | 150,000 | 0 | | | |
| **Total INN Program Estimated Expenditures** | 5,043,156 | 4,980,550 | 62,605 | 0 | 0 | 0 |

# Workforce, Education and Training (WET) Component Worksheet

County: Alameda Date: 8/7/20

| | | Fiscal Year 2020/21 | | | | | |
|---|---|---|---|---|---|---|---|
| | | A | B | C | D | E | F |
| | | Estimated Total Mental Health Expenditures | Estimated WET Funding | Estimated Medi-Cal FFP | Estimated 1991 Realignment | Estimated Behavioral Health Subaccount | Estimated Other Funding |
| **WET Programs** | | | | | | | |
| Action 1 | Workforce Staffing & Support | 739,208 | 480,485 | 258,723 | | | |
| Action 2 | Staff Development, Training/Conference and Consultants | 48,397 | 48,397 | 0 | | | |
| Action 3 | Graduate Internship Program | 91,500 | 91,500 | 0 | | | |
| Action 4 | The ACBHCS Training Institute | 826,558 | 826,558 | 0 | | | |
| Action 5 | Post Graduate Certificate Program | 227,805 | 227,805 | 0 | | | |
| Action 7 | Graduate Intern Stipend Program | 125,000 | 125,000 | 0 | | | |
| Action 8 | Loan Assumption Program | 500,000 | 500,000 | 0 | | | |
| Action 9 | PEER Training & Support | 497,762 | 497,762 | 0 | | | |
| Action 10 | MHSA Support and Public Education Campaign & CBL | 387,941 | 387,941 | 0 | | | |
| | | 0 | | | | | |
| | | 0 | | | | | |
| | | 0 | | | | | |
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| | | 0 | | | | | |
| | | 0 | | | | | |
| **WET Administration** | | 0 | | | | | |
| **Total WET Program Estimated Expenditures** | | 3,444,171 | 3,185,448 | 258,723 | 0 | 0 | 0 |

County: Alameda Date: 8/7/20

| | | Fiscal Year 2021/22 | | | | | |
|---|---|---|---|---|---|---|---|
| | | A | B | C | D | E | F |
| | | Estimated Total Mental Health Expenditures | Estimated WET Funding | Estimated Medi-Cal FFP | Estimated 1991 Realignment | Estimated Behavioral Health Subaccount | Estimated Other Funding |
| **WET Programs** | | | | | | | |
| Action 1 | Workforce Staffing & Support | 739,208 | 480,485 | 258,723 | | | |
| Action 4 | The ACBHCS Training Institute | 189,007 | 189,007 | 0 | | | |
| Action 5 | Post Graduate Certificate Program | 127,805 | 127,805 | 0 | | | |
| Action 8 | Loan Assumption Program | 300,000 | 300,000 | 0 | | | |
| Action 9 | PEER Training & Support | 297,762 | 297,762 | 0 | | | |
| | | 0 | | | | | |
| | | 0 | | | | | |
| | | 0 | | | | | |
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| | | 0 | | | | | |
| | | 0 | | | | | |
| | | 0 | | | | | |
| **WET Administration** | | 0 | | | | | |
| **Total WET Program Estimated Expenditures** | | 1,653,782 | 1,395,059 | 258,723 | 0 | 0 | 0 |

# Workforce, Education and Training (WET) Component Worksheet (contd.)

County: Alameda Date: 8/7/20

| | | Fiscal Year 2022/23 | | | | | |
|---|---|---|---|---|---|---|---|
| | | A | B | C | D | E | F |
| | | Estimated Total Mental Health Expenditures | Estimated WET Funding | Estimated Medi-Cal FFP | Estimated 1991 Realignment | Estimated Behavioral Health Subaccount | Estimated Other Funding |
| **WET Programs** | | | | | | | |
| Action 1 | Workforce Staffing & Support | 739,208 | 480,485 | 258,723 | | | |
| Action 4 | The ACBHCS Training Institute | 189,007 | 189,007 | 0 | | | |
| Action 5 | Post Graduate Certificate Program | 127,805 | 127,805 | 0 | | | |
| Action 9 | PEER Training & Support | 297,762 | 297,762 | 0 | | | |
| | | 0 | | | | | |
| | | 0 | | | | | |
| | | 0 | | | | | |
| | | 0 | | | | | |
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| | | 0 | | | | | |
| | | 0 | | | | | |
| | | 0 | | | | | |
| **WET Administration** | | 0 | | | | | |
| **Total WET Program Estimated Expenditures** | | 1,353,782 | 1,095,059 | 258,723 | 0 | 0 | 0 |

# Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: Alameda Date: 8/7/20

| | Fiscal Year 2020/21 | | | | | |
|---|---|---|---|---|---|---|
| | A | B | C | D | E | F |
| | Estimated Total Mental Health Expenditures | Estimated CFTN Funding | Estimated Medi-Cal FFP | Estimated 1991 Realignment | Estimated Behavioral Health Subaccount | Estimated Other Funding |
| **CFTN Programs - Capital Facilities Projects** | | | | | | |
| CF1 Crisis Residential Treatment & Stabilization Unit | 300,000 | 300,000 | 0 | | | |
| CF2 Respite Bed Expansion | 300,000 | 300,000 | 0 | | | |
| CF3 County Facility Renovation | 950,000 | 950,000 | 0 | | | |
| CF4 Alameda Point Collaborative | 1,500,000 | 1,500,000 | 0 | | | |
| CF5 AA Wellness Hub | 2,000,000 | 2,000,000 | 0 | | | |
| CF6 A Street Shelter Project | 400,000 | 400,000 | 0 | | | |
| | 0 | | | | | |
| | 0 | | | | | |
| | 0 | | | | | |
| | 0 | | | | | |
| **CFTN Programs - Technological Needs Projects** | | | | | | |
| TN1 Behavioral Health Management System | 2,110,016 | 2,110,016 | 0 | | | |
| TN2 Web-based dashboard | 127,000 | 127,000 | 0 | | | |
| TN3 County Equipment & Software Update | 1,722,186 | 1,722,186 | 0 | | | |
| TN4 Consulting Services | 664,980 | 664,980 | 0 | | | |
| | 0 | | | | | |
| | 0 | | | | | |
| | 0 | | | | | |
| | 0 | | | | | |
| | 0 | | | | | |
| | 0 | | | | | |
| **CFTN Administration** | 1,247,124 | 810,630 | 436,493 | | | |
| **Total CFTN Program Estimated Expenditures** | 11,321,305 | 10,884,812 | 436,493 | 0 | 0 | 0 |

County: Alameda Date: 8/7/20

| | Fiscal Year 2021/22 | | | | | |
|---|---|---|---|---|---|---|
| | A | B | C | D | E | F |
| | Estimated Total Mental Health Expenditures | Estimated CFTN Funding | Estimated Medi-Cal FFP | Estimated 1991 Realignment | Estimated Behavioral Health Subaccount | Estimated Other Funding |
| **CFTN Programs - Capital Facilities Projects** | | | | | | |
| | 0 | | | | | |
| | 0 | | | | | |
| | 0 | | | | | |
| | 0 | | | | | |
| | 0 | | | | | |
| | 0 | | | | | |
| | 0 | | | | | |
| | 0 | | | | | |
| | 0 | | | | | |
| | 0 | | | | | |
| **CFTN Programs - Technological Needs Projects** | | | | | | |
| TN1 Behavioral Health Management System | 31,500 | 31,500 | | | | |
| TN2 Web-based dashboard | 97,000 | 97,000 | | | | |
| TN3 County Equipment & Software Update | 822,186 | 822,186 | | | | |
| TN4 Consulting Services | 414,980 | 414,980 | | | | |
| | 0 | | | | | |
| | 0 | | | | | |
| | 0 | | | | | |
| | 0 | | | | | |
| | 0 | | | | | |
| | 0 | | | | | |
| **CFTN Administration** | 997,699 | 648,504 | 349,195 | | | |
| **Total CFTN Program Estimated Expenditures** | 2,363,365 | 2,014,170 | 349,195 | 0 | 0 | 0 |

# Capital Facilities/Technological Needs (CFTN) Component Worksheet (contd.)

County: Alameda Date: 8/7/20

| | Fiscal Year 2022/23 | | | | | |
|---|---|---|---|---|---|---|
| | A | B | C | D | E | F |
| | Estimated Total Mental Health Expenditures | Estimated CFTN Funding | Estimated Medi-Cal FFP | Estimated 1991 Realignment | Estimated Behavioral Health Subaccount | Estimated Other Funding |
| **CFTN Programs - Capital Facilities Projects** | | | | | | |
| | 0 | | | | | |
| | 0 | | | | | |
| | 0 | | | | | |
| | 0 | | | | | |
| | 0 | | | | | |
| | 0 | | | | | |
| | 0 | | | | | |
| | 0 | | | | | |
| | 0 | | | | | |
| | 0 | | | | | |
| **CFTN Programs - Technological Needs Projects** | | | | | | |
| TN1 Behavioral Health Management System | 31,500 | 31,500 | | | | |
| TN2 Web-based dashboard | 97,000 | 97,000 | | | | |
| TN3 County Equipment & Software Update | 64,800 | 64,800 | | | | |
| TN4 Consulting Services | 414,980 | 414,980 | | | | |
| | 0 | | | | | |
| | 0 | | | | | |
| | 0 | | | | | |
| | 0 | | | | | |
| | 0 | | | | | |
| | 0 | | | | | |
| **CFTN Administration** | 997,699 | 648,504 | 349,195 | | | |
| **Total CFTN Program Estimated Expenditures** | 1,605,979 | 1,256,784 | 349,195 | 0 | 0 | 0 |

# Alameda County Profile

## Demographics

Alameda County is the seventh most populous county in California, with the City of Dublin being one of the 15 fastest growing cities in the United States. Compared to neighboring Bay Area counties, Alameda, experienced the highest numeric increase in population from 2018 to 2019 with over 4,500 people and the third highest percent of foreign-born residents (32.4%). Since the 2010 Census, the population has increased 10.70%, the highest of any Bay Area County (**Table 1**).

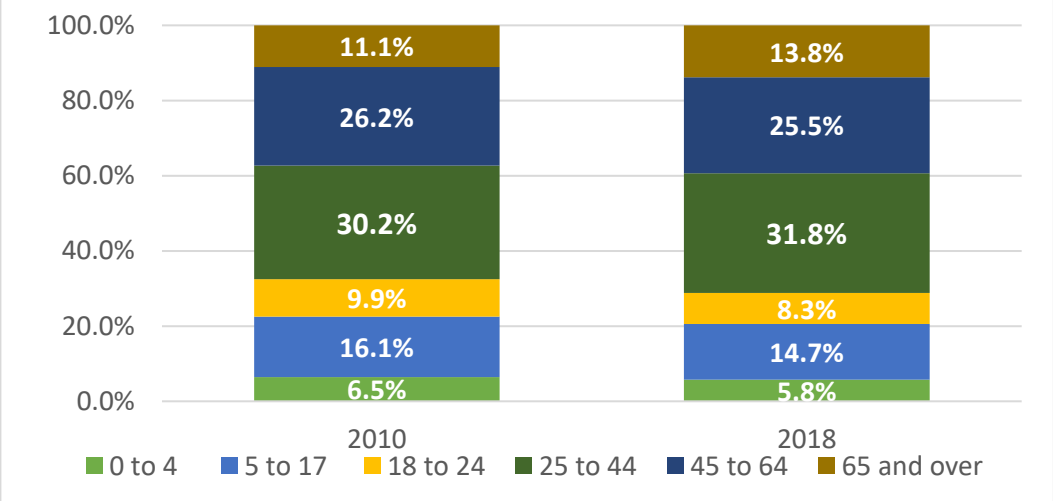
**Table 1: Alameda and Select Bay Ares Counties Population Characteristics**

| Description | Alameda | Contra Costa | Marin | San Francisco | Santa Clara |
|---|---|---|---|---|---|
| Census, April 1, 2010 | **1,510,271** | 1,049,025 | 252,409 | 805,235 | 1,781,642 |
| Estimates base, April 1, 2010, (V2019) | **1,510,271** | 1,049,204 | 252,430 | 805,184 | 1,781,686 |
| Estimates, July 1, 2019, (V2019) | **1,671,329** | 1,153,526 | 258,826 | 881,549 | 1,927,852 |
| Change April 1, 2010 (estimates base) to July 1, 2019, (V2019) | **10.70%** | 9.90% | 2.50% | 9.50% | 8.20% |
| Total change estimates, July 1, 2018 to July 1, 2019 | **4,573** | 3,007 | -836 | 853 | -4,485 |
| Foreign-born residents, percent 2014-2018 | **32.40%** | 25.00% | 18.40% | 34.40% | 38.70% |

Source: 2020 Census Quickfacts and Annual Estimates of the Resident Population for Counties in California: April 1, 2010 to July 1, 2019 (CO-EST2019-ANNRES-06), U.S. Census Bureau, Population Division, Release Date: March 2020

Even though Alameda County is growing in size, the number of children is decreasing and overall the county is aging; according to the Census Bureau the median age has increased from 36.6 in 2010 to 37.7 years in 2018. Between 2010 and 2018 Alameda County was home to fewer children 0 to 4 years old (6.5% to 5.8%), youth 5 to 17 (16.1% to 14.7%), young adults 18 to 24 (9.9% to 8.3%), and adults 45 to 64 (26.2% to 25.5%). The two age groups that increased between 2010 and 2018 were adults 25 to 44 (30.2% to 31.8%) and adults 65 and older (11.1% to 13.8%) (**Figure 1**). Women are 50.8% of the county population and is home to 50,497 Veterans (2014-2018), which is the second-highest number among Bay Area Counties with Santa Clara having the most and Marin having the least.

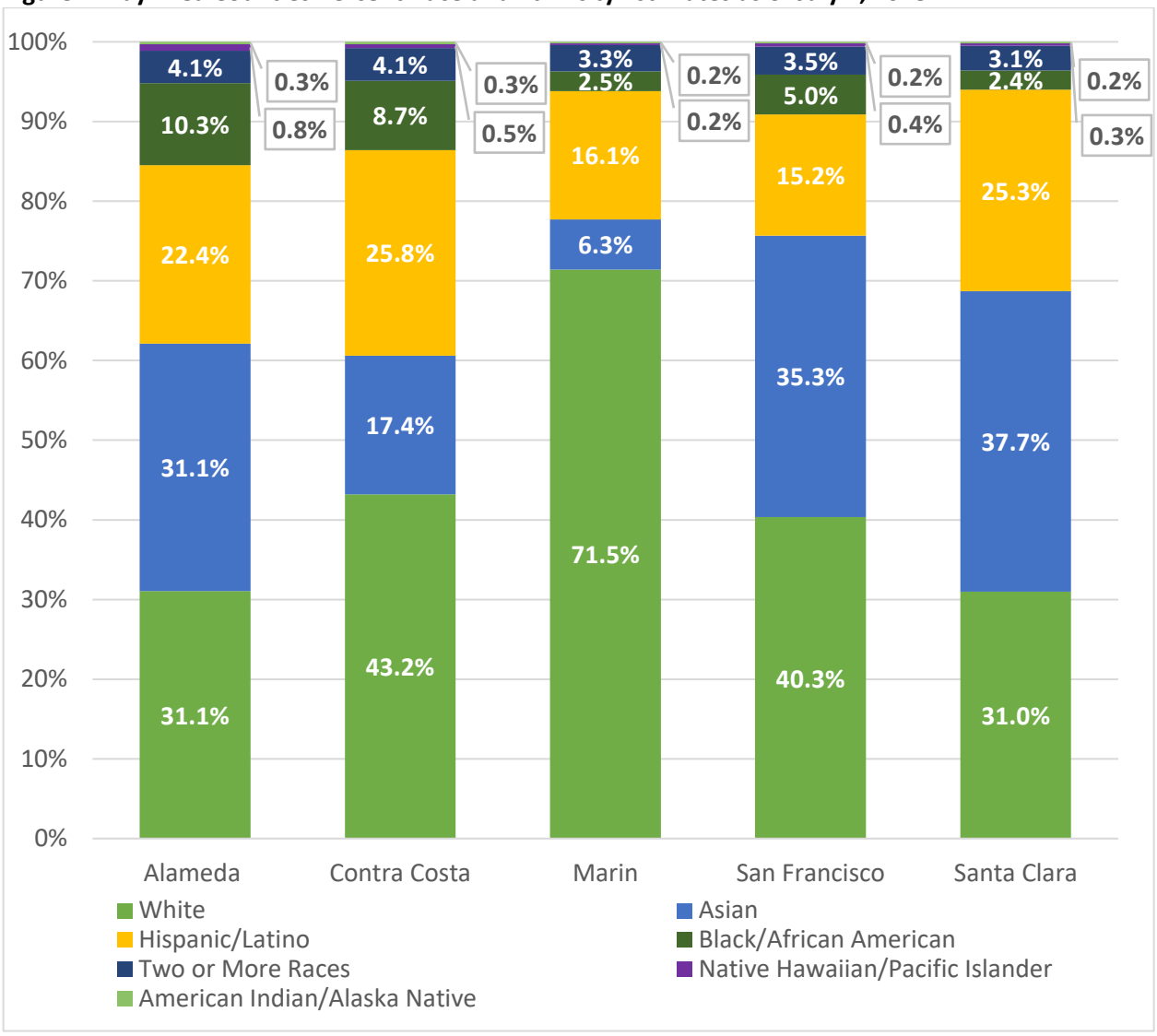
**Figure 1: Alameda County Age Group as a Percentage of Total Population, 2010 v. 2018**




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

Alameda County ranks as one of the most diverse counties, consisting of 31.1% each of White and Asian, 22.4% Hispanic/Latino, 10.3% Black or African American, 4.1% Two or more races, 0.8% Native Hawaiian or Pacific Islander, and 0.3% American Indian or Alaska Native (**Figure 2**). The percent of Asian residents in Alameda County is approximately double the State of California's.

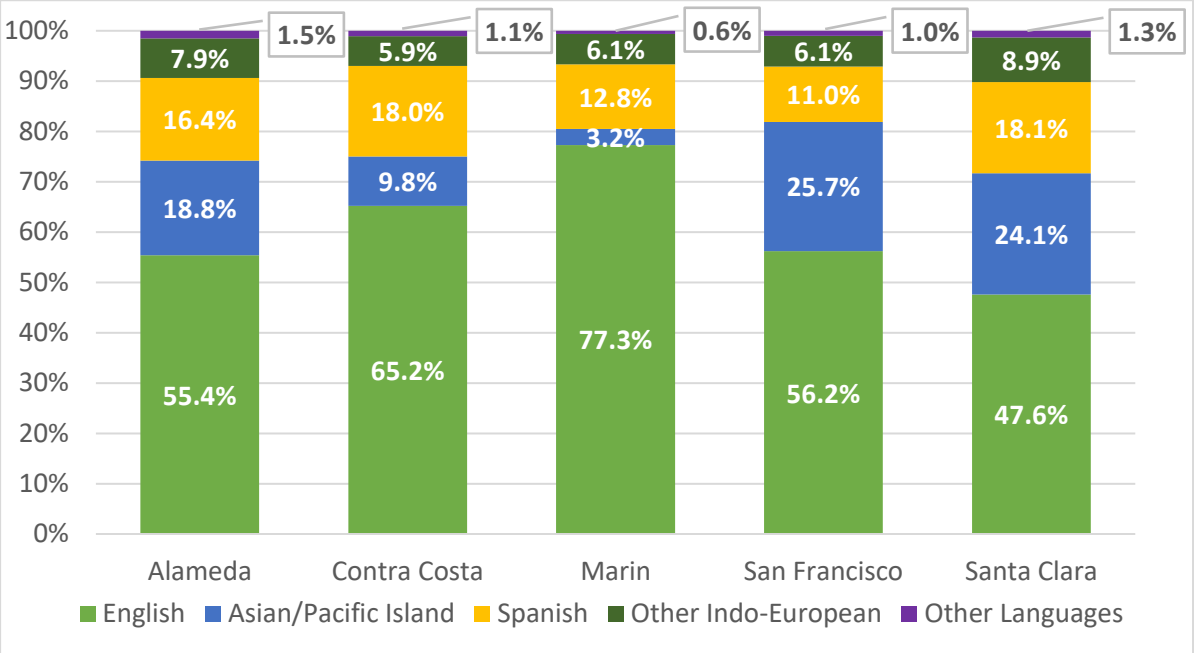
**Figure 2: Bay Area Counties Percent Race and Ethnicity Estimates as of July 1, 2018**




Source: Annual Estimates of the Resident Population for Counties in California: April 1, 2010 to July 1, 2019 (CO-EST2019-ANNRES-06), U.S. Census Bureau, Population Division, Release Date: March 2020

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

**Figure 3: Bay Area Counties Languages Spoken at Home**




Source: 2018 Population Estimates Census, Release date December 2018

## Burden of Poverty

Alameda County Behavioral Health Care Services (ACBH) clients face a variety of challenges around income, housing, and food security. Compared to other Bay Area counties Alameda County residents have the lowest median household and per capita income (**Table 2**). While the median rent is the lowest among the Bay Area Counties, Alameda County has the second highest rental rate compared to Contra Costa, Marin, and Santa Clara counties, meaning a higher percentage of residents do not own a home. Additionally, almost 50% of those that rent spend 30% or more of their income on their rent, this means that the rent they pay is burdensome. Alameda County also has the second highest percent of people in poverty for all ages and for children. The Supplemental Nutrition Assistance Program (SNAP) is a federal program for low-income individuals that provides help with purchasing food and beverages. Even though only 5.2% of Alameda County residents receive SNAP, this is tied for the second highest percent compared to neighboring counties, and ACBH clients report that they do not know where they would go if they needed help with food[1].

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

**Table 2: Poverty Indicators for Bay Area Counties**

| Indicator | Alameda | Contra Costa | Marin | San Francisco | Santa Clara |
|---|---|---|---|---|---|
| Median household income±, 2014-2018 | **$92,574** | $93,712 | $110,217 | $104,552 | $116,178 |
| Per capita income, past 12 months±, 2014-2018 | **$44,283** | $45,524 | $69,275 | $54,157 | $52,451 |
| Median gross rent, 2014-2018 | **$1,674.00** | $1,702.00 | $1,970.00 | $1,805.00 | $2,126.00 |
| Rental Rate, 2014-2018 | **46.7%** | 34.4% | 36.2% | 62.4% | 43.3% |
| Households whose rent is 30% or more of their income | **49.7%** | 53.7% | 55.0% | 37.1% | 47.3% |
| Poverty percent, all ages | **9.0%** | 7.8% | 6.6% | 10.1% | 7.3% |
| Poverty percent, under 18 | **9.8%** | 9.2% | 6.4% | 10.9% | 7.1% |
| Households with SNAP, percent | **5.2%** | 4.7% | 3.9% | 6.5% | 5.2% |

±In 2018 dollars

Sources: Quickfacts 2020, 2018 American Community Survey, and Small Area Income and Poverty Estimates (SAIPE) Program
Release date: December 2019

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

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

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

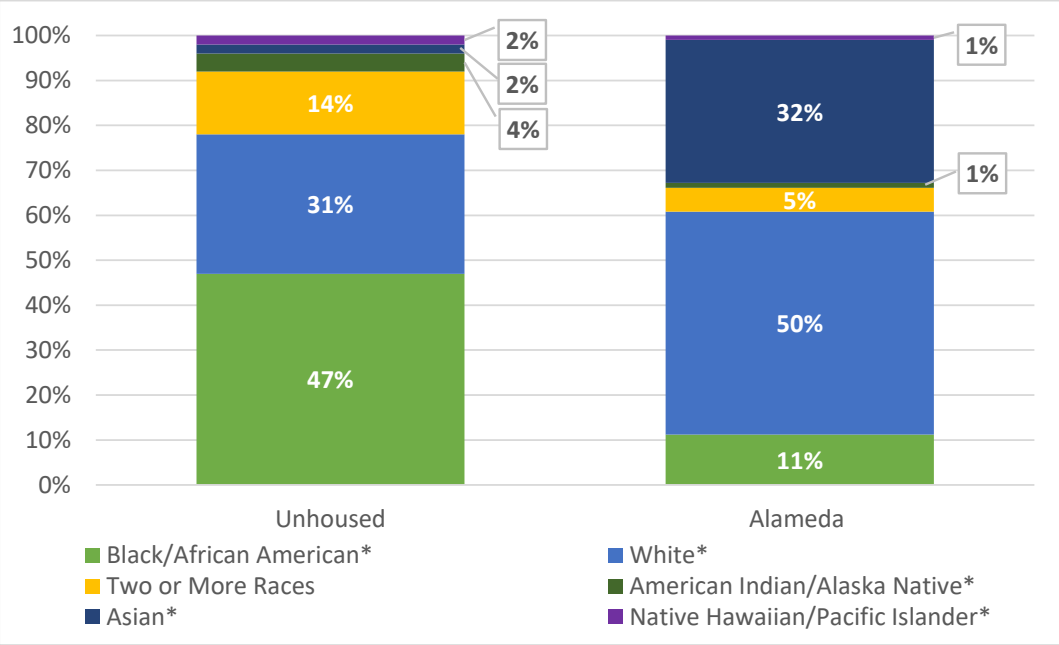
Survey respondents reported the following health conditions: psychiatric/emotional conditions (39%), alcohol and drug use (30%), post-traumatic stress disorder (30%), and traumatic brain injury (13%). Only three percent of respondents were not interested in independent, affordable rental housing or housing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

Multiple populations were overrepresented in the homeless populations, compared to the overall Alameda County population, e.g. veterans (9% versus 5%) and adults with serious mental illness when

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

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

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




*Includes persons reporting only one race
Source: 2020 Census Quickfacts and Alameda County: Homeless Count and Survey Comprehensive Report 2019

## Physical Health

Alameda County has the second lowest life expectancy, at 82.9 years compared to the neighboring counties (range 82.4 - 85.4). Alameda and San Francisco Counties have much higher rates of violent crime than the other neighboring counties. Those without health insurance under the age of 65 (range 4.8% - 5.9%) have similar rates across all neighboring Bay Area Counties. The percent of those under 65 that are disabled, defined as limited or restricted to fully participate in activities at school, home, work, or in their community, is 5.9% (**Table 3**).

**Table 3: Health Indicators for Bay Area Counties**

| Indicator | Alameda | Contra Costa | Marin | San Francisco | Santa Clara |
|---|---|---|---|---|---|
| Life expectancy, years | **82.9** | 82.4 | 85.4 | 83.8 | 84.6 |
| Violent crime rate (per 100,00 people) | **629** | 336 | 178 | 760 | 264 |
| Persons without health insurance, under age 65 years | **5.0%** | 5.9% | 4.8% | 4.8% | 5.1% |
| With a disability, under age 65 years, 2014-2018 | **5.9%** | 7.5% | 5.0% | 5.9% | 4.5% |

Sources: County Health Rankings and QuickFacts 2020

In contrast to life expectancy, Alameda County has the second lowest age-adjusted[12] death rates due to drugs (9.9) or suicide (8.6) per 100,000 when compared to its neighboring counties (**Table 4**). These are lower than the Healthy People 2020 Objective of 11.3 and 10.2 per 100,000, respectively. However, these low rates do not reflect the differences in these rates among different populations in Alameda County. For example, the Centers for Disease Control and Prevention reports that nationally the highest rates of suicide across the life span occur among American Indian/Alaska Natives and Whites. Veterans and sexual minority youth also have higher rates of suicide. Additionally, suicide is the second leading cause of death for those between the ages of 10 to 24 and increased from 6.8 in 2007 to 10.6 per 100,000 in 2017.

**Table 4: Selected Causes of Death, 2015-2017**

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

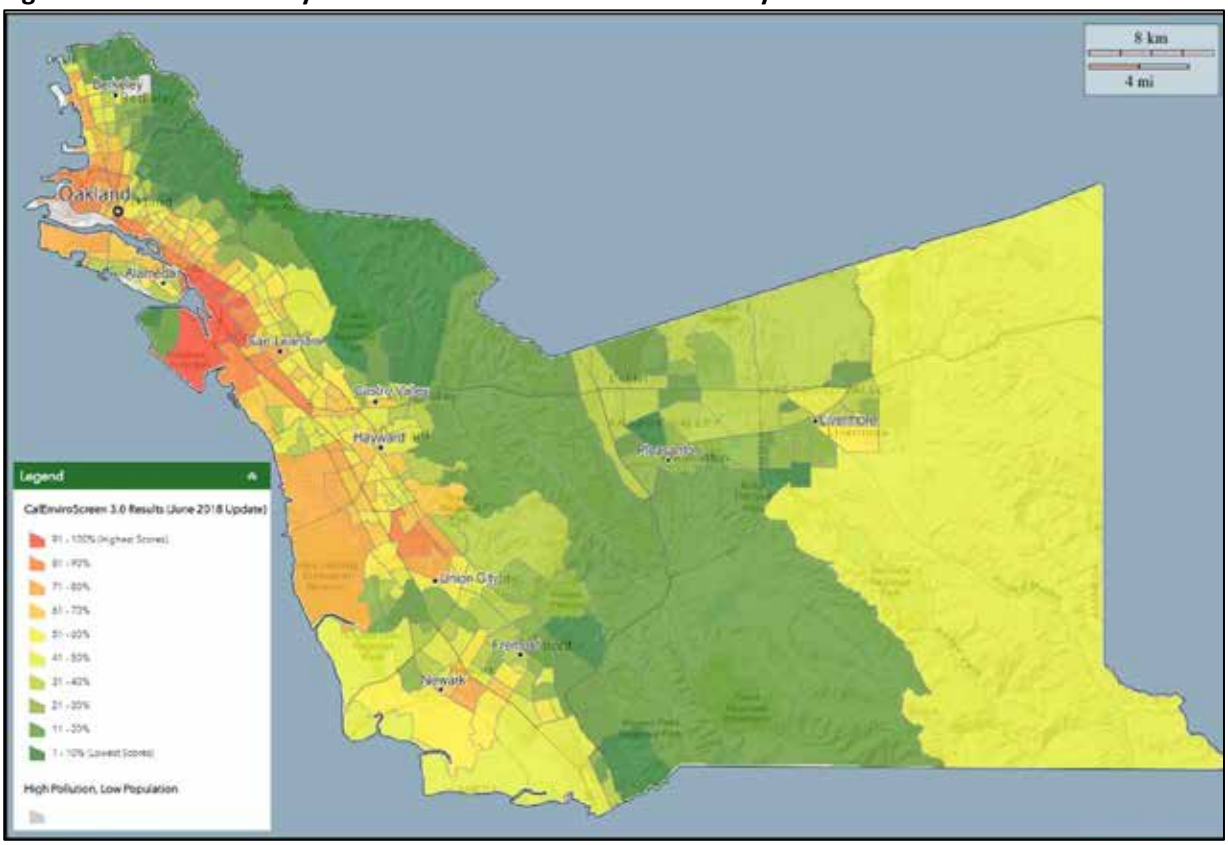
Source: California Department of Public Health, California Comprehensive Master Death Files, [2015-2017] Compiled, August 2018.

## Environmental Health

California's Office of Environmental Health Hazard Assessment has created the CalEnviroScreen 3.0 model[2] to assess pollution burden and population characteristics that increase vulnerability to pollution among census tracts throughout the state. The pollution burden is measured through the averages of environmental exposures and effects. Population Characteristics are measured through the average of sensitive populations and socioeconomic factors components. The total score is calculated by combing the pollution burden and population characteristics. Below is a map of the 2018 CalEnviroScreen results for Alameda County (**Figure 5**). Briefly, the areas with lower burden and vulnerability to pollution are green and the neighborhoods with the highest are red. Areas of Oakland, San Leandro, and Union City have the highest burden of pollution and vulnerability to pollution.

[1] A detailed explanation of the model can be found here: https://oehha.ca.gov/calenviroscreen/scoring-model.
[2] Rates are age-adjusted to correct for the influence of age on health outcomes, allowing counties with different age profiles to be compared.

**Figure 5: Alameda County Burden of Pollution and Vulnerability to Pollution Scores**




## Mental Health

The California Health Interview Survey (CHIS) is conducted continuously through internet and telephone surveys to give a detailed picture of health and the healthcare needs of Californians, this includes a set of questions about mental health. All of the neighboring counties have a similar percent of people that have "likely had psychological distress during the last year" (range 5.7% - 9.6%), however Alameda County has the highest percent of residents reporting distress with 9.6% (**Table 5**). Alameda had the second highest percentage of people that reported a moderate or severe "social life impairment" during the past year (16.2%) and the highest percentage of people who reported that they had "ever seriously thought about committing suicide" (10.5%). In Alameda County, 20.2% of respondents reported that they "needed help for emotional/mental health problems or use of alcohol/drugs" and of those, 66.1% of them reported receiving treatment, which is the second highest percent. The ratio of mental health providers to residents is 160:1 in Alameda County, which makes it in the middle among neighboring counties.

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

| Indicator | Alameda | Contra Costa | Marin | San Francisco | Santa Clara |
|---|---|---|---|---|---|
| Likely has had serious psychological distress in the past year | **9.6%** | 8.8% | 5.7% | 9.1% | 7.1% |
| Moderate or severe social life impairment in the past year | **16.2%** | 15.6% | 12.9% | 18.9% | 12.1% |
| Ever thought about committing suicide | **10.5%** | 10.2% | 8.9% | 13.3% | 8.7% |
| Needed help for emotional/mental health problems or use of alcohol/drugs | **20.2%** | 18.9% | 25.3% | 28.0% | 15.7% |
| Of those that needed help, received treatment for mental/emotional and/or alcohol/drug issues | **66.1%** | 64.3% | 74.7% | 56.7% | 58.0% |
| Mental health providers | **160:1** | 300:1 | 130:1 | 110:1 | 290:1 |

Source: 2015, 2016, 2017, 2018 California Health Interview Survey and County Health Rankings

While Alameda County and neighboring counties are similar on mental health indicators, overall there are inequities in these same measures across racial and ethnic groups in the county (**Table 6**). Whites have highest rates of all the mental health indicators, except needing help for emotional or mental health or alcohol or drugs. Those that are Two or More Races had a much higher percentage reporting that they "needed help for emotional/mental health or alcohol/drugs" (27.9%). Among those that needed help for emotional/mental health problems African Americans were the least likely to receive help (66.5%). These rates do not reflect the role that stigma might play in survey participant's responses that may result in underreporting among certain racial and ethnic groups.

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

| Indicator | Hispanic/Latino | White | African American | Asian | Two or More Races |
|---|---|---|---|---|---|
| Likely has had serious psychological distress in the past year | 7.9% | 8.6% | 8.1% | 5.8% | - |
| Moderate or severe social life impairment in the past year | 12.1% | 17.1% | 15.6% | * | * |
| Ever thought about committing suicide | 6.9% | 13.7% | 8.7% | * | * |
| Needed help for emotional/mental health or alcohol/drugs | 16.5% | 24.0% | 18.6% | 14.4% | 27.9% |
| Of those that needed help, received treatment for mental/emotional and/or alcohol/drug issues | 70.2% | 78.5% | 66.1% | 74.3% | * |

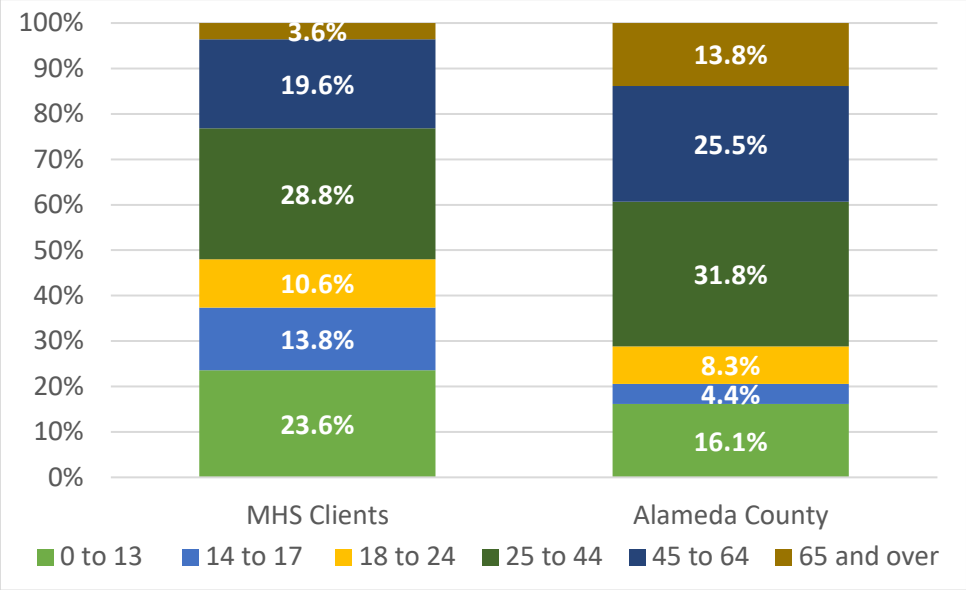
* = suppressed because statistically unstable; -= suppressed due to sample size
Note: American Indian or Alaska Native and Native Hawaiian or Pacific Islander suppressed due to statistically unstable or sample size.
Source: 2012, 2013, 2014, 2015, 2016, 2017, 2018 California Health Interview Survey

## Alameda County Behavioral Health Care Services Utilization

During FY2018/19, ACBH provided behavioral health services to total of 28,636 clients and consumers. Adults 25 and over make up the majority of the consumer population (52.0%). Children and Youth 0 to 13 are 23.6%, teenagers 14 to 17 are 13.8%, and Young Adults 18 to 24 are 10.6% of the clients. ACBH serves more men (54.0%) than women (46.0%). Nationally women have higher rates of any mental illness (22.3% versus 15.1%), severe mental illness (5.7% versus 3.3%), and treatment for mental illness (47.6 versus 34.8)[3].

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

**Figure 6: ACBH Clients and Alameda County Age Groups as a Percentage of the Total Population**




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

**Table 7** shows the mental health services penetration rate by race and ethnicity. The penetration rate is the percentage of eligible Medi-Cal insured individuals who are utilizing mental health services. Despite having the second highest number of beneficiaries, Asians have the lowest penetration rate at 1.1%. Alaska Native/American Indian represent the highest penetration rate (8.3%), with the other rates by race/ethnic groups penetration rates as follows 8.0% of Black/African Americans, 7.5% of Pacific Islanders, 6.4% of Whites, 4.9% of Hispanic/Latinos, and 4.5% of Other/Unknown of Alameda County Medi-Cal beneficiaries.

**Table 7: Fiscal Year 18/19 Alameda County Mental Health Services Medi-Cal Penetration Rate by Race and Ethnicity**

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

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

**Table 8: Fiscal Year 18/19 Alameda County Mental Health Services Medi-Cal Penetration Rate by Language**

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

## COVID-19 in Alameda County

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 June 17, 2020, Alameda County had a total of 4,638 cases and 117 deaths the highest number of cases of any Bay Area county. However, the Alameda's case rate is 282 per 100,000, which is the third highest rate in the bay area, and the death rate is 7.1 per 100,000, which is the second highest (**Table 9**).

**Table 9: Bay Area County's COVID-19 Case and Death Rates**

| Indicator | Alameda | Contra Costa | Marin | San Francisco | Santa Clara |
|---|---|---|---|---|---|
| Number of Cases | **4,638** | 2,111 | 796 | 3,020 | 3,363 |
| Case Rate (per 100,000) | **282** | 186 | 305 | 347 | 175 |
| Number of Deaths | **117** | 55 | 18 | 47 | 152 |
| Death Rate (per 100,000) | **7.1** | 4.9 | 6.9 | 5.4 | 7.9 |

Source: San Francisco Chronicle Coronavirus Tracker, https://projects.sfchronicle.com/2020/coronavirus-map/

Residents of Alameda County are disproportionately affected by the virus. **Table 10** has the cases and deaths by race and ethnicity. The most affected group by far is Hispanic/Latinos which make up 50.5% of the confirmed cases and 28.2% of deaths followed by those of unknown race/ethnicity with 14.9% of cases. In the unlikely scenario that all 666 or 14.9% cases that have unknown race/ethnicity were some other race/ethnicity than Hispanic/Latino they would still have the highest burden of COVID-19 cases in Alameda County. **Figure 6** is a map of the cases in Alameda County by zip code, where the darker the color the higher the case rate. This also reflects the disproportionate burden in Hispanic/Latino neighborhoods.

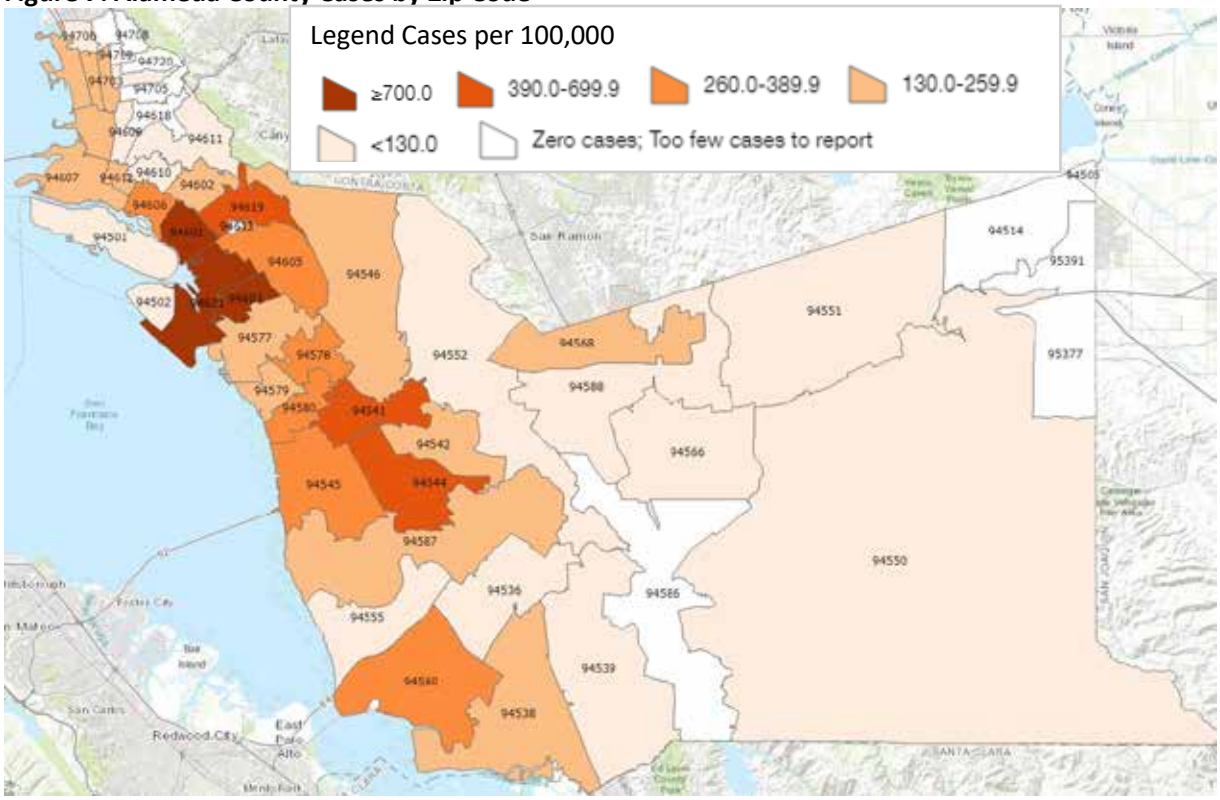
[4] Medi-Cal is called Medicaid nationally. CHIP is the Children's Health Insurance Program. Individuals aged 19 or younger are eligible for this plan.

**Table 10: Alameda County Cases by Race/Ethnicity**

| Race Ethnicity | Cases | Percent Cases | Deaths | Percent Deaths |
|---|---|---|---|---|
| White | 493 | 11.0% | 32 | 27.4% |
| Hispanic/Latino | 2,256 | 50.5% | 33 | 28.2% |
| Asian | 608 | 13.6% | 21 | 17.9% |
| African American/Black | 369 | 8.3% | 26 | 22.2% |
| Pacific Islander | 24 | 0.5% | - | - |
| Native American | 15 | 0.3% | - | - |
| Two or More Races | 37 | 0.8% | - | - |
| Unknown Race/Ethnicity | 666 | 14.9% | * | * |
| Suppressed Race/Ethnicity | N/A | N/A | 5 | 4.3% |
| Total | 4,468 | 100.0% | 117 | 100.0% |

Source: Alameda County Department of Public Health https://ac-hcsa.maps.arcgis.com/apps/opsdashboard/index.html#/1e0ac4385cbe4cc1bffe2cf7f8e7f0d9

**Figure 7: Alameda County Cases by Zip Code**



# MHSA Community Program Planning Process (CPPP)

MHSA Community Program Planning Process And Stakeholder Engagement

WIC Sec 5848 and Sec 3300 state all counties shall partner with stakeholders, including clients and their families, throughout the community input process, and specifically stresses the imprtance of meaningful stakeholder involvement.

The MHSA (MHSA) Community Program Planning Process (CPPP) engaged stakeholders in various outreach efforts, education forums, workgroups, and planning panels for the MHSA Three-Year Plan. Since 2005, over one thousand six hundred Alameda County residents have contributed to the development of all five MHSA component plans through formalized stakeholder meetings, focus groups and planning councils.

During 2020, outreach and community input was solicited from more than 14,069 stakeholders in Alameda County, and resulted in 627 unduplicated survey completions from stakeholders. The process was faciliated by multiple leadership groups consisting of more than fourteen individuals each representing the diversity of consumers, family members, and service providers. Stakeholder leads were provided training on core MHSA elements, policies & procedures, participant expectations, and focus group facilitation. The MHSA Senior Planner provided technical assistance and stipends to consumer stakeholder members for their participation.

## Community Program Planning Process Steering Committee

The MHSA CPPP Steering Committee (MHSA CPPP-SC) was a workgroup established in February 2020 to develop an outreach mobilization strategy for three-year planning activities. In addition to the MHSA Stakeholder Group (MHSA-SG), the MHSA CPPP-SC was leveraged as an additional resource to assure continuity of services and adminsitrative transparency for all community outreach efforts, which included: approving marketing plans, coordinating community focus groups, and approving assessment instruments. The steering group participated in biweekly meetings, and participated in a total of 10 planning sessions during the planning period.

**Table 11: MHSA CPPP Steering Committee Full Membership**

| Full Name | Role/Title | Affiliation |
|---|---|---|
| Mariana Dailey | MHSA Senior Planner/ Trauma Informed Care (TIC) Coordinator | Alameda County Behavioral Health Care Services (ACBH) - MHSA |
| Tracy Hazelton | MHSA Division Director | ACBH - MHSA |
| Mary Hogden | Manager/ Program Specialist | ACBH - Pool of Consumer Champions (POCC) |
| Asa Kamer | Healthcare Policy & Communications Advisor | Alameda County Board of Supervisors (BOS) - District 4 |

| | | |
|---|---|---|
| L.D. Louis | Assistant District Attorney | Alameda County Mental Health Advisory Board (MHAB) |
| Sarah Marxer | Program Evaluation Specialist | Peers Envisioning & Engaging in Recovery Services (PEERS) |
| Cheryl Narvaez | Prevention Specialist | ACBH - MHSA |
| Carly Rachocki | Management Analyst | ACBH - MHSA |
| Kelly Robinson | Prevention & Early Intervention (PEI) Coordinator | ACBH -MHSA |
| Darryl Stewart | Senior Constituent Liaison & Organizer | Alameda County BOS District 4 |
| Colette Winlock | Executive Director | Health & Human Resource Education Center (HHREC) |
| Ava Square | Technical Assistance Program Manager | HHREC |
| Amy Woloszyn | Graphic Designer | Amymade Graphic Design |
| Sally Zinman | Mental Health Advocate | POCC - Public Policy Committee |

## MHSA Stakeholder Engagement

The Ongoing Planning Council (OPC) was the initial stakeholder body which coordinated the first MHSA planning process, developed the MHSA plans, and reviewed the initial program implementation. In 2010, the OPC transitioned to the MHSA Stakeholder Group (MHSA-SG). The mission of the MHSA-SG is to advance the principles of the MHSA and the use of effective practices to assure the transformation of the mental health system in Alameda County. This group of consumers, family members, providers and other key constituencies from the commuity review funded strategies and provide input on current and future funding priorities. The functions of the MHSA-SG include:

- Reviewing the effectiveness of funded strategies;
- Recommending current and future funding priorities;
- Consulting with ACBH and the community on promising approaches that have potential for transforming the mental health systems of care, and
- Communicating with relevant mental health constituencies.

The MHSA-SG strives to maintain a focus on the people being service, while working together with oppenss and mutual respext. The group convenes on a monthly basis, and all meetings are open to the public allowing for significant public comment and discussion (see **Appendix A** for MHSA-SG Meeting Calendar).

During the FY21-23 MHSA planning process, the MHSA-SG expeirenced a 27% increase in memebership, growing from 11 participants to 15 participants (see Table 12). Membership selection is a multi-step process beginning with a Selection Panel consisting of three MHSA-SG members. During FY19/20, the MHSA-SG increased representation of underserved/unserved ethnic groups by 150 percent.

the MHSA-SG reviewed programmatic data, participated and coordinated CPPP focus groups, conducted site visits, provided input on program implementation, and made recommendations for quality improvement.

**Exhibit 2: MHSA-SG Demographics, FY19/20**

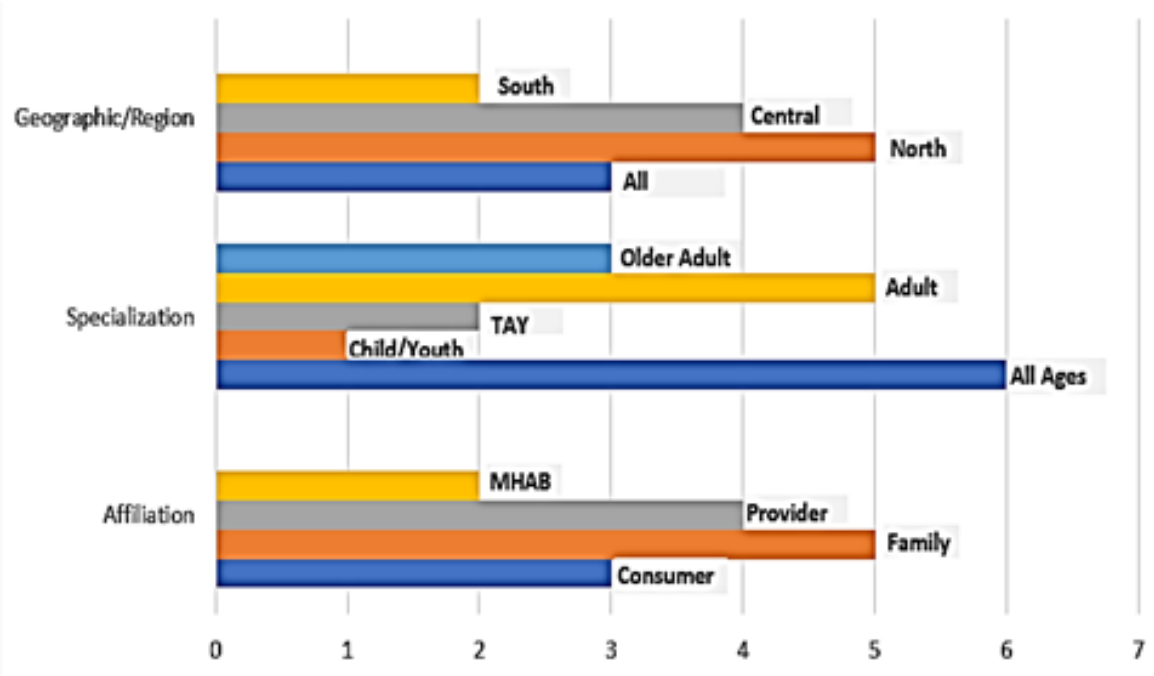



**Table 12: MHSA Stakeholder Group Full Membership**

| Name | | Seat/Role | Title/Affiliation |
|---|---|---|---|
| Annie | Bailey | Provider | Division Administrator, City of Fremont Youth & Family Services Division |
| Viveca | Bradley | Consumer | Mental Health Advocate |
| Jeff | Caiola | Consumer | Recovery Coach |
| Lisa | Carlisle | ACBH – Agency Leadership | Children's System of Care Director |
| Aaron | Chapman | ACBH – Agency Leadership | Medical Director |
| Mariana | Dailey | ACBH | MHSA Senior Planner TIC Coordinator |
| Margot | Dashiell | Family Member | National Alliance on Mental Illness (NAMI), East Bay Facilitator, African American Family Support Group |

| | | | |
|---|---|---|---|
| Tracy | Hazelton | ACBH - Agency Leadership | MHSA Division Director |
| Katherine | Jones | ACBH - Agency Leadership | Adult System of Care Director |
| Janet | King | Provider | Community Relations Coordinator, Native American Health Center |
| Terri | Kennedy | ACBH | MHSA Administrative Assistant |
| L.D. | Louis | MHAB | Vice Chair, MHAB<br>Assistant District Attorney |
| Sarah | Marxer | Family Member | PEERS |
| Imo | Momoh | ACBH - Agency Leadership | Deputy Behavioral Health Director/ Plan Administrator |
| Liz | Rebensdorf | Family Member | NAMI, East Bay |
| Elaine | Peng 彭一玲 | Consumer/ Family Member | NAMI Mental Health Association for Chinese Communities (MHACC) |
| Katy | Polony | Provider | Family Advocate, Abode Services |
| Karyn | Tribble | ACBH - Agency Leadership | Behavioral Health Director |
| Danielle | Vosburg | Provider | Administrator, Telecare Corporation |
| James | Wagner | ACBH | Deputy Behavioral Health Director |
| Mark | Walker | Provider | Associate Director of East Bay Programs, Swords to Plowshares |
| Shawn | Walker-Smith | Family Member | Business Owner |
| Javarre | Wilson | ACBH - Agency Leadership | Ethnic Services Manager |

## Community Input Process

During the FY21-23 MHSA community input process, ACBH staff provided programmatic updates and information on current MHSA programs. Community members provided input on mental health needs and services and submitted 627 unduplicated surveys, and participated in 12 community-based focus groups.

The MHSA community input process was conducted from April 27, 2020 – May 31, 2020. ACBH conducted outreach to providers, consumers, family members and residents of Alameda County. For outreach, ACBH collaborated with the MHSA CPPP-SC consisting of community-based providers,

consumers, family members, and ACBH leadership. The MHSA CPPP-SC collaborated with community-based agency Health & Human Resource Education Center (HHREC), and Alameda County's consumer empowerment group, Pool of Consumer Champions (POCC). More than 14,069 MHSA Community Input Meeting invitations were distributed by mail, listservs, or email to stakeholders, providers, consumers, family members, and other community members.

COVID-19 Impact on Planning Activities

The COVID-19 public health emergency is an urgent threat to extremely vulnerable populations, including people experiencing mental health challenges, homelessness, those living in permanent supportive housing, and mental health providers. COVID-19 produced a variety of challenges to CPPP activities and required an immediate response to address implementation barriers as a result of social distancing regulations and disruptions to programs and services. The MHSA CPPP-SC identified the following key implementation challenges:

- **Administrative barriers:**
  - Communication delays: Public information offices prioritized COVID-19 safety messages and/or participation in emergency response activities.
  - Lack of state guidance related to the MHSA planning process.
  - Resources: Many government agencies, government affiliates, and community providers reported staff shortages related to emergency response deployment, COVID-19 time-off, or noticed a decrease in responsivity.
- **Resource Disparities**
  - A remote/online process required emotional and social resources to know about the information or be affiliated with MHSA service providers.
  - Capacity Building: remote learning requires knowledge and illuminated the need for capacity building.
  - Digital Divide: POCC members reported some consumers lacked the technological capacity or resources to complete online surveys, or used flip phones to collect survey responses.
- **Community Stress**: Requests to prioritize/participate in community planning efforts may not have been client-centered, addressed the immediate needs of the community during a COVID-19 crisis, and could increase stress.

The MHSA CPPP-SC focused on reducing public outreach and awareness campaign barriers related to social vulnerability factors such as poverty, lack of access to technology to complete online surveys (e.g. computer, internet); lack of transportation access to provider sites where surveys were proctored, and fragmented communication and messaging. From April 27, 2020– May 31, 2020, The MHSA CPPP-SC adapted the MHSA public outreach campaign, launched a new community input website resulting in 2,145 new users, coordinated outreach through social media platforms (e.g. Facebook), social justice distributions lists and media outlets (e.g. KPIC, KTVU, and KRON), and hosted teleforums where community members were able to provide remote input in three different ways: 1) online innovations webform, 2) remote focus groups, and 3) online community input surveys which were embedded in electronic palm cards, e-flyers, and proctored by telephone assistants through the Office of Consumer Empowerment. In the midst of COVID-19, MHSA identified key successes related to planning activities, such as:

- **MHSA Staff Support**: The MHSA CPPP-SC highlighted the importance of the MHSA Sr. Planner/MHSA CPPP-SC chair who remained flexible with diverse members and opinions, identified roles & responsibilities, established boundaries, encouraged engagement, championed and increased visibility of efforts, and reduced duplication of efforts.
- **Macro-level Outreach:** The CPPP outreach strategies expanded to included macro-level strategies such as utilizing paid ads on social media platforms; leveraging online ethnic-oriented news outlets (e.g. Bay Area Reporter), posting PSAs on traditional media outlets (KRON, KPIX, KTVU, Tri Valley Paper, Post News group, East Bay Times, Alameda Contra Costa Medical Association newsletters), and utilizing social justice public relations firms to distribute information to thousands of Alameda County residents.
- **Stakeholder Engagement:** The MHSA CPPP-SC leveraged the expertise and knowledge of established and engaged MHSA funded programs, services and stakeholder groups to coordinate planning and outreach strategies.
- P**ool of Consumer Champions**: Trained peer volunteers and partners exhibited ownership of MHSA planning activities, provided community canvassing to help consumers complete surveys, participated in steering committees' workgroups, focus groups, and helped brand outreach activities.
- **COVID-19 Commercial Ads at Transportation Hubs across Alameda County** – A COVID-19 Ad Campaign was launched Late Spring/Summer 2020 as part of a Health Care Services Agency (HCSA) collaboration with Public Health and ACBH. The ads were conceptualized by the Office of Ethnic Services, and addressed pre-existing inequalities across gender, race, ethnic, and other groups which are often exacerbated during a crisis. (see **Appendix B-3**)
- **Trauma Informed Care COVID-19 training assessment** – launched July 2020 and focused on surveying behavioral health system providers to identify COVID-19 policy, planning and training content to address staff competencies related to severe class, gender, and race disparities in relation to COVID-19 (see **Appendix B-4**)

The revised strategy was coordinated in response to COVID-19 barriers and resulted in more than 14,069 Alameda County residents and employees receiving CPPP information. In addition, remote focus group trainings were coordinated for 16 ACBH and community members who facilitated 12 remote focus groups. Twenty-one POCC volunteers were trained to provide telephonic outreach and proctor surveys. Six hundred and twenty-seven unique respondents completed the 2020 MHSA Community Input Survey which was a 14% increase from 2018-20 (N= 550).

**Table 13: FY 21/23 MHSA Community Input Outreach Plan** (See **Appendix B-1** for complete plan)
Outreach Period: April 27, 2020 – May 31,2020

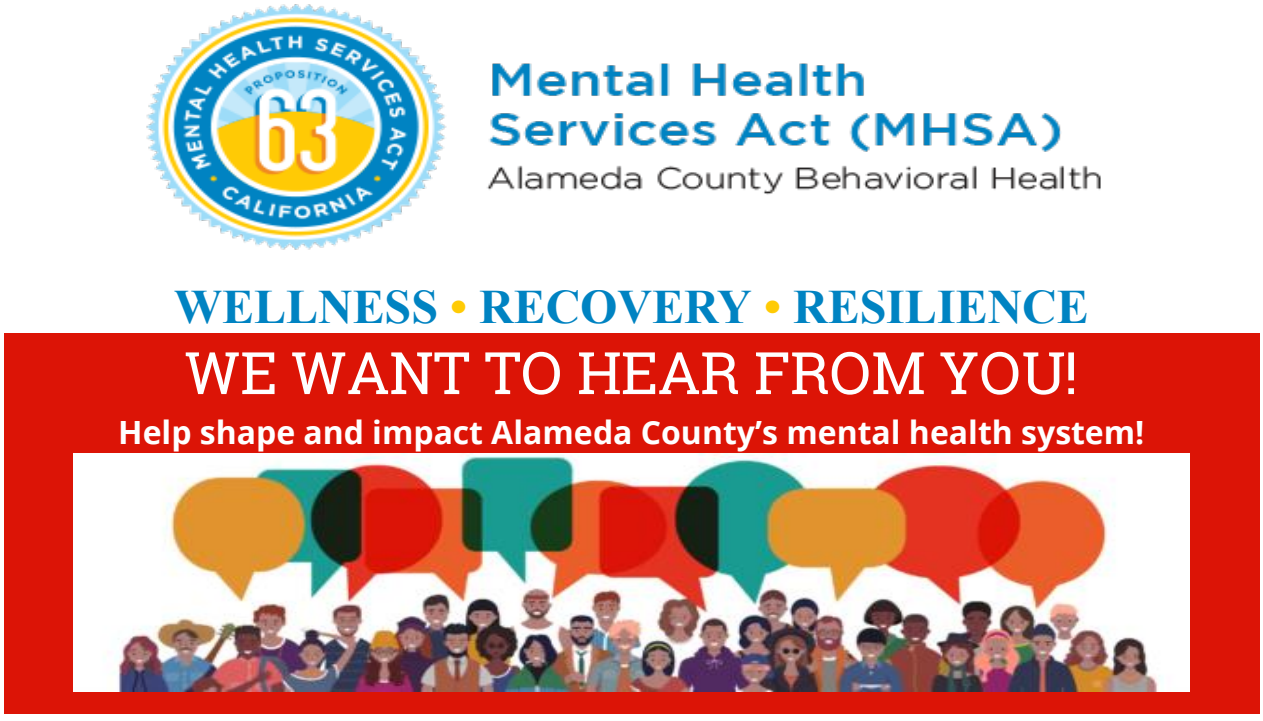
| Community Organization/ Location | Location | Outreach Method |
|---|---|---|
| Alameda County Board of Supervisors | county-wide | Email |
| MHSA Stakeholder Group | county-wide | Email |
| Mental Health Advisory Board (MHAB) | county-wide | Email |

| | | |
|---|---|---|
| Mental Health Assoc. of Alameda County (MHAAC) | county-wide | Email |
| MHAAC Family Caregiver and Advocacy | John George Psychiatric Pavilion | Email |
| NAMI East Bay Family Support Group | Fremont | Email |
| Berkeley Families Support Group | Berkeley | Email |
| Albany Public Library | Albany | Email |
| Berkeley Public Library, all branches (Central, West, South, North, and Claremont) | Berkeley | Email |
| Native American Health Center | Oakland | Email |
| NAMI East Bay and African American Family/Caregiver Support Group | Oakland | Email |
| Filipino Advocates for Justice (FJA) | Oakland/Union City | Email |
| Filipino Mental Health Initiative-Alameda County (FMHA-AC) | Oakland | Email |
| **Community Organization/ Location** | **Location** | **Outreach Method** |
| Family Education and Resource Center (FERC) | Oakland | Email |
| City of Oakland Cultural Funding | Oakland | Email - 55 contributors |
| Bonita House | Oakland | Email |
| LaNiece Jones | Oakland | Email |
| Lesbians of African Descent | ---- | Email |
| Pacific Center | Berkeley | Email |

| | | |
|---|---|---|
| Health Human Resource & Education Center (HHREC) | Oakland | Email/ In Person |
| Helping Hands | Oakland | Email |
| Native American Health Center | Oakland | Email |
| East Bay Agency for Children (EBAC) | Oakland | Email |
| Eden Medical Center, and Board of Mental Health Assoc. Of Alameda County | Castro Valley | Email |
| East Oakland Health Center | East Oakland | In person Invitation |
| St. Mary's Senior Advocates for Hope & Justice | Oakland | Email |
| City of Fremont, Aging & Family Services Division | Fremont | Email |
| Association of Black Psychologists- Bay Area Chapter | --- | Email |
| AECreative Consulting Partners, LLC | Oakland | Email |
| Doctors Without Borders | --- | Email |
| **Community Organization/ Location** | **Location** | **Outreach Method** |
| PEERS | Oakland | Email - 2,500 subscribers |
| San Leandro Main Library | San Leandro | Email |
| Bay Area Reporter | Oakland | Email |
| Oakland Cultural Arts | Oakland | Email |
| Pool of Consumer Champions | Oakland | Email - 1,600 subscribers |
| Allen Temple Church | Oakland | E-mail |

| | | |
|---|---|---|
| Innovations Grantees and Conference Participants | Previous INN Grantees | E-mail Total 750 |
| Alameda County District Attorney's Office | Oakland | Email |
| Alameda County Environmental Services | Oakland | Email |
| Alameda County Probation Department | Oakland | Email |
| Alameda County Public Health | San Leandro | Email |
| ACBH Providers | Providers of Mental Health and Substance Use Disorder services | E-mail |

**Figure 8: MHSA Community Input E-Palm Card and Community Input Website**



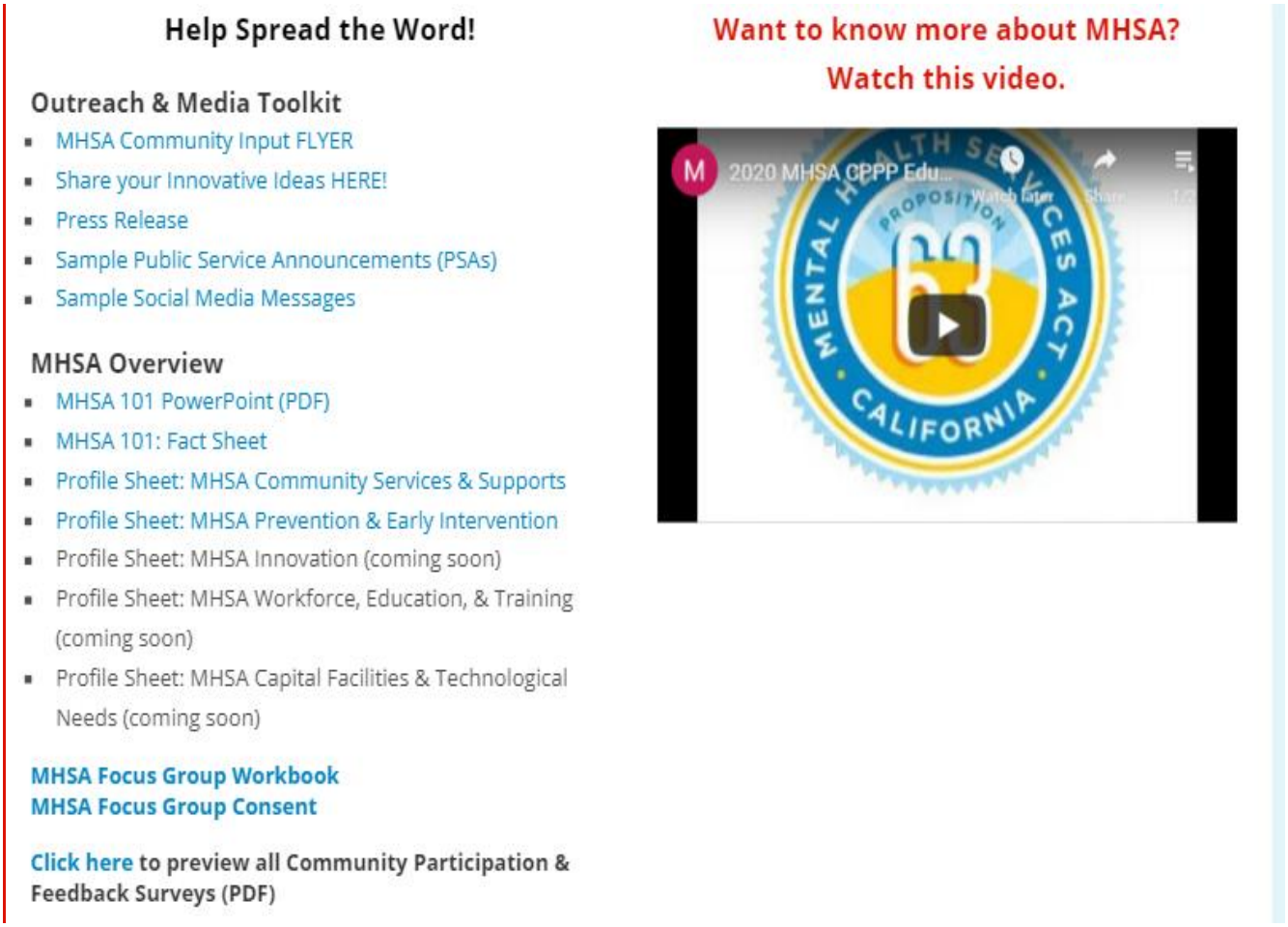
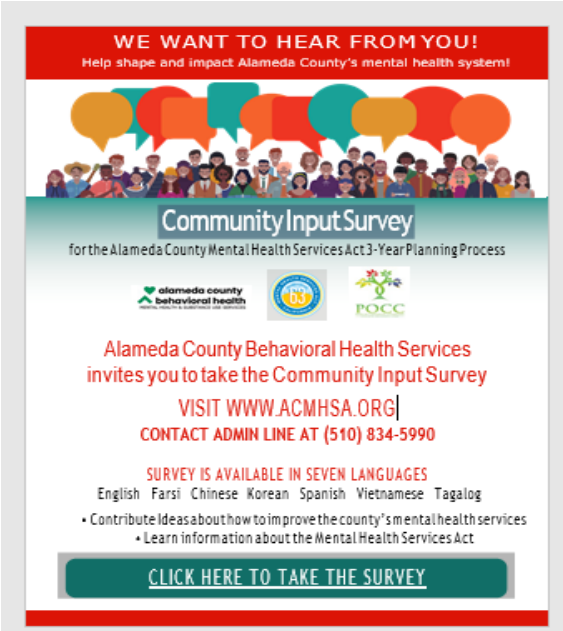



**Figure 9: MHSA Community Input E-Flyer/Palm Card (**see **Appendix B-2, Chinese Translation also developed)**



MHSA Community Input Focus Groups

Twelve focus groups were coordinated and hosted by ACBH, the MHSA CPPP-SM, the Alameda County Mental Health Advisory Board (MHAB), and community-based organizations in which stakeholders provided input on mental health needs, priority underserved populations and mental health services.

The MHSA Division developed a new focus group toolkit consisting of MHSA 101 Fact Sheets, MHSA PowerPoint presentation, Consent Form, and a Focus Group Workbook (includes a standardized Meeting Agenda, Facilitator Guide, and Q&A Sheet to record responses). The toolkit is publicly available on the new MHSA Community Input website (see **Appendix C** for materials). Sixteen ACBH staff and community volunteers participated in remote focus group trainings and facilitated twelve community-based forums.

During the focus groups, MHSA Senior Planner, MHSA Division Director and MHSA CPPP-SC members administered verbal consents and presented information regarding MHSA components and current MHSA-funded services. Focus group participants provided verbal and/or written input on seven questions reflected from the CPPP Survey allowing respondent to identify mental health challenges, prioritize existing services, identify unserved/underserved populations, and recommend future innovative programs and services. Approximately one hundred ninety-seven participated in the MHSA Community Input Focus Groups. Interpreter services were available if requested, and surveys were available in Spanish, Chinese, Korean, Tagalog, Vietnamese, and Farsi.

**Table 14: MHSA Community Input Focus Groups** (Please see **Appendix D** for complete list of recommendations)

| MHSA Focus Group | Description / # Participants | Recommendations |
|---|---|---|
| ACBH Operations Meeting – Leadership | ACBH Executive and expanded leadership members held on 4/6/20, 44 participants | ISSUES: 19<br>RECOMMENDATIONS: 3 |
| Mental Health Services Act Stakeholder Group (MHSA-SG) | 14-member group consists of consumers, family members, and providers from each supervisorial district. The group reviews funded strategies, recommends priorities, and consults with ACBH held on 4/24/20, 11 participants | ISSUES: 12<br>RECOMMENDATIONS: 4 |
| Peers Envisioning and Engaging in Recovery Services (PEERS) Hope & Faith Program | African American and faith-based community members held on 5/12/20 with 7 participants. | ISSUES: 28<br>RECOMMENDATIONS:22 |
| La Clinica de La Raza- Cultura y Bienestar (CyB) | La Clinica-CyB consists of Latinx health educators. The program provides education, consultation, outreach, & mental health services; held on 5/13/20 with 9 participants. | ISSUES: 26<br>RECOMMENDATIONS: 23 |

| | | |
|---|---|---|
| Mental Health Advisory Board (MHAB) General Meeting | Operates under WIC 5600 et seq. And exists to review and evaluate the Alameda County mental health needs, facilities, services, and problems held on 5/18/20 with 19 participants. | ISSUES: 9<br>RECOMMENDATIONS:18 |
| MHAB Children's Advisory Committee | held on 5/20/20 with 34 participants. | ISSUES: 35<br>RECOMMENDATIONS: 26 |
| Underserved Ethnic Language Programs (UELP) | API & east bay immigrant/refugee providers & advocates on 5/22/20 with 13 participants. | ISSUES: 28<br>RECOMMENDATIONS: 18 |
| MHAB Adult Committee | Older adults held on 5/26/20 with 5 participants. | ISSUES: 5<br>RECOMMENDATIONS: 10 |
| Health & Human Resource Education Center (HHREC) and the Office of Ethnic Services – LGBTQI2S Communities | Providers who serve consumers with developmental disabilities and mental illness Providers for LGBTQQIA+ Community held on 5/27/20 with 6 participants. | ISSUES: 19<br>RECOMMENDATIONS: 26 |
| MHAB Criminal Justice Committee | Held on 5/27/20 with 10 participants | ISSUES: 17<br>RECOMMENDATIONS: 15 |
| Pool of Consumer Champions (POCC) Public Policy Education Committee & CAMHPRO: "Have Your Voice heard on Innovations for Alameda County" Webinar | Members provide education on public policy involving mental health and public policy processes held on 5/27/20 with 28 participants. | ISSUES: N/A<br>RECOMMENDATIONS:11 |
| Office of Family Empowerment-Family Dialogue Group | Participants represent family members of consumers and family member advocacy groups (e.g. NAMI, VOMA, FASMI) and provide input on program, policy ,and administrative decisions. Held on 7/23/20 with 12 participants | ISSUES: 54<br>RECOMMENDATIONS: 22 |
| **12 Focus Group Meetings** | **Total number participants: 198** | |

# MHSA Community Input Survey Results

During the community input period of April 27, 2020 – May 31, 2020, community members were asked to complete a 23-question survey that was hosted on SurveyMonkey and linked to the MHSA website. The survey was available in English, Chinese, Spanish, Farsi, Korean, Tagalog, and Vietnamese, seven of Alameda County's threshold languages. A total of 627 unduplicated surveys were completed, while the survey was translated into 6 non-English languages over 90% of the surveys were English (**Table 16**). The following sections detail the demographics of survey participants and the results of the survey.

**Table 15: Number of Survey Respondents by Survey Language**

| Survey Languages | Number of Responses |
|---|---|
| 1. English | 587 |
| 2. Chinese | 31 |
| 3. Spanish | 9 |
| **Total** | **627** |

## Demographics

Survey participants were mostly adults aged 26-59 (68.58%), older adults 60 and over (24.08%), and Female (69.38%) (**Figures 10 and 11**). Compared to the general Alameda County population these three groups are overrepresented among the survey participants (**Figure 1**).

**Figure 10: Participant's Age Groups (n=627)**

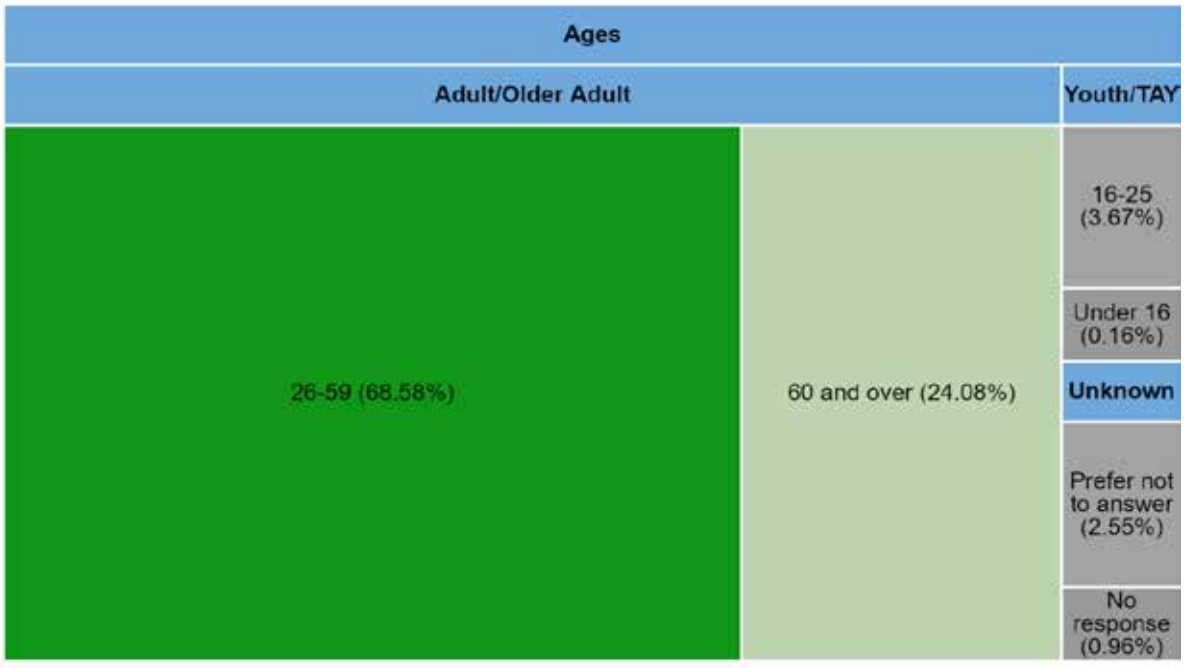
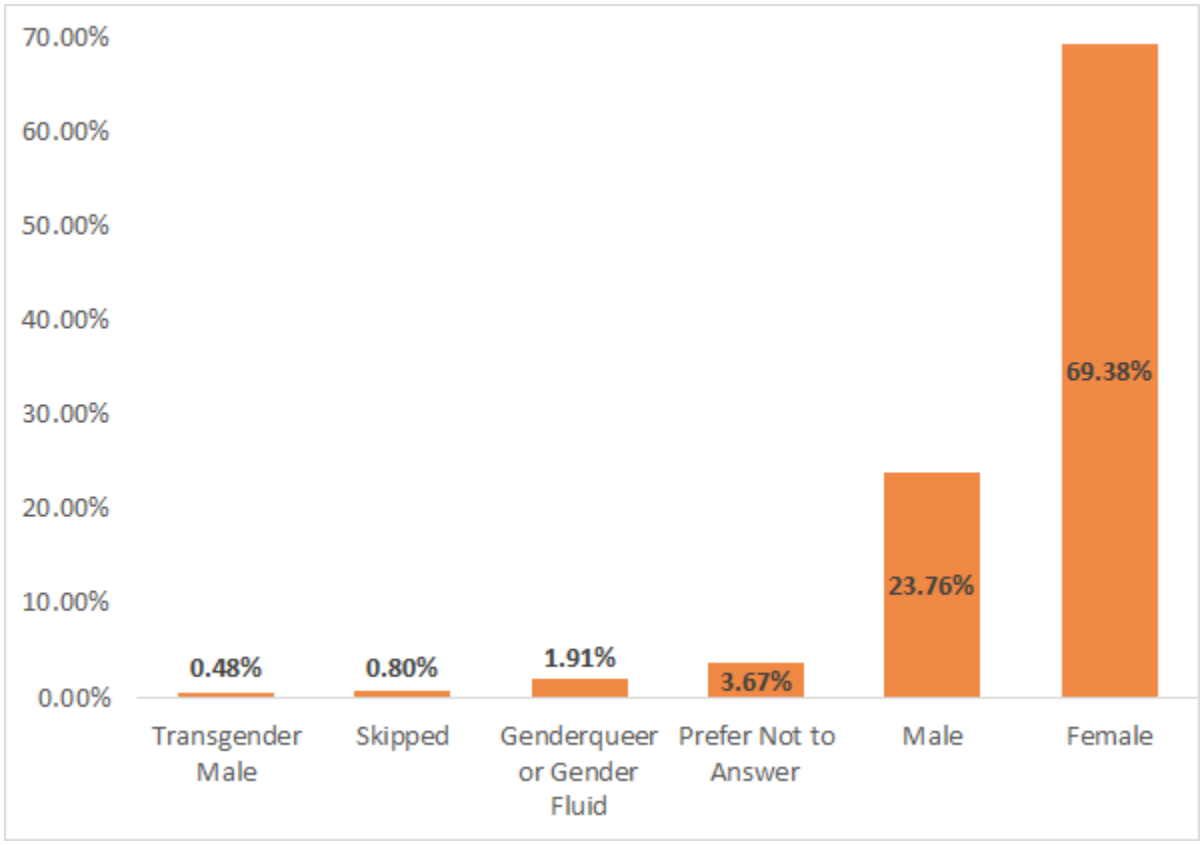


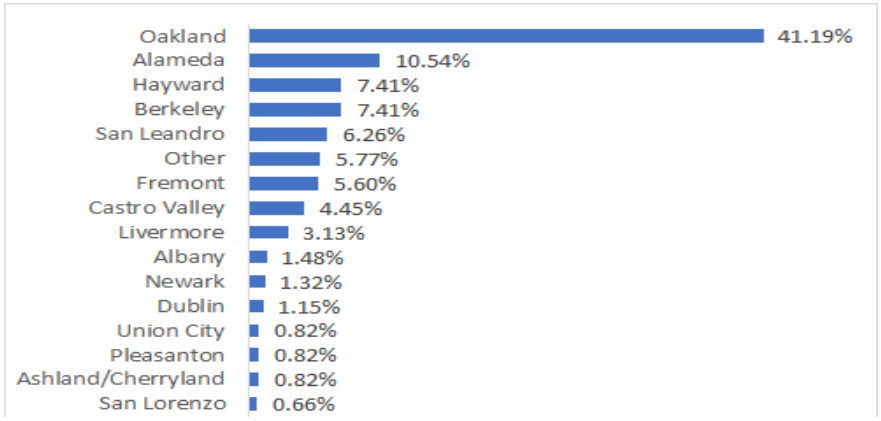
**Figure 11: Participant's Gender Identity (n=627)**




*No Transgender Female participants.

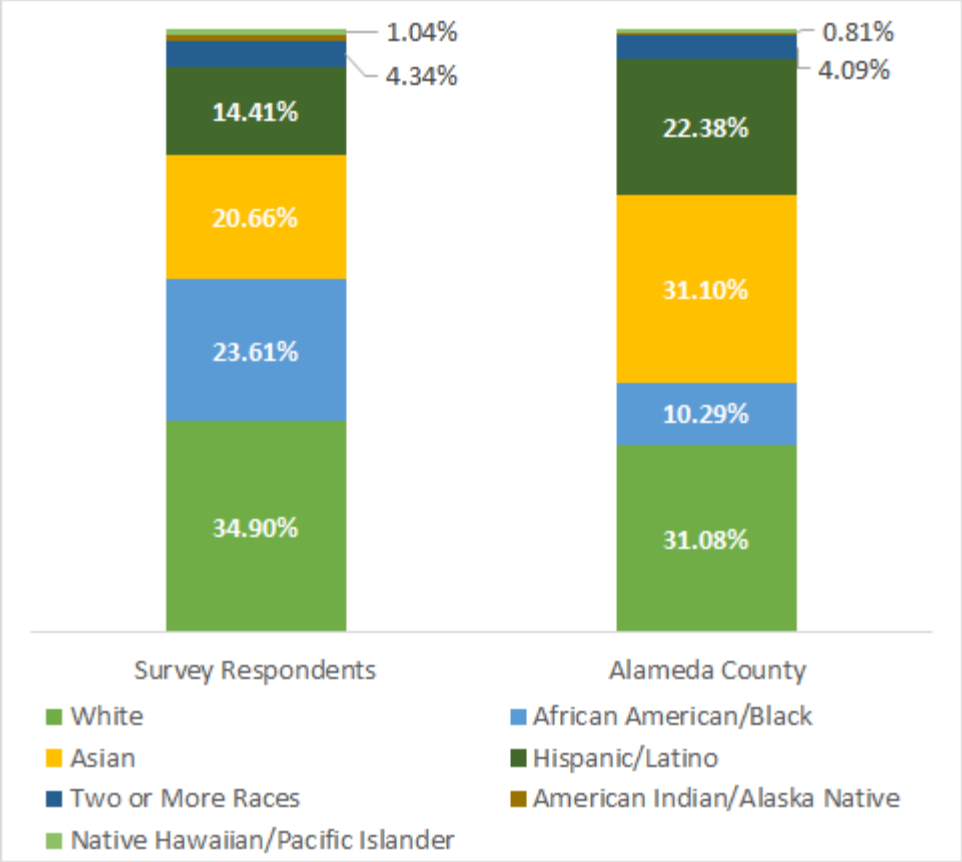
Outreach was conducted throughout the county and compared to the previous MHSA Community Program Planning Process there was an increase in resident representation throughout the county. Oakland is 26.04% of the county's population, however 41.19% of the survey participants reported living in Oakland. Other cities that participants lived in were Alameda (10.54%), Hayward and Berkeley (both with 7.41%), and San Leandro (6.26%). There are 5.77% of participants that live outside of Alameda County, but most of this group are providers within Alameda. **Figure 12** below shows details of participant's city of residence.

**Figure 12: Participant's City of Residence (n=607)**



When comparing the race and ethnicity of the survey respondents to Alameda County residents, White (34.90% vs 31.08%), African American/Black (23.61% vs 10.29%), Two or More Races (4.34% vs 4.09%), and American Indian/Alaskan Native were overrepresented. Hispanic/Latino (14.41% vs 22.38%) and Asian (20.66% vs 31.10%) were underrepresented among survey respondents (**Figure 13**). The percentages in the figure below are excluding the 44 participants that chose the response "prefer not to answer" and the four participants that skipped the race and ethnicity questions.

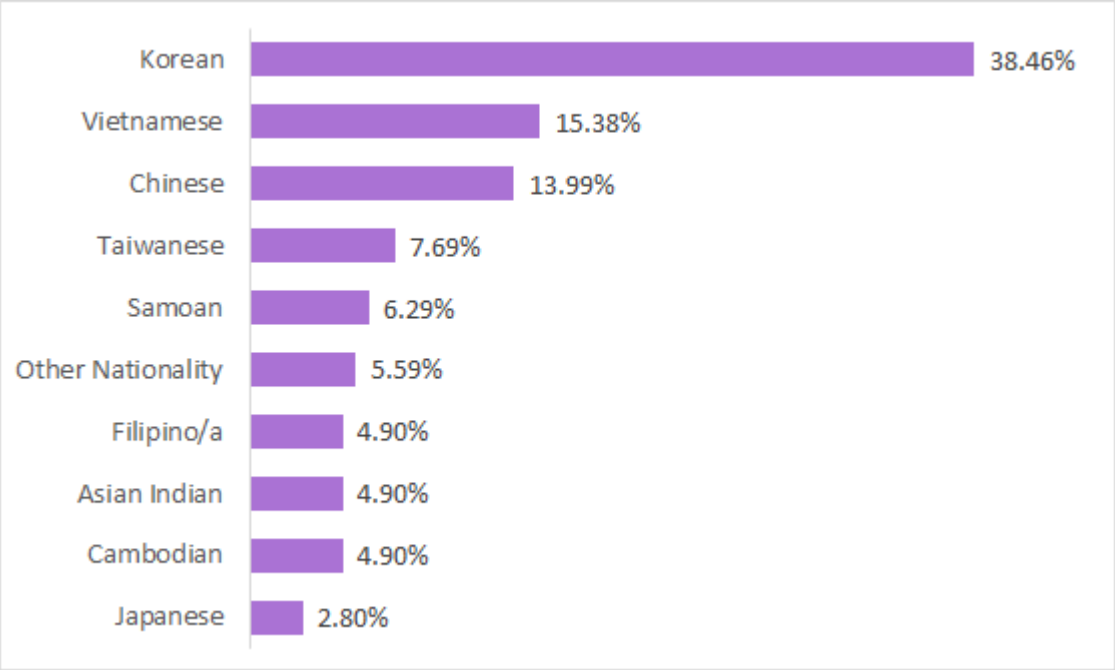
**Figure 13: Race and Ethnicity Survey Respondents (n=579) and Alameda County**




Alameda County Source: Annual Estimates of the Resident Population for Counties in California: April 1, 2010 to July 1, 2019 (CO-EST2019-ANNRES-06), U.S. Census Bureau, Population Division, Release Date: March 2020

Among the 144 participants who chose an Asian or Pacific Islander nationality or country of origin, Korean was chosen the most (38.46%). This is more than double the next highest, Vietnamese (15.38%) and Chinese (13.99%) (**Figure 14**).

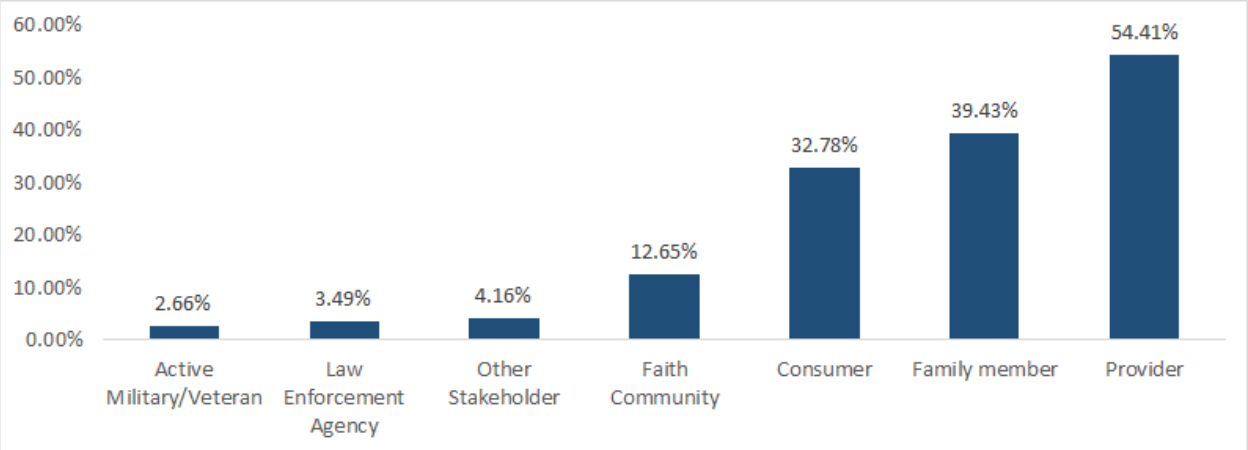
**Figure 14: Participant's Nationality or Country of Origin (N= 144)**




*Participants can choose more than one so the percent total is more than 100%.

Participants were asked what stakeholder group they represented and most identified as a provider (54.41%), followed by family member (39.43%). Due to the nature of the outreach to participants it makes sense that providers would be the most represented group and despite the barriers to technology that our consumers may have they made up 32.78% of the participants (**Figure 15**).

**Figure 15: Participant's Stakeholder Group (n= 601)**




*Participants can choose more than one so the percent total is more than 100%.

ACBH offers a variety of services to residents of Alameda County. Most participants of the survey are not currently receiving services (n= 449) or skipped the question (n= 18). Of the 160 participants that recorded that they were currently receiving services 78.13% were receiving mental health services, 31.88% were in a community group, 8.75% were receiving vocational rehabilitation, 5.00% were

receiving homeless services, and finally, 3.13% were receiving alcohol and other drug services. Participants were allowed to choose more than one service.

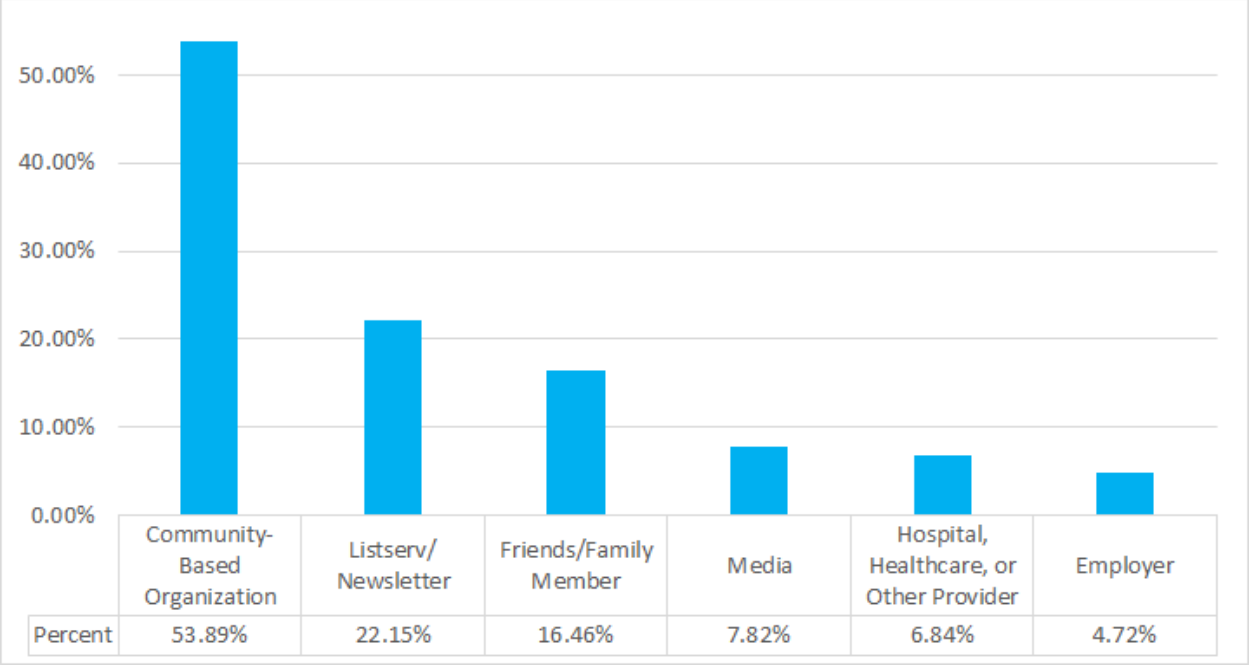
**Table 16: Services Received by Participants (n= 160)**

| Service | Number | Percent |
|---|---|---|
| Mental Health Services | 125 | 78.13% |
| Community Group | 51 | 31.88% |
| Vocational Rehabilitation | 14 | 8.75% |
| Homeless Services | 8 | 5.00% |
| Alcohol & Other Drug Services | 5 | 3.13% |

*Participants can choose more than one so the percent total is more than 100%.

A variety of outreach methods were employed by the MHSA Stakeholder group to invite community members to participate in the survey. Over half of the participants reported that they learned about the survey through a community-based organization (53.89%). The other ways that the participants learned about the survey were through listserv/newsletter (22.15%), friends/family member (16.46%), media (7.82%), provider (6.84%), and employer (4.72%). Given that 54.41% of survey participants identified themselves as a provider it is surprising that so few participants learned about the survey through their employer (4.72%). Additionally, 83.89% of participants stated it was their first-time providing input for the MHSA planning process reflecting the ability of community-based organizations to connect with people (**Table 17**).

**Figure 16: Learn about Community Participation and Feedback Survey (n=614)**




*Participants can choose more than one so the percent total is more than 100%.

**Table 17: First Time Participating in MHSA Community Program Planning Process (n= 627)**

| Response | Number | Percent |
|---|---|---|
| Yes | 526 | 83.89% |
| No | 51 | 8.13% |
| Not Sure | 44 | 7.02% |
| No Response | 6 | 0.96% |
| **Total** | **627** | **100.00%** |

## MHSA Survey Results

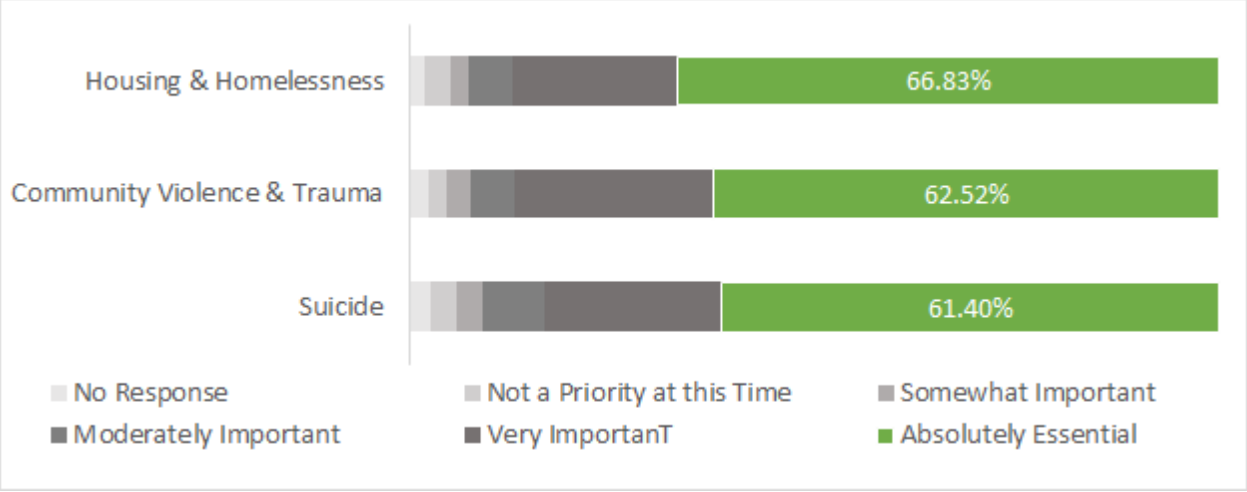
The following are the results of the MHSA Survey provided by 627 unduplicated individuals living and/or working in Alameda County. In response to the community input, ACBH has provided information on current programs and focus group recommendations that address each of the top identified needs.

**Survey Question #2: Mental Health Issues for Children/ Youth/ TAY – Prioritized**

*Q2. What concerns related to Children/Youth/Transitional Age Youth (TAY) are most important to you and/or your family member(s)? (Rate in order with 1 as "Absolutely Essential" to 5 as being "Not a Priority at this time").*

Participants identified the top three concerns for children, youth and, TAY as: 1) Housing and Homelessness (66.83%); 2) Community Violence & Trauma (62.52%); and 3) Suicide (61.40%). See **Appendix E-2** for the other concerns.

**Figure 17: Top Three Concerns Related to Children/Youth/Transitional Age Youth (n=627)**




## Analysis of Children/Youth/TAY Concerns

**Table 18: Available Programs and Focus Group Recommendations for Children/Youth/TAY**

| **Prioritized Needs for Children/ Youth/ Transitional Age Youth** | **Available** (Programs in implementation) | **Future Opportunity** (for future consideration) |
|---|---|---|
| 1. Homelessness | X | X |
| 2. Community Violence & Trauma | X | X |
| 3. Suicide | X | X |

## Concern 1: Housing & Homelessness

Homelessness continues to be an overwhelming challenge in Alameda County, and impacts children, youth, and, TAY. Participants reflected these concerns in the free response portion of the survey. Selected quotes are below:

> "There should be a safe place for this population to go to without an end date to address their safety and mental health concerns if they need to leave their parents' house, are homeless or not in a safe place."

> "Safe place to lay one's head, be healthily fed, and access services free of political agendas (including LGBTQ). Youth are in vulnerable seasons of life often unpacking heavy trauma amidst it. They do not need pressure from ANY agenda. They need practical care and a safe place to have life."

## Current Programs

To combat homelessness ACBH funds TAY Full Service Partnerships such as Supportive Services for Transition Aged Youth (STAY) and Prevention, Advocacy, Innovation, Growth, and Empowerment (PAIGE). PEI and CSS funded programs also helps TAY and families find housing opportunities:

- Berkeley Place - Casa De La Vida
- Casa Maria
- Dream Youth Clinics with Sobrante Park Community Project
- Housing Solutions for Health
- No Place Like Home

## Focus Group Recommendations

> "There are inadequate subacute and acute beds in continuum of care facilities, and a quick release of 5150s and those on holding, we need an increased supply of licensed board and care" - MHSA-SG Focus Group participant

> " [We need} more long-term facilities for adults and TAY (legal adults), so that people can be stabilized both medically and therapeutically. TAY over 18 and families have no legal rights….youth need services that support education, vocational training, peer support and family support for families who need to be included early on." – Family Dialogue Focus Group participants

> "Co-occurring substance use and mental illness is not well addressed and/or treated…youth's culture is frequently anti-pharmaceuticals and pro marijuana and alcohol to dampen symptoms" – Family Dialogue Focus Group participants

## Concern 2: Community Violence & Trauma

Given the high violent crime rate of 629 violent crimes per 100,000 in Alameda County compared to 421 overall in California it is not surprising that community violence and trauma is one of the top concerns among survey respondents. Participants reflected these concerns in the free response portion of the survey. Selected quotes are below:

"Need an African American Wellness Center like Native Americans **[sic]**. like La Clinica, like the Asian Medical places Need Something that focuses on our needs such as our Historical trauma and our Current trauma !!"

"young people are having trouble identifying unhealthy and abusive relationship behaviors in all forms of relationships. they cannot advocate for themselves and seek out early intervention if they do not realize their social environment is harmful to their development. They will be at risk for engaging in abusive cycles in other areas of life, often leading to crime and self-destructive choices."

Current Programs

For Children and Youth: Trauma Trainings are available for faculty and staff on school sites so that they can be better equipped to receive children and youth experiencing community violence and trauma. Additionally, many of the children/ youth providers offer groups focusing on the effects of trauma and offer those support for children and youth in schools. For TAY, current programs address community violence and trauma include the STAY and PAIGE FSP programs and PEI funded programs such as:

- Youth UpRising
- Beats Rhymes & Life (BRL)
- PEERS & Tri Cities Faith and Spirituality Based Program
- REACH Ashland Youth Center
- Crisis Support Services Community Education trainings

Focus Group Recommendations

"...Programs like Dr. Ike Silberman (neurologist) is working with Boldly Me to give children mentors and a mental health doctor" - MHAB Children's Advisory Committee

"More in-school counseling for at-risk youth. Better follow up after hospitalization for suicide attempt"

Concern 3: Suicide

While Alameda County has the second lowest age-adjusted death rate due to suicide (8.6) compared to other Bay Area Counties, it has the highest average deaths (149.3) (**Table 4**). Nationwide youth suicide increased 56% between 2007 and 2017[1]. Participants reflected these concerns in the free response portion of the survey. Selected quotes are below:

"...Children can't be compartmentalized. They need what they need and the adults have to provide it. They must be treated holistically..." - MHAB Children's Advisory Committee Focus Group participant

"[Leverage] Senator Jim Beall's bill SB 906 to certify peer providers" - MHAB Children's Advisory Committee Focus Group participant

Current Programs

[1] Curtin SC, Heron M. Death rates due to suicide and homicide among persons aged 10–24: United States, 2000–2017. NCHS Data Brief, no 352. Hyattsville, MD: National Center for Health Statistics. 2019.

Suicide prevention services for TAY are currently being provided by Full Service Partnerships (STAY and PAIGE) and Crisis Support Services of Alameda County– Text Line (PEI), Suicide Prevention Crisis Line (OESD 32), and school-based suicide prevention programming called Teens for Life (PEI), as well as other crisis stabilization services, such as the In-Home Outreach Team (IHOT).

Focus Group Recommendations

"...Schools need educational assemblies that connect with teens – ask them how to run an assembly on mental illness..." - MHAB Children's Advisory Committee Focus Group participant

" ...Bring AB22 to the forefront..." - MHAB Children's Advisory Committee Focus Group participant

"...Incorporate mental wellness into mandatory class to encourage youth to seek help..." - MHAB Children's Advisory Committee Focus Group participant

"... Use the 'First Break Team' mobile evaluation clinics similar to Planned Parenthood" - MHAB Children's Advisory Committee Focus Group participant

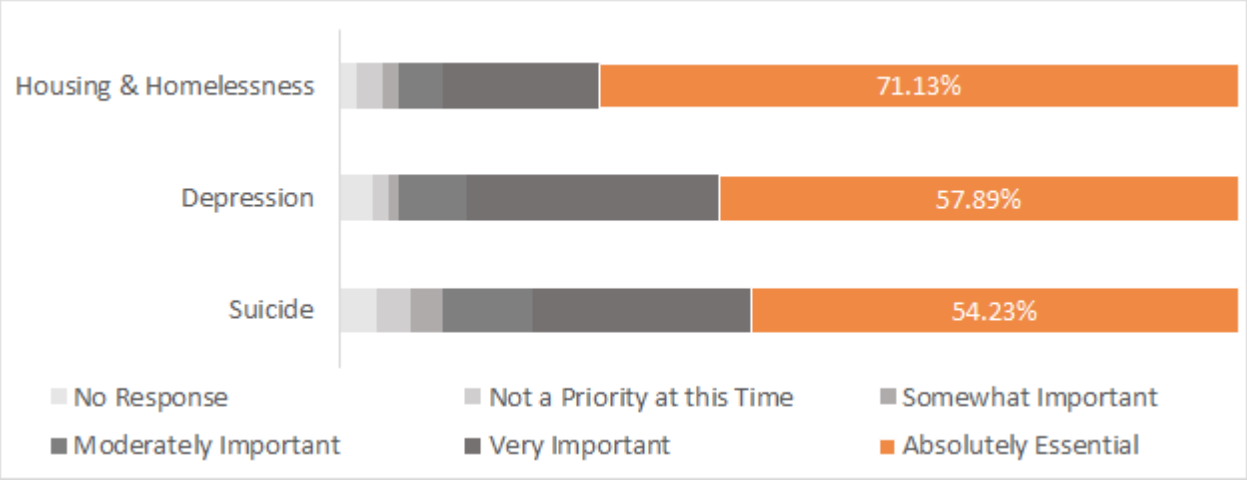
"... Diversion programs/location for youth experiencing mental health crisis and appropriate training for law enforcement" - ACBH Operations Expanded Leadership Focus Group participant

**Survey Question #3: Mental Health Issues for Adults and Older Adults – Prioritized**

*Q3. What concerns related to Adults/Older Adults are most important to you and/or your family member(s)? (Rate in order with 1 as "Absolutely Essential" to 5 as being "Not a Priority at this time").*

Participants identified the top three concerns for adults and older adults as: 1) Housing & Homelessness (71.13%); 2) Depression (57.89%); and 3) Suicide (54.23%). See **Appendix E-2** for the other concerns.

**Figure 18: Top Three Concerns Related to Adults/Older Adults (n=627)**



## Analysis of Adults and Older Adults

**Table 19: Available Programs and Focus Group Recommendations for Adults/Older Adults**

| Prioritized Mental Health Needs for Adults and Older Adults | Available Services | Focus Group Recommendations |
|---|---|---|
| 1. Housing & Homelessness | x | X |
| 2. Depression | x | |
| 3. Suicide | x | |

### Concern 1: Housing & Homelessness

Similarly, to the concerns for Children/Youth/TAY, homelessness is also the top concern for Adults and Older Adults. Of those interviewed by the Alameda County Continuum of Care (ACCC), during the Point-in-Time over 67% first experienced homelessness as an adult over the age of 25. Participants reflected these concerns in the free response portion of the survey. Selected quotes are below:

> "If a person is homeless then a place where they can have their own room and wrap around services on site is essential. Adults with severe mental health issues or that are homeless will continue to cycle through our system unless something more solid is put into place."

> "...The root cause of homeless encampments is mental health and substance abuse. The only solution is long-term mental health care and treatment in a humane, stable environment. The criminal justice system should not be the default treatment as it is now."

### Current Programs

To combat homelessness ACBH funds Adult and Older Adult Full-Service Partnerships such as Abode's Greater Hope and Homeless Engagement Action team (HEAT) from BACS. PEI, CSS, and CFTN funded programs also helps Adult, Older Adult, and families find housing opportunities:

- Housing Solutions for Health (ACBH Housing Office)
- Increased training and payment rates for locally contracted Board and Care homes
- No Place Like Home projects
- Alameda Point Collaborative Senior Housing and Medical Respite Center (in development)
- South County Homeless Project (A Street Shelter)

### Focus Group Recommendations

> "... We need housing subsidies for staff working at programs to address turnover and retention issues" - UELP Focus Group participant

> "... Partnership with managed care plans and rapid rehousing" - ACBH Operations Leadership Focus Group participant

> "... More licensed board and care and subacute and acute beds" - MHSA-SG Focus Group participant

> "... MHSA spending needs to focus on the seriously mentally ill--people who cannot lobby or petition or agitate for their own treatment. The most important thing MHSA money can do under current restrictions is build more board-and-cares. If the most seriously ill are not to be hospitalized, they need to be in the best possible housing specifically for them" - MHAB Criminal Justice Committee Focus Group participant

## Concern 2: Depression

Depression has not been a concern during previous planning process. Alameda County has the highest percent of people that report having had serious psychological distress on the CHIS at 9.6% (**Table 5**). Depression as a concern was reflected in the free response portion of the survey. Selected quotes are below:

> "More supports for adults who are experiencing moderate or mild mental health issues so that they do not develop into more severe symptoms, especially those who are struggling with parenting stress."
>
> "Help for vocational training and depression in life."

## Current Programs

Multiple programs in the ACBH system treat and work towards preventing and treating depression. ACBH funds behavioral health and primary care integration, including the ACHCH/Lifelong TRUST health center through CSS funds. The PEI component funds the following program support groups:

- Asian Health Services including their "Walking 4 Wellness"
- Center for Empowering Refugees and Immigrants (CERI)
- Afghan Path toward Wellness (International Rescue Committee (IRC))

## Focus Group Recommendations

"... We have to have multifaceted approach. We need black police, more black teachers, and healthcare providers. Education, Judicial system and Healthcare.... African Americans have historically been a trusting people, we need to build the relationship and the village and get people involved...create rites of passage [ceremonies] for adolescents." -PEERS Hope & Faith Focus Group participant

"Older Black lesbians can't find their space that's culturally responsive. We might have to go out the mental health system to create a system of mental health for this group. Alameda County has the Nia Collective, Women's Cancer Resource Center that aren't part of the system of care but want to be, and they have the ability to penetrate into that grouping. Many women report they are on fixed income but can't find clinicians who will take their Medi-Cal. There is an income issue when it comes to affordability" - LGBTQIA+ Focus Group participant

" [We need more services for] those who are cycling in and out of Santa Rita and John George, those who do not have the capacity to direct their own care because they do not recognize their illness such as schizophrenia, schizoaffective and bipolar." – Family Dialogue Focus Group participant

"... trainings that address the digital divide." -PEERS Hope & Faith and CyB Focus Group participants

"... cultural exchange or storytelling events to get exposure to other cultures..." -UELP Focus Group participant

"In Long Beach they created a community garden for Cambodian refugees which also connects culturally." -UELP Focus Group participant

"Nontraditional healers!" - UELP & PEERS Hope & Faith Focus Group participants

## Concern 3: Suicide

Suicide was the third highest concern during the previous planning process as well. While Alameda County has the second lowest age-adjusted death rate due to suicide (8.6) compared to other Bay Area Counties, it has the highest average deaths (149.3) (**Table 4**). Nationwide male adults 75 and over continue to have the highest suicide rates[2]. Suicide rates among females has increased by 50% from 4.0 per 100,000 in 2000 to 6.0 in 2016[3]. Suicide was a concern reflected in the free response portion of the survey. Selected quotes are below:

> "Case management support is not sufficient for people suffering from severe mental illness. More intensive care is essential to prevent hospitalizations, homelessness and suicide."

> "A campaign uses [sic] giant smartphone displays for suicide awareness."

## Current Programs

There are multiple programs that work towards deescalating people in crisis, preventing suicide, and following-up with those affected by deaths by suicide, attempted suicide, and suicidal ideation. Adults and Older Adults FSP teams such as Telecare STRIDES and BACS Circa 60. Other programs include:

- Suicide Prevention Crisis Line and the Activating Hope Project (OESD 32)
- In Home Outreach Teams (OESD 27)
- Crisis Residential programs, Amber House/Refuge (OESD 11/23)
- Family Education and Resource Center (PEI)
- ACBH Training Institute's Suicide Assessment & Intervention (WET)
- Crisis Response Program (OESD 5a/11)
- Community Based Voluntary Crisis Services Transition to Mobile Crisis Team (MCT) and Mobile Evaluation Teams (MET) (OESD 5a)
- Mobile Integrated Assessment Team for Seniors (OESD 29)
- Older Adults Peer Support (PEI)

## Focus Group Recommendations

> "... [We should be] coordinating clinicians that have similar cultural backgrounds and resources to help expand services..." -UELP Focus Group participant

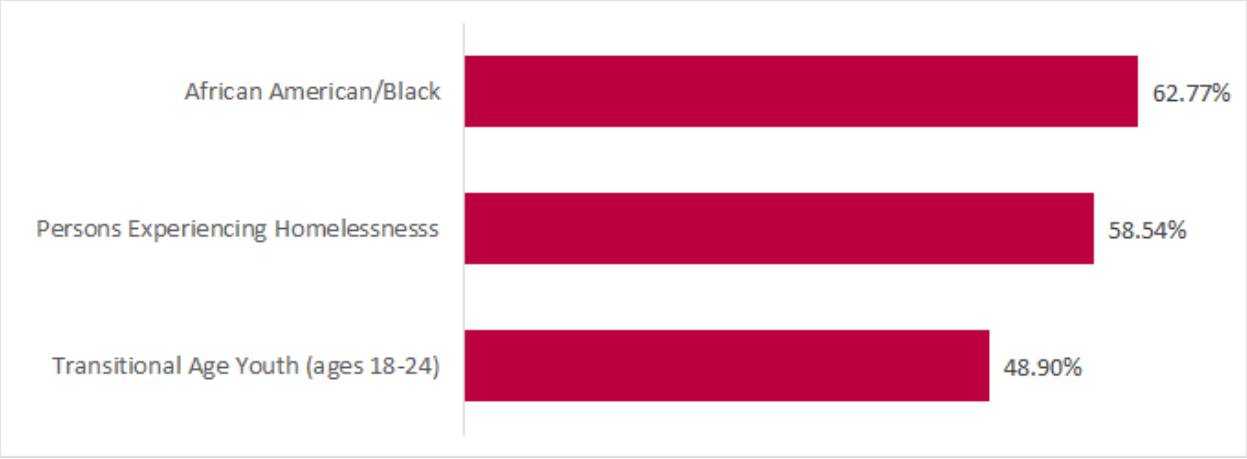
### Survey Question #4 and #5: Unserved & Underserved Populations

*Q4. Are there any populations or groups of people whom you believe are not being adequately served by the behavioral health system of Alameda County?*

The groups participants identified most often as being underserved were: 1) African-American/Black (62.77%), 2) Persons Experiencing Homelessness (58.54%), and 3) Transitional Age Youth, ages 18-24 (48.90%). See **Appendix E-2** for details on other identified underserved populations.

[2] Hedegaard H, Curtin SC, Warner M. Suicide rates in the United States continue to increase. NCHS Data Brief, no

**Figure 19: Top Three Populations or Groups not Adequately Served by System (n=591)**




*Participants can choose more than one so the percent total is more than 100%.

*Q5. Based on your answers for Question 4, please identify who you feel are the three most underserved groups (please be specific)*.

There were 554 participants that identified at least one group. The top three groups that participants identified as most underserved are the most underserved were: 1) African American/Black (36.10%), 2) Persons Experiencing Homelessness (23.47%), 3) Older Adults (14.44%). This top three is slightly different than the results above in that Older Adults are in the top three among the free response but TAY were in the top three for question four above.

**Table 20: Available Programs and Focus Group Recommendations for Underserved Populations**

| Prioritized Underserved Populations | Available Services | Focus Group Recommendations |
|---|---|---|
| 1. African American/Black | x | X |
| 2. Persons experiencing homelessness | x | X |
| 3. TAY, ages 18-24 | x | X |
| 4. Older Adults* | x | X |

**Identified by free response in question 5.*

## Underserved Population 1: African American/Black

Compared to neighboring Bay Area Counties, Alameda County has the highest percentage of African Americans/Black residents at 10.3% (**Figure 2**) and they are overrepresented in the population experiencing homelessness (**Figure 4**). Among Alameda County residents that reported needing help for mental/emotional and/or alcohol/drug issues on the California Health Interview Survey, African Americans/Black self-report having the lowest treatment rates (**Table 6**). However, ACBH serves 8.0% of African Americans/Black Medi-Cal recipients, which is the second highest percent (**Table 7**).

## Current Programs

Programs funded through the CSS component to serve or increase the quality of service to the African American/Black community include Pathways to Wellness's trainings to providers on the complexity of trauma in the community and accurate diagnosis, African American Wellness Hub Complex Planning

Phase, and ROOTS's AfiyaCare. Culturally responsive PEI programs that serve the African American community include:

- Partnerships for Trauma Recovery
- Beats, Rhymes and Life
- Restorative Justice for Oakland Youth
- PEERS's and Tri Cities Faith and Spirituality Based Program, Everyone Counts Campaign, and African American Action Team
- Sobrante Park Community Project- Roots Community Health Center.

## Focus Group Recommendations

"... Trans community, and specifically, Black Trans are killed at a higher rate. I've advocated to place $1M towards this group. They need more resources and end up traveling to San Francisco for resources which seem to be drying up..." -LGBTQIA+ Focus Group participant

"... African American males in their 20s-late 30s , experience community rejection, issues living as mentally ill trying to integrate, living homeless with no connections..." -MHAB Criminal Justice Committee Focus Group participant

"... Individuals who are stepping down from psychiatric hospitalization. It is not clear that there are community resources that network residents to behavioral health services in a supportive peer and professional environment...." -MHAB Focus Group participant

"... Undocumented Spanish speaking only communities, unaccompanied minors, Guatemalan families speaking native dialects...." -UELP Focus Group participant

"... Those in board and care facilities such as Psynergy and Everwell...TAY consumers who have "aged out" their housing and case management which results in destabilization at a critical time…" -Family Dialogue Focus Group participants

## Underserved Population 2: Persons Experiencing Homelessness

Alameda County's Point-in-Time Count for 2019, recorded 8,022 people experiencing homelessness and 79% of these were unsheltered. This is a population that participants of the previous program planning process felt was underserved.

## Current Programs

For MHSA Housing programs serving persons experiencing homelessness, see FSP 10 Housing and above for FSP programs.

## Focus Group Recommendations

"... Asian LGBTQ are invisible. We know we don't serve Asian American at the penetration rate they are in Alameda County...." -LGBTQIA+ Focus Group participant

## Underserved Population 3: TAY, ages 18-24

MHSA regulations mandate that at least 51% of PEI funds served individuals 25 years and younger. TAY make 8.3% of the county's population (**Figure 1**).

Current Programs

See information about TAY services under question 2 above.

Focus Group Recommendations

"We need mental health services accessible via different platforms such as standard practices (e.g. telehealth, use technology to deliver services)...." -UELP Focus Group participant

Underserved Population 4: Older Adults

Adults 65 and older make up 13.8% of the county's population (**Figure 1**) and those that are 60 and above they are 14% of the homeless population.

Current Programs

See information about Older Adult services under questions 3 above.

Focus Group Recommendations

"... We have noticed the use of Zoom has allowed individuals that normally would not participate in our program to join, we need a digital kinship network to address the digital divide." -PEERS Hope & Faith Program Focus Group participant

"... Give families a voice in commitment and conservatorship proceedings so they do not have to fight with the Public Defender and the guardian...." -Family Dialogue+ Focus Group participant

Underserved Population: Emerging Populations

Participants were asked if there are other populations that are not adequately served by the behavioral health system. Seventy-six participants responded filled in responses. Among those responses the three groups below received the most responses:

- African Refugees, Immigrants, and Asylum Seekers (n=7)
- Severely Mentally Ill (n=7)
- Women/Mothers (n=5)

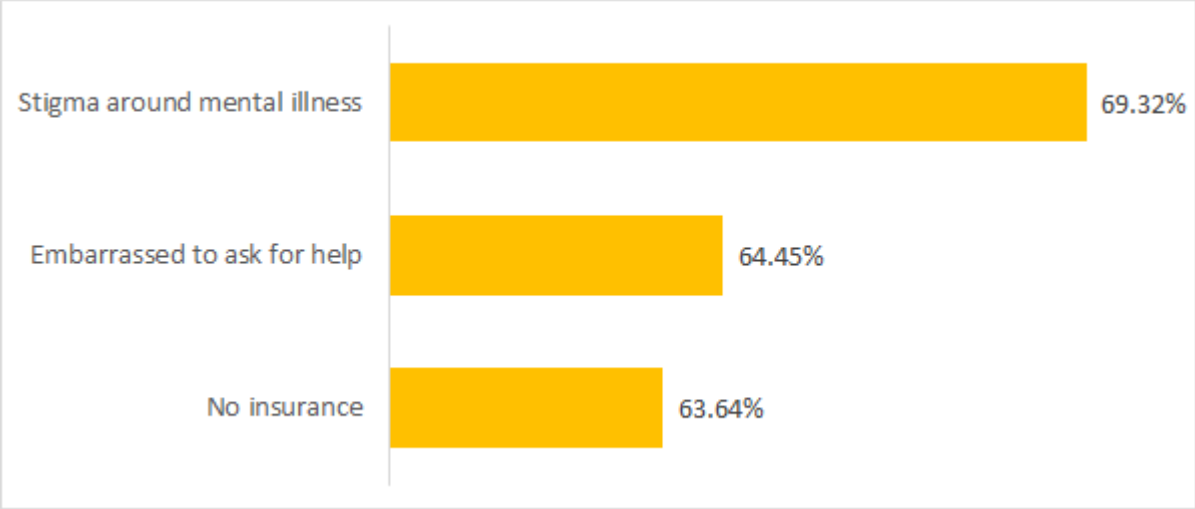
ACBH will continue to monitor these emerging populations and evaluate their needs further.

**Survey Question #6: Barriers towards Accessing Mental Health Services**

*Q6. What barriers make it more challenging for individuals and family member(s) with mental health challenges to access mental health services?*

Respondents prioritized the top three barriers to accessing mental health services as: 1) Stigma around mental illness in the community (69.32%); 2) Embarrassed to ask for help (64.45%); and 3) No insurance (63.64%). See **Appendix E-2** for details on other identified barriers.

**Figure 20: Top Three Barriers to Accessing Mental Health Services (n=616)**




*Participants can choose more than one so the percent total is more than 100%.

**Table 21: MHSA Programs to Address Barriers to Mental Health Services**

| Barriers to accessing services | Available Programs | Focus Group Recommendations |
|---|---|---|
| 1. Stigma in community | x | X |
| 2. Embarrassed to ask for help | x | x |
| 3. No insurance | x | X |

Barriers 1 and 2: Stigma in Community and Embarrassed to Ask for Help

Stigma around mental health and being embarrassed to ask for help can decrease access to needed services and realizing that there is a need for services.

Current Programs

All programs funded through the CSS component of MHSA funding work towards reducing stigma around mental health. These programs range from working with clients or outreach and education in the community. For example, the Asian Health Services Specialty Mental Health Language ACCESS Asian program has created an anti-stigma campaign targeting Asian American Youth through social media. One of the treatment programs, Chrysalis, a Program of Horizon Services, Inc., educates clients and their family members about stigma and discuss the effects on clients.

PEI funded Stigma Reduction Campaign called Everyone Counts http://www.everyonecountscampaign.org/ provides education and training in community to combat stigma which prevents consumers and family members in seeking help for mental health issues. Consumer empowerment groups such as the Pool of Consumer Champions (POCC) and PEERS are engaged in outreach, education and program decisions. See information above for more information about PEERs.

A subset of PEI funded programs called Underserved Ethnic Language Population (UELP) Programs work with traditionally underserved populations. During the program evaluation in FY 18-19, the data showed a change in perception of mental health for both types of services, suggesting a reduction in personal stigma. Ninety-one percent of Prevention respondents and 92% of Preventative Counseling (PC)

respondents reported having a stronger belief that most people with mental health experiences have the ability to grow, change and recover.

Focus Group Recommendations

> " We need more Mum speaking services [at local provider sites] and media usage" Latinx Focus Group participant
>
> " We need more gender-specific groups for young men and mental health services accessible via different platforms as a standard practice, such as telehealth..." - UELP Focus Group participants
>
> " [We need] peer coaching and peer navigators....to conduct mental health outreach in the church... we need programs that use African-American interventions or research, science developed by African-Americans." African American & faith-Based Focus Group participant

Barriers 3: No Insurance

MHSA acknowledges that a system of care for individuals with severe mental illness is vital for successful management of mental health. It requires a comprehensive and coordinated system of care to address mental illness and deliver cost-effective programs. Any MHSA funded service or program must be identified in the three-year expenditure plan and annual update, and be vetted through a local stakeholder process.

The County is authorized to fund CSS programs to include (but are not limited to): individualized treatment plans, substance abuse treatment, referrals and linkages to community services, housing assistance, medication management transportation, and psychiatric services. In addition to CSS programs, PEI programs may also fund childhood trauma prevention and early intervention to address the early origins of mental health, early psychosis and mood disorder detection, youth outreach, culturally competent services, and strategies targeting the mental health needs of older adults.

Barriers: Emerging Populations

Participants were asked if there were other barriers that were not among the ones listed in the survey. Eighty-seven participants listed other barriers. The top three were:

- Lack of diverse workforce/Quality of providers (n=20)
- Bureaucratic/Hard to navigate system (n=18)
- Anosognosia/difficult to engage clients (n=16)

ACBH will continue to monitor the frequency of these barriers and will discuss with current providers at their meetings to explore if there are needed services to decrease these barriers.

**Survey Question #7. Effectiveness of MHSA Services**

*Q7. Which of the following MHSA Service areas do you feel have been effective in addressing our local mental health concerns?*

Respondents ranked top three effective programs: 1) Crisis Services (48.63%); 2) Suicide Prevention, crisis hotline/training & education (40.07%); and 3) Mental Health Outreach Teams (39.21%). See **Appendix E-2** for details on other effective services.

**Figure 21: Top Three Most Effective MHSA Service Areas (n= 584)**


*Participants can choose more than one so the percent total is more than 100%.

Below are some selective responses from the focus group:

> " [The most effective services] support family members, drive elderly and others to their doctor's appt/grocery shopping."- MHAB Criminal Justice Focus Group participant
>
> "The Pacific Center has done amazing work. We should look at where they are located and whether it reflects the population of hat Alameda County looks like. A Black trans youth in the foster care told me they wouldn't go there. Perhaps we can look at expanding what they do to different regions and groups." - LGBTQI2S Communities Focus Group participant
>
> " I was unable to open up to my mother and during this age, our relationship is so rigged and I just feel like I was so alone and helpless. This went on for 3 years until I met her Boldly Me program." - MHAB Children's Advisory Committee Focus Group participant

## Survey Question #8. Innovative Services

*Q8. MHSA funds INNOVATIVE SERVICES to improve and transform our county mental health system. The goal of the Innovations program is to contribute to learning and improving our system in three ways: (a) introduce new mental health practices & approaches that have never been done before, (b) make a change to an existing mental health service, and (c) introduce a new community-driven approach that has been successful in a non-mental health setting.*

There were 358 respondents with 556 unduplicated ideas. Of the ideas submitted the top three innovative program areas were: 1) Community and Home-based Services (n= 69); 2) Outreach to Educate about Services and Decrease Stigma (n= 61); and 3) School-based Services (n= 44). See **Appendix E-2** for the top ten innovative ideas.

**Table 22: Top Three Innovative Ideas**

| Innovative Idea recommendations | Available | Ideas submitted virtually via web form and/or Focus Group recommendations for specific populations |
|---|---|---|
| 1. Community and Home-based Services | x | X |
| 2. Outreach to Educate about Services and Decrease Stigma | x | x |
| 3. School-based Services | x | X |

Innovative Idea 1: Community and Home-based Services
Below are some selective responses from the survey:

> "Because of the limitations of Medi-Cal, I think more of these funds need to be utilized for Family Resource Centers and Early Childhood Mental Health Consultation. ECMHC has been proven to have positive impacts on development for children and FRC's have demonstrated impact on economic mobility of immediate neighborhood, even for those who don't directly receive services."

> "Have providers go the home, as often as necessary, like Trieste Italy does. Psychiatrists, Registered Nurses, Psychologists, etc. go to the home to PREVENT hospitalizations. This county does not have enough beds so this is the only way to help the SMI in crisis."

Current Programs
There are a variety of community and home-based services that are provided via the CSS and PEI components. Programs are listed below:

- In Home Outreach Teams (OESD)
- Full Service Partnerships (CSS)
- Family Education and Resource Center (PEI)
- Crisis Response Program (OESD)
- Community Based Voluntary Crisis Services Transition to Mobile Crisis Team (MCT) and Mobile Evaluation Teams (MET) (OESD)
- Mobile Integrated Assessment Team for Seniors (OESD)
- Center for Empowering Refugees and Immigrants (PEI)
- Afghan Path toward Wellness (International Rescue Committee) (PEI)
- Beats, Rhymes and Life (PEI)
- Restorative Justice for Oakland Youth (PEI)

Innovative Idea 2: Outreach to Educate about Services and Decrease Stigma
Below are some selective responses from the survey:

> "One idea is to have a roving mental health information vehicle. Sites and times where people can come to get more information via brochures, literature, etc., can be posted on various medias and handing out via postcards. Set times and sites with service on weekends also."

> "Create a cultural wellness center for API community with in language staff. Provide resource for outreach and engagement to reduce stigma."

Current Programs

The current programs that are funded to decrease stigma and advertise services are listed under question 6, barriers 1 and 2 above.

Innovative Idea 3: School-based Services
Below are some selective responses from the survey:

> "possibly adding full spectrum of services in elementary, middle, and high school similar to a full-scale family resources centers; accessibility to tangible services from 7am to 5pm. Monday thru Friday. Possibly even adding a full-scale family resource center at Laney, Chabot, Merritt, and Alameda community colleges."

> "Enhancing schools existing tiered support structures with tiered mental health services so that mental health providers are able to provide prevention and early intervention services. This allows schools to support students before their needs escalate to the point of medical necessity. Mental health providers are then freed up to serve all students, including those who may benefit from social skills groups that bolster protective factors and address risk factors before they escalate."

Current Programs
A variety of school-based programs are funded through the PEI components and are described under question 2 above.

Web Form
MHSA invites community members to present new and innovative approaches for further exploration or future funding. The previous innovation recommendation form was paper-based, time-limited, and submitted to MHSA via email. MHSA developed a web-based form in response to COVID-19, automation efforts, and the community interest in innovative projects. The nine-item questionnaire is permanently available on the Alameda County MHSA Innovative & Community Based Learning website. Community members are encouraged to (1) identify an innovative concept, target population demographics, evidence-based rationale, and potential implementation obstacles. The form is submitted via the website to the MHSA program email inbox, and reviewed weekly by division staff.

POCC and CAMPHRO Innovation Webinar

On May 27, 2020, ACBH, POCC and the California Association of Mental Health Peer-Run Organizations (CAMPHRO) hosted the "Have your voice hear on MHSA Innovation (INN) Proposals" webinar which was attended by community advocates and consumers. The webinar included a MHSA educational presentation, a panel on Innovation projects and the procurement process, overview of the INN Community Land Trust, and a series of interactive polling activities allowing attendees to recommend on vote on innovative ideas. Fifty-six percent of participants indicated this webinar was their first-time providing input and information for the MHSA CPPP. Additional demographic data was collected through polls and demonstrated 78% of participants identified as a consumer, client, peer, survivor, or ex-patient; 11% identified as mental health advocate; 6% identified as a county or community-based agency provider; and 6% identified as a parent/family member or caregiver.

The webinar resulted in 11 INN recommendations. The following INN recommendations received the most support:

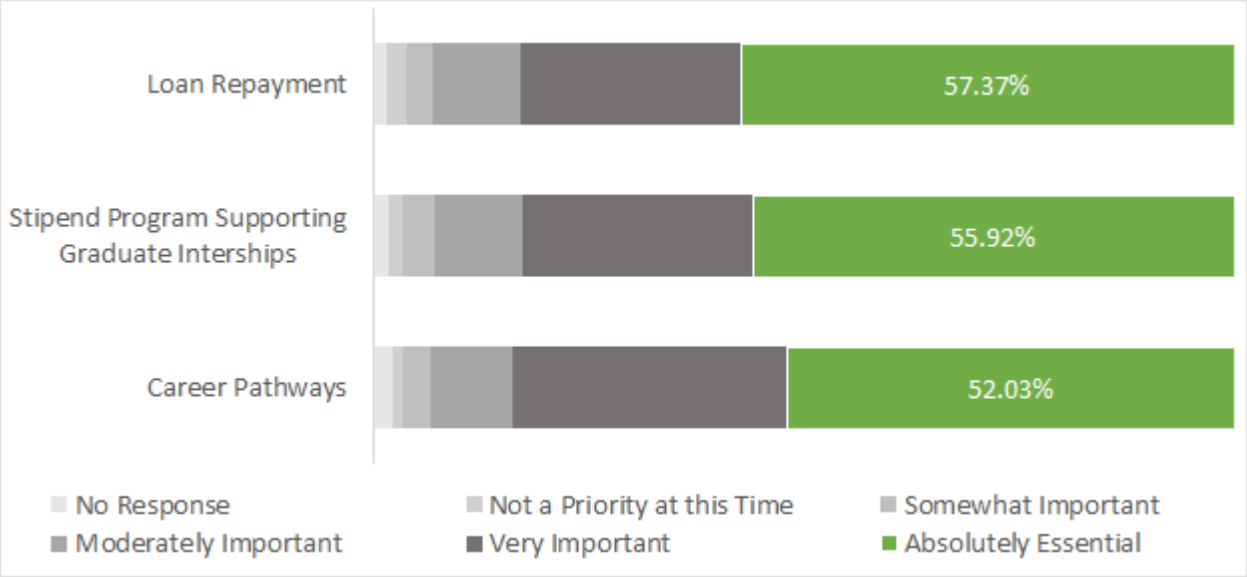
- "2connect 2": Laptop, Internet & Peer Trainer: Polling Vote: 78%
- Peer respite for new target population (for INN eligibility): Polling Vote: 47%
- Virtual live events online with mental health speakers: Polling Vote: 26%

**Survey Question #9. Workforce, Education & Training Activities - Prioritized**

*Q9. MHSA funds WORKFORCE, EDUCATION & TRAINING activities to help develop a behavioral health workforce sufficient in size, diversity, language, and cultural responsiveness for consumers/family. Please rank the importance of the following Workforce Development strategies. (Rate in order with 1 as "Absolutely Essential" to 5 as being "Not a Priority at this time").*

Respondents identified the top three essential WET services as: 1) Loan Repayment Program for Qualified Educational Loans for Clinical Staff (57.37%); 2) Stipend Program to Support Graduate Level Behavioral Health Internships (55.92%); and 3) Career Pathways Pipeline Programs (to promote and increase career choices in the Mental Health field) (52.03%). Participants were asked if there are other important workforce development strategies and training was written in by 15 people out of the 75 people that wrote in free responses. See **Appendix G** for details on the other WET activities.

**Figure 22: Top Three Absolutely Essential WET Activities (n= 617)**




*Participants can choose more than one so the percent total is more than 100%.

**Table 23: MHSA WET Activities Available Programs and Future Opportunities**

| **Prioritized Needs for WET** | **Available** (Programs in implementation) |
|---|---|
| 1.Loan Repayment Program | X |
| 2.Stipend Program for behavioral health internships | X |
| 3.Career Pathways Pipeline Programs | X |

Financial Incentive Program

The Workforce, Education and Training (WET) Unit offers financial incentives to increase local workforce diversity. Financial Incentives are offered to individuals employed in ACBH, graduate interns placed in

ACBH, and contracted community-based organizations who are linguistically and or culturally able to serve the underserved and unserved populations of the County. During FY 18/19 WET launched the seventh cycle of the Graduate Stipend Program, awarding twenty stipends of $6,000 each for 720 internship hours. Seventy percent of awardees represented the diverse communities of Alameda County.

Career Pathways Pipeline Programs

WET currently collaborates with high schools, post-secondary educational partners, and industry partners to develop mental health classroom curriculum and work-based learning experiences. The Community College Career Pathway is a collaboration with community colleges to create pathways for consumers, family members, and ethnically and culturally diverse students and individuals that can lead to employment in the behavioral health care field. Educational pathways focus on cultivating mental health career pipeline strategy in community colleges, which serve as an academic entry point for consumers, family members, ethnically and culturally diverse students, and individuals interested in human services education, and can lead to employment in the ACBH workforce.

During FY18/19 WET launched a two-year Infant & early childhood Mental Health Postgraduate Certificate Program at Cal State University, East Bay. The overarching goals was to build capacity in a culturally diverse early childhood mental health workforce to meet the social, emotional and developmental needs of young children, ages birth to five, and families in Alameda County.

# COMMUNITY SERVICES AND SUPPORTS

# Community Services & Supports (CSS) Program Summaries
## *"Extending Our Hands"*

*The Community Services and Supports* (CSS) is the largest component, which is focused on community collaboration, cultural competence, client and family driven services and systems, wellness focus. CSS uses funds for direct therapeutic services to adults with severe mental illness (SMI) and children with severe emotional disturbance (SED).

As of FY 20/21, CSS component funds 12 Full Service Partnerships (FSP) programs and 21 Outreach Engagement/System Development (OESD) programs. CSS programs are implemented through ACBH's two age-based Systems of Care which serves four age groups:

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

**CSS Components:** CSS provides funding and direct services to individuals with severe mental illness (SMI) and/or severe emotional disturbance (SED) and is comprised of two service areas: Full Service Partnerships (FSPs) and Outreach Engagement/System Development (OESD) programs.

**Service Recipients:** Individuals living in Alameda County living with or in recovery from an SMI (adults) and/or SED (children/youth).

**Service Delivery Approaches:** FSPs provide wrap around or "whatever it takes" services to consumers, who are called partners. OESD programs cover multiple treatment modalities and services including: outpatient treatment: crisis response: crisis stabilization and residential care; peer respite; behavioral health court; co-occurring substance use disorders; integrated behavioral health & primary care; integrated behavioral health & developmental disability services, and in-home outreach.
CSS programs focus on community collaboration, cultural competence, client and family driven services and systems and wellness. Housing and housing support are also included in the CSS component.

**Referral Process:** All individuals seeking services are screened and referred through the ACBH ACCESS system by calling 1-800-491-9099.

**Outcomes:** CSS programs address one of the following priorities developed in the community planning process: Reduce homelessness; Reduce involvement with justice and child welfare systems; Reduce hospitalization and frequent emergency medical care; Promote a client- and family-driven system; Reduce ethnic and regional service disparities; Develop necessary infrastructure for the systems of care

## FY 18/19 AGGREGATED FSP DEMOGRAPHICS & PERFORMANCE INDICATORS

### FY 18/19 FSP Demographic Data[1]

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

**RACE/ETHNICITY**

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

**GENDER**

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

**PRIMARY LANGUAGE**

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

[1] Due to timing of the development of this report FY 19/20 data was not yet available. FY 19/20 data will be available for the FY 21/22 MHSA Plan Update.

**AGE**

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

**COUNTY REGION CLIENTS RESIDE IN**

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

**FY 18/19 FSP Performance Indicators**

FSP providers are continually working with ACBH to develop and/or refine performance indicators in order to document and highlight the impact of FSP services. Additional metrics regarding reductions in incarceration, increases in stable housing, employment/education have been developed and will be shared in the next Plan Update once FY 19/20 data is available.

1. Reductions in Psychiatric Emergency, Inpatient, Crisis Stabilization Days: Percentage of FSP partners with a reduction in psychiatric emergency services/inpatient/crisis stabilization unit (CSU), comparing unduplicated days from the 12 months prior to program enrollment to the latest 12 months of program enrollment.

To qualify for this measure, an FSP partner must have at least one qualifying event (psychiatric emergency service, inpatient, CSU) in the 12 months prior to program enrollment, and must be enrolled in the program for at least six consecutive months during the reporting period.

| Eligible Episodes | Episodes with Reduction | % with Reduction |
|---|---|---|
| 162 | 131 | 81% |

2. Primary Care visit within one year of service: The percent of active FSP partners who've completed at least six months of treatment who received at least one primary care visit within one year of their participation in the FSP.

| Eligible Clients | Clients with Primary Care Visit During this FY | % with Primary Care Visit During this FY |
|---|---|---|
| 450 | 249 | 55% |

Research shows that individuals with a severe mental illness die up to 25 years younger than the average individual due to preventable illnesses; thus, connections with primary care are a vital part of health and recovery.

3. FSP Acute Follow up within 5 Days: The percent of FSP partners who were seen (face-to-face) by their FSP staff within five days of: discharge from a hospital for a mental health diagnosis, discharge from an institution of mental disease, receiving crisis stabilization (CSU), discharge from psychiatric health facility, and/or discharge from the County Justice System.

| Hospital/Crisis Episodes | Follow-Up in 5 Days | Success Rate |
|---|---|---|
| 21 | 16 | 76% |

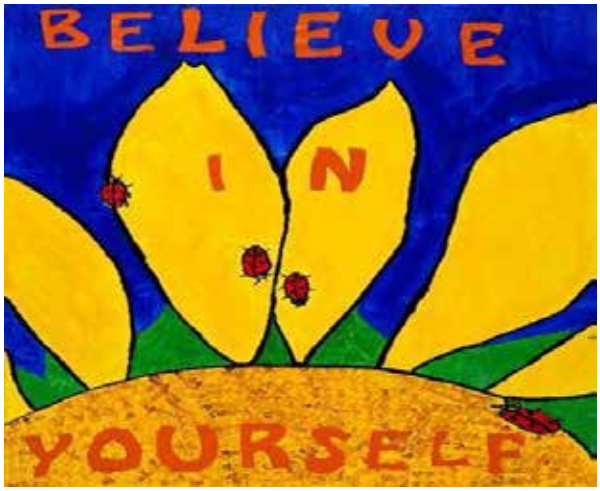
4. FSP Average of 4+ Visits per Month: The percent of FSP partners who have been open to a provider for at least 30 days who have had 4 or more face to face visits with FSP staff.

| Clients with Episode(s) | Clients with Average of 4+ Visits Per Month | Success Rate (%) |
|---|---|---|
| 753 | 422 | 56% |

5. No Gaps in Service over 30 days: The percent of FSP partners who did not have a service gap of over 30 days during the fiscal year. To qualify for this metric FSP partners needed to be open for at least three months during the fiscal year.

| Clients | Clients with No Gap Over 30 Days | % No Gap Over 30 Days |
|---|---|---|
| 25 | 24 | 96% |

### Client Vignette (Success Story)




The **I**n **H**ome **O**utreach **T**eam (IHOT), run by the agency La Familia, worked with a 56-year-old physically disabled Caucasian gentleman who was homeless, who also suffered from challenges with emotional regulation, depressed mood, and self-harming behaviors, which resulted in eight psychiatric hospitalizations in 2018.

The IHOT team was able to engage their client and get him admitted to a long-term shelter and enrolled him in a payee service program so he would have support with managing his money.

Over the course of services, it became suspected that a family member was abusing the client financially. IHOT collaborated closely with Adult Protective Services (APS) to address and stop the abuse. IHOT also supported the client by assisting him to obtain basic necessities, transported him to numerous medical appointments and got him enrolled at the TRUST Clinic.

For long term mental health services IHOT collaborated with APS and linked the client to ACBH's new Case Management for Older Adults with Disabilities program run by the Felton Institute.

Currently, this gentleman is stable and housed and has had significantly fewer contacts with ACBH's crisis system and the John George Psychiatric Hospital.

# CHILDREN & YOUTH FSPs

**FSP # FS16**

**PROVIDER NAME: Seneca Family of Agencies**

**PROGRAM NAME: Alameda Connections**

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

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

**Age Group:** Children

**Operational Budget:** $734,580

Program Outcomes & Impact: FY18/19

**PERFORMACE INDICATORS: How Much Did We Do?**

Number of Clients Served: 18

**PERFORMANCE INDICATORS: How Well Did We Do?**

Demographics of FSP Partners Served

| Fiscal Year | Ethnic Group | Clients | % of Clients |
|---|---|---|---|
| FY 2018-2019 | Asian | 1 | 6% |
| | Black or African American | 11 | 61% |
| | Hispanic or Latino | 2 | 11% |
| | Other/Unknown | 2 | 11% |
| | White | 2 | 11% |
| | | 18 | 100% |

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

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

**PERFORMANCE INDICATORS: Is Anyone Better Off?**
Our program has successfully supported two families to secure housing and we continue to work hard in order to locate and obtain needed housing for our other families in need.

We're particularly proud of the work we did with a 7-year-old boy and his mother who distrusted the mental health and school systems due to negative previous experiences. Our Care Coordinator spent hours working with client's mother to obtain better housing as the family had been living in substandard conditions in which mold permeated most of the house. Our Care Coordinator went to SSI hearings with her in order to help explain what she needed to do in order to receive needed benefits. Our Care Coordinator and Support Counselor worked regularly with the client's school in order to develop intervention plans and to ensure continued placement. Our Support Counselor also worked with the client in the community on his pro-social and regulation goals. Our Care Coordinator provided regular coaching to client's mother on how to regulate herself when triggered and how to communicate effectively with client. Although we were only able to find them housing outside of Alameda County, our team worked relentlessly with mom to transition services to the new county, including client's IEP to a new school district, their housing subsidy, Medi-Cal benefits, and therapy services. Finally, although mom had been initially opposed to inviting her existing familial supports to Family Team Meetings (FTM), at the last transition FTM, this mother invited several family members (Aunt, Uncle, Cousin) to help plan how they could continue supporting client and family after the Wrap program closed.

### FSP METRICS

| Metrics | % of FSP Partners who met the Metric |
|---|---|
| Reductions in Psychiatric Emergency, Inpatient, Crisis Stabilization Days | N/A program was new in FY18/19 |
| Primary Care Connection | 100% |
| Partners who received a follow up visit within 5-days after a mental health hospitalization or crisis. | 0% |
| The average of four or more visits per month per client. | 87% |
| No Gaps in Service over 30 days: | 100% |

**FSP # FS17**

**PROVIDER NAME: Fred Finch Youth Center**

**PROGRAM NAME: East Bay Wrap FSP**

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

**Target Population:** East Bay Wrap-FSP entry criteria include having repeated or recent hospitalizations or having at least 2 of the following: Failed multiple appointments with past providers; school absenteeism; risk of homelessness; high score for trauma on CANS; or lack of significant progress in Therapeutic Behavioral Services (TBS).

**Age Group:** Children/Youth

**Operational Budget:** $735,585

Program Outcomes & Impact: FY18/19

**PERFORMACE INDICATORS: How Much Did We Do?**

Number of Clients Served: 21

**PERFORMANCE INDICATORS: How Well Did We Do?**

Demographics of FSP Partners Served

| Fiscal Year | Ethnic Group | Clients | % of Clients |
|---|---|---|---|
| FY 2018-2019 | Asian | 1 | 5% |
| | Black or African American | 5 | 24% |
| | Hispanic or Latino | 6 | 29% |
| | Other/Unknown | 7 | 33% |
| | White | 2 | 10% |
| | | 21 | 100% |

**Language Capacity:** We have a Spanish-speaking Youth Partner on our team.

**Challenges:** Since this was our first year in operation, we had several challenges to address. The main challenge was staffing. Hiring at a non-profit in an ever-growing unaffordable location is becoming more complex. We have found that it takes more time to bring in high quality candidates to fill all positions at our agency. We hired an internal staffer to the position of Clinical Supervisor who came with extensive Quality Assurance experience. We added the first licensed clinician to the team in November and the

second one started in April. Our Youth Partner started in May and we completed our team with a Parent Partner in June. Prior to having a full team, staff assisted from other parts of the department. We hope that now that we have a full team, this issue will be less pronounced in the coming fiscal year.

**PERFORMANCE INDICATORS: Is Anyone Better Off?**

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

Client Story: We have one client who has been enrolled in our program since January and the family has been working closely with Wraparound and TBS. When the youth started, she was presenting with physical and verbal aggression at home/school and with extreme social anxiety. However, the youth and family have been engaging in services and the youth has been thriving over the summer, making new friends at her summer camp, using coping skills, and expressing feelings at home. The youth is getting along much better with their mother and is being open to trying new experiences as well.

**FSP METRICS**

| Metrics | % of FSP Partners who met the Metric |
|---|---|
| Reductions in Psychiatric Emergency, Inpatient, Crisis Stabilization Days | N/A program was new in FY18/19 |
| Primary Care Connection | 80% |
| Partners who received a follow up visit within 5-days after a mental health hospitalization or crisis. | 80% |
| The average of four or more visits per month per client. | 65% |
| No Gaps in Service over 30 days: | 93% |

# TRANSITION AGE YOUTH FSPs

**FSP # FS3**

**PROVIDER NAME: Fred Finch Youth Center**

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

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

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

**Age Group:** Transition Age Youth

**Operational Budget:** $2,969,073

Program Outcomes & Impact: FY18/19

**PERFORMACE INDICATORS: How Much Did We Do?**

Number of Clients Served: 71

**PERFORMANCE INDICATORS: How Well Did We Do?**

Demographics of FSP Partners Served

| Fiscal Year | Ethnic Group | Clients | % of Clients |
|---|---|---|---|
| FY 2018-2019 | Black or African American | 28 | 39% |
| | Hispanic or Latino | 11 | 15% |
| | Other/Unknown | 26 | 37% |
| | White | 6 | 8% |
| | | 71 | 100% |

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

**Challenges:** The program's primary challenges were related to housing and staffing. The housing crisis continued in Alameda County during the fiscal year, leaving a dearth of affordable housing units. Financial pressures have driven many board and care operators out of the business, leaving fewer supported, group living options for housing in the area. The housing crisis, combined with the cost of living in the Bay Area, have contributed to a much more challenging hiring environment for community

mental health programs. Finding master's level clinicians for the program continues to be particularly difficult**.**

**PERFORMANCE INDICATORS: Is Anyone Better Off?**

*Increasing Income*: 14 STAY participants secured employment with the support of the program's vocational services. Three STAY participants were granted SSI, with STAY program support required while following through with the application and appeals processes.

*Connection to healthcare*: 12 of 17 participants completing their first 12 months in the program were connected to primary health care.

*Housing*: The program connected 17 participants to transitional or permanent housing and provided intervention to support 12 participants in maintaining housing.

*Education*: Ten STAY participants enrolled in educational programs with support from the STAY program.

*Social Connection*: The STAY Program connected 51 of 65 to social activities during the period.

*ANSA-T Results*: From the start of the fiscal year to the end of the second quarter, 64% of program participants had an improved total score for the Individual Strengths domain, and 84% of participants showed improvement in at least one area of the ANSA-T during the same period.

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

**FSP METRICS**

| Metrics | % of FSP Partners who met the Metric |
|---|---|
| Reductions in Psychiatric Emergency, Inpatient, Crisis Stabilization Days | 86% |
| Primary Care Connection | 64% |
| Partners who received a follow up visit within 5-days after a mental health hospitalization or crisis. | 61% |
| The average of four or more visits per month per client. | 68% |
| No Gaps in Service over 30 days: | 60% |

**FSP # FS21**

**PROVIDER NAME: Bay Area Community Services**

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

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

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

**Age Group:** Transition Age Youth

**Operational Budget:** $1,484,534

Program Outcomes & Impact: FY18/19

**PERFORMACE INDICATORS: How Much Did We Do?**

Number of Clients Served: 36

**PERFORMANCE INDICATORS: How Well Did We Do?**

Demographics of FSP Partners Served

| Fiscal Year | Ethnic Group | Clients | % of Clients |
|---|---|---|---|
| FY 2018-2019 | Asian | 3 | 8% |
| | Black or African American | 6 | 17% |
| | Hispanic or Latino | 12 | 33% |
| | Other/Unknown | 6 | 17% |
| | White | 9 | 25% |
| | | 36 | 100% |

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

**Challenges:** One of the challenges we had was receiving appropriate referrals in the areas contracted. A remedy for this challenge was to extend service locations.

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

**PERFORMANCE INDICATORS: Is Anyone Better Off?**

Since the launch of PAIGE in November 2018, PAIGE has served 36 youth. Since receiving support from the PAIGE team, many of the youth have shown a significant reduction in mental health symptoms, improvement in interpersonal and communication skills, and an increase in engagement. Many of the youth who struggled to engage in meaningful activities are now engaging in community outings and events and establishing social connections with other peers.

PAIGE has supported many clients in taking a big step toward achieving educational and employment goals. PAIGE has supported clients by enrolling them in GED/diploma programs, community college, security card classes, CPR/AED/First Aid Certification classes, a four-week intensive job readiness program, and food handler certification classes. Sixteen of the youth have been referred to receive employment services and four are currently employed.

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

**FSP METRICS**

| Metrics | % of FSP Partners who met the Metric |
|---|---|
| Reductions in Psychiatric Emergency, Inpatient, Crisis Stabilization Days | N/A program was new in FY18/19 |
| Primary Care Connection | 77% |
| Partners who received a follow up visit within 2-days after a mental health hospitalization or crisis. | 46% |
| The average of four or more visits per month per client. | 55% |
| No Gaps in Service over 30 days: | 63% |

# ADULT FSPs

**FSP #: FS4**

**PROVIDER NAME: Abode Services**

**PROGRAM NAME: Greater HOPE FSP**

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

**Target Population:** Chronically homeless adults

**Age Group:** Adults

**Operational Budget:** $4,398,759

Program Outcomes & Impact: FY18/19

**PERFORMACE INDICATORS: How Much Did We Do?**

Number of Clients Served: 82

**PERFORMANCE INDICATORS: How Well Did We Do?**

Demographics of FSP Partners Served

| Fiscal Year | Ethnic Group | Clients | % of Clients |
|---|---|---|---|
| FY 2018-2019 | Asian | 2 | 2% |
| | Black or African American | 11 | 13% |
| | Hispanic or Latino | 8 | 10% |
| | Other/Unknown | 30 | 37% |
| | White | 31 | 38% |
| | | 82 | 100% |

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

**Challenges:** We have found the Quality Assurance compliance demands for Medi-Cal have been difficult to keep up with and deters from service delivery.

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

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

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

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

**PERFORMANCE INDICATORS: Is Anyone Better Off?**

We served 82 unduplicated chronically homeless adults and of those 82, 60% are stably housed in Permanent Supportive Housing or are in interim housing or shelters. Through use of client flex funds, we helped prevented several participants from become homeless i.e. paying for bed bug eradication, paying rent arrears, etc.

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

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

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

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

### FSP METRICS

| Metrics | % of FSP Partners who met the Metric |
|---|---|
| Reductions in Psychiatric Emergency, Inpatient, Crisis Stabilization Days | 85% |
| Primary Care Connection | 61% |
| Partners who received a follow up visit within 2-days after a mental health hospitalization or crisis. | 46% |
| The average of four or more visits per month per client. | 32% |
| No Gaps in Service over 30 days: | 40% |

**FULL SERVICE PARTNERSHIP (FSP) REPORT**
**FSP #: FS10**

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

**PROGRAM NAME: Housing Solutions for Health**

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

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

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

**Age Group:** Adults

**Operational Budget:** $13,238,669

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

1) Long-term housing subsidy programs and housing partnership support contracts that make it possible for individuals with serious mental illness to live in permanent supportive housing and licensed board and cares;
2) Short-term housing financial assistance to help individuals with serious mental illness to obtain and maintain housing with one-time and short-term payments of security deposits and rent;
3) Supportive services linked with permanent subsidized housing to create "permanent supportive housing" options for individuals to live in community-based rental housing settings;
4) Temporary housing programs for individuals with serious mental illness experiencing homelessness to be sheltered and supported while they work to return to permanent housing;
5) Street outreach and housing navigation services focused on helping homeless individuals with serious mental illness living in public places and emergency shelters to return to permanent, safe, and supportive housing as quickly as possible;

6) Supporting an affordable housing search website and news alerts related to current housing opportunities relevant to people with serious mental illness and extremely low incomes;
7) Referrals, coordination, clinical consultation, training ,and oversight of a network of more than 450 licensed board and care and permanent support housing slots countywide;
8) Housing education and counseling sessions at ACBH-funded Wellness Centers and other community locations;
9) Staff involvement and financial support toward countywide efforts focused on addressing homelessness;
10) MHSA affordable housing project application preparation in partnership with nonprofit affordable housing developers.

Program Outcomes & Impact: FY18/19

**PERFORMACE INDICATORS: How Much Did We Do?**

**Number of Clients Served:** CMHSA-funded housing service programs reach at least 1,500 people with serious mental illness each fiscal year.

**PERFORMANCE INDICATORS: How Well Did We Do?**

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

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

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

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

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

**PERFORMANCE INDICATORS: Is Anyone Better Off?**

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

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

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

ACBH resources helped Alameda Point Collaborative to secure and plan for the development of a recuperative care and supportive housing project in the City of Alameda. The project will have 80-90 permanent supportive housing units for seniors age 55 and older with disabilities including serious mental illness and 50 recuperative care/medical respite beds. Residents in the City of Alameda voted to support the project moving forward and the project secured some additional local and private funding to keep the effort moving forward. More information about the project can be found at: http://caringalameda.org/

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

**FSP # FS11**

**PROVIDER NAME: Telecare Corporation**

**PROGRAM NAME: Community Conservatorship (CC) Program**

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

**Target Population:** Adults diagnosed with severe mental illness, many of whom would otherwise require extended care in institutional settings.

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

**Age Group:** Adults

**Operational Budget:** $1,191,636

Program Outcomes & Impact: FY18/19

**PERFORMACE INDICATORS: How Much Did We Do?**

Number of Clients Served: 22

**PERFORMANCE INDICATORS: How Well Did We Do?**

Demographics of FSP Partners Served

| Fiscal Year | Ethnic Group | Clients | % of Clients |
|---|---|---|---|
| FY 2018-2019 | Asian | 1 | 5% |
| | Black or African American | 3 | 14% |
| | Hispanic or Latino | 2 | 9% |
| | Other/Unknown | 10 | 45% |
| | White | 6 | 27% |
| | | 22 | 100% |

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

**Challenges:** Many of our clients are challenging to engage with in the field due to transient behaviors.

Limited housing resources and the income of our clients not being enough to cover the daily needs in housing.

**PERFORMANCE INDICATORS: Is Anyone Better Off?**

Telecare Community Conservatorship (CC) program is an intensive community support services program using an Assertive Community Treatment (ACT) for individuals with a severe mental illness. The CC team provides support for partners daily, such as individual rehabilitation, targeted case management services/collateral services, and medication support. We engage with our partners up to 7 days a week to ensure they have the means and support to be successful with transitioning back into a community setting. The CC treatment team also communicates daily with community supports, board and care staff, and conservators.

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

**FSP # FS12**

**PROVIDER NAME: Telecare Corporation**

**PROGRAM NAME: Assisted Outpatient Treatment (AOT) Program**

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

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

**Age Group:** Adults

**Operational Budget:** $123,450

Program Outcomes & Impact: FY18/19

**PERFORMACE INDICATORS: How Much Did We Do?**

Number of Clients Served: 37

**PERFORMANCE INDICATORS: How Well Did We Do?**

Demographics of FSP Partners Served

| Fiscal Year | Ethnic Group | Clients | % of Clients |
|---|---|---|---|
| FY 2018-2019 | Alaska Native or American Indian | 1 | 3% |
| | Asian | 4 | 11% |
| | Black or African American | 6 | 16% |
| | Hispanic or Latino | 2 | 5% |
| | Other/Unknown | 11 | 30% |
| | White | 13 | 35% |
| | | 37 | 100% |

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

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

**PERFORMANCE INDICATORS: Is Anyone Better Off?**

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

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

**FSP # FS 13**

**PROVIDER NAME: Telecare Corporation**

**PROGRAM NAME: CHANGES**

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

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

**Age Group:** Adults

**Operational Budget:** $2,974,107

Program Outcomes & Impact: FY18/19

**PERFORMACE INDICATORS: How Much Did We Do?**

Number of Clients Served: 89

**PERFORMANCE INDICATORS: How Well Did We Do?**

Demographics of FSP Partners Served

| Fiscal Year | Ethnic Group | Clients | % of Clients |
|---|---|---|---|
| FY 2018-2019 | Alaska Native or American Indian | 1 | 1% |
| | Asian | 7 | 8% |
| | Black or African American | 34 | 38% |
| | Hispanic or Latino | 5 | 6% |
| | Other/Unknown | 20 | 22% |
| | White | 22 | 25% |
| | | 89 | 100% |

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

**Challenges:** The greatest challenge faced by the CHANGES FSP in FY18/19 was the team's two-month relocation to another site during October and November. Since the majority of FSP consumers live in East Oakland, San Leandro, and southern Alameda County, moving from East Oakland to downtown Oakland increased the distance they had to travel to the FSP office. The increase in travel distance and time resulted in a decrease in client FTF contact due to fewer drop-in clients being seen by case managers, and more missed and cancelled appointments with nurses and prescribers. Staff efforts to compensate for the decrease in proximity to services by increasing field contacts were only partially successful due the increased distance FSP staff had to travel to deliver services to consumers at their homes and in their communities, coupled with the difficulty of being able to consistently locate individual clients. The overall impact of the dislocation was to decrease the team's operational effectiveness and efficiency.

The CHANGES FSP also faced many challenges resulting from the expansion of the team's census from 50 to 100 consumers in FY18/19. Most of these challenges were predictable, and included hiring and training additional staff (the FSP team doubled in size), and securing the many logistical supports needed for the increased staff size, including office space, furniture, computers, phones and phone lines, etc. There was also a lag in new consumer referrals so that the CHANGES FSP is still 13% below capacity.

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

**PERFORMANCE INDICATORS: Is Anyone Better Off?**

As a direct result of the integrated, individualized consumer-driven services and supports provided by the CHANGES FSP, five (5) consumers transitioned to a lower level of service, fifteen (15) new referrals were linked to primary care, four (4) consumers were linked to BALA for assistance getting SSI benefits, eighteen (18) consumers were housed, and sixteen (16) consumers worked with the FSP's vocational specialist during the report period, resulting in one (1) consumer getting a job and two (2) returning to school.

Client Story: Since her enrollment in the FSP team, WC has greatly reduced her utilization of acute services (i.e. mobile crisis, JGPES, criminal justice, etc.): she had 39 acute contacts in 2016, 11 in 2017, 5 in 2018, and none in 2019. In addition, when WC was first referred the CHANGES FSP, she couldn't get a housing interview, let alone an offer for housing placement, due to her history of behavioral outbursts and serious substance use. However, with the support of the FSP team, WC was able to maintain her housing for the entire 12 months of the reporting period.

Client Story: Consumer RB had 15 PES contacts, 6 hospitalizations, and 1 incarceration in FY17/18. Utilizing FSP support and resources, he was able to reduce his system utilization to 2 PES contacts, 2 hospitalizations, and 1 incarceration in FY18/19, and his overall total hospital days were significantly decreased. Furthermore, he went from being chronically homeless, to transitional housing at the Henry Robinson, and ultimately to S+C subsidized permanent housing. As his housing stabilized, RB was able to make use of the linkages created by the FSP team with primary and specialty healthcare providers, so that he is now receiving much needed medical care for multiple chronic medical conditions.

### FSP METRICS

| Metrics | % of FSP Partners who met the Metric |
|---|---|
| Reductions in Psychiatric Emergency, Inpatient, Crisis Stabilization Days | 76% |
| Primary Care Connection | 60% |
| Partners who received a follow up visit within 2-days after a mental health hospitalization or crisis. | 54% |
| The average of four or more visits per month per client. | 69% |
| No Gaps in Service over 30 days: | 51% |

**FSP # FS14**

**PROVIDER NAME: Telecare Corporation**

**PROGRAM NAME: STRIDES**

**Program Description**: STRIDES is a Full-Service Partnership program based on the Assertive Community Treatment model.

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

**Age Group:** Adults

**Operational Budget:** $2,974,105

Program Outcomes & Impact: FY18/19

**PERFORMACE INDICATORS: How Much Did We Do?**

Number of Clients Served: 126

**PERFORMANCE INDICATORS: How Well Did We Do?**

Demographics of FSP Partners Served

| Fiscal Year | Ethnic Group | Clients | % of Clients |
|---|---|---|---|
| FY 2018-2019 | Asian | 10 | 8% |
| | Black or African American | 41 | 33% |
| | Hispanic or Latino | 3 | 2% |
| | Other/Unknown | 34 | 27% |
| | White | 38 | 30% |
| | | 126 | 100% |

**Language Capacity:** Language Line, Spanish, Tagalog, and Edo.

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

**PERFORMANCE INDICATORS: Is Anyone Better Off?**

STRIDES continues to engage with our members daily and provide individual rehabilitation, targeted case management services, and medication support. Individual rehabilitation focuses on targeted skills in training for our members in the areas of community living, which include housing stability, self-care, socialization, daily activities, coping skills, symptom management, and money management. We communicate with family members and our clients' existing social supports and we view this as a strength. Our nurses and licensed providers provide psychoeducation to our team and to our members

about the importance of medication issues and they coordinate with outside medical providers, hospitals, pharmacies, labs and other health-related service providers. Our nurse collaborates in assessing physical health and coordinating medical and psychiatric treatment for our members. Our vocational specialist provides modeling skills and employment support, using the IPS model, to our members who have employment goals. They provide support around job development, benefits counseling, job placement (including going back to school), benefits counseling, and they act as a liaison between our members and employers. STRIDES strives to reduce hospitalizations and incarceration by using evidenced-base practice techniques and education around crisis management. When clients are in subacute and acute settings, we communicate and collaborate with inpatient teams to coordinate the care of our members.

Client Story**:** MB was a community referral from Herrick Hospital. According to her MHA140, MB was going to the Highland and Summit emergency rooms, and to John George PES, at least 3-5 times a day. She was not connected to any benefits and appeared to be exploited in the community. When she was referred to STRIDES, we immediately provided outreach and admitted her to our program within 24 hours. MB presented with memory loss and endorsed delusions and hallucinations of bugs crawling out of her back. Although she was very friendly, she informed us that she has never had a place to sleep, however, she had a "friend in the community" who gave her money sometimes. She did not want to identify this friend or where he lived. She appeared to have poor hygiene and was very disheveled. In the beginning of our engagement, MB did not trust us and often forgot who we were. Our team made a plan to see her every day and informed social workers from Summit and Highland to immediately contact us if she self-presented at the ER. When we received phones calls from the ER, we immediately engaged with MB and provided support with what she needed. We provided her with clothing and food since she did not have access to her SSI. After engaging with her at least 3-4 times a week, she began to trust our team. She agreed to sign the application to be a part of the substitute payee program and find housing. We viewed several housing options with her until we found a place where MB felt comfortable. Since placing her in the community, her hospital visits have reduced from 3-5 times daily to 3-4 times a month. She continues to maintain her housing and is able to engage with STRIDES to get her needs met.

### FSP METRICS

| Metrics | % of FSP Partners who met the Metric |
|---|---|
| Reductions in Psychiatric Emergency, Inpatient, Crisis Stabilization Days | 80% |
| Primary Care Connection | 46% |
| Partners who received a follow up visit within 2-days after a mental health hospitalization or crisis. | 52% |
| The average of four or more visits per month per client. | 68% |
| No Gaps in Service over 30 days: | 44% |

**FSP # FS18**

**PROVIDER NAME: Bay Area Community Services**

**PROGRAM NAME: Homeless Engagement Action Team (HEAT)**

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

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

**Age Group:** Adults

**Operational Budget:** $4,398,760

Program Outcomes & Impact: FY18/19

**PERFORMACE INDICATORS: How Much Did We Do?**

Number of Clients Served: 76

**PERFORMANCE INDICATORS: How Well Did We Do?**

Demographics of FSP Partners Served

| Fiscal Year | Ethnic Group | Clients | % of Clients |
|---|---|---|---|
| FY 2018-2019 | Black or African American | 35 | 46% |
| | Hispanic or Latino | 4 | 5% |
| | Other/Unknown | 27 | 36% |
| | Pacific Islander | 1 | 1% |
| | White | 9 | 12% |
| | | 76 | 100% |

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

**Challenges:** One of HEAT's challenges continues to be related to the Bay Area Housing crisis, acutely felt in Oakland where a majority of our clients live. This coupled with the rise in cost of living and our clients' fixed incomes, often SSI has created some barriers to HEAT finding appropriate and sustainable housing placements that will meet our clients' unique needs. Given that HEAT is charged with serving chronically

and literally homeless adults, the expectations of immediate permanent housing versus the reality of lack of affordable housing often come into stark contrast and managing client or community partner expectations around this fact is a constant practice.

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

**PERFORMANCE INDICATORS: Is Anyone Better Off?**

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

Given that HEAT serves a majority of homeless clients, of the 76 clients served in our 3rd and 4th quarters, we have successfully found housing solutions (temporary/transitional/permanent housing) for approximately 70 clients.

Employing the housing first philosophy has led to our clients having decreased the revolving cycle of psychiatric hospitalizations, ED visits, and incarcerations.

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

### FSP METRICS

| Metrics | % of FSP Partners who met the Metric |
|---|---|
| Reductions in Psychiatric Emergency, Inpatient, Crisis Stabilization Days | N/A program was new in FY18/19 |
| Primary Care Connection | 69% |
| Partners who received a follow up visit within 2-days after a mental health hospitalization or crisis. | 56% |
| The average of four or more visits per month per client. | 78% |
| No Gaps in Service over 30 days: | 68% |

**FSP # FS20**

**PROVIDER NAME: Bay Area Community Services**

**PROGRAM NAME: Lasting Independence Forensic Team (LIFT)**

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

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

**Age Group:** Adults

**Operational Budget:** $2,969,072

Program Outcomes & Impact: FY18/19

**PERFORMACE INDICATORS: How Much Did We Do?**

Number of Clients Served: 84

**PERFORMANCE INDICATORS: How Well Did We Do?**

Demographics of FSP Partners Served

| Fiscal Year | Ethnic Group | Clients | % of Clients |
|---|---|---|---|
| FY 2018-2019 | Alaska Native or American Indian | 3 | 4% |
| | Asian | 3 | 4% |
| | Black or African American | 33 | 39% |
| | Hispanic or Latino | 4 | 5% |
| | Other/Unknown | 30 | 36% |
| | White | 11 | 13% |
| | | 84 | 100% |

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

**Challenges:** One of the challenges LIFT has faced is connecting our partners who do not have financial means to SSI/SSDI benefits. This has been particularly true for partners who have a difficult time consistently engaging due to lack of stability. The team is consistently working to build rapport and to improve engagement efforts to support our partners.

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

**PERFORMANCE INDICATORS: Is Anyone Better Off?**

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

A majority of our partners are connected with financial benefits. Those who are not yet connected with benefits are currently in the application process and will be connected with community resources such as the Homeless Action Center and Bay Area Legal Aid should they be denied financial benefits.

**FSP METRICS**

| Metrics | % of FSP Partners who met the Metric |
|---|---|
| Reductions in Psychiatric Emergency, Inpatient, Crisis Stabilization Days | N/A program was new in FY18/19 |
| Primary Care Connection | 53% |
| Partners who received a follow up visit within 2-days after a mental health hospitalization or crisis. | 54% |
| The average of four or more visits per month per client. | 60% |
| No Gaps in Service over 30 days: | 38% |

**FSP # FS22**

**PROVIDER NAME: Telecare Corporation**

**PROGRAM NAME: Justice and Mental Health Recovery (JAMHR)**

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

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

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

**Age Group:** Adults

**Operational Budget:** $4,257,760

Program Outcomes & Impact: FY18/19

**PERFORMACE INDICATORS: How Much Did We Do?**

Number of Clients Served: 54

**PERFORMANCE INDICATORS: How Well Did We Do?**

Demographics of FSP Partners Served

| Fiscal Year | Ethnic Group | Clients | % of Clients |
|---|---|---|---|
| FY 2018-2019 | Asian | 2 | 4% |
| | Black or African American | 17 | 31% |
| | Hispanic or Latino | 6 | 11% |
| | Other/Unknown | 20 | 37% |
| | White | 9 | 17% |
| | | 54 | 100% |

**Language Capacity:** Spanish and Urdu in Vivo. We regularly use Language Line to provide linguistically appropriate services to those who speak other languages.

**Challenges:** JAMHR opened in October 2018 and we went from zero to 54 partners. When we opened, our team was very knowledgeable about behavioral health services, but needed to learn about the justice system. We increased our knowledge about the justice system, homeless resources, substance use treatment resources and benefit support as well.

**PERFORMANCE INDICATORS: Is Anyone Better Off?**

JAMHR successfully engaged and admitted 54 new partners. Some highlights for JAMHR's first year in operation include:

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

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

# OLDER ADULT FSPs

**FSP # FS19**

**PROVIDER NAME: Bay Area Community Services**

**PROGRAM NAME: Circa60**

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

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

**Age Group:** Older Adults

**Operational Budget:** $2,905,008

Program Outcomes & Impact: FY18/19

**PERFORMACE INDICATORS: How Much Did We Do?**

Number of Clients Served: 92

**PERFORMANCE INDICATORS: How Well Did We Do?**

Demographics of FSP Partners Served

| Fiscal Year | Ethnic Group | Clients | % of Clients |
|---|---|---|---|
| FY 2018-2019 | Asian | 2 | 2% |
| | Black or African American | 35 | 38% |
| | Hispanic or Latino | 4 | 4% |
| | Other/Unknown | 31 | 34% |
| | White | 20 | 22% |
| | | 92 | 100% |

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

**Challenges:** During this fiscal year, Circa60 has faced numerous challenges as our program grows and develops. One of these includes finding appropriate licensed board and care homes for our partners

needing this level of care but who earn only minimum SSDI or are not making enough money to afford Alameda County rates. In these circumstances, we are left with no choice but to house partners in sub-optimal living arrangements and to increase our weekly contacts and to work to get IHHS started. Overall, housing and keeping some of our partners stably housed has been a challenge.

**PERFORMANCE INDICATORS: Is Anyone Better Off?**

Our team has received referrals for 92 partners and we are working to open more consumers to services. We continue to improve the ability of our partners to achieve and maintain an optimal level of functioning and recovery by providing supportive case management and wrap around services.
Our team is able to respond quickly and efficiently to emergent partner needs. Numerous times over the past six months, a partner would have an increase in mental health symptoms and problematic behaviors that jeopardized housing and overall well-being. By responding rapidly and increasing partner contact, we were able to intervene, to help stabilize our partners' symptoms, and to prevent crises before they happen. We have also built effective and responsive relationships with many of our partners' landlords and housing managers. We use these relationships to help maintain and to avoid disruptions in in housing. Circa60 team members work with all our partners to identify areas of interest and help develop engagement in meaningful activities. We also worked hard to identify and build existing supports for many of our partners.

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

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

**FSP METRICS**

| Metrics | % of FSP Partners who met the Metric |
|---|---|
| Reductions in Psychiatric Emergency, Inpatient, Crisis Stabilization Days | 91% |
| Primary Care Connection | 40% |
| Partners who received a follow up visit within 2-days after a mental health hospitalization or crisis. | 36% |
| The average of four or more visits per month per client. | 34% |
| No Gaps in Service over 30 days: | 33% |

# OUTREACH ENGAGEMENT/ SYSTEM DEVELOPMENT (OESD) REPORTS

**OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT**

**OESD #: OESD 4A**

**PROVIDER NAME: City of Fremont**

**PROGRAM NAME: Mobile Integrated Assessment Team for Seniors**

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

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

**Operational Budget:** $647,453

Program Outcomes & Impact: FY18/19

**PERFORMACE INDICATORS: How Much Did We Do?**

Number of Clients Served: 55

**PERFORMANCE INDICATORS: How Well Did We Do?**

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

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

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

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

**PERFORMANCE INDICATORS: Is Anyone Better Off?**

- The ultimate goal of the program is to provide services to the recovery of our clients. The program helps many clients in successfully meeting their desired treatment goals thus giving clients the mental and emotional stability they need and regaining independence. Gaining stability relieves stress in the family and once client recovers family recovers as well and family becomes an invaluable resource for the clients. The program provides family therapy and other supportive services and the program staff works with them through diagnosis and beyond.

- Clients with mental illness have identity and voice, so the program engages them in an open and honest discussion when it comes to their own treatment and we recognize and praise their strengths and progress.

- Clients diagnosed today can expect better outcome than before i.e.: medication have improved and new evidence based psychotherapeutic interventions can have powerful and positive effects on
  client's recovery per our psychiatrist and Physician Assistant.

- The program develops a wide range of community support services to address the diverse needs of the program population.

- The program supports on-going professional staff development including trainings to advance staff's knowledge/understanding of different culture of the client (cultural competency trainings).

- City of Fremont- as a city organization actively engages mental health advocacy efforts toward increasing community awareness aimed at reducing stigma associated with mental illness.

**OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT**

**OESD #: OESD 5A**

**PROVIDER NAME: Alameda County Behavioral Health (ACBH)**

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

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

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

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

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

**Operational Budget:** $2,935,937

Program Outcomes & Impact: FY18/19

**PERFORMACE INDICATORS: How Much Did We Do?**

Number of Clients Served: 925

**PERFORMANCE INDICATORS: How Well Did We Do?**

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

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

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

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

**PERFORMANCE INDICATORS: Is Anyone Better Off?**

Below are a number of examples of the impacts the mobile crisis teams have on individuals, families, and the greater community:

- A friend of a homeless man living near a storage facility called to request assistance. The individual had a history of psychiatric hospitalizations in various counties in California but was not connected to care. The mobile crisis team responded to the location and met the friend who had called there. The team coordinated getting this individual to an urgent psychiatric medication clinic where he received medications. He was also connected to ACCESS and referred to a specialty mental health medication clinic for ongoing services.

- The mobile team provided support to a family after they discovered their love one had died by suicide. With permission, staff followed up with the child's school to ensure that the counselors were alerted that the child might need support upon returning to school.

- MET was dispatched to a 911 generated call regarding a person behaving bizarrely in the community. Once it was determined that the individual was intoxicated, a detox/sobering center was offered and the person accepted services. The team transported the individual to the most appropriate level of care.

- A mother called MCT to evaluate her son who was severely depressed, nearly mute, and had been making suicidal gestures. His mother was very concerned since her son had a serious suicide attempt a few years ago. The team arrived and the son was supported to a psychiatric hospital and admitted.

**OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT**

**OESD #: OESD 7**

**PROVIDER NAME: Alameda County Behavioral Health**

**PROGRAM NAME: Behavioral Health Court (BHC)**

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

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

Operational Budget: $ 510,391

Program Outcomes & Impact: FY18/19

**PERFORMACE INDICATORS: How Much Did We Do?**

Number of Clients Served: Approximately **226 clients were assessed** for Behavioral Health Court, and if qualified and agreeable were connected to specialty mental health treatment. At close of FY2019, there were approximately **104 clients who additionally met the criteria and were actively admitted** into Behavioral Health Court. Approximately, **24 individuals "graduated"** from Behavioral Health Court last year, and had their criminal charges reduced, dismissed, or probation removed or resumed.

**PERFORMANCE INDICATORS: How Well Did We Do?**

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

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

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

**PERFORMANCE INDICATORS: Is Anyone Better Off?**

As a result of Behavioral Health Court, clients were able to have improved access to treatment, increased engagement with wellness and recovery activities, and reduced number of days in institutional settings. The BHC program also improves public safety, health, and property of the surrounding community.

**OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT**

**OESD #: OESD 7**

**PROVIDER NAME: Mental Health Court Specialist**

**PROGRAM NAME: Court Advocacy Project (CAP)**

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

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

**Operational Budget:** $510,391

Program Outcomes & Impact: FY18/19

**PERFORMACE INDICATORS: How Much Did We Do?**

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

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

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

**PERFORMANCE INDICATORS: How Well Did We Do?**

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

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

**PERFORMANCE INDICATORS: Is Anyone Better Off?**

*Case Example for CAP*: "John" is a 24-year-old African-American Transition Age Youth. John has suffered multiple traumas in his short life. His mother died of cancer when John was 12. His father struggled with an addiction to heroin and he went to prison when John was 15 years old. John was able to identify only one remaining main support. He was referred to CAP through his Public Defender after being arrested and charged with multiple attempted car burglaries. John was homeless and he broke in cars to get some sleep or take items that would get him money to survive. John experienced severe depression with psychosis. CAP assessed him and advocated for him to be connected with a Full-Service Partnership through the Fred Finch STAY program. It took some negotiation with the District Attorney, who initially didn't want to grant a re-entry plan for client, because he felt John had multiple offenses, and was a potential danger to the community. In response to this concern, CAP was able to refer John to Jay Mahler Recovery Center as an initial transition place after incarceration. The STAY Program was able to engage with him more there and assisted him in his transition to live with a friend. John was able to also re-connect with his brother. John continues to work with the STAY Program. STAY was able to secure housing for him, help him to manage his mental health symptoms, and as a result he has not returned to jail. While he initially had follow up court dates to provide progress reports from his treatment team, he was eventually placed back on probation with no further court dates. John has not returned to jail since his involvement with the Court Advocacy Project, and continues to thrive in his recovery with the STAY Program.

Overall, CAP reduces recidivism back to jail by connecting people with serious mental health issues to outpatient mental health services; and crafting mental health dispositions for re-entry back into the community.

As a result of CAP services:

- Clients spent fewer days in jail and more time connected to community treatment at the right-matched level of behavioral health care support;

- Criminal Justice Professionals were better able to recognize, understand, and address the underlying issues leading to recidivism, and

- Families and community treatment providers were better able to navigate the court system and advocate for their loved ones/partners, and clients were linked to.

**OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT**

**OESD #: OESD 8**

**PROVIDER NAME: Alameda County Behavioral Health**

**PROGRAM NAME: Juvenile Justice Transformation of the Guidance Clinic (GC)**

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

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

**Operational Budget:** $492,235

Program Outcomes & Impact: FY18/19

**PERFORMACE INDICATORS: How Much Did We Do?**

Number of Clients Served: 576

**PERFORMANCE INDICATORS: How Well Did We Do?**

**Language Capacity:** Current language capacity includes: Cantonese, Spanish, and Vietnamese.

**Challenges:** Staffing was a major challenge for the GC and our services this year.

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

**PERFORMANCE INDICATORS: Is Anyone Better Off?**

Case study/client-family story:
A young man, BT[1], was detained at the Juvenile Justice Center (JJC) earlier this year. It was the first time BT had every been detained. During his detention, BT was assessed by a Guidance Clinic (GC) crisis clinician after a referral from the JJC medical clinic. BT disclosed to the GC crisis clinician that he had attempted suicide several times in the past. While the GC crisis clinician determined that BT was not

[1] Not real initials.

actively suicidal, she did feel that BT would benefit from regular mental health services, which he had not received in the past. The GC crisis clinician referred BT for a medication evaluation, referred BT to the unit clinician for ongoing therapy, and helped BT create a safety plan that identified specific goals, triggers, and coping strategies that BT could use to address any suicidal feelings while BT was in detention. The GC crisis clinician also worked with Probation staff in the JJC to establish a safety protocol to monitor BT.

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

The GC mental health team also worked with BT's Probation Officer to connect with BT's father. The GC team discussed BT's needs with BT's father and highlighted the importance of regular mental health services. BT's father agreed with the plans established by the GC team and understood the need for ongoing services once BT was released.

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

**Additional Impact:**

- Youth entering the Juvenile Justice Center were assessed by a Guidance Clinic clinician and provided the opportunity for ongoing therapeutic support.

- Youth in the Juvenile Justice Center were provided crisis support during traumatic/triggering events associated with being detained.

- Upon release from the Juvenile Justice Center, the mental health needs of youth were assessed (using records from Clinician's Gateway and recommendations from Guidance Clinic clinicians), and youth and families were referred to appropriate care, e.g., therapy, psychiatry, etc. A total of 513 youth were seen by a GC staff person in the Transition Center.

**OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT**

**OESD #: OESD 9**

**PROVIDER NAME: Seneca Family of Agencies**

**PROGRAM NAME: Multi-Systemic Therapy (MST)**

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

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

**Operational Budget:** $878,823

Program Outcomes & Impact: FY18/19

**PERFORMACE INDICATORS: How Much Did We Do?**

Number of Clients Served: 52

**PERFORMANCE INDICATORS: How Well Did We Do?**

**Language Capacity:** English and Spanish

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

**PERFORMANCE INDICATORS: Is Anyone Better Off?**

Client story: AA came to the attention of the MST program through a weekly meeting in which youth are considered for out of home placement. When the MST program was recommended to AA's mother, she stated that she would "do whatever it takes" to keep her son at home.

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

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

AA and his family, though discouraged, remained hopeful and demonstrated continuous effort to maintain his areas of progress. AA continued participating with MST therapy, completed extra hours of community service hours, graduated high school, and again obtained letters of support to advocate for his dismissal at his next court date. MST clinician provided services aimed at family continuing to sustain advances made and to ensure that Freddy maintained progress. In addition, MST clinician utilized advocacy techniques with AA's probation officer to ensure that all work together so that she may recommend his dismissal, adding more power to his chances of being dismissed at only 4 months of being on probation.

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

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

**OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT**

**OESD #: OESD 11**

**PROVIDER NAME: Seneca Family of Agencies**

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

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

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

**Operational Budget:** $3,114,946

Program Outcomes & Impact: FY18/19

**PERFORMACE INDICATORS: How Much Did We Do?**

Number of Clients Served: 985 unique clients, 1,165 admissions

**PERFORMANCE INDICATORS: How Well Did We Do?**

**Language Capacity:** English, Spanish, Vietnamese. Additional language services provided through contracted interpreters.

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

**PERFORMANCE INDICATORS: Is Anyone Better Off?**

41% of CSU clients were diverted from inpatient hospitalization. The remaining 59% were referred to the appropriate level of care to continue receiving necessary treatment.

**OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT**

**OESD #: OESD 14**

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

**PROGRAM NAME: Language ACCESS Asian**

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

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

**Operational Budget:** $772,979

Program Outcomes & Impact: FY18/19

**PERFORMACE INDICATORS: How Much Did We Do?**

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

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

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

**PERFORMANCE INDICATORS: How Well Did We Do?**

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

**Challenges:** High percentage of referrals were made by PCP and family/friends, the corresponding API clients experienced reluctance and ambivalence to be engaged in help seeking process due to shame &

stigma, knowledge gap about MH, and lack of trust in MH providers. In average it took more than 5 services/contacts to complete screening and make appropriate service arrangement. For some clients, screening/services were stiffly declined or it took weeks for the engagement process.
Owing to untimely service seeking, a good number of API clients suffered from S/I, H/I and severe psychiatric symptoms upon the receipt of referrals. It led to difficulties making urgent arrangement of psychiatric services with the limited/allocated resources in a short time frame.

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

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

**PERFORMANCE INDICATORS: Is Anyone Better Off?**

Client Story: “Ms. L is a 47-year-old Vietnamese woman who immigrated from Vietnam to join her husband in 2017 and fled from the abusive marital relationship in 2018. She suffered from cultural adjustment issues, symptom of depression and trauma, and suicidal ideation leading to an overnight stay at JGP.

When she was referred to ACCESS Asian Intake Services, she presented as defensive, concerned, frightened about her situation and was resistant to services due to the stigma of mental health in Vietnamese culture. Through the outreach and rapport building from bilingual and bicultural Vietnamese speaking clinician with ACCESS Asian, she eventually became open to go through screening and receive services. However, client’s insurance and unclear document status complicated service arrangement. It required the collaboration between CRP’s supervisor and ACCESS Asian supervisor to coordinate care for client given her safety risks and immediate mental health needs before the case was successfully open under ACCESS Asian Treatment Services. As she continued treatment, she experienced a lot of barriers but she made steady progress. There were times when she disengaged completely or became extremely angry at her case manager and mental health services in general. But she always came back and continued to demonstrate resiliency and courage to move forward. This client continues to experience severe days of depression and PTSD but she is less resistant, less frightened, and more aware and knowledgeable of her role an individual seeking help.

Her being a treatment client under ACCESS Asian provided her with an opportunity to connect with a bicultural and bilingual clinician, who at the very least, can provided culturally competent services. As she approached the end of treatment under ACCESS Asian, she was aware that her road to recovery might take longer than preferred. However, she stayed connected and engaged and was granted Level 1 services. It was what she gained and benefitted in treatment while in ACCESS Asian that motivated her to continue treatment under Level 1 program.

She still has bad days where she is angry at her situation. But what’s important is that she continues to strive to get better knowing that she has support.”

**OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT**

**OESD #: OESD 15**

**PROVIDER NAME: La Clinica**

**PROGRAM NAME: ACCESS Staffing to Latino Population**

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

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

**Operational Budget:** $828,277

Program Outcomes & Impact: FY18/19

**PERFORMACE INDICATORS: How Much Did We Do?**

Number of Clients Served: 3,919 were screened and given referrals/support, 680 received treatment services.

**PERFORMANCE INDICATORS: How Well Did We Do?**

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

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

Although the system change that made ACCESS the gatekeepers for referral services may be beneficial in the future, the current rollout has been challenging. This involves retraining staff to master an already complicated referral process. There has been a lack of clarity around the NACT rules that make compliance difficult when the standards are not clearly defined.

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

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

**PERFORMANCE INDICATORS: Is Anyone Better Off?**

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

The therapist received email a few months later as the client had been contacted by a company called “Why Do We Keep Quiet” who asked her to become an ambassador due to her Instagram page. The client credited the work she did with the therapist for this opportunity and mentioned that her previous attempts at therapy had been unsuccessful.

**OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT**

**OESD #: OESD 17**

**PROVIDER NAME: Horizon Services, Inc.**

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

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

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

**Operational Budget: NA for 19/20, this program is no longer funded with MHSA**

Program Outcomes & Impact: FY18/19

**PERFORMACE INDICATORS: How Much Did We Do?**

Number of Clients Served: 218

**PERFORMANCE INDICATORS: How Well Did We Do?**

**Language Capacity:** English, Hindi, Tagalog, Cantonese, Spanish (to some capacity). The other languages can be utilized through translation services.

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

**PERFORMANCE INDICATORS: Is Anyone Better Off?**

Client story: One of our clients was a trans-identifying (female to male) client who came to us with a documented diagnosis of PTSD and Schizoaffective, and multi-substance use including Methamphetamine. His psychiatrist was claiming the client had dissociative identity disorder. In our observations, this client had a very confrontational relationship with his step-mother, and his biological father was very passive/permissive.

None of his family members were accepting of his identity. Through various observations and interventions, we were able to determine that this client's appropriate diagnosis was PTSD and that the other symptoms were primarily due to defense mechanisms, flashbacks, and substance use, rather than schizoaffective or DID diagnosis.

After determining the appropriate diagnosis and needs of the client, he was able to have a positive transition to his next placement to receive the necessary care and treatment.

It was the first time he had ever completed a treatment program successfully.

**OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT**

**OESD #: OESD 17**

**PROVIDER NAME: Horizon Services, Inc.**

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

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

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

**Operational Budget: NA for 19/20, this program is no longer funded with MHSA**

Program Outcomes & Impact: FY18/19

**PERFORMACE INDICATORS: How Much Did We Do?**

Number of Clients Served: 94

**PERFORMANCE INDICATORS: How Well Did We Do?**

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

**Challenges:** Places to refer people out to other co-occurring facilities

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

**PERFORMANCE INDICATORS: Is Anyone Better Off?**

Clients have reported they have a voice, they are at a safe space, that they matter.

They have also reported that our staff are respectful, and knowledgeable in both SUD and MH issues. The information they receive from groups and the structure provided has helped boost their self-confidence, self-esteem, self-worth and self-efficacy.

Client story: 40 yr. Old AA female with one adult child and a partner. She reports trying several times to stop using her drug of choice (cocaine, benzo's and cannabis) her diagnosis was Major Depressive Disorder. Client used substances to cope with her feelings of depression and her use became habitual. Before entering program client did not have the tools to maintain a balanced life.

Being in Chrysalis allowed the client to obtain coping skills, structure in her life, and she began addressing her mental health issues and was able to process what was standing in the way of her living a healthy lifestyle by making good choices.

She gained a stronger relationship with her partner. She was able to be a more stable parent for her adult child. She learned how to set boundaries and restored her relationship with her family.

**OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT**

**OESD #: OESD 18**

**PROVIDER NAME: BACS**

**PROGRAM NAME: Wellness Centers**

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

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

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

**Operational Budget:** $2,773,537

Program Outcomes & Impact: FY18/19

**PERFORMACE INDICATORS: How Much Did We Do?**

**a.** Number of Clients Served: In addition to a large number of partners who participated in the Wellness Center programs, the following are the client counts for Mental Health Services described:

Towne House Wellness Center:
Case Management Clients: 32, Med Management Clients: 53
Hedco Wellness Center: Case Management Clients: 37 Med Management Clients: 59
South County Center: Case Management Clients: 40
Valley Wellness Center: Case Management Clients: 35

**PERFORMANCE INDICATORS: How Well Did We Do?**

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

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

**PERFORMANCE INDICATORS: Is Anyone Better Off?**

Some of the programs we have for our participants include employment coordination, housing coordination, case management, Psychiatric medication management, health services through Health Care for Homeless, health education through Cal State East Bay Nursing students, 1 on 1 support, socialization and other skills groups, cultural awareness activities, safety drills, community building activities and events (such as meals, holidays, birthday celebrations), AA meetings, NA meetings, NAMI meetings, SSI Advocacy trainings, referrals to specific services (housing, employment, medical, etc.), include incorporating DBT principles into our groups, more robust social skills training, increased movement exercises, creating a more welcoming and functional space, and adding a new FSP program, and transportation to and from the center. Some of the special events we hosted this quarter include Family & Friends Night, and a Graduation BBQ.

We also incorporated vocational (IPS) services into our program on a regular basis. Our on-site Employment Coordinator (EC) runs a weekly Employment group, teaching all participants the skills needed to search, apply for, and maintain employment. Our EC and Wellness Center staff followed up on these groups by providing individual support on creating resumes, shopping for professional attire, and preparing for job interviews. Our EC planned and hosted employment fairs, and supported our participants in engaging in employment fairs and on-site recruitment events (OSR's) on a weekly basis.

We were able to support participants in finding regular employment, enrolling in Trade Schools, and in traditional Academic Schools. Our EC made many direct employer contacts on behalf of our participants throughout the year.

**OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT**

**OESD #: OESD 18**

**PROVIDER NAME: Bonita House**

**PROGRAM NAME: Wellness Centers**

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

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

Additional Requirements for IPS Supported Employment:

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

**Operational Budget: $**1,272,902

Program Outcomes & Impact: FY18/19

**PERFORMACE INDICATORS: How Much Did We Do?**

Number of Clients Served: Total units of service for FY 2018-19 was 14,448, exceeding target by 145% of MHSA Outpatient Goal of 8,400. 108 total current active enrollees.

**PERFORMANCE INDICATORS: How Well Did We Do?**

**Language Capacity:** English and Spanish.

**Challenges:** Many members only participate in “Wellness Activities” and are not Outpatient billable as they already have Case Management elsewhere.

**PERFORMANCE INDICATORS: Is Anyone Better Off?**

The program strives to:

Reduce mental health stigma: Inclusive, Non-judgmental, trainings/interventions, avoidance of clinical language and jargon with focus on equality in/toward wellness. Implementation of Cultural Competence/Humility amongst staff.

Create a welcoming environment: Person- centered needs exploration/ triaging/ linkage/ service delivery. “Casa culture” incorporates inclusion, respect, non-judgement, focus on personal growth, and communal support(s). Staff engagement by meeting/greeting every person that enters Casa U Program.

**OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT**

**OESD #: OESD 18**

**PROVIDER NAME: Network of ACNMHC**

**PROGRAM NAME: Wellness Centers**

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

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

**Operational Budget:** $930,102

Program Outcomes & Impact: FY18/19

**PERFORMACE INDICATORS: How Much Did We Do?**

Number of Clients Served: 16,268

**PERFORMANCE INDICATORS: How Well Did We Do?**

**Language Capacity:** English and minimal Spanish. Materials provided in other languages besides English and Spanish.

**Challenges:**

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

**PERFORMANCE INDICATORS: Is Anyone Better Off?**

This program strives to:

Reduce mental health stigma: The Network reduces mental health stigma through active peer support, community engagement/consumer input and consumer employment. Housing advocacy and intensive case management provided by individuals who have lived experience receiving mental health services mold recovery.

Create a welcoming environment: The Network strives to maintain a welcoming environment by offering a warm presentation, possibly a program volunteer, is there to greet consumers when they arrive and a safe and clean waiting space. Minimally, all of our spaces provide water, coffee and snacks. All of our programs have brochures about the agency available as well as a variety mental health recovery motivated material.

**OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT**

**OESD #: OESD 19**

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

**PROGRAM NAME: Pathways to Wellness Medication Clinics**

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

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

**Operational Budget:** $1,885,347

Program Outcomes & Impact: FY18/19

**PERFORMACE INDICATORS: How Much Did We Do?**

Number of Clients Served: 3,427

**PERFORMANCE INDICATORS: How Well Did We Do?**

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

**Challenges: Challenges:** Over the last year, re-gentrification has created a significant impact on our communities. Homelessness has increased exponentially which has increased the impact of our client's mental health. Our clients have become absent of homes and safety within the only community that they know. Clients have also been impacted by increases in the cost of living especially for basic needs such as food, healthcare costs, childcare, and transportation without an increase in SSI, Medi-Cal, or GA benefits. Our clients are in a state of survival unlike ever before. These stressors have increased the impact of our client's mental health which has made their symptoms more severe. As a result, clients

are having more crisis incidents, more complex trauma symptoms, and an increase in overall health disparities. Pathways to Wellness has been working hard to connect clients to services but it has been difficult especially when finding housing resources. We also still continue to struggle with discharging high volumes of clients to lower level of care due to the inability for PCPs to take our clients.

**PERFORMANCE INDICATORS: Is Anyone Better Off?**

The impact of providing services over the last year has positively impacted our clients and our community. Clients have received ongoing medication management, crisis intervention, engagement services, brokerage services to receive resources and we were able to improve client education and understanding of medications this year. We also reduced incarcerations and hospitalizations over the last year. This year our clinics were able to increase PCP collaboration.

**OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT**

**OESD #: OESD 19**

**PROVIDER NAME: Telecare- STEPS**

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

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

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

**Operational Budget:** $1,862,062

Program Outcomes & Impact: FY18/19

**PERFORMACE INDICATORS: How Much Did We Do?**

Number of Clients Served: 69 clients; 3,304 hours billed services, 239 hours outreach services.

**PERFORMANCE INDICATORS: How Well Did We Do?**

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

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

**PERFORMANCE INDICATORS: Is Anyone Better Off?**

The STEPS program provides support to individuals around re-entry to the community from long-term hospitalizations, as well as support to reduce immediate risk of deterioration in the community. We assist clients with connecting to PCP/psychiatry services/on-going case management, coach and instruct clients around developing and practicing coping strategies from Evidenced Based Practices, such as DBT, CBT, Seeking Safety, use Motivational Interviewing techniques to reduce functional impairments and problematic behaviors in the community, explore and locate safer housing options including applying for low-income subsidized housing, connect with community groups and activities including employment

services and SUD services, provide psycho-education around understanding diagnosis and symptom management, understanding and accessing resources and services such as food pantries, free resources, and transportation, and increasing self-advocacy skills.

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

**OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT**

**OESD #: OESD 20**

**PROVIDER NAME: Alameda County Vocational Services**

**PROGRAM NAME: Individual Placement Services (IPS)**

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

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

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

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

**Operational Budget:** $3,866,353

Program Outcomes & Impact: FY18/19

**PERFORMACE INDICATORS: How Much Did We Do?**

Number of Clients Served: 275

**PERFORMANCE INDICATORS: How Well Did We Do?**

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

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

**PERFORMANCE INDICATORS: Is Anyone Better Off?**

Vocational Services is reviewed annually based on the 25 standard Fidelity Review by external reviewers and has sustained a "Fair" level of fidelity. (115 - 125 = Exemplary Fidelity, 100 -114 = Good Fidelity, 74 - 99 = Fair Fidelity, 73 and below = Not IPS).

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

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

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

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

**List of Employers:**

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

OAKLAND UNIFIED SCHOOL DISTRICT
PAPA JOHN'S PIZZA
PARK PLACE DESIGN, LLC
PAULINE PURCELL INC.
PEPSI BEVERAGES COMPNAY
PET SUPPLIES PLUS
PIZZA HUT
PLUCKED CHICKEN & BEER
PUP TOWN STAY AND PLAY
PUPTOWN DOG DAYCARE & BOARDING
QUANTUM MARKET RESEARCH
RITE AID
ROCKY MOUNTAIN RECREATION CO.
ROSS DRESS FOR LESS
SAFEWAY
SALVATION ARMY
SAUL'S RESTAURANT
SEASIDE REFRIGERATED TRANSPORT
SHELL GAS STATION
SPROUTS
STAR PROTECTION AGENCY
SWEET TOMATOES
TELECOM INC.
THE COLLEGE INTERNSHIP PROGRAM
THE VILLAGE AND HAYES VALLEY
TJ MAXX
TRADER JOES
UBER
UPS
VICTORIA CARE HOME
WALMART
WENDYS

**List of Positions include:**

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

**OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT**

**OESD #: OESD 22**

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

**PROGRAM NAME: African American Wellness Hub Complex Planning Phase**

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

**Target Population:** African American Community in Alameda County.

**Operational Budget:** $313,253

**I. Progress to date**

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

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

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

MHSA Capital Facilities and Technology (CFTN) funding has been allocated in this Three-Year Plan to begin the exploratory phase of building purchase and renovation.

**OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT**

**OESD #: OESD 23**

**PROVIDER NAME: REFUGE**

**PROGRAM NAME: Crisis Residential Services**

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

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

**Operational Budget:** $1,642,071

Program Outcomes & Impact: FY18/19

**PERFORMACE INDICATORS: How Much Did We Do?**

Number of Clients Served: 6

**PERFORMANCE INDICATORS: How Well Did We Do?**

**Language Capacity:** English and Spanish.

**Challenges:** Getting clients to stay in group during an episode (depression, psychosis, etc.).

**PERFORMANCE INDICATORS: Is Anyone Better Off?**

REFUGE creates an environment that:

- Normalizes the client's experiences
- Foster new connections that are healthy and encouraging
- Created structure in the client's day to day lives
- Connected clients to resources in the community to help them after discharge

Client Story: Tiffany a 21-year-old African American female entered our program in March 2019. She began experiencing audio hallucinations at the age of 16 but was so ashamed of the stigma attached to mental illness she refused to tell anyone and began to isolate due to her psychotic episodes. After battling with her depressive symptoms, she attempted suicide and was hospitalized. She is diagnosed with Schizoaffective disorder. In our program she has learned that life doesn't have to be isolating and

that she can live a normal life full of love and support. Her mother is an active support person and is willing to participate in any capacity as needed (she also struggles with her own mental illness). Initially Tiffany was guarded when starting our day rehabilitation program, and after 2 months of treatment she began to share freely becoming a mentor to her peers. During her depressive episodes Tiffany would have a hard time communicating her feelings and staff would recognize that she was having a hard time due to the state of her room and difficulty getting out of the bed in the morning. She will be discharging in September and has successfully began adult school to complete her high school diploma and gained permanent housing. She has definitely been an inspiration to us all.

**OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT**

**OESD #: OESD 24**

**PROVIDER NAME: Alameda County Behavioral Health**

**PROGRAM NAME: Schreiber Center**

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

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

**Operational Budget:** $408,914

Program Outcomes & Impact: FY18/19

**PERFORMACE INDICATORS: How Much Did We Do?**

Number of Clients Served: 67

**PERFORMANCE INDICATORS: How Well Did We Do?**

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

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

**PERFORMANCE INDICATORS: Is Anyone Better Off?**

Schreiber Center clinicians have become competent practitioners with regard to comprehensive and accurate assessment and differential diagnosis for individuals with developmental and intellectual disabilities (DD/ID). Our competencies have grown such that the Schreiber Center team has been asked to provide clinical trainings to ACBH ACCESS program as well as both the TAY & Crisis systems of care. Clients continue to be better served on a *micro*-level at Schreiber Center clinic due to improved diagnostics which inform best-matched therapeutic and psychiatric treatment. Clients receiving ACBH specialty

mental health services who have co-occurring DD/ID are also better served on a *macro*-level due to Schreiber Center clinicians sharing competencies with both the ACBH/Behavioral Health community of providers as well as the RCEB/Disabilities community of providers. Doing so has enhanced services on both sides and contributed to improved communication & collaboration between systems of care.

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

**OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT**

**OESD #: OESD 25**

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

**PROGRAM NAME: Behavioral Health - Primary Care Integration Project**

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

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

**Operational Budget: $**

Program Outcomes & Impact: FY18/19

**PERFORMACE INDICATORS: How Much Did We Do?**

Number of Clients Served: 31

**PERFORMANCE INDICATORS: How Well Did We Do?**

**Language Capacity:** PATH provides services in English, Spanish, Punjabi and Hindi.

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

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

**PERFORMANCE INDICATORS: Is Anyone Better Off?**

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

**OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT**

**OESD #: OESD 25**

**PROVIDER NAME: Oakland-PATH/LifeLong Medical Care and Fremont-PATH/Tri-City Health Care**

**PROGRAM NAME: Behavioral Health - Primary Care Integration Project**

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

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

**Operational Budget:** $1,604,193

Program Outcomes & Impact: FY18/19

**PERFORMACE INDICATORS: How Much Did We Do?**

Number of Clients Served: 314

**PERFORMANCE INDICATORS: How Well Did We Do?**

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

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

**PERFORMANCE INDICATORS: Is Anyone Better Off?**

In our recent monthly debrief, a patient's case manager wanted to express her gratefulness to our program. She is a new case manager and was interviewing one of her patients who had a swollen leg. The case manager reached out to the PATH nurse who was able to triage the patient and get him in to see a clinician the same day. The nurse coordinated a Doppler evaluation and patient was ultimately cleared. The team worked together to care for the patient without a delay in care.

**OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT**

**OESD #: OESD 25**

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

**PROGRAM NAME: TRUST Clinic Health Center**

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

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

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

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

**Operational Budget:** $4,708,036

Program Outcomes & Impact: FY18/19

**PERFORMACE INDICATORS: How Much Did We Do?**

Number of Clients Served: 1,348

**PERFORMANCE INDICATORS: How Well Did We Do?**

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

**Challenges:** The most concerning challenge to the program is the continued explosion of homelessness, with a 42% increase in Alameda County between 2017-2019. We have been highly successful in engaging our clients, however, with increasing homelessness we have a responsibility to our community to continue engaging our current patients, as well as work to engage new patients. This presents difficulties in regard to staffing, which is not just a question of serving more people but also people with multiple complex conditions developed from living outside for some time. In addition, our physical space is quite small for the number of clients we are serve, so we are pursuing various options to remedy this but none would be a long-term solution to parallel the increased demand for services.

**PERFORMANCE INDICATORS: Is Anyone Better Off?**

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

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

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

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

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

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

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

**OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT**

**OESD #: OESD 26A**

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

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

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

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

**Operational Budget:** $334,581

Program Outcomes & Impact: FY18/19

**PERFORMACE INDICATORS: How Much Did We Do?**

Number of Clients Served: There were a total of 101 (unique) persons in attendance at our four scheduled trainings. However, we had a total of 166 persons who were registered for the trainings and for a variety of reasons were unable to attend.

**PERFORMANCE INDICATORS: How Well Did We Do?**

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

**Challenges:** Our primary challenge in the first year of the program was 1. Starting the contract mid- year and having a shorter period to develop the training curriculum. 2. Engaging more prescribers from the behavioral health system. While the program has engaged a mixture of behavioral health personnel we would like to see more prescribers involved in the trainings. We believe that we will be able to increase the prescriber attendance once we have the ability to issue CMEs. This will significantly increase the non-medical staff attendance as well.

**PERFORMANCE INDICATORS: Is Anyone Better Off?**

The training program was able to engage a mix of professional disciplines and we had at least five agencies that attended two or more of the training sessions. These agencies are now in a position to begin to make the needed changes in their organization that will improve the behavioral health services for their African-American client population.

In one of the trainings the participants had an opportunity to begin to develop an intake form that would be more culturally sensitive for the African-American population.

There were also two trainings that offered very specific information regarding prescribing more appropriate medications for use with the African-American population.

Overall participants reported knowing more about *how to better serve* this particular population or at minimum learning something new about best practices after leaving our trainings. We received several calls and numerous emails about our trainings and how valuable this service was in Alameda County. We also received requests to come out to individual program sites to assist with the implementation of a number of strategies and techniques presented in our trainings.

**OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT**

**OESD #: OESD 26B**

**PROVIDER NAME: ROOTS**

**PROGRAM NAME: AfiyaCare**

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

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

**Operational Budget:** $386,481

Program Outcomes & Impact: FY18/19

**PERFORMACE INDICATORS: How Much Did We Do?**

Number of Clients Served: 11

**PERFORMANCE INDICATORS: How Well Did We Do?**

**Language Capacity:** English

**Challenges:** An ongoing challenge has been that we have not had access to needed systems (Clinician Gateway and INSYST) and the infrequency of required trainings before AfiyaCare was implemented. This has caused us to have late documentation entries in Clinician's Gateway, inability to open clients in INSYST at start of service, and having a delay in completing needed paperwork, data entry, and documentation that have to be done in a certain order, within certain timelines. Due to completing INSYST training after AfiyaCare was implemented we were unable to open clients in INSYST until July 2019. We are currently working closely with ACBHS staff about our concerns, questions, and updates throughout this transition.

**PERFORMANCE INDICATORS: Is Anyone Better Off?**

We have found success with gaining eligible AfiyaCare clients through our internal referral system. This has led us to have clients that are already successfully linked to benefits and already in the process of being linked to needed resources, but who need additional support by those trained to address their behavioral concerns as well. Through Prop 47 funds and additional housing resources, our care navigators have been able to help two clients secure housing during our short time implementing AfiyaCare.

Client story: Amr. P is a 48-year-old veteran of the Gulf and Afghanistan wars. Mr. P has a mental health diagnosis of PTSD, Generalized Anxiety disorder with psychotic features. Mr. P's story is a tragic one of how the trauma which caused the development of his diagnosis was a result of his service for our country. The client was further traumatized by the military due to the fact they would not acknowledge

the part they played in the traumatic event. In addition, Mr. P was further victimized by the fact the military denied his war injury and gave him a less than honorable discharge, which prevented his access to veteran benefit which could put him on the road to health.

Mr. P left the military frustrated, handicapped physically and emotionally and his less than honorable discharge was a barrier to sustained employment. Mr. P suffers from sleep deprivation which was a result of his military conditioning that required him to exist on two hours of sleep a night. To this day has not returned to a normal sleep pattern. Lack of sleep has resulted in symptoms visual and auditory hallucinations. Mr. P developed an anger management problem which led to his incarceration in Billings, Montana. When Mr. P was released he returned to Oakland California and his association with Roots Community health began.

Mr. P's association with Roots Community Health changed his perspective about health care in general and mental health specifically. Mr. P benefited from culturally congruent health navigation services that Roots offers it client many of the navigators have shared life experiences and they are able to instill hope as well as guide the client through barrier removal. AfiyaCare clients are educated about health in general and the direct correlation between physical health and mental health. This helps to remove this stigma of accepting mental health services in the African-American community.

Mr. P has attended Anger management classes offered at Roots. The client was directed to the office of Veteran Affairs at Eastmont Mall from one of our health navigators and is now in the process of getting his discharge reviewed and changed to honorable. In speaking with his health navigator Mr. P is an active participant with the supportive services offered.

My relationship with Mr. P as his behavioral health clinician is new since just completed my first month with Roots Community Health. Mr. P was my first client and I have seen him every week at his scheduled appointment on time. On our first session you could tell Mr. P was physically uncomfortable due to the fact he was experiencing muscle spasms in his right arm. The clinic gave him a referral for acupuncture which he hopes will bring him some relief.

After gathering some history, we began with some somatic exercises to manage triggers which will precipitate some of his mental health symptoms. Mr. P is exploring themes of time lost with family and re-establishing those connections. Mr. P redirects his energies toward achieving the goals that are set before him now, seeking employment, getting his own apartment and making arrangements to marry his fiancé. Mr. P currently resides with his father and he has been employed at the family church installing sprinkler system and landscaping. In our last session Mr. P had over five job interviews scheduled.

The integrative care approach model used with our AfiyaCare clients from a healing community (Roots) which mirrors the client's experiences within the community at large proves to be beneficial with clients like Mr. P.

**OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT**

**OESD #: OESD 26C**

**PROVIDER NAME: Pending**

**PROGRAM NAME: MH Wellness Supports at MHSA Housing sites**

**Program Description:** Culturally Responsive MH supports and activities for residents living in MHSA funded housing sites.

**Target Population:** Residents living in MHSA funded housing sites throughout Alameda County.

**Progress to Date:** This project is pending. There are discussions happening in regards to having these supports and activities implemented by the ACBH housing team or engaging in a public procurement process. More information will be shared when decisions are finalized.

**OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT**

**OESD #: OESD 27**

**PROVIDER NAME: ABODE Services**

**PROGRAM NAME: In-Home Outreach Team (IHOT)**

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

**Target Population:** IHOT serves adults (age 25+) with severe mental illness, who are not currently engaged in mental health treatment or have become disengaged, who are considered resistant or reluctant to participating voluntarily and present with a variety of barriers that prevent them from connecting to mental health services and other community resources. IHOT serves adults throughout Alameda County; STARS TAY IHOT Program focuses on transitional age youth (TAY) ages 16-24 years old, throughout Alameda County.

**Operational Budget:** $556,371

Program Outcomes & Impact: FY18/19

**PERFORMACE INDICATORS: How Much Did We Do?**

Number of Clients Served: 113

**PERFORMANCE INDICATORS: How Well Did We Do?**

**Language Capacity:** As an agency, we utilize the language line in order to reach out to as many clients/family members as we can regardless of what they identify as their primary language. We have not encountered any major language barriers at this time.

**Challenges:** Working on an IHOT team is difficult. We as a team have dealt with staffing challenges during this last fiscal year, however, we utilized those times as learning experiences and made efforts to streamline our processes to be more efficient in our service delivery. Hiring and maintaining clinical staff still remain a huge challenge. Barriers include inability for our agency to meet county salaries or other offers, stress from working with a population with high acuity, and the general shortage of social workers.

**PERFORMANCE INDICATORS: Is Anyone Better Off?**

For FY18/19, 41 of the 90 (# of clients closed out of 113) clients were referred to other programs ranging from FSP, private MH, case management, drug/substance abuse and psychiatric SNF. Another 41 were referred to some other programs (i.e. shelters, Wellness Centers, etc.). Unfortunately, the exact referral was not clear, however, they were connected to services in some way. The remaining 8 clients were referred to AOT and BH Court.

100% of families engaged with IHOT services were connected to resources such as FERC and NAMI. We have connected family members to NAMI groups whose primary language is not English and provided information in other languages such as Cantonese, Spanish and Vietnamese. In addition to FERC and NAMI, our family advocate runs a support group specifically for family members. Our family support group has been running monthly for approximately 1 year and has an average attendance of 5 family members. We have seen the group grow to as many as 10 family members present for support and are hopeful this will continue to grow into the future fiscal year.

We have worked with many family members and the following is a small example of how our team has helped a family navigate an often overwhelming system:

“I am so grateful that Katy and the other IHOT team members were able to support me. I was supported with all doctor visits. I was given books to read/learn more about schizophrenia. All of the advocates were sincere and cared about my welfare and my fathers. If it weren’t for Katy and the other advocates, I would have missed a lot of work and possibly been out of a job. They were all my guardian angels."

This is a statement from one of our family members. Her father is our client and after his unexpected release from John George our team has worked tirelessly to ensure he is connected to resources (medical and mental health) for continued monitoring and medication as well as maintaining his current housing. This client has a history of losing housing due to increased behaviors when he is not medication compliant. The team provided invaluable support to the daughter and allowed her the flexibility and comfort of knowing her father was being taken care of.

We do not track client hospitalizations within our own data system however, providing clients with a line of communication to someone who is advocating for them and educating involved family members about community resources and mental health, we have seen a decrease in the use of crisis or emergency services over the time we are involved with the client and/or family. Our team makes every attempt to outreach to our clients and families on a weekly basis. Sometimes this is in the form of a phone call and other times it is face to face. Often our staff will assist the family/support network at the initial and follow up appointments to make certain clients are engaged in the treatment process as well as following our contractual obligations.

**OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT**

**OESD #: OESD 27**

**PROVIDER NAME: Bonita House**

**PROGRAM NAME: In-Home Outreach Team (IHOT)**

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

**Target Population:** IHOT serves adults (ages 18-59) with severe mental illness, who are not currently engaged in mental health treatment or have become disengaged, who are considered resistant or reluctant to participating voluntarily and present with a variety of barriers that prevent them from connecting to mental health services and other community resources. IHOT serves adults throughout Alameda County; STARS TAY IHOT Program focuses on transitional age youth (TAY) ages 16-24 years old, throughout Alameda County.

**Operational Budget:** $556,371

Program Outcomes & Impact: FY18/19

**PERFORMACE INDICATORS: How Much Did We Do?**

Number of Clients Served: 90 (Target: $\geq$ 50)

**PERFORMANCE INDICATORS: How Well Did We Do?**

**Language Capacity:** English explicit at this time. Looking at budget for bi-lingual staff, and/or use of Language Line. To date, language needs have been satisfactorily addressed.

**Challenges:** Provider listed none.

**PERFORMANCE INDICATORS: Is Anyone Better Off?**

- At least 62 percent of engaged clients were successfully linked to outpatient mental health services or rehabilitation and recovery services within the first 12 months of referral (Target = $\geq$ 50%).

- 88 percent of engaged clients experienced a decrease in access to crisis stabilization, psychiatric health facility, or psychiatric hospitalization within their first 12 months of entry in to the program.

Client story*:
SJ is a 30y/o Asian- American male with history of suicide attempts, with history of inconsistently taking medications, reluctant to engage with clinicians, disengaged with friends, family and the community. SJ viewed his family as the enemy and threatened to harm his family after a suicide attempt which included him placing a belt around his neck in front of his mother, and threatening to harm his family. The family packed up and moved into a hotel for 8 months because they felt unsafe in their house. The barriers were that the mother didn't want SJ to "hate" her. The IHOT family coach encouraged the family to attend her weekly family support group where they were coached in healthy tools to break their fears of returning home. The IHOT team worked with the family to enter the house, to approach SJ who had barricaded himself in the family home and had decompensated to the point of needing hospitalization. Through the family attending the weekly meetings, and its engagement with the IHOT team, SJ agreed to open the door. With the help of the Mobile Crisis Team, Alameda Police, and the Bonita House IHOT team, SJ surrendered after 7 hours, and the family was able to return home again.

*For confidentiality purposes pseudo initials are used in story below.

**OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT**

**OESD #: OESD 27**

**PROVIDER NAME: La Familia**

**PROGRAM NAME: In-Home Outreach Team (IHOT)**

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

**Target Population:** IHOT serves adults (ages 18-59) with severe mental illness, who are not currently engaged in mental health treatment or have become disengaged, who are considered resistant or reluctant to participating voluntarily and present with a variety of barriers that prevent them from connecting to mental health services and other community resources. IHOT serves adults throughout Alameda County; STARS TAY IHOT Program focuses on transitional age youth (TAY) ages 16-24 years old, throughout Alameda County.

**Operational Budget:** $556,371

Program Outcomes & Impact: FY18/19

**PERFORMACE INDICATORS: How Much Did We Do?**

Number of Clients Served: 93

**PERFORMANCE INDICATORS: How Well Did We Do?**

**Language Capacity:** Three (3) of our five (5) La Familia IHOT staff speak fluent Spanish.

**Challenges:** We observed three (3) main challenges:

The first trend is an increasing prevalence of older adults (ages 52 – 62) who are socially isolated and homeless. These older adults manifest symptoms which severely impact their ability to seek supportive services and maintain self-sufficiency, and yet they are also not old enough to meet the criteria to receive services from the Older Adult Division of Alameda County Behavioral Health.

The second trend we observed is the inequitable discrepancy between how ACBH considers the level of self-sufficiency that a person with mental illness is supposed to seek and maintain their engagement in services vs. the manifestation of this actualization. For example, we have worked with numerous clients on the moderate to severe continuum of symptoms of mental illness who do not meet the criteria for

Level 1 Service Teams, but who are also not self-sufficient enough to seek services on their own from Level 3 Providers.

The third trend we observed is the gap in capacity and commitment to offer services to people who possess private insurance, or at-risk of losing private insurance. We have engaged numerous clients who possess private insurance, however their private insurance provider does not possess the capacity or commitment to provide the level of services the client needs.

**PERFORMANCE INDICATORS: Is Anyone Better Off?**

A substantial percentage of La Familia IHOT clientele were linked to specialty mental health services within Alameda County Behavioral Health, including, Level 1 Service Teams, Full Service Partnerships, Felton Institute, and Assisted Outpatient Treatment. Furthermore, this clientele was referred and linked to supplemental services and basic needs, such as General Assistance, Social Security Income, legal services regarding housing and other areas of need, homeless shelters, and residential care facilities. This clientele was able to enroll in clinical case management and psychiatric services, and access medication management for an initial episode or resume treatment after a long period of inaccessibility or refusal of services.

La Familia IHOT has been able to accompany clientele through various transitions, interpersonal and institutional, including, but not limited to, substance abuse treatment and sobriety from chemical dependence; mental health stabilization and mental health treatment from psychiatric hospitalization; stable temporary or long-term housing from homelessness; a return into the community from short periods of incarceration; family stability and community integration from severe isolation and family conflict. La Familia IHOT consistently provides psycho-education to family members regarding mental illness.

Families also receive consistent coaching regarding how to navigate the vast array of services within Alameda County Behavioral Health. IHOT has also supported community members who refer clients to IHOT in very similar ways as family members.

Client Story: La Familia IHOT worked with a homeless 56-year-old Caucasian male with a history of eight psychiatric hospitalizations in 2018; physical disability and mobility issues; as well as challenges with emotional regulation, depressed mood, and self-harming behaviors. IHOT was able to admit the client into a long-term homeless shelter operated by Building Opportunities for Self-Sufficiency. IHOT was also able to enroll the client in a payee service with Building Opportunities for Self- Sufficiency. Over the course of services, it became suspected that a family member was abusing the client financially and IHOT collaborated closely with Adult Protective Services (APS) to address and stop the abuse. IHOT also supported the client by assisting him to obtain basic necessities, such as clothes and other household products. IHOT also transported the client to numerous medical appointments as well as enroll him in a medical clinic. IHOT requested a Level I Service Team program but the client was found ineligible for this level of care due to a Traumatic Brain Injury. Therefore, IHOT collaborated with APS and enrolled the client in the Felton Institute, Case Management for Older Adults with Disabilities.

**OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT**

**OESD #: OESD 27**

**PROVIDER NAME: STARS**

**PROGRAM NAME: In-Home Outreach Team (IHOT)**

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

**Target Population:** IHOT serves adults (ages 18-59) with severe mental illness, who are not currently engaged in mental health treatment or have become disengaged, who are considered resistant or reluctant to participating voluntarily and present with a variety of barriers that prevent them from connecting to mental health services and other community resources. IHOT serves adults throughout Alameda County; STARS TAY IHOT Program focuses on transitional age youth (TAY) ages 16-24 years old, throughout Alameda County.

**Operational Budget:** $481,960

Program Outcomes & Impact: FY18/19

**PERFORMACE INDICATORS: How Much Did We Do?**

Number of Clients Served: 52

**PERFORMANCE INDICATORS: How Well Did We Do?**

**Language Capacity:** English / Punjabi / Turkish

**Challenges:** Some individuals may benefit from changing their insurance providers to Medi-Cal. The current model has IHOT meeting with these individuals once or twice only to suggest a switch to Alameda Medi-Cal. However, some individuals may not be in a state to comprehend what the IHOT team may be suggesting due to decompensation. Or they may feel too anxious and untrusting to sit down with the IHOT team to hear about potential benefits to change their insurance.

Other difficulties are when clients who are in a decompensated state commit an act that causes them to be arrested. The IHOT team cannot connect with them in jail, as it has been deemed that jail is a location that is a lockout for IHOT services. However, they may still need that support to assist them with being

willing to be linked to a provider. When the individual is released from jail, they may become quickly difficult to locate again.

**PERFORMANCE INDICATORS: Is Anyone Better Off?**

- Out of 52 clients served during the fiscal year, 22 clients were able to be relinked to a previous provider or linked to a provider when they had not had any services previously.

- The IHOT team was able to provide informational overviews to several different agencies including WestCoast Children's Clinic, Fred Finch STAY and Fred Finch Transitions, as well as TriCity and Covenant House.

- The IHOT team created connection for collaboration with the YEAH shelter and Covenant House.

- The IHOT team was able to provide a training as a team for the CASRA conference this year on how to do outreach and connect individuals to care.

**OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT**

**OESD #: OESD 28**

**PROVIDER NAME: BACS**

**PROGRAM NAME: Success At Generating Empowerment (SAGE)**

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

**Target Population:** SAGE serves adults (ages 18-59) and older adults (60+) who have a qualifying behavioral health diagnosis and are in the process of obtaining SSI benefits through local legal advocacy firms, Homeless Advocacy Center (HAC) and Bay Area Legal Aid (BALA). All participants live in extreme poverty, at or are under 10% Area Median Income (AMI). Many individuals are exiting jails or hospitals. The majority of individuals are homeless.

**Operational Budget:** $2,569,040

Program Outcomes & Impact: FY18/19

**PERFORMACE INDICATORS: How Much Did We Do?**

Number of Clients Served: 410

**PERFORMANCE INDICATORS: How Well Did We Do?**

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

**Challenges:** Locating clients that have a long history of non-engagement.

**PERFORMANCE INDICATORS: Is Anyone Better Off?**

The SAGE program addresses mental health barriers and supports client to medical and mental health appointments that aid the client in building their SSI case. SAGE allows clients to build skills that support linkages to the community that will aid the client in being able to maintain connections with providers after they receive their SSI and their time with SAGE is complete.

SAGE also works clients in identifying and the barriers their mental health symptoms create in their life and work on enabling the client to build skills that will address those barriers. SAGE also provides advocacy letters that highlight the client's specific struggles and how those struggles impact the client's ability to meet their needs.

This work has enabled clients to become more independent and learn how to navigate their specific challenges in a more adaptive way. This has helped clients to maintain connections with providers and the client's support system and to maintain housing by addressing the issues that had led to displacements previously.

One such client that SAGE has worked with for the last year was living on the street. The client was unable to stay engaged with his legal advocate, providers and his case manager. The client could not be found when important appointments came up for him and would never respond to the case managers' outreach, only leaving sporadic voicemails in the middle of the night. The client was going to PES at least monthly and had a significant amount of substance use.

Recently, we were able to temporarily house him in a hotel so that we could get him to important medical appointments and so that he could recover from minor surgery. This aided us in being able to find him consistently and work on addressing his specific barriers with him.

The client has made all of his appointments, stopped all use, and addressed previous housing barriers that enabled him to get a permanent housing opportunity.

**OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT**

**OESD #: OESD 29**

**PROVIDER NAME: The Felton Institute**

**PROGRAM NAME: Older Adult Service Team**

**Program Description:** The Older Adult Service Team (OAST) is a specialized, multidisciplinary mental health program for aging adults with serious mental illness, the first of its kind in the county. OAST is part of the Felton Institute's Senior Division continuum of care model for mental health treatment and services for aging adults. Significant to this model is providing services across the silos of mental health and aging services.

OAST's objective is to improve the lives of older adults living with the comorbidity of mental illness and health conditions, as well as substance abuse. We provide clinical case management support and that promotes our community to age in place and maintain as much autonomy and community involvement as possible.

**Target Population:** The Older Adult Service Team serves older adults (age 60+) who are living with severe mental illness impairments resulting in at least significant impairments in important areas of life functioning.

**Operational Budget:** $1,063,845

Program Outcomes & Impact: FY18/19

**PERFORMACE INDICATORS: How Much Did We Do?**

Number of Clients Served: 96

**PERFORMANCE INDICATORS: How Well Did We Do?**

**Language Capacity:** Our clinicians provide services in Spanish, Vietnamese, Cantonese, French and English.

**Challenges:** *Accessibility and Efficiency*: Many of the resources we are working to connect our clients with are challenging to access. Whether clients are challenged by mobility issues, strained systems and bureaucracy, each attempt to connect clients with different services from food stamps to IHSS to primary care, is more challenging for the aging adults in our program.

*Frequency of Services*: While our program is considered a Level 1 Service Team we find that we meet with most of our clients weekly and sometimes more. OAST received many clients during the transition of FSP programs and many of our clients continue to require FSP-level care.

*Advocacy and Accompaniment:* Most of our clients have emerging or ongoing challenges associated with mobility. They do not take the bus and require support with assisted transportation services like paratransit. We accompany our clients to most of their appointments, supporting them to communicate with different providers.

*Crisis Services*: Several clients (approx. 4) have cycled through emergency and inpatient psychiatric services multiple times since connecting with our program. These clients, in particular, would benefit

from inpatient care at Morton Bakar Center. The process and communication associated with this linkage has been incredibly challenging – resulting in breakage of rapport with clients due to systemic challenges and miscommunication between systems of care. We hope that the communication challenges between inpatient and emergency psychiatric support with the service teams and other providers is addressed and resolved with support from ACBHS.

*Undetected/Emerging Needs*: As our clients age, physical and mental health issues emerge and evolve. We seek additional resources around cognitive changes with clients – many of our clients are dealing with emerging or fully diagnosed Alzheimer's and/or Dementia diagnoses. We are also often connecting our clients with specific providers to ensure consistent and quality medical care.

**PERFORMANCE INDICATORS: Is Anyone Better Off?**

Client story: Mr. S. is a 68-year-old white male living with ongoing symptoms associated with Schizophrenia. He frequently responds to internal stimuli and reports command auditory hallucinations and presents with disorganized and delusional thought patterns. He has a history of tobacco, alcohol and marijuana use and a distant history of experimenting with hallucinogens and marijuana at the time of his first psychotic break at age 22. Prior to being connected with our program, Mr. S. was receiving services through a service team for adults living with severe mental illness. Mr. S. loves music and has a wonderful historical knowledge of San Leandro history. Our providers enjoy working with him because he has a beautiful singing voice and plays the guitar quite well and when accompanying him to appointments, he reflects on historical nuances and locations in San Leandro and Oakland. He is compassionate and seeks to contribute in the community.

When he first was referred to our program, Mr. S. had recently been attacked at the Independent Living Home where he was living and was hospitalized with significant stab injuries to his back incurred while he was being robbed by other residents of the ILH. Mr. S. lives also with numerous chronic medical conditions, including emphysema, COPD, hypertension, cancer and Hep C.

Mr. S's functional impairments associated with his mental health challenges include maintaining housing, accessing medical care and community involvement.
He misses appointments and requires significant support advocating for himself with medical providers due to the impact of mental health symptoms and cognitive challenges associated with aging. He has a pattern of eviction from Board and Care residences due to his refusing to follow house rules and smoking in bed. He can become verbally aggressive and has some insight into the intersection of his anger with his ongoing physical pain and challenges with mental health symptoms.

Mr. S. receives supports from our program, and currently requires weekly support from clinical and peer staff. He is currently being evicted from his licensed board and care and additionally receives support through the HSP program. Our primary foci with him at present are connecting him with a new housing resource and supporting him in accessing eye surgery and smoking cessation resources. We anticipate he will require emergency medical care in the near future due to the ongoing issues with his continuing to smoke and symptoms associated with COPD and emphysema.

**OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT**

**OESD #: OESD 30**

**PROVIDER NAME: La Familia Counseling Services**

**PROGRAM NAME: Sally's Place Peer Respite**

**Program Description:** Sally's Place is a Peer Respite Home and is the first and only of its kind in Alameda County. It is staffed by peers, in alignment with the objectives of our local agencies- Pool of Consumer Champions (POCC) and the Alameda County Accelerated Peer Specialist Program (ACAPS). Guests receive support from compassionate peer staff and can stay for up to 14 days. Sally's Place Peer Respite is a voluntary, short-term program that provides non-clinical crisis support to help people find new understanding and ways to move forward with their recovery. It operates 24 hours per day in a homelike environment.

**Target Population:** Sally's Place serves adults, 18 years of age or older, who are experiencing mental health concerns or distress, have an identified place to stay in Alameda County at the time of intake (which could include a shelter), are able to manage medical needs independently and who voluntarily agree to engage in services.

**Operational Budget:** $1,023,101

Program Outcomes & Impact: FY18/19

**PERFORMACE INDICATORS: How Much Did We Do?**

Number of Clients Served: Sally's Place Peer Respite opened for services on January 21, 2019. During FY 2018-19 Sally's Place has provided peer support services to 70 unduplicated new guests and re-admitted 6 guests who returned for additional support either with referrals or respite services. Data shows that Sally's Place has served and supported 23 females, 53 males and two no-binary individuals.

**PERFORMANCE INDICATORS: How Well Did We Do?**

**Language Capacity:** Among the majority of the staff at Sally's Place, all speak English, however an effort is made to have at least 1 Spanish speaking staff on each shift. When guest arrive to Sally's Place and there is a language barrier we connect the guest to the Language Line, staff can access interpreters speaking many languages via phone – and most languages are available on-demand.

**Challenges:** Even though we have a current process on reaching the interested, pending and return guests that are on the waiting list we still face challenges with matching the bed availability to the immediate need for respite services. Sometimes when a bed becomes available we have difficulty contacting the next guest which sometimes results in a waitlist.

Sally's Place has continuously received referrals that exceed the established bed capacity. This is good because it means that word is getting out about our services and that guests and providers are sharing their positive experiences, but the challenge for staff is holding the knowledge that many of these individuals will go unserved.

It's also challenging when we receive a referral from a case manager, who gives staff a qualifying address for the guest, but once the guest arrives, the guest will state that they are effectively homeless. Our current resolution is to forward the information to our Peer Advocate who works on housing during the 14 day stay. To date, we've been successful in finding a housing option for these guests upon exit from Sally's Place. In order to resolve this, we do our best to be as clear as possible about the criteria and explain the rationale to referring providers. We have also worked to identify alternatives to Sally's Place for individuals who do not meet our criteria.

Another challenge that some of the staff at Sally's Place share their personal story in ways that can be triggering to guests; the staff have been coached on how to do more listening and how to thoughtfully gauge how much self-disclosure is useful and helpful for the guests.

**PERFORMANCE INDICATORS: Is Anyone Better Off?**

According to our guest exiting survey most of the guests were pleased with the peer support services given and felt hopeful and connected after they had worked with the Peer Advocate on the 4 phases during their duration of stay at Sally's Place.

During Phase #1 the 1-2 days the guest and the Peer Advocate work on the Welcoming and Program overview. During phase #2 –Day 2-6 is spent working on Connections with family and outside social services that the guest would qualify for in Alameda County.

Phase #3-day 6-8 is when the Peer Advocate works with the guest on Reflection, checks on how the referrals are going and if any of the referrals were helpful; during this phase the guest would be supported on creating a list of supporters or local sponsors. This is intended to let guest know they're not alone. The Sally's Place team collaborates on alternatives needed for challenging situations and on Phase #4 day 10-14 is the Preparation phase by where the staff and the Peer Advocate will continue to encourage the guest with tools of hope and motivating words.

There are always reminders that Sally's Place staff are here to support her/him/them with information and resources even after exiting. By creating the four Phases chart we will be able to ensure that we give complete care and support to each guest that Sally's Place comes in contact with, and that it's well documented.

**OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT**

**OESD #: OESD 31**

**PROVIDER NAME: Family Service Agency of San Francisco (FSA)**

**PROGRAM NAME: Felton Early Psychosis Programs - (re)MIND® and BEAM (formerly PREP Alameda)**

**Program Description:** The Felton Early Psychosis Programs - (re)MIND® and BEAM - formerly known as PREP Alameda, provide evidence-based treatment and support for transition age youth (TAY) who are experiencing an initial episode of psychosis or severe mood disorder. We provide outreach and engagement, early intervention services and outpatient services that include: Mental Health Services, case management/brokerage, medication support/dispensing, crisis intervention and Individual Placement and Support (IPS) supported employment and education services. The service goals of (re)MIND® and BEAM Alameda are to delay or prevent the onset of chronic and disabling psychosis and mood disorders; reduce client hospitalizations and utilization of emergency services for mental health issues; improve the ability of clients to achieve and maintain an optimal level of functioning and recovery as measured by a functional assessment tool; connect clients with ongoing primary healthcare services and coordinate healthcare services with clients' primary care providers; increase educational and/ or vocational attainment among clients; increase meaningful activity as defined by the client; decrease social isolation among clients; and assist clients with advocating for adjustment of medications to the minimum amount necessary for effective symptom control.

**Target Population:** Transition Age Youth (TAY) ages 16-25, who are experiencing the onset of first episode psychosis associated with serious mental illness (SMI).

**Operational Budget:** $1,340,001

Program Outcomes & Impact: FY18/19

**PERFORMACE INDICATORS: How Much Did We Do?**

Number of Clients Served: 58

**PERFORMANCE INDICATORS: How Well Did We Do?**

**Language Capacity:** Currently, our language capacity for the program is for two additional languages, Spanish and Gujarati, in addition to English. In addition, we have access to interpreter services as needed for other threshold languages.

**Challenges:** During most of the FY 2018-19, we operated with multiple unfilled staff positions which created challenges that resulted in smaller caseloads, less referrals and more reliance on other community resources. Due to these open positions (that included both management and line staff), as well as to transitioning out of previous contractual partnership (previous partner held the administrative oversight function for the program), we addressed pervasive quality assurance issues. Therefore, most of Q2 and Q3 focused on updating charts to meet Medi-Cal standards. During Q4, although the program was almost fully staffed, new staff onboarding and training impacted capacity to increase caseloads rapidly and we continued to rely on other community resources. Another challenge was having the need to slow down referrals in Q3 which impacted the flow of referrals in Q4 (which continued to be low). Moreover, during Q4, we also relocated to another site which required a new site certification.

**PERFORMANCE INDICATORS: Is Anyone Better Off?**

Overall during FY 2018-19, we have been able to successfully meet our three impact objectives: reducing number of psych hospitalizations, decrease number of incarcerations, and clients having stable housing within 6 months of enrollment.

Client story: The first success story involves a high school student experiencing psychosis. Like many of the young people we serve, they had experienced multiple psychiatric hospitalizations when they enrolled in the Felton Early Psychosis program in Alameda County.

This young person's first hospitalization was due to being at-risk for self-harm and experiencing distressing auditory hallucinations and disorganized thinking and behavior. In addition to their increased psychiatric symptoms they also experienced other life stressors including the loss of their adoptive mother. Due to stressors and increased psychosis, they continued to experience multiple hospitalizations and needed support to regain stability in the community.

Luckily, this young person had a supportive extended family where their adoptive grandmother and siblings sought services and helped them connect with specialized treatment. Over the course of several months this young person worked with our staff therapist and learned skills to identify triggers to symptoms and coping strategies to minimize delusions and thoughts of suicide.

Through the course of treatment, they were able to gain insight into their symptoms, practice learned skills and coping strategies, and their symptoms stabilized. This young person will be graduating high school this year and will attend junior college in the Fall.

**OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT**

**OESD #: OESD 32**

**PROVIDER NAME: Crisis Support Services of Alameda County**

**PROGRAM NAME: Suicide Prevention Crisis Line**

**Program Description:** The Suicide Prevention Crisis Line is a 24-Hour Crisis line provided by Alameda County Crisis Support Services to provide: Crisis counseling in order to reduce the incidence of suicidal acts; lessen the number of psychiatric hospitalizations needed by individuals with suicidal thoughts; resolve crises; decrease self-destructive behavior; and increase awareness of suicide risk factors.

**Target Population:** The Suicide Prevention Crisis line provides a 24-Hour phone line for assistance to people of all ages and backgrounds during times of crisis, or their families, to work to prevent the suicide. Translation is available in more than 140 languages. We also offer teletype (TDD) services for deaf and hearing-impaired individuals.

**Operational Budget:** $275,165

**Note:** The crisis line program responds to calls on our 24-hour crisis lines (1-800-309-2131), National Suicide Prevention Lifeline (1-800-273-8255), ACCESS afterhours (1-800-491-9099), and Substance Use Helpline After hours (844)682-7215.

Program Outcomes & Impact: FY18/19

**PERFORMACE INDICATORS: How Much Did We Do?**

Number of Clients Served: 9,343 unique clients on all 4 lines

a. Crisis Line (1-800-309-2131) - 2893 clients
**b.** National Suicide Prevention Lifeline (1-800-273-8255) – 3700 clients
**c.** ACCESS Afterhours (1-800-491-9099)- 1983 clients
**d.** Substance Use Disorder Helpline Afterhours (1-844-682-7215) - 767 clients

**PERFORMANCE INDICATORS: How Well Did We Do?**

**Language Capacity:** The program accesses a translation service that is available 24/7 and includes over 140 languages.

**Challenges:**

- Over the last 5 years, we have seen a steady increase in high risk calls and new callers to our crisis lines. This is due to factors outside our control, including increased media attention after prominent celebrity suicide deaths.

- As the crisis system delivery expands, the program anticipates a greater number of appropriate referrals from other parts of the Alameda County crisis continuum of care to our Crisis Lines and

ACCESS lines after hours. Knowledge and skill expectations and workload on the ACCESS after-hours line has increased as we now function as dispatch for Mobile Crisis Team M-F 5pm-8pm. As the MCT expands to weekends, our responsibility to dispatch the Mobile Crisis Team will expand to the weekends as well.

- Utilizing a volunteer workforce poses its own set of challenges, including annual volunteer turnover, maintaining a high level of skill with a diverse team of volunteers, and quality control and oversight. A typical volunteer shift is 4 hours/week, and so a volunteer's skills may not have the benefit of repetition and exposure. To mitigate these challenges, the program utilizes staff shift supervisors who provide consultation and ongoing training and oversight.

**PERFORMANCE INDICATORS: Is Anyone Better Off?**

| IMPACT MEASURES | IMPACT OBJECTIVES | ACTUAL IMPACT | Objective Met? |
|---|---|---|---|
| The percent of crisis line callers with a risk level of 1 or higher who self-report a reduction in suicide intent from the initiation of the call to the end of the call among those who report suicide intent at the start and end of the call. | At least 20% | 14.8% | No* |
| The number of duplicated crisis line callers with risk level 3-5 who have been stabilized at the end of the call without law enforcement or hospital intervention. | 440 duplicated callers | 838 duplicated callers | Yes |
| The percentage of duplicated crisis line callers with risk level of 3-5 who were stabilized by the end of the call without law enforcement or hospital intervention. | At least 80% | 83.5% | Yes |

*The program director would like to explain why the first impact was not met. In reflection, callers with suicide risk rating of 1 are unlikely to report a reduction in suicidal intent because they are already exhibit low intent at the start of the call.

When only callers with suicide risk of 2 and above are included in the measure (the caller is at medium risk of suicide at the start of the call), then the impact outcome is 29.9% of crisis line callers with a risk level of 2 or higher self-report a reduction in suicide intent from the initiation of the call to the end of the call and among those who report suicide intent at the start and end of the call.

Other impacts: In February 2019, the program successfully expanded follow up care for clients on the Lifeline who presented with medium to high risk for suicide, but did not require law enforcement or hospital intervention.

Follow up calls were opportunities for the program to reconnect with clients after their initial call to provide ongoing support, additional suicide assessment and intervention, additional safety planning, and connection to resources. 163 referrals were made by crisis line staff and volunteers, and 112 people received at least 1 follow up call (67.87%). The number of outreach calls to medium-high suicide risk callers increased by 138% from 117 calls in FY 17/18 to 279 calls in FY 18/19.

**OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT**

**OESD #: OESD 33**

**PROVIDER NAME: Family Service Agency of San Francisco**

**PROGRAM NAME: Deaf Community Counseling Services (DCCS)**

**Program Description:** DCCS provides outpatient mental health services, including assessments, individual psychotherapy, family therapy, collateral and indirect services to provide information and referrals to community members.

**Target Population:** DCCS provides services for residents of Alameda county who have medi-cal, medi-medi or who are medi-cal eligible who are Deaf, Deafblind, deaf with additional disabilities, late Deafened (those who were born hearing and became Deaf or lost their hearing in adulthood), hard of hearing (those who do not use sign language but use spoken language), from age 5 years to older adults. We also work with parents and family members of Deaf children or adult Deaf children. For the rest of this report, the word: "Deaf" will be used to include all clients with any kind of hearing impairment or loss or preferred communication mode.

**Operational Budget:** $497,752

Program Outcomes & Impact: FY18/19

**PERFORMACE INDICATORS: How Much Did We Do?**

Number of Clients Served: DCCS provided direct services to 28 Deaf adults and 9 Deaf children and their families. We also provided indirect services, such as phone calls for referrals, and provided community workshops and presentations, so estimated people we served is at least 200-250.

**PERFORMANCE INDICATORS: How Well Did We Do?**

**Language Capacity:** DCCS staff must be flexible in using communication modes when working with Bay Area Deaf clients. Deaf individuals living in the Bay Area often have many different modes of communication, not only American Sign Language, some use spoken English. Often Deaf clients come from families where primary language is Spanish or Tagalog. Although our DCCS staff are all fluent in American Sign Language, we also utilize certified sign language interpreters as needed to communicate with family members who may not be fluent in sign language. We use other spoken language interpreters, such as Spanish, for working with families, with parents who are Spanish speaking and have a Deaf child. When a Deaf client is from another and has fluency in spoken Tagalog, but not spoken English language or American Sign Language, then we are flexible in using writing back and forth if that is best way for the client to communicate. Other Deaf clients have additional disabilities, such as intellectual impairment, limited language skills, or need Pro Tactile sign language for individuals who are both Deaf and Blind, so staff must be linguistically flexible, skilled and ready to accommodate the various communication modes that Deaf people use.

**Challenges:** There is a long history of and continues to be an issue of Deaf being underserved minority as far as accessing mental health treatment and resources. There is still much stigma about accessing mental health resources and medications. Working with Deaf is especially harder when Deaf clients cannot access other social support systems due to lack of sign language access such as AA, Al Anon, parent support groups and many other important resources that are available to those without hearing

loss. 2. Maintaining a program for Deaf community is challenging is that it is difficult to find trained mental health professionals who are also skilled in sign language, knowledgeable about working with various Deaf individuals and their issues, experiences and cultural values and practice cultural sensitivity to working with Deaf individuals, with the stance of “working with, rather than “for “the Deaf client.” One cannot hire mental health professionals and expect them to become “fluent “in sign language, which often takes years of training and practice.

**PERFORMANCE INDICATORS: Is Anyone Better Off?**

DCCS has made positive impact on the community in increasing awareness of accessible mental health services in American Sign Language through our workshops and presentations to the Deaf community and assist the community to become more educated, more aware, and as a result, a more supportive community for all.

DCCS creates positive impacts on individuals and families by providing direct services to Deaf clients and families we assist Deaf clients in managing their mental health conditions or reducing their symptoms so that they can function better within their families, communities and in their jobs. For example, we have worked with Deaf clients who have chronic depression with some risk for suicide so our work has reduced risk for suicidal behaviors and to increase functioning.

We also work with Deaf children diagnosed with ADHD or Oppositional Defiant behaviors or anxiety and struggling both at home and school and work with these children and their families to reduce their impairment in their functioning and to get along better with peers, families and able to learn in the classroom.

We also work with Deaf women or men in domestic violence relationships, helping them to improve their functioning and safety and reduce their personal risk. We also help Deaf individuals with severe mental illness change their lives such as how we helped one Deaf individual. This particular client was a Deaf male, age 48, who was arrested for stalking and attempted assault. With our assessment in his preferred language, American Sign Language, it was discovered this Deaf client had an undiagnosed psychotic disorder, and substance abuse disorder, so with an accurate diagnosis, treatment, medication, reduced substance use and then linkage to a job training program for Deaf people, this Deaf client was able to begin and keep a job, then secured stable housing and reconnected with his family again.

Without access to our clinical team with whom he could communicate with easily in sign language, client may never have gotten accurate diagnosis, treatment and medication or re-established family relationships or may have returned to the criminal system. We have more similar stories about transformed lives.

**OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT**

**OESD #: OESD 34**

**PROVIDER NAME: Multiple Providers**

**PROGRAM NAME: School-based Behavioral Health**

**Program Description:** MHSA Braided funding for Expansion of School-Based Behavioral Health in the Oakland Unified School District (OUSD). MHSA funding is being braided with Educationally Related Mental Health Services (ERMHS) and Early Periodic Screening Diagnosis and Treatment (EPSDT) funds to provide enhanced (non Medi-Cal billable) mental health services and supports to children in Counseling-Enriched Special Day Classes (CESDC) and two of its School Based Behavioral Health (SBBH) programs in OUSD in order to assist these children and their families in becoming successful in school and at home.

**Target Population:** Youth attending Counseling-Enriched Special Day Classes (CESDC) and/or two of its School Based Behavioral Health (SBBH) programs in OUSD.

**Operational Budget:** $1,359,621

***How Much Did We Do?***

**I. FY 18/19**

a. **Number of clients served:**

This program was started mid FY 18/19. More information and data/results will be provided in the FY 21/22 Plan Update.

# PREVENTION & EARLY INTERVENTION

# Prevention & Early Intervention (PEI) Program Summaries
## *"It Takes A Village"*

The *Prevention and Early Intervention* (PEI) services embrace a preventative approach that engage individuals before the development of mental illness, and provides services to intervene early to reduce negative mental health symptoms so as to reduce prolonged suffering. PEI services emphasize the development, implementation, and promotion of strategies that are non-stigmatizing and non-discriminatory.[1]

PEI programs create partnerships with unserved and underserved ethnic and linguistically isolated communities, schools, the justice system, primary care and a wide range of social, wellness, cultural and spiritual support services and community groups. Services are centrally located where people receive and participate in routine health care, wellness, leisure, educational, recreational, faith, and spiritual healing.

**PEI Plan Requirements:** The PEI Community Planning Process requires local stakeholders to recognize the following parameters for this funding stream:

- All ages must be served and at least 51% of the funds must serve children and youth ages 0-25 years;
- Disparities in access to services for underserved ethnic communities must be addressed;
- All regions of the county must have access to services;
- Early intervention should generally be low-intensity and short duration;
- Early intervention may be somewhat higher in intensity and longer in duration for individuals experiencing first onset of psychosis associated with serious mental illness.

**Service Requirements:** Individuals at risk of or indicating early signs of mental illness or emotional disturbance and links them to treatment and other resources. [2]

**PEI strategies & Approaches:**

- *Outreach* to families, employers, primary care health providers, and others to recognize the early signs of potentially severe and disabling mental illness. The goal is to catch mental health issues in their earliest stages to prevent long-term suffering.
- *Access and linkage* to medically necessary care…as early in the onset of these conditions
- *Reduction in stigma and discrimination* associated with either being diagnosed with a mental health condition or seeking mental health services (MHSA, Section 4, Welfare and Institutions Code (WIC) § 5840(b).
- *Promote* wellness, foster health, and prevent the suffering that can result from untreated mental illness.

**Referral Process:** Non-clinical PEI programs receive clients through provider outreach and engagement. Outreach is based on location, service geography, staffing capacity, cultural needs, and preferences of the target populations.

**Outcomes:** PEI programs focus on reducing seven negative outcomes that may result from untreated mental illness: suicide, incarceration, school failure or dropout, unemployment, prolonged suffering, homelessness, and removal of children from their homes

[1] Proposition 63: Mental Health Services Act 2004

[2] MHSOAC PEI Fact Sheet, December 2017

## STATE DEFINED PREVENTION AND EARLY INTERVENTION PROGRAMS

**PREVENTION**

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

**EARLY INTERVENTION**

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

**OUTREACH**

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

**STIGMA & DISCRIMINATION REDUCTION**

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

**ACCESS & LINKAGE TO TX**

- Related activities to connect children, adults, and seniors with severe mental illness to medically necessary care and treatment as early in the onset as possible.
- Examples include screening, assessment, referral, telephone help lines, & mobile response.
- Includes targeted access and linkage activities for cultural populations.

**SUICIDE PREVENTION**

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

# PREVENTION & EARLY INVERVENTION PROGRAM SUMMARIES:
# PREVENTION PROGRAMS

**MHSA Program #: PEI 1A**

**PROVIDER NAME: Blue Skies Mental Wellness Team**

**PROGRAM NAME: School-Based Mental Health Consultation in Preschools**

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

Program Outcomes & Impact: PEI Data Report FY18/19

**PERFORMANCE INDICATORS: How Much Did We Do?**

| **Total Numbers Served through PEI MHSA** | |
|---|---|
| Number of unduplicated individuals your program serves who are at-risk of developing a serious mental illness (SMI) | 99 |
| Number of unduplicated individuals your program serves who show early signs of forming a more severe mental illness | 0 |
| Number of unduplicated individual family members served indirectly by your program: | 0 |
| Grand TOTAL of unduplicated individuals served in the Quarter that you are reporting about. [This number (D) should = A=B+C.] | 99 |

**PERFORMANCE INDICATORS: How Well Did We Do?**
Demographics

**Age Group (Unduplicated)**

| | |
|---|---|
| Children/Youth (0---15) | 42 |
| Transition Age Youth (16---25) | 21 |
| Adult (26---59) | 36 |
| Older Adult (60+) | 0 |
| Unknown/ Declined to Answer | 0 |

**Race (Please mark only one choice)**
*If Hispanic or Latino, choose "Another race not listed."*

| | |
|---|---|
| American Indian or Alaska Native | 1 |
| Asian | 1 |
| Black or African American | 36 |
| Native Hawaiian or other Pacific Islander | 0 |
| White | 9 |
| More than one race | 0 |
| Another race not listed | 12 |
| Unknown/ Declined to Answer | 40 |

**Gender Identity (Please mark both parts A & B)**

| | |
|---|---|
| A) Assigned sex at birth: (Please mark only one choice) | |
| Male | |
| Female | |
| Other sex not listed (e.g. Intersex) | |
| Unknown/Decline to Answer | 99 |
| B) Current Gender Identity: (Please mark only one choice) | |
| Male | |
| Female | |
| Transgender | |
| Genderqueer | |
| Questioning or Unsure of Gender Identity | |
| Another Gender Identity not listed | |
| | 99 |

**Ethnicity /Cultural Heritage (Please mark only once choice)**

| |
|---|
| **If Hispanic or Latino, please specify:** |
| Caribbean |
| Central American |
| Mexican/Mexican--American/Chicano |
| Puerto Rican |
| South American |
| Another Hispanic/Latino ethnicity not listed |
| Unknown/Declined to Answer |
| **If Non-Hispanic or Non-Latino, please specify:** |
| African |
| African American |
| Asian Indian/South Asian |
| Cambodian |
| Chinese |
| Eastern European |
| European |
| Filipino |
| Japanese |
| Korean |
| Middle Eastern |
| Vietnamese |
| Other Non-Hispanic or Non-Latino ethnicity not listed |
| **More than one ethnicity** |
| **Unknown /Declined to Answer** |

**Primary Language (Please mark only one choice)**

| | |
|---|---|
| English | 14 |
| Spanish | 6 |
| Farsi | 0 |
| Cantonese | 0 |
| Mandarin | 0 |
| Other Chinese Dialects | 0 |
| Vietnamese | 0 |
| Korean | 0 |
| Tagalog | 0 |
| Other Filipino Dialect | 0 |
| Japanese | 0 |
| Laotian | 0 |
| Cambodian | 0 |
| Mien | 0 |
| Hmong | 0 |
| Samoan | 0 |
| Thai | 0 |
| Russian | 0 |
| Polish | 0 |
| German | 0 |
| Italian | 0 |
| Turkish | 0 |
| Hebrew | 0 |
| French | 0 |
| Portuguese | 0 |
| Armenian | 0 |
| Arabic | 0 |
| Sign ASL | 0 |
| Other primary language not | 0 |
| Unknown/ Decline to Answer | 79 |

**Sexual Orientation (Please mark only one choice)**

| | |
|---|---|
| Gay or Lesbian | |
| Heterosexual or Straight | |
| Bisexual | |
| Questioning or unsure of sexual orientation | |
| Queer | |
| Another sexual orientation not listed | |
| Unknown/Decline to Answer | 99 |

**Disability Status** (Please mark all that apply)

| | |
|---|---|
| None | 99 |
| Yes. If yes, please specify (choose from list below): | |
| Difficulty Seeing | 0 |
| Difficulty hearing, or having speech understood | 0 |
| Mental Domain | 0 |
| Physical/Mobility Domain | 0 |
| Chronic Health Condition | 0 |
| Another disability not listed | 0 |
| Unknown/Decline to Answer | 0 |

**Veteran Status (Please mark only one choice)**

| | |
|---|---|
| Yes | |
| No | |
| Unknown/Decline to Answer | 99 |

**ADDITIONAL INFORMATION**

Please include the number of clients and/or contacts you estimate to serve in:

FY 19/20: 100
FY 20/21: 101

Please tell us about any changes you intend to make to your program over the next two fiscal years and explain your rationale for making these changes:

We plan to add two additional half time staff to work with our existing Blue Skies Mental Wellness Team of BHC's II who provide prevention brief therapy and clinical case management to our perinatal clients in public health home visiting to enhance our mental health supports provided in our department. The first half time therapist will offer perinatal mood disorder brief therapy to clients in need of parenting support and depression/anxiety management. The second half time therapist will provide consultation to a newly formed Health Education Team offering Group Psycho-Educational training support and will model fidelity oversight and debriefing for the team. We will continue to work on team building and focusing on ways to integrate our mental health clinicians, providing services to offer a consistent model of supportive, reflective and engaging consultation, brief therapy, clinical case management and mental health referral services for home visiting clients. We plan to continue to implement access to service linkages and treatment and to engage underserved perinatal populations to provide introductory offerings for mental health supports.

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

Each UELP program is built on a framework of three core strategies: *1) Outreach & Engagement, 2) Mental Health Consultation, and 3) Early Intervention service*s. These strategies are implemented through a variety of services, including one-on-one outreach events; psycho-educational workshops/classes; mental health consultation sessions with a variety of stakeholders (e.g., families, teachers, faith community, and community leaders); support groups; traditional healing workshops; radio/television/blogging activities; and short-term, low-intensity early intervention counseling sessions for individuals and families who are experiencing early signs and symptoms of a mental health concern.

Alameda County is an incredibly diverse population of over 1.5 million people. To address its diversity, Alameda County Behavioral Health Care Services (ACBH) has contracted thirteen programs to provide culturally responsive Mental Health PEI services to state-identified underserved populations, which include the communities of Afghan/South Asian, African, Asian/Pacific Islander (API), Native American, and Latinos. The following organizations provide these programs: [1]

- Afghan Coalition
- Asian Health Services
- Center for Empowering Immigrants & Refugees
- Community Health for Asian Americans
- Filipino Advocates for Justice
- International Rescue Committee
- Korean Community Center of the East Bay
- La Clinica de la Raza
- Native American Health Center
- Partnerships for Trauma Recovery
- Portia Bell Hume Center
- Richmond Area Multi-Service, Inc.
- Tri-City Health Center

Alameda County Behavioral Health Care Services (ACBH) worked with seven Underserved Ethnic Language Population (UELP) programs to develop an outcome-based survey. The survey was first given in 2014 and again in 2015. The outcome-based survey was revised in 2016 and split into two different data tools – the UELP Community Health Assessment and the UELP Community Wellness Client Satisfaction Survey.

The health assessment and satisfaction surveys were disseminated to the UELP community in 23 different languages including English, Spanish, Vietnamese, Chinese, Dari, Hindi, Khmer, Nepali, Korean, Thai, and Burmese and covered the following outcomes:

- Forming and strengthening identity;
- Changing knowledge and perception of mental health;
- Building community and wellness;
- Connecting individual and family with their culture;
- Improving access to services and resources;
- Transforming mental health services; and
- Increasing workforce and leadership development.

The evaluation used mixed methods. To better understand the meaning of survey responses, ACBH also conducted focus groups and a key informant interview with the UELP program participants.

All UELP providers offer services in two main categories: 1) Prevention services, for clients who are at higher than average risk of developing a significant mental illness and 2) Preventative Counseling (PC) services, designed for clients who are showing early signs and symptoms of a mental health concern. Responses to these survey questions were analyzed separately for Prevention and PC services to measure any differences between the two types of services.

**KEY FINDINGS**

In FY 18/19, the data shows that UELP providers in total produced:

- 7,895 *Prevention* events, which is a 37% increase from last year;
- 56,848 people were served at these *Prevention* events (duplicated count); and
- 895 unique clients were served through *PC* services, which is an 18% increase in the number of clients served in FY 17/18.

The revised client satisfaction survey and focus groups were used to assess the program outcomes. All the critical findings of the analysis are summarized below.

In 2019, a total of 251 respondents from nine of the thirteen UELP programs completed the survey.

- <u>Forming and Strengthening Identity</u>

  Participants are more **empowered** and confident in themselves. Eighty-four percent of *Prevention* and *PC* respondents reported feeling better about themselves. While participating in their programs, they developed the strength, motivation, and courage to address their challenges.

- Changing Individual Knowledge and Perception of Mental Health Services

  Providers are working towards changing the perception and narrative around mental health. Eighty-eight percent of *Prevention* respondents and ninety-one percent of *PC* respondents reported having a stronger belief that most people with mental health experiences can grow, change, and recover. Each reporting year, more clients are reporting becoming comfortable sharing their experiences with people outside of their programs. Having these discussions more frequently and openly works towards normalizing mental health and reducing the **stigma** associated with it.

- Building Community and Its Wellness

  UELP providers are working towards a healthier community for their clients. Respondents reported ***establishing relationships*** because of their participation in services. UELP programs provide an instant community for clients and reduce the risk of social isolation. Eighty-six percent of *Prevention* respondents and ninety percent of *PC* respondents reported that they have people with whom they can do enjoyable things.

- Connecting Individual and Family with Their Culture

  UELP programs provide clients with opportunities to connect with their culture. Focus group/interview respondents reported that they had increased their participation in ***cultural celebrations and traditions*** since engaging with UELP services. Eighty-three percent of *Prevention* respondents and ninety percent of *PC* respondents reported feeling more connected to their culture and community.

- Improving Access to Services and Resources

  UELP programs strive to improve access to services and resources for their client populations. Respondents reported several examples in which their program has connected them to ***resources*** such as employment, legal services, voting rights, and health care. Eighty percent of *Prevention* respondents and eighty-one percent of *PC* respondents reported becoming more effective in getting the resources that they or their family need.

- Transforming Mental Health Services

  UELP programs are transforming the way mental health services are delivered in Alameda County. One example is by providing ***linguistic and cultural competency***. Services are offered to program participants in the language that they speak and by people who understand their cultural background. Eighty-eight percent of *Prevention* respondents and ninety-three percent of *PC* respondents also said that staff were sensitive to their cultural backgrounds.

  Respondents reported strong ***relationships with service providers*** and often referred to staff as family. Ninety-three percent of *Prevention* respondents and ninety-seven percent of *PC* respondents reported that program staff treated them with dignity and respect.

  UELP programs also provide a welcoming and ***safe space*** for their clients. Many respondents reported that “this is the place” where they come and tell their “secrets.”

- Increase Workforce and Leadership Development

  This outcome is still a new area of exploration for the UELP evaluation**.** However, data from the focus groups/interview indicates that UELP programs are creating opportunities with their clients for *community leadership.*

**CHALLENGES**

- Community *outreach*: Focus group/interview respondents suggested the need for more**.** Other people in their communities are struggling with similar challenges and need to be aware of UELP services and its benefits.

- *Location:* Is a reported barrier for participants that may not have access to a car or live in a different city other than where their program is located.

- Housing: Alameda County is still in a housing crisis. Housing access and affordability continue to be a large barrier for UELP program participants.

**ADDITIONAL FINDINGS**

Fiscal year 18/19 data demonstrates that UELP clients are benefiting from their services. Overall, respondents reported improved quality of life because of their participation in their programs but still reported a need for continued support. *PC* respondents are also benefitting from more intensive services from their UELP providers. The majority (80%) of *PC* respondents reported fewer crises, and half (50%) improved their overall health from the pre to post-assessment period. Very few respondents reported a worse score.

**MHSA Program #: PEI 5**

**PROVIDER NAME**: **Cultura y Bienestar (La Clinica)**

**PROGRAM NAME: Outreach, Education & Consultation for Latino community**

**Program Description:** Cultura y Bienestar (CyB), La Clinica's UELP MHSA Prevention and Early Intervention program, serves Latinos throughout Alameda County through a three-agency collaboration. La Clinica de La Raza, the lead agency, serves Latinos in Northern Alameda County, La Familia Counseling Services serves the Central region, La Familia's East Bay serves the East County region, and Tiburcio Vasquez Health Center serves the Southern region of Alameda County.

Program Outcomes & Impact: UELP Prevention Data Report FY18/19

**PERFORMANCE INDICATORS: How Much Did We Do?**

| **Total Numbers Served through PEI MHSA** | |
|---|---|
| Number of unduplicated individuals your program serves who are **at-risk** of developing a mental health problem or serious mental illness (SMI) | 17,609 |
| Number of unduplicated individuals your program serves who show **early signs** | 391 |
| Number of unduplicated individual family members served indirectly by your program: | |
| Grand TOTAL of unduplicated individuals served in the Quarter that you are reporting about. [This number (D) should = A+B+C.] | 18,000 |

**PERFORMANCE INDICATORS: How Well Did We Do?**

Demographics

**Age Group (Unduplicated)**

| | |
|---|---|
| Children/Youth (0--15) | 3,958 |
| Transition Age Youth (16--25) | 2,699 |
| Adult (26--59) | 8,351 |
| Older Adult (60+) | 1,791 |
| Unknown/ Declined to Answer | 820 |

**Race (Please mark only one choice)**
*If Hispanic or Latino, choose "Another race not listed."*

| | |
|---|---|
| American Indian or Alaska Native | 3 |
| Asian | 376 |
| Black or African American | |
| Native Hawaiian or other Pacific Islander | |
| White | |
| More than one race | |
| Another race not listed | 17,230 |
| Unknown/ Declined to Answer | |

**Sexual Orientation (Please mark only one choice)**

| | |
|---|---|
| Gay or Lesbian | 24 |
| Heterosexual or Straight | 6,59 |
| Bisexual | |
| Questioning or unsure of sexual orientation | |
| Queer | 1 |
| Another sexual orientation not listed | 74 |
| Unknown/Decline to Answer | 10,91 |

**Ethnicity /Cultural Heritage (Please mark only once choice)**

| | |
|---|---|
| **If Hispanic or Latino, please specify:** | |
| Caribbean | 1,442 |
| Central American | 1,078 |
| Mexican/Mexican--American/Chicano | 6,775 |
| Puerto Rican | 44 |
| South American | 83 |
| Another Hispanic/Latino ethnicity not listed | 5,261 |
| Unknown/Declined to Answer | |
| **If Non-Hispanic or Non-Latino, please specify:** | |
| African | |
| African American | |
| Asian Indian/South Asian | |
| Cambodian | |
| Chinese | |
| Eastern European | |
| European | |
| Filipino | |
| Japanese | |
| Korean | |
| Middle Eastern | |
| Vietnamese | |
| Other Non-Hispanic or Non-Latino ethnicity not listed | |
| **More than one ethnicity** | |
| **Unknown /Declined to Answer** | |

| **Primary Language (Please mark only one choice)** | |
|---|---|
| English | 3,939 |
| Spanish | 13,39 |
| Farsi | |
| Cantonese | |
| Mandarin | |
| Other Chinese Dialects | |
| Vietnamese | |
| Korean | |
| Tagalog | |
| Other Filipino Dialect | |
| Japanese | |
| Laotian | |
| Cambodian | |
| Mien | |
| Hmong | |
| Samoan | |
| Thai | |
| Russian | |
| Polish | |
| German | |
| Italian | |
| Turkish | |
| Hebrew | |
| French | |
| Portuguese | |
| Armenian | |
| Arabic | |
| Sign ASL | |
| Other primary language not listed | 279 |
| Unknown/ Decline to | |

| **Gender Identity (Please mark both parts A & B)** | |
|---|---|
| A) Assigned sex at birth: (Please mark only one choice) | |
| Male | 5,745 |
| Female | 11,311 |
| Other sex not listed (e.g. Intersex) | |
| Unknown/Decline to Answer | 556 |
| B) Current Gender Identity: (Please mark only one choice) | |
| Male | |
| Female | |
| Transgender | 5 |
| Genderqueer | |
| Questioning or Unsure of Gender Identity | |
| Another Gender Identity not listed | |
| Unknown/Decline to Answer | 17,614 |

| **Disability Status** (Please mark all that | |
|---|---|
| None | 4,428 |
| Yes. If yes, please specify (choose from list | |
| Difficulty Seeing | 10 |
| Difficulty hearing, or having speech | 16 |
| Mental Domain | 4 |
| Physical/Mobility Domain | 122 |
| Chronic Health Condition | 384 |
| Another disability not listed | 2 |
| Unknown/Decline to Answer | 12,653 |

| **Veteran Status (Please mark only one choice)** | |
|---|---|
| Yes | 41 |
| No | 5,91 |
| Unknown/Decline to Answer | 17,61 |

**PROGRAM OVERVIEW**

1. What were the successes/accomplishments of the past year? Please provide one example or case study of a success your agency is particularly proud of.

   Fiscal year 18-19 brought many major successes for CyB. First, the Cultura y Bienestar program was able to exceed most of the program deliverables. The activities that far exceeded program deliverables were workshops/support groups for seniors with a 327% achievement rate, early intervention visits with a 232% achievement rate, and fairs/community events with a 183% achievement rate. All of these efforts continue gaining the Latino community's trust and support.

   Also, traditional healing events have been the highlight of all the events provided during FY18-19. Community members have a vested interest in utilizing traditional medicine and traditional healing methods. For example, our clients have continued to show interest in therapeutic drumming circles as a form of wellness and the use of herbs as a form of medicine. This year alone, the Cultura y Bienestar has provided fourteen traditional healing events, many of which have focused on healing through herbal medicine.

   Moreover, Cultura y Bienestar not only has engaged the adults in the traditional healing events; the kids have been a part of these events as well. CyB engaged the kids through traditional story-telling. For one of the events, character dress-up was utilized as a story-telling technique. The kids really enjoyed the event and were extremely involved the entire time.

   Additionally, as part of the $1.14 Million CyB received from the California Department of Public Health, California Reducing Disparities Project, CyB continues to staff various positions to their full FTE. The funding has also allowed the advancement on evaluating CyB program model to see if CyB can be replicated in other Latino communities to reduce mental health stigma. The findings from the preliminary analysis suggest that the proposed target population is being recruited for the prevention services and that based on the client profiles, many have received some form of treatment for serious mental illness or other physical health problems.

   Lastly, CyB was heavily involved in making progress towards standardizing all program curricula and assuring that all CyB staff is providing the same trainings in a standardized format despite agency affiliation. La Clinica hired an MPH student intern to work with CyB staff develop the program manual. Technical Assistance Providers (TAP) from the California Reducing Disparities Project have assisted in reviewing the program manual drafts and have provided ongoing feedback to advance the development of the manual. Cultura y Biesntar expects to have a finalized the manual in FY19-20.

2. What were the challenges and how did your agency mitigate challenges?
   Due to the change in the political climate towards immigrants in recent years, there has been an overall decline in the rate of immigrants seeking out public services. To a great extent, this decline has been as a result of fear of the release of their personal information, which could have an impact on migratory status. La Clínica aims to draw on its history and expertise working with this population to strategize ways to mitigate fear and encourage participation in these important services. When clients come to receive services, CyB makes a welcoming environment and makes it clear that they can trust the program and that their personal will be kept safe and confidential.

CyB will continue to strive to increase community outreach by participating in local events, partnering with other agencies, and continue to present of services that CyB offers.

3. Please describe the innovative ways your program has weaved the topics of mental health/emotional well-being into your activities. Please give at least one example.

   Mental health topics are woven into all of the program's activities, outreach, CBO trainings, individual, couple, family, and consultations with family and community members, as well as the traditional medicine workshops. Recently, CyB was able to weave in mental health/emotional well-being through consultation visit with a client. CyB had a client who visited CyB because he was having marital problems. CyB staff listened with an open-mind and allowed the client to share his feelings about his marriage and the impact they were having on his mental and emotional health. The staff also walked him through an activity to reflect on how the problems that he was experiencing were also taking a toll on his partner's mental and emotional health. He received information about ways to effectively communicate with his partner and how to relate better to each other. The client came back to share that the information he received has made a huge improvement in his marriage and wanted to receive more services such as men's group.

4. Please describe how your program has encouraged access to your services and your strategies for successful linkage for mental health treatment.
   All staff is expected to provide outreach to the communities that CyB serves. Staff provides outreach at community events, and various other locations where the Latino community congregates in order to provide information on mental health and the services that the program provides. Additionally, once CyB engages clients, staff completes referral forms so that the coordinator for the program can follow up and contact each client to see if they have followed through on the referral and in order to make additional referrals as necessary. CyB works directly with La Clinica medical providers to increase access for clients who are also La Clinica patients. For example, if a patient has been recently diagnosed with diabetes, the provider will continue to support the patient to improve their physical health and will refer the patient to CyB for staff to provide mental health support. Likewise, if a patient comes for mental health services but also needs medical services, CyB will refer them to La Clinica's medical department.

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

6. What are your goals for your program for the upcoming fiscal year?

   CyB's primary goal for this upcoming fiscal year is to continue to expand to make services available to all community members who need it as well as to continue provide high quality care. Moreover, another goal for this upcoming year is to develop a youth leadership program at the schools that we currently partner with to empower young people to become our future leaders. Through this initiative, we hope to teach youth the skills required work in collaboration with their peers to overcome challenges, to teach youth how to be a mentor for others, and also to improve communication while at the same time weaving in mental health topics to this work.

**ACCESS & LINKAGE TO MENTAL HEALTH TREATMENT (QUESTION 1 AND 3 ARE REQUIRED PER YOUR EXHIBIT A - QUALITY MEASURES)**

1. Number of individuals with serious mental illness (SMI) or exhibit symptoms of a SMI who received a paper referral (i.e. referrals via phone do not apply) from your program…
    a. To an ACBH-funded mental health treatment program: 6
    b. To a non-ACBH-funded mental health treatment program: 2

2. List type(s) of mental health treatment programs the individual was referred to (i.e. outpatient, inpatient, etc.):
    Outpatient

3. Number of individuals who were successfully referred and linked (i.e. client has been seen at least once in person by a treatment provider):
    a. To an ACBH mental health treatment program: 6
    b. To a non-ACBH-funded mental health treatment program: 2

4. Average duration in weeks of signs of untreated mental illness (per client self-report) *(write "n/a" or "unknown" when applicable): 16 weeks*

5. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with a mental health treatment provider *(write "n/a" or "unknown" when applicable)*: 4 weeks

**TIMELY ACCESS (TO OTHER PEI-FUNDED PROGRAMS)**

1. Number of separate paper referrals to another ACBH **PEI-funded** program. *(write "n/a" or "unknown" when applicable)*: 0

2. Number of individuals followed through on referral & engaged in an ACBH PEI-funded program *(write "n/a" or "unknown" when applicable)*: N/A

3. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with the ACBH PEI-funded provider *(write "n/a" or "unknown" when applicable)*: N/A

**MHSA Program #: PEI 6**

**PROVIDER NAME: Asian Health Services**

**PROGRAM NAME: Outreach, Education & Consultation for Asian Pacific Islander Community**

**Program Description:** Asian Health Services, founded in 1974, provides health, social, and advocacy services for all regardless of income, insurance status, immigration status, language, or culture. Our approach to wellbeing focuses on "whole patient health," which is why we provide more than primary care services, including mental health, case management, nutrition, and dental care to more than 27,000 patients in English and over 12 Asian languages: Cantonese, Vietnamese, Mandarin, Khmer, Korean, Tagalog, Mien, Lao, Thai, Mongolian, Karen, Karenni, and Burmese. We offer medical, dental, and mental health services for all ages.

Program Outcomes & Impact: UELP Data Report FY18/19

**PERFORMANCE INDICATORS: How Much Did We Do?**

| Total Numbers Served through PEI MHSA | |
|---|---|
| Number of unduplicated individuals your program serves who are **at-risk** of developing a mental health problem or serious mental illness (SMI) | 5,348 |
| Number of unduplicated individuals your program serves who show **early signs** of forming a more severe mental illness | 34 |
| Number of unduplicated individual family members served indirectly by your program: | |
| Grand TOTAL of unduplicated individuals served in the Quarter that you are reporting about. [This number (D) should = A+B+C.] | 5,382 |

**PERFORMANCE INDICATORS: How Well Did We Do?**
Demographics

**Age Group (Unduplicated)**

| | |
|---|---|
| Children/Youth (0---15) | 799 |
| Transition Age Youth (16---25) | 892 |
| Adult (26---59) | 2,436 |
| Older Adult (60+) | 1,217 |

**Race (Please mark only one choice)**
*If Hispanic or Latino, choose "Another race not listed."*

| | |
|---|---|
| American Indian or Alaska Native | 2 |
| Asian | 4,632 |
| Black or African American | 118 |
| Native Hawaiian or other Pacific Islander | 7 |
| White | 133 |
| More than one race | 332 |
| Another race not listed | 113 |
| Unknown/ Declined to Answer | 11 |

**Sexual Orientation (Please mark only one choice)**

| | |
|---|---|
| Gay or Lesbian | 31 |
| Heterosexual or Straight | 2,365 |
| Bisexual | |
| Questioning or unsure of sexual orientation | 69 |
| Queer | 56 |
| Another sexual orientation not listed | 2,876 |
| Unknown/Decline to Answer | |

**Ethnicity /Cultural Heritage (Please mark only once choice)**

| | |
|---|---|
| **If Hispanic or Latino, please specify:** | |
| Caribbean | |
| Central American | |
| Mexican/Mexican--American/Chicano | |
| Puerto Rican | |
| South American | |
| Another Hispanic/Latino ethnicity not listed | 80 |
| Unknown/Declined to Answer | |
| **If Non-Hispanic or Non-Latino, please specify:** | |
| African | |
| African American | |
| Asian Indian/South Asian | 3 |
| Cambodian | 5 |
| Chinese | 1, |
| Eastern European | |
| European | |
| Filipino | 1 |
| Japanese | 25 |
| Korean | 1 |
| Middle Eastern | |
| Vietnamese | 1, |
| Other Non-Hispanic or Non-Latino ethnicity not listed | 5<br>8 |
| Lao -48 | 8 |
| Mien - 391 | |
| Mongolian-29 | |
| Nepalese - 3 | |
| Samoan-3 | |
| Sri Lankan-2 | |
| Taiwanese – 17 | |
| Other Asian – 72 | |
| Other Pacific Islander – 1 | |
| Other South Asian – 21 | |
| **More than one ethnicity** | |

**Primary Language (Please mark only one choice)**

| | |
|---|---|
| English | 2,13 |
| Spanish | |
| Farsi | |
| Cantonese | 1,11 |
| Mandarin | 87 |
| Other Chinese Dialects | 25 |
| Vietnamese | 126 |
| Korean | 12 |
| Tagalog | 2 |
| Other Filipino Dialect | |
| Japanese | 14 |
| Laotian | 5 |
| Cambodian | 23 |
| Mien | 31 |
| Hmong | |
| Samoan | |
| Thai | |
| Russian | |
| Polish | |
| German | |
| Italian | |
| Turkish | |
| Hebrew | |
| French | |
| Portuguese | |
| Armenian | |
| Arabic | |
| Sign ASL | |
| Other primary language not listed Fijiian-12 Leu-1 Mongolian-1 Other - 8 | 22 |
| Unknown/ Decline to Answer | |

**Gender Identity (Please mark both parts A &**

| | |
|---|---|
| A) Assigned sex at birth: (Please mark only one choice) | |
| Male | 1,74 |
| Female | 3,09 |
| Other sex not listed (e.g. Intersex) | 42 |
| Unknown/Decline to Answer | |
| B) Current Gender Identity: (Please mark only one choice) | |
| Male | |
| Female | |
| Transgender | 9 |
| Genderqueer | |
| Questioning or Unsure of Gender Identity | |
| Another Gender Identity not listed | |
| Unknown/Decline to Answer | |

**Disability Status** (Please mark all that apply)

| | |
|---|---|
| None | 1,74 |
| Yes. If yes, please specify (choose from list below): | |
| Difficulty Seeing | 2 |
| Difficulty hearing, or having speech | 2 |
| Mental Domain | 34 |
| Physical/Mobility Domain | 19 |
| Chronic Health Condition | 35 |
| Another disability not listed | 7 |
| Unknown/Decline to Answer | 3,18 |

**Veteran Status (Please mark only one choice)**

| | |
|---|---|
| Yes | 1 |
| No | 3,51 |
| Unknown/Decline to Answer | 5,34 |

**PROGRAM OVERVIEW**

1. What were the successes/accomplishments of the past year? Please provide one example or case study of a success your agency is particularly proud of.

The program succeeded at meeting and surpassing two of its main contractual goals for FY 18-19. Through various Prevention activities throughout the FY 18-19-year, staff engaged a total of 6,012 community contacts (in excess of the 5,640 expected). Prevention staff conducted a total of 173 mental health consultation events throughout the year, when 165 events were expected.

One of the other biggest accomplishments of the past year was sustaining the program's implementation of an "Introduction to Mental Health" presentation/workshop, which empowers participants to identify signs of stress and develop healthy coping strategies for stress in order to prevent more serious mental health problems. Staff developed Introduction to Mental Health using knowledge gained at a training on Dynamic Mindfulness during FY 17-18 as well as from trainings on Mental Health First Aid, and Seeking Safety training from previous years. They designed the presentation to be highly interactive and to use language and concepts accessible to everyday community members. Staff first piloted Introduction to Mental Health in the earlier months of FY 17-18 with youth audiences during outreach activities with AYPAL, one of our community partner organizations, and "in-reach" activities at AHS' The Spot, another division of AHS where several youth programs are held. Staff also conducted the workshop for students and staff at Laney College; this workshop was led in English, while Chinese and Vietnamese staff were available for interpretation as needed. Over time, Prevention staff refined the presentation based on internal discussions as well as feedback from audience members. They finalized a standard version of the presentation and translated the written presentation from English to Korean, Chinese, and Vietnamese. We were able to successfully continue this program in FY 18-19 and share our presentations with our programs doing mental health awareness presentations focusing on the API community.

2. What were the challenges and how did your agency mitigate challenges?

First, due to staff turnover in fourth quarter 2019, the program lost one Vietnamese outreach worker and our Prevention Program manager resigned. This made it more difficult to effectively outreach to these communities and find enough referrals to the Preventive Counseling program. We attempted to mitigate the loss by continuing to facilitate the group with other Vietnamese outreach workers and MSW intern. We shifted management responsibilities to our Division Director, Kao Saechao, and QI Manager, Shadia Gadoy, and will fill the position in August 2019 with an internal AHS candidate. We hired an MSW intern for 10 weeks beginning in June 2019, which allowed us to extend our outreach efforts to the Chinese community, such as translating the Introduction to Mental Health API outreach materials, tabling events, and co leading our Chinese support groups.

Second, some staff had ongoing difficulties adjusting to the EPIC Health Record System to record and adjust work flows for some Prevention activities. Staff spent a significant amount of time in starting in April through May attending EPIC trainings. One-on-one training and consultation were provided as needed to coach staff in documenting in EPIC for those who continued to struggle using the system. The staff continues to receive trainings and support.

Third, transitioning to our new East Asian UELP grant was disruptive to our overall service delivery during the 4th quarter. Our Southeast Asian (SEA) clients had to be notified of the change in our scope and service delivery and we also began transitioning our support groups and our individual consultation clients. This affected client care to some extent as some clients reported feeling "sad", and did not seek to be transitioned out to other programs.

3. Please describe the innovative ways your program has weaved the topics of mental health/emotional well-being into your activities. Please give at least one example.

Our "Walking 4 Wellness" support group continued this year to engage API community members in innovative mental health activities, primarily through light physical activity and discussion. The group was held every week, and many participants became regular attendees. Through their weekly walks, participants engaged in physical wellness activities while also being able to discuss mental health topics (such as depression or anxiety), share their experiences with one another, and support each other on their road of recovery.

Another innovative program we began this FY was incorporating our AHS NP fellows (Nurse Practitioner Fellows from AHS) to present at health and wellness workshops. These were highly popular and successful as the NP fellows were exposed to working with our API community and the community was able to interact with the NP's outside a clinic setting. This provided much needed health education, training, and activities to promote wellness amongst our API populations about their health and mental health.

4. Please describe how your program has encouraged access to your services and your strategies for successful linkage for mental health treatment.

One of our most successful strategies is to integrate our specialty mental providers in the Prevention programs. All of our Prevention program staff are trained mental health professional (Mental Health Rehabilitation Specialist (MHRS), board registered AMFT's, LCSW, MSW interns, or family partners) in our Specialty mental health treatment programs. We are able to successful engage the clients in preventative services and transition with them to specialty mental health services as needed. Most of the time, the same prevention program staff will become the client's specialty mental health treatment counselor. This helps to reduce the stigma, improve warm handoffs, and encourage access to services. Also, our Prevention programs are located in the same building as the specialty mental health treatment services. This helps client develop a familiarity and routine with visiting our clinic for services, further reducing stigma and increasing engagement.

5. Describe how your program interacted with various other ACBH funded programs/projects such as school-based programs, other prevention programs, the stigma and discrimination reduction campaign, 10 x 10 campaign etc.

One of our continued successful partnerships this year was our participation in Alameda County's annual 10 x 10 Wellness Campaign event, in Marina Park, San Leandro in May 2019. As in previous years, our Prevention Program sent representatives to the campaign's monthly Community Advisory Board meetings, so that we could be involved in the planning and coordination of the event as mental health consultants. Through our outreach and coordination, we also accomplished sending 70 (50 in the previous year) API community members already linked into our services to the all-day event, where they participated in healthy physical activities, learned about other wellness services and resources around the county, and confronted the stigma of mental health by being part of this public effort to raise mental health awareness. Finally, our program hosted one of the many community resource tables at the event. We designed an interactive engagement activity for 10 x 10 attendees who came to our table, where they were able to identify signs of stress and effective ways of coping with stress. We then shared information about our SMH Treatment and Prevention services with attendees. Through this engagement, we reached 108 unique community contacts in in San Leandro (last year 98 unique clients), representing a portion of the county that we have not outreached to often but would like to connect with more.

We participated in other prevention-related projects in the wider Alameda County BHCS system as well. As previously mentioned, we partnered with Burma Family Refugee Network to continue to facilitate a Karen adult wellness support group this past year. Another partnership we had was with Alameda County BHCS, Child and Young Adult System of Care (CYASOC), who invited us to provide mental health consultation/training to master's level interns at the Juvenile Justice Center and other CYASOC programs. Here, the Program Manager presented on the topic of intergenerational trauma in API families and other communities of color.

Through sharing this perspective developed by working with our clients, we hope that the awareness, treatment, and prevention of important issues affecting underserved API communities becomes more widespread throughout Alameda County.

Finally, the Prevention Program collaborated with various other community-based and school-based organizations by providing outreach, engagement, consultation, resource tabling, and psycho-education meant to engage low-income, underserved API community members in mental health and wellness. Some of these collaborations have been mentioned elsewhere in this report. Others include partnerships with Public Health Institute to promote the wellness of Asian Youth throughout Oakland and Alameda County; the Asian Outreach Committee of Samuel Merritt University's Ethnic Health Institute to provide mental health consultation on outreaching to Asians in the Bay Area regarding various health-related resources.

6. What are your goals for your program for the upcoming fiscal year?
    - Meet our contract goals (esp. preventive counseling and consultation)
    - Diversify support groups, workshop series, and large-scale outreach events to reach more community members, and focused on the East Asian populations
    - Continue to outreach and establish a presence in Central County (building on relationships made at Moon Festival, San Leandro Library, and EHI Asian Outreach Committee)
    - Continue to recruit new culturally competent Manager, staff, and interns for the program to meet the needs of our new grant.

**ACCESS & LINKAGE TO MENTAL HEALTH TREATMENT (QUESTION 1 AND 3 ARE REQUIRED PER YOUR EXHIBIT A - QUALITY MEASURES)**

1. Number of individuals with serious mental illness (SMI) or exhibit symptoms of a SMI who received a paper referral (i.e. referrals via phone do not apply) from your program…
    a. To an ACBH-funded mental health treatment program: 3
    b. To a non-ACBH-funded mental health treatment program: 0

2. List type(s) of mental health treatment programs the individual was referred to (i.e. outpatient, inpatient, etc.): Outpatient Specialty Mental Health Services

3. Number of individuals who were successfully referred and linked (i.e. client has been seen at least once in person by a treatment provider):
    a. To an ACBH mental health treatment program: 3
    b. To a non-ACBH-funded mental health treatment program: 0

4. Average duration in weeks of signs of untreated mental illness (per client self-report) *(write "n/a" or "unknown" when applicable): Within 10 Business days the clients are linked to SMH services*

5. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with a mental health treatment provider *(write "n/a" or "unknown" when applicable)*: Within 10 business days the clients are linked to SMH services

**TIMELY ACCESS (TO OTHER PEI-FUNDED PROGRAMS)**

1. Number of separate paper referrals to another ACBH **PEI-funded** program. *(write "n/a" or "unknown" when applicable)*: 2

2. Number of individuals followed through on referral & engaged in an ACBH PEI-funded program *(write "n/a" or "unknown" when applicable)*: 2

3. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with the ACBH PEI-funded provider *(write "n/a" or "unknown" when applicable)*: Unknown

**MHSA Program #: PEI 6**

**PROVIDER NAME: Center for Empowering Refugees and Immigrants (CERI)/Reviving Our Youth's Aspirations (ROYA)**

**PROGRAM NAME: Outreach, Education & Consultation for Asian Pacific Islander Community**

**Program Description**: The mission of the Center for Empowering Refugees and Immigrants (CERI) is "to improve the social, psychological, and economic health of refugee families in which one or more individuals have been affected by war trauma, genocide, torture or another form of extreme trauma." Core services include: individual, family, and group counseling; case management, advocacy, and referrals; a range of wellness and enrichment activities; and culturally-grounded community gatherings, projects, and events, on-site at CERI and in local community venues. Through its youth/young adult program, ROYA, CERI also provides services for children, teens, Transition-Age Youth (TAY), and young adults, designed to address the intergenerational impact of war trauma and empower young people from the CERI community who are at risk for becoming involved in crime, drugs, violence, and sexual exploitation.

Program Outcomes & Impact: UELP Data Report FY18/19

**PERFORMANCE INDICATORS: How Much Did We Do?**

| **Total Numbers Served through PEI MHSA** | |
|---|---|
| Number of unduplicated individuals your program serves who are **at-risk** of developing a mental health problem or serious mental illness (SMI) | 6,443 |
| Number of unduplicated individuals your program serves who show **early signs** of forming a more severe mental illness | 25 |
| Number of unduplicated individual family members served indirectly by your program: | |
| Grand TOTAL of unduplicated individuals served in the Quarter that you are reporting about. [This number (D) should = A+B+C.] | 6,468 |

**PERFORMANCE INDICATORS: How Well Did We Do?**

Demographics

**Age Group (Unduplicated)**

| | |
|---|---|
| Children/Youth (0---15) | 371 |
| Transition Age Youth (16---25) | 947 |
| Adult (26---59) | 3,451 |
| Older Adult (60+) | 1,490 |
| Unknown/ Declined to Answer | 194 |

**Race (Please mark only one choice)**
*If Hispanic or Latino, choose "Another race not listed."*

| | |
|---|---|
| American Indian or Alaska Native | 16 |
| Asian | 5,379 |
| Black or African American | 156 |
| Native Hawaiian or other Pacific Islander | 3 |
| White | 210 |
| More than one race | 79 |
| Another race not listed | 320 |
| Unknown/ Declined to Answer | 266 |

**Sexual Orientation (Please mark only one choice)**

| | |
|---|---|
| Gay or Lesbian | 130 |
| Heterosexual or Straight | 4385 |
| Bisexual | 19 |
| Questioning or unsure of sexual orientation | 8 |
| Queer | 326 |
| Another sexual orientation not listed | 40 |
| Unknown/Decline to Answer | 1528 |

**Ethnicity /Cultural Heritage (Please mark only once choice)**

| | |
|---|---|
| **If Hispanic or Latino, please specify:** | |
| Caribbean | |
| Central American | |
| Mexican/Mexican | |
| -- | |
| Puerto Rican | |
| South American | |
| Another Hispanic/Latino | 286 |
| Unknown/Declined to Answer | |
| **If Non-Hispanic or Non-Latino, please specify:** | |
| African | |
| African American | |
| Asian Indian/South Asian | 8 |
| Cambodian | 4,709 |
| Chinese | 68 |
| Eastern European | |
| European | |
| Filipino | |
| Japanese | 17 |
| Korean | 6 |
| Middle Eastern | |
| Vietnamese | 108 |
| Other Non-Hispanic or Non- Latino ethnicity not listed | 315 |
| Fijian - 44<br>Afghan - 40<br>Pacific Islander – 3 Indonesian – 20<br>Lao – 3<br>Nepalese- 46<br>Persian Iranian – 78 Thai – 11 | |
| **More than one ethnicity** | |
| **Unknown /Declined to Answer** | |

**Primary Language (Please mark only one choice)**

| | |
|---|---|
| English | 2,29 |
| Spanish | 49 |
| Farsi | 19 |
| Cantonese | |
| Mandarin | |
| Other Chinese Dialects | |
| Vietnamese | 39 |
| Korean | 2 |
| Tagalog | |
| Other Filipino Dialect | |
| Japanese | |
| Laotian | |
| Cambodian | 3,92 |
| Mien | |
| Hmong | |
| Samoan | |
| Thai | |
| Russian | |
| Polish | |
| German | |
| Italian | |
| Turkish | |
| Hebrew | |
| French | |
| Portuguese | |
| Armenian | |
| Arabic | 11 |
| Sign ASL | |
| Other primary language not listed | 107 |

Hindi – 6
Persian – 30
Punjabi – 5
Unknown/ Decline to Answer

**Gender Identity (Please mark both parts A &**

| | |
|---|---|
| A) Assigned sex at birth: (Please mark only one | |
| Male | 1,60 |
| Female | 4,38 |
| Other sex not listed (e.g. Intersex) | |
| Unknown/Decline to Answer | 213 |
| B) Current Gender Identity: (Please mark only one choice) | |
| Male | |
| Female | |
| Transgender | 106 |
| Genderqueer | |
| Questioning or Unsure of Gender Identity | |
| Another Gender Identity not listed | |
| Unknown/Decline to Answer | 6,337 |

**Disability Status** (Please mark all that apply)

| | |
|---|---|
| None | 2,43 |
| Yes. If yes, please specify (choose from list below): | |
| Difficulty Seeing | 13 |
| Difficulty hearing, or having speech | 12 |
| Mental Domain | 2,78 |
| Physical/Mobility Domain | 84 |
| Chronic Health Condition | 43 |
| Another disability not listed | 8 |
| Unknown/Decline to Answer | |

**Veteran Status (Please mark only one choice)**

| | |
|---|---|
| Yes | 0 |
| No | 5,74 |
| Unknown/Decline to Answer | 64 |

**PROGRAM OVERVIEW**

1. What were the successes/accomplishments of the past year? Please provide one example or case study of a success your agency is particularly proud of.

   Over the past year, CERI had notable successes and accomplishments in three key areas:

**YOUTH/YOUNG ADULT SERVICES:**

CERI expanded its services for at-risk youth and young adults in three ways. First, it launched a Co-Ed Support Group facilitated by a second-generation Cambodian American staff member, age 35.

Currently, 14 youth and young adults (ages 16-22) participate in the weekly group, which focuses on both leadership and advocacy skills and emotional support. The participants in this group also created CERI's new youth-led Youth Development Team, which meets regularly with the City of Oakland's Equity and Race Initiative team. Finally, in response to the local need for LGBTQ services specifically for Southeast Asians, CERI now provides a drama therapy group with a social justice focus, as well as individual therapy as needed, for up to 20 Southeast Asian LGBTQ young adults (ages 18 to 30), facilitated by an MFTI from the LGBTQ Southeast Asian community. The group has been instrumental in providing support in combating stigma, homelessness, prevention of major mental illness, and even suicidal ideation among this vulnerable population of young people as they explore their sexual identity in the context of their own culture and society at large.

**ADULT/OLDER ADULT SERVICES:**

CERI continues to provide clinical services, support groups, care management, and community activities for its adults and older adults, who were most directly impacted by the Khmer Rouge genocide. Over the last year, it has continued its Drama Therapy group for adult survivors, which has helped empower them to tell their story and achieve a new level of healing. CERI has also hired a new Cambodian American interpreter and care manager, who helped revive the women's groups. As a result, the number of individuals participating in these support groups has increased and more elders are taking a leadership role in the community. For many, this ongoing support has been life changing, as in the case of V. below.

**Case Study of V.:**

One of CERI's clients, V., a 59-year-old female who, in the past, had been sexually abused and sold into prostitution, was suicidal with plans. When she first came to CERI, she had severe Post-Traumatic Stress Disorder (PTSD), major depression, and persistent flashbacks about what had happen to her and her family during the Cambodian genocide. At CERI she received individual therapy and psychiatric treatment and, over time, started to come to support groups and participate in community activities, such as dance and potluck parties, field trips and camping. She also became the leader in community garden program. Recently, V., who now has no suicidal ideation, spoke at a public event about her experience as a refugee. She had been interviewed with a writer and her story is going to be a chapter in a book about refugees. Although she still gets some flashbacks and dreams about the past, they are now about her childhood memories before war. She remembers things she forgot long time ago. She recently told the CERI staff that "Life is a beautiful thing" and that "she wants to live."

**FUNDRAISING:** One of CERI's goals last year was to expand and diversify its funding. CERI made great progress toward this goal, receiving support from the Devata Giving Circle, the Episcopal program funds, and Beacon funding. It also got two grants from the City of Oakland, for youth leadership and a written word workshop for teenagers and adults, led by a Cambodian American writer. It is currently working with clients to plan a major fundraising/cultural event this fall to mark the 40$^{th}$ Anniversary of the end of the reign of the Khmer Rouge.

2. What were the challenges and how did your agency mitigate challenges?

CERI faced two main challenges over the past year:
1) Safety issues related to its youth program expansion; and,
2) ICE raids and deportations impacting the Cambodian refugee community.

**CHALLENGE #1: SAFETY ISSUES RELATED TO EXPANDED YOUTH SERVICES**

One of the positive aspects of CERI's expanded youth services is that it brought more teens and young adults into CERI to engage in services.

This also raised safety concerns, as many of these young people have been involved in gangs, drug dealing, and the sex trade. CERI's adult clients voiced concerns about keeping CERI a safe place for the community to meet. CERI addressed this issue by engaging in community conversations to establish new ground rules for the CERI community (i.e., no drugs, alcohol, smoking, weapons, violence, stealing, or solicitation), preventative work, and restorative justice practices. Participating youth and young adults made a verbal commitment to respect these rules. CERI also created a new front desk position to monitor youth activities, run by a former member of the youth program who has a criminal past but has since turned her life around and can serve as a role model and resource for these youth.

**CHALLENGE #2: ICE RAIDS AND DEPORTATION**

February 2019 marked the beginning of ICE raids that would devastate the Cambodian community, tearing families apart. Several CERI community members were targeted for deportation—mostly individuals now in their 40s, born in Cambodia or resettlement camps, who, here in the U.S., had acquired a criminal record as teens or young adults.

CERI addressed this crisis by holding a community meeting on March 6, 2019, co-hosted with the Asian Law Caucus (ALC) and the Asian Prisoner Support Committee (APSC), two local advocacy organizations dedicated to helping impacted individuals fight deportation. This was the first collaboration of this kind for CERI, which joined the anti-deportation efforts and offered emotional support to clients and loved ones impacted while the collaborating organizations held the legal and political organizing pieces. As a result of this meeting, CERI started a series of Impacted Families Support Sessions, to help hold space for family members as they navigated this emotional journey.

On March 13$^{th}$, the CERI, APSC, and ALC communities came together to rally and support individuals who were scheduled to turn themselves in, protesting at the ICE office in San Francisco. Over the next couple of months, CERI elders were introduced to education around deportation policies, in order to understand their rights and know what needed to happen legally for people to be able to stay. They learned how to lobby, visiting legislators in Sacramento, and became more empowered and politicized to be able to share their own narratives and how Cambodian deportations were affecting the community. CERI staff also provided psychological evaluations, which were submitted to the judges.

After months of intense organizing, the four members of the CERI community who had been targeted got their convictions vacated or were pardoned by the Governor and their deportation orders were rescinded—an amazing feat. The attorneys involved said that if it were not for the active involvement of CERI's clients these individuals would not have been pardoned. Unfortunately, 37 other Cambodian Americans from California and the rest of the country were deported in early July. CERI plans to continue its partnership with ALC and APSC, as more ICE raids are expected.

CERI will continue to provide ongoing support for clients around this issue to address the heightened fear generated by the deportation raids, which triggered reactivation of PTSD symptoms. This type of mental health and wellness support is particularly important for highly-traumatized genocide survivors.

3. Please describe the innovative ways your program has weaved the topics of mental health/emotional well-being into your activities. Please give at least one example.

During the FY 2018-2019 UELP contract period, CERI continued to pursue innovative ways to expand its grassroots, community-based mental health model to support the mental health and emotional well-being of its clients:

**YOUTH LEADERSHIP COMPONENT:**
In addition to expanding services for youth and young adults and establishing related safety policies and strategies, CERI recruited Cambodian Americans from similar backgrounds to serve as role models for the youth.

These include: 1) a former CERI youth program member turned staff member (for five years) who had turned her life around (i.e., finishing high school, completing her AA degree) after engaging in various crimes as a teen, now serves as the front desk person and monitors youth activities; and, 2) a former gang member, who now co-facilitates the new Co-Ed Support Group for youth and young adults and educates them about the realities of incarceration and the criminal justice system.

**LGBTQ COMPONENT:** Through CERI's new Southeast Asian LTBTQ support services—among the first services of this kind in the county—CERI has begun to raise awareness about and reduce stigma around being gay, which has been a taboo topic in the Southeast Asian community. As a result, one Cambodian American staff member has since "come out" as gay, and as many as 20 youth and young adults primarily Cambodian American, have sought support and been empowered.

**DRAMA THERAPY:** Over the last year, CERI has continued to use Drama Therapy/Expressive Arts Therapy as an innovative approach for highly-traumatized and largely non-English speaking Cambodian refugees to process their experience during the Cambodian genocide and reach a deeper level of healing. To support this innovation, all CERI clinical staff members have undergone at three-month training in using Drama Therapy to therapeutic tool for healing trauma, taught by an expert in the field.

**ANTI-DEPORTATION ADVOCACY AND SUPPORT:**
Through CERI's recent anti-deportation work, CERI's adult and older adult clients have been empowered to learn their rights and play a role in protecting their families and community. CERI provide emotional support services for families facing the possible deportation of a loved one. CERI also prepared psychological evaluations for the four CERI community members targeted, for use in pleading their court case.

**CIVIC EDUCATION AND ADVOCACY:**
The anti-deportation work is part of a larger effort within CERI to provide civic education, information, and advocacy training for its clients to help them move from isolation to engagement in issues affecting their community. In response to proposed government cutbacks in food stamps, for example, CERI has helped clients, who are all SSI recipients, to register with CalFresh, in order to feed their families. CERI has also worked with clients to help them to register to vote, understand the ballot, and educate themselves about their rights in American society. This is particularly important for these clients, as under the Khmer Rouge regime, they did not have any rights or freedom of expression and taking a stand could lead to imprisonment, torture, or death for them and their family.

**SUPPORT SYSTEM FOR FAMILIES:**
Finally, CERI has recently introduced a new support feature for impacted family families. Now every Tuesday, from 4 to 6 pm, CERI holds family nights. Parents and couples and can get individual, family therapy and group support while their children engage in play therapy.

**YOGA FOR TRAUMA SURVIVORS:**
This year CERI added an additional offering to its wellness menu: Yoga for Trauma Survivors. Held on-site at CERI's center, this weekly class focuses on gentle yoga movement designed to help trauma survivors reconnect with their body and begin to process long-held emotions from past traumatic experiences. CERI clinical staff members are on hand to help support clients in addressing any emotions that may arise. CERI staff members also have their own restorative yoga class on-site to address self-care and prevent staff burnout and increase staff resiliency and retention.

4. Please describe how your program has encouraged access to your services and your strategies for successful linkage for mental health treatment.

**ACCESS TO SERVICES:**
CERI's primary strategy for creating access is to provide culturally and linguistically appropriate clinical services within the context of a community center (vs. medical office) setting. CERI's center is designed to be warm and welcoming and open to all. The waiting room resembles a comfortable living room, providing an inviting space for people to come in, have coffee and tea, meet others, and get the help they need. The center also has larger rooms for social gatherings and celebrations, dance classes, support groups, and wellness programs, along with two kitchens in which clients can cook and prepare communal meals. CERI has now become known throughout the local Cambodian community as a safe and supportive resource.

During the hours of operation, CERI always has a Khmer-speaking staff member available to provide services in Khmer and English. Trained interpreters from the community assist with confidential individual, family, and group therapy sessions, and referrals, as needed.

In addition to its on-site services, CERI also conducts about 20-25 percent of its services out in the community. CERI staff members regularly make home visits to meet with CERI families. CERI also maintains a heavy care management workload as, whenever a client is referred to a service, CERI usually follows up by helping clients set the appointment and accompanying them to the appointment. This entails going with a client to a medical appointment (with an interpreter, as needed), working with clients to help resolve SSI, MediCal, housing, immigration, and/or legal issues, and helping them navigate social services and school, and legal systems.

**REFERRALS:**
CERI also provides referrals (psychiatric, medical, legal, housing, social services, etc.) to clients, as needed. To support its ability to connect clients with needed services, CERI maintains strong partnerships with a range of community-based organizations (CBOs) and school-based programs. Ongoing community partners include: Asian Health Services, Bay Area Community Services (BACS), Bay Area Legal Aid, Banteay Srei, Homeless Action Center, and La Clinica San Antonio Health Services.

CERI also works with local law enforcement and county mental health providers, as needed, to support clients in crisis. In a recent example, a young woman, second generation Cambodian American, who is schizophrenic, became increasingly isolated and stopped taking her medication.

When the police were called to her home to intervene in a domestic dispute, CERI was able to work with them to advocate for psychiatric emergency services. She was taken to a psychiatric emergency ward, hospitalized for one week and then spent two weeks at Woodrow Place, a local crisis stabilization residential program operated by the Bay Area Community Services (BACS). While in that program, she participated in family therapy sessions with CERI staff to develop a safety plan so that she could go home. After her release, CERI worked with county services to connect her to a Level 1 service team so that she could get follow-up care management and psychiatric services. She is now stabilized and doing well.

5. Describe how your program interacted with various other ACBH funded programs/projects such as school-based programs, other prevention programs, the stigma and discrimination reduction campaign, 10 x 10 Campaign, etc.

CERI interacts with other ACBH programs/projects in several ways. In terms of school-based programs, CERI works closely with counseling programs at various Oakland public schools to help CERI youth clients navigate issues that arise in the school setting and help these young clients to stay in school.

CERI also supports ACBH's commitment to ensuring that underserved populations—particularly refugees and asylees—in Alameda County have access to mental health and wellness services.

To this end, CERI is actively partnering and exploring projects with other community-based groups serving the local Southeast Asian population to see how it can strengthen its own model and expand it to other underserved populations. These include: Asian Refugees United (ARU), which works with LGBTQ individuals and elders in the Vietnamese and Bhutanese refugee communities; Banteay Srei, which serves as a resource for Southeast Asian young women at risk for sexual exploitation; Burma Refugee Family Network, which serves the local Burmese refugee community.

This past year CERI has been much more involved with other UELP providers, including the Korean Community Center of the East Bay (KCCEB), Filipino Advocates, Hume Center and Partnership for Trauma Recovery (PTR). These collaborations have coordination around service delivery and best practices, advocacy around language-specific services for different populations, and joint planning for the upcoming U.S. Census.

Through its Wellness in Action program, CERI also facilitates a monthly professional development group for UELP providers, to support one another in working with highly traumatized refugee populations. All of the group participants are from the same background as the population that their agency serves and, therefore, must continue to learn healthy ways to deal with their own trauma while serving this population.

CERI has also partnered with the Asian Law Caucus (San Francisco) and the Asian Prisoners Support Committee (Oakland) to protect the legal rights of clients in relation to deportation issues. CERI has also partnered with the City of Oakland Equity and Race Initiative to foster youth leadership development and involvement around equity issues and continued to work with ARU around stigma reduction in the Southeast Asian community. Finally, CERI participates in BHCS's 10 x 10 campaign, which is designed to reduce disparities for individuals with mental health challenges, by organizing rides and providing transportation stipends for clients to attend public health walks and fairs and other related community events.

6. What are your goals for your program for the upcoming fiscal year?

CERI has five interrelated goals for the upcoming fiscal year (FY 2019-2010):

- **STRENGTHENING COMMUNITY-BASED MENTAL HEALTH AND WELLNESS SERVICES**: Continue to build its capacity to serve the current and emerging needs of its multigenerational client population through expanded services and wellness programs (i.e., specialized support groups; Drama Therapy; stigma reduction campaigns; services for youth and young adults; services for the Southeast Asian LGBTQ community, etc.), delivered in a culturally sensitive and linguistically appropriate manner.

- **EXTENDING THE CERI MODEL COUNTYWIDE:** Over the next year, CERI plans to work with other UELP providers and community-based organizations to extend the CERI model to other Southeast Asian refugee and asylee populations through on-site and off-site services, advocacy, community events, and strategic partnerships.

- **EMPOWERING CLIENTS THROUGH CIVIC EDUCATION AND ADVOCACY:** CERI will continue to collaborate with community partners to provide leadership and advocacy training, information, and emotional support for clients, to help them engage in civic issues, learn about their rights, and protect their community, with a focus on the upcoming U.S. Census campaign.

- **EXPANDED SERVICES FOR YOUNGER CHILDREN:** CERI will also focus on expanding its services through children in the CERI community using play, Expressive Arts/Drama Therapy, visual arts, and basic Khmer language learning.

- **SUSTAINABILITY:** Diversify and expand funding sources to sustain and grow CERI's program over the next five years.

**ACCESS & LINKAGE TO MENTAL HEALTH TREATMENT (QUESTION 1 AND 3 ARE REQUIRED PER YOUR EXHIBIT A - QUALITY MEASURES)**

1. Number of individuals with serious mental illness (SMI) or exhibit symptoms of a SMI who received a paper referral (i.e. referrals via phone do not apply) from your program
   a. To an ACBH-funded mental health treatment program: 1
   b. To a non-ACBH-funded mental health treatment program: 2 (not paper referrals)

2. List type(s) of mental health treatment programs the individual was referred to (i.e. outpatient, inpatient, etc.):
   PES, in- patient, crisis stabilization, outpatient level 1 services team
   Outpatient Mental health services- non ACBH, no paper trail

3. Number of individuals who were successfully referred and linked (i.e. client has been seen at least once in person by a treatment provider):
   a. To an ACBH mental health treatment program: 1
   b. To a non-ACBH-funded mental health treatment program: 2

4. Average duration in weeks of signs of untreated mental illness (per client self-report) *(write "n/a" or "unknown" when applicable):* Unknown

5. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with a mental health treatment provider *(write "n/a" or "unknown" when applicable)*: client was seen the day of referral due to crisis.

**TIMELY ACCESS (TO OTHER PEI-FUNDED PROGRAMS)**

1. Number of separate paper referrals to another ACBH PEI-funded program. *(write "n/a" or "unknown" when applicable)*:
   This year we did not do paper referrals to other PEI funded programs, however we made phone referrals for 8 to 10 clients to other PEI programs including Partnership for Trauma Recovery, Hume Center, and Asian Health Services.

2. Number of individuals followed through on referral & engaged in an ACBH PEI-funded program *(write "n/a" or "unknown" when applicable)*: Unknown

3. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with the ACBH PEI-funded provider *(write "n/a" or "unknown" when applicable)*: Unknown

**MHSA Program #: PEI 6**

**PROVIDER NAME: Community Health for Asian Americans (CHAA)**

**PROGRAM NAME: Outreach, Education & Consultation for Asian Pacific Islander Community**

**Program Description**: Asian Pacific Islander Connections (APIC)/UELP program has offered a full continuum of community-driven, Prevention and Early Intervention services for underserved Asian Americans Immigrants and refugee populations. Such as Burmese, Karen, Thai, Tibetan, Mongolian, Tibetan, Nepalese, Bhutanese, Pacific Islanders. APIC celebrated its 9th year of providing services. This includes expansion of prevention/early intervention, outreach, education, Medi-Cal outreach, spiritual and cultural healing services, community-driven partnerships, language/translation services, including case management.

Program Outcomes & Impact: UELP Data Report FY18/19

**PERFORMANCE INDICATORS: How Much Did We Do?**

| Total Numbers Served through PEI MHSA | |
|---|---|
| Number of unduplicated individuals your program serves who are **at-risk** of developing a mental health problem or serious mental illness (SMI) | 1,862 |
| Number of unduplicated individuals your program serves who show **early signs** of forming a more severe mental illness | |
| Number of unduplicated individual family members served indirectly by your program: | |
| Grand TOTAL of unduplicated individuals served in the Quarter that you are reporting about. [This number (D) should = A+B+C.] | 1,862 |

**PERFORMANCE INDICATORS: How Well Did We Do?**

Demographics

**Age Group (Unduplicated)**

| | |
|---|---|
| Children/Youth (0---15) | 214 |
| Transition Age Youth (16---25) | 218 |
| Adult (26---59) | 1,309 |
| Older Adult (60+) | 91 |
| Unknown/ Declined to Answer | 30 |

**Gender Identity**

| | |
|---|---|
| A) Assigned sex at birth: (Please mark only one choice) | |
| Male | 649 |
| Female | 1,187 |
| Other sex not listed (e.g. Intersex) | |
| Unknown/Decline to Answer | 26 |
| B) Current Gender Identity: (Please mark only one choice) | |
| Male | |
| Female | |
| Transgender | |
| Genderqueer | |
| Questioning or Unsure of Gender Identity | |
| Another Gender Identity not listed | |
| Unknown/Decline to Answer | 1,862 |

**Race (Please mark only one choice)**
*If Hispanic or Latino, choose "Another race not listed."*

| | |
|---|---|
| American Indian or Alaska Native | |
| Asian | 1,828 |
| Black or African American | 2 |
| Native Hawaiian or other Pacific Islander | 24 |
| White | 6 |
| More than one race | |
| Another race not listed | |
| Unknown/ Declined to Answer | 2 |

**Sexual Orientation (Please mark only one choice)**

| | |
|---|---|
| Gay or Lesbian | 17 |
| Heterosexual or Straight | 1,73 |
| Bisexual | |
| Questioning or unsure of sexual orientation | |
| Queer | |
| Another sexual orientation not listed | |
| Unknown/Decline to Answer | 11 |

| | |
|---|---|
| Spanish | |
| Farsi | |
| Cantonese | |
| Mandarin | |
| Other Chinese Dialects | |
| Vietnamese | |
| Korean | 2 |
| Tagalog | |
| Other Filipino Dialect | |
| Japanese | |
| Laotian | |
| Cambodian | |
| Mien | |
| Hmong | |
| Samoan | |
| Thai | |
| Russian | |
| Polish | |
| German | |
| Italian | |
| Turkish | |
| Hebrew | |
| French | |
| Portuguese | |
| Armenian | |
| Arabic | |
| Sign ASL | |
| Other primary language not listed Burmese - 86<br>Genapali – 15<br>Karen – 13<br>Karenni – 2<br>Mon -3<br>Mongolian – 1391<br>Rakhaing - 7<br>Thai – 226<br>Tibetan – 44<br>Tongan – 28<br>Other – 2 | 1,817 |
| Unknown/ Decline to Answer | |

| | |
|---|---|
| Difficulty Seeing | 2 |
| Difficulty hearing, or having speech | |
| Mental Domain | 1 |
| Physical/Mobility Domain | 1 |
| Chronic Health Condition | 3 |
| Another disability not listed | |
| Unknown/Decline to Answer | 281 |

**Veteran Status (Please mark only one choice)**

| | |
|---|---|
| Yes | |
| No | 1,625 |
| Unknown/Decline to Answer | 235 |

**PROGRAM OVERVIEW**

1. What were the successes/accomplishments of the past year? Please provide one example or case study of a success your agency is particularly proud of.

We successfully provided resources to clients and implemented families strengthening programs to reduce stress and to cope with the challenges of life events. We provided individual consultation and educational resources and linked them to referral services based on the need of the clients.

Majority of our EI clients are survivors of domestic violence and war and PTSD. Currently, domestic violence and other abuses are affecting API communities. 1/3 of all APIC's Early intervention clients are experiencing domestic violence and or other forms of violence/ issues.

We are particularly proud of the case management services and Domestic Violence/ Trauma-Informed Care services that were rendered to domestic violence (DV) clients who needed emergency services including shelter, food, transportation, interpretation and translation services, legal referrals, and mental health and family therapy and job placement. For example: we assisted a homeless client who faced many discriminations from within the community and suffered from DV and PTSD. We also referred this client for legal services to assist with court proceedings and created a support group for healing and social connectivity to help the client integrate into the mainstream society. As a result, of the services that we are provided the client was able to secure employment and become self-sufficient.

2. What were the challenges and how did your agency mitigate challenges?

The challenge has been the lack of sustainable funding for UELP program, which affected staff morale and uncertainty about adequately addressing the need of community. Despite the funding challenges we continue to provide services to all our clients by leveraging resources within the community. For example, we created traditional and spiritual healing by working with local CBO's and faith and traditional healers. As such, we have been able to provide culturally competent services to clients with limited funding sources.

3. Please describe the innovative ways your program has weaved the topics of mental health/emotional well-being into your activities. Please give at least one example.

Mental and behavioral services have many challenges, especially systemic challenges and stigma in API communities about seeking mental health support. We have developed a collaborative care model that incorporates mindfulness based on traditional healing model. We encouraged faith and spiritual healers to understand mental health issues and to provide mindfulness and yoga model and to work with our clients.

APIC staff organized the Mental Health and Spirituality and traditional healing event. This became very popular within the community as more clients and community members sought the services that we provided, which has increased the number of clients we serve.

4. Please describe how your program has encouraged access to your services and your strategies for successful linkage for mental health treatment.

In order to provide enhance access to our services, we engaged in extensive outreach and organized a wide variety of workshops, events and support groups. Community-based approaches to enhance access mental health; enhance access and continuity, culturally and linguistic appropriate services, culturally appropriate

communication, client need-based support and care, referral and follow-up, coordinate care coordination, continues quality improvement.

All these activities were designed to target community members who faced enormous barriers to gaining access to mental health services. In addition, we targeted individuals and families who were struggling emotionally, financially or legally. We wanted to ensure that through effective case management, services were provided in a coordinated manner with our clinical program and other providers to meet the needs of the clients.

Our strategies for successful linkage for mental health treatment included educating the communities on critical issues related to trauma. Some of the issues involved immigration problem, family conflict, legal, employment, language barriers, and problems related to cultural integration in a new country. As such, we were able to provide prevention and early intervention services which included screening assessment, linkage to resources and treatment. Additionally, we translated mental health related educational materials in their language for the various populations that we serve. Moreover, we ensure that client had access to their own traditional and spiritual healing practices.

5. Describe how your program interacted with various other ACBH funded programs/projects such as school-based programs, other prevention programs, the stigma and discrimination reduction campaign, 10 x 10 campaign etc.

During the 2018-2019 fiscal year, we highlighted the importance of addressing mental health disparities and reducing health inequities in our community. This was achieved through a comprehensive partnership with community-based organizations, schools and mental health partner agencies. For example: we collaborated with PEERS, La Clinical, Native Americans Health Center and culturally responsive community-based organizations to deliver stigma reduction campaign, workshops, trainings.

6. What are your goals for your program for the upcoming fiscal year?

Our overarching goal is to ensure that clients will continue to receive critically needed services for their mental health and emotional wellbeing. Because of the long-standing relationships we have built between the community and our staff, we want to ensure that our program will continue to thrive. Our final goal is for our communities to be treated with dignity, respect, and without discrimination.

**ACCESS & LINKAGE TO MENTAL HEALTH TREATMENT (QUESTION 1 AND 3 ARE REQUIRED PER YOUR EXHIBIT A - QUALITY MEASURES)**

1. Number of individuals with serious mental illness (SMI) or exhibit symptoms of a SMI who received a paper referral (i.e. referrals via phone do not apply) from your program: 8 clients total.
   a. To an ACBH-funded mental health treatment program: 3
   b. To a non-ACBH-funded mental health treatment program: 5

2. List type(s) of mental health treatment programs the individual was referred to (i.e. outpatient, inpatient, etc.):
   - John George Hospital
   - Native American Health Center
   - Stanford Neurological Department then to Boston Behavioral Health
   - UCSF Mental Health Department

- Kaiser Permanente Psychiatric Department Oakland and Concord
- Kaiser Permanente Richmond Psychiatric Department (one Client)
- Mindfulness and Traditional Healing Alodaw Pyi Monastery (Newark) CHAA clinical program, therapists
- Asian Community Mental Health Regional Center in San Leandro

3. Number of individuals who were successfully referred and linked (i.e. client has been seen at least once in person by a treatment provider):
   a. To an ACBH mental health treatment program: 3
   b. To a non-ACBH-funded mental health treatment program: 4

4. Average duration in weeks of signs of untreated mental illness (per client self-report) *(write "n/a" or "unknown" when applicable):* Stigma, shame, embarrassment, as well as the inability to seek help. Some clients seek help after several weeks.

5. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with a mental health treatment provider *(write "n/a" or "unknown" when applicable)*: Some providers 2 weeks or less. But we advocate on behalf of our clients to get services.

**TIMELY ACCESS (TO OTHER PEI-FUNDED PROGRAMS)**

1. Number of separate paper referrals to another ACBH PEI-funded program. *(write "n/a" or "unknown" when applicable)*: CHAA clinical program and Native American Health Center

2. Number of individuals followed through on referral & engaged in an ACBH PEI-funded program *(write "n/a" or "unknown" when applicable)*: 7 individuals

3. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with the ACBH PEI-funded provider *(write "n/a" or "unknown" when applicable)*: 2 weeks

**MHSA Program #: PEI 6**

**PROVIDER NAME: Asian Community Wellness Program**

**PROGRAM NAME: Outreach, Education & Consultation for Asian Pacific Islander Community - Korean Community Center of the East Bay (KCCEB)**

**Program Description**: KCCEB Asian Community Wellness Program: ACWP provides culturally competent and responsive programming on mental health to marginalized communities, with a focus on East Asian (Chinese, Japanese, Korean and Mongolian) population. The goal is to reduce mental health stigma, improve awareness of mental health issues facing Asians, and increase mental health service access to those that historically had difficulty accessing mental health support due to cultural and/or linguistic barriers. We serve individuals, families, and seniors in English, Korean, and Chinese language.

Program Outcomes & Impact: UELP Data Report FY18/19

**PERFORMANCE INDICATORS: How Much Did We Do?**

| **Total Numbers Served through PEI MHSA** | |
|---|---|
| Number of unduplicated individuals your program serves who are **at-risk** of developing a mental health problem or serious mental illness (SMI) | 2,068 |
| Number of unduplicated individuals your program serves who show **early signs** of forming a more severe mental illness | 34 |
| Number of unduplicated individual family members served indirectly by your program: | |
| Grand TOTAL of unduplicated individuals served in the Quarter that you are reporting about. [This number (D) should = A+B+C.] | 2,102 |

**PERFORMANCE INDICATORS: How Well Did We Do?**

Demographics

**Age Group (Unduplicated)**

| | |
|---|---|
| Children/Youth (0--15) | 155 |
| Transition Age Youth (16--25) | 155 |
| Adult (26--59) | 782 |
| Older Adult (60+) | 909 |
| Unknown/ Declined to Answer | 67 |

**Race (Please mark only one choice)**
*If Hispanic or Latino, choose "Another race not listed."*

| | |
|---|---|
| American Indian or Alaska Native | 3 |
| Asian | 1,573 |
| Black or African American | 69 |
| Native Hawaiian or other Pacific Islander | 1 |
| White | 105 |
| More than one race | 2 |
| Another race not listed | 106 |
| Unknown/ Declined to Answer | 209 |

**Sexual Orientation (Please mark only one choice)**

| | |
|---|---|
| Gay or Lesbian | 9 |
| Heterosexual or Straight | 1,00 |
| Bisexual | 2 |
| Questioning or unsure of sexual orientation | |
| Queer | 17 |
| Another sexual orientation not listed | |
| Unknown/Decline to Answer | 1,03 |

**Ethnicity /Cultural Heritage (Please mark only once choice)**

| | |
|---|---|
| **If Hispanic or Latino, please specify:** | |
| Caribbean | |
| Central American | |
| Mexican/Mexican | |
| -- | |
| Puerto Rican | |
| South American | 6 |
| Another | 89 |
| Hispanic/Latino | |
| Unknown/Declined to Answer | |
| **If Non-Hispanic or Non-Latino, please specify:** | |
| African | |
| African American | |
| Asian Indian/South Asian | |
| Cambodian | 36 |
| Chinese | 293 |
| Eastern European | |
| European | |
| Filipino | 18 |
| Japanese | 6 |
| Korean | 1,005 |
| Middle Eastern | |
| Vietnamese | 36 |
| Other Non-Hispanic or Non- Latino ethnicity not listed Afghan – 7 Asian Pacific Islander – 46 Indonesian – 2 Mongolia -2 Malaysian – 2 Nepalese – 14 Pakistani – 4 Samoan – 1 Taiwanese – 4 Thai – 4 Other South Asian – 3 Other Southeast Asian | 90 |
| **More than one ethnicity** | |
| **Unknown /Declined to Answer** | |

**Primary Language (Please mark only one choice)**

| | |
|---|---|
| English | 68 |
| Spanish | 56 |
| Farsi | 19 |
| Cantonese | 12 |
| Mandarin | 10 |
| Other Chinese Dialects | |
| Vietnamese | 11 |
| Korean | 93 |
| Tagalog | |
| Other Filipino Dialect | |
| Japanese | 1 |
| Laotian | |
| Cambodian | |
| Mien | |
| Hmong | |
| Samoan | |
| Thai | |
| Russian | |
| Polish | |
| German | |
| Italian | |
| Turkish | |
| Hebrew | |
| French | |
| Portuguese | |
| Armenian | |
| Arabic | |
| Sign ASL | |
| Other primary language not listed Bengali-1 Genpali – 15 Hindi – 1 Indonesian – 2 Kachin – 1 Karen – 7, Other - 87 Unknown/ Decline to Answer | 115 |

**Gender Identity (Please mark both parts A & B)**

| | |
|---|---|
| A) Assigned sex at birth: (Please mark only one | |
| Male | 7 |
| Female | 1,2 |
| Other sex not listed (e.g. Intersex) | |
| Unknown/Decline to Answer | 1 |
| B) Current Gender Identity: (Please mark only one choice) | |
| Male | |
| Female | |
| Transgender | |
| Genderqueer | |
| Questioning or Unsure of Gender Identity | |
| Another Gender Identity not listed | |
| Unknown/Decline to Answer | 2,0 |

**Disability Status** (Please mark all that apply)

| |
|---|
| None |
| Yes. If yes, please specify (choose from list below): |
| Difficulty Seeing |
| Difficulty hearing, or having speech |
| Mental Domain |
| Physical/Mobility Domain |
| Chronic Health Condition |
| Another disability not listed |
| Unknown/Decline to Answer |

**Veteran Status (Please mark only one choice)**

| |
|---|
| Yes |
| No |
| Unknown/Decline to Answer |

**PROGRAM OVERVIEW**

1. What were the successes/accomplishments of the past year? Please provide one example or case study of a success your agency is particularly proud of.

This was KCCEB's inaugural year in the UELP Program, Asian Community Wellness Program. The major success for us was in creating a new mental health program from the ground up including finding staff, developing forms and protocols, partner outreach, and meeting all the county deliverables.

**Staffing:** Our contract began in Sept -Quarter 2 (Sept-Dec) and was focused on finding the right staffing for the program. We were able to find a bilingual English/Korean and bilingual English/Mandarin staff and a bilingual English/Portuguese staff specializing in working with undocumented Asian young people. While we were able to find these staff by October, a major challenge was finding the licensed clinician for our program. This is a critical role as this person has the expertise to develop the one-on-one mental health components for the team. By December, we hired Pysay Phinith, LCSW, a seasoned API mental health clinician who has experience with the County's PEI programming. It should be noted to the County that first-time UELP contractors need more time and thus reduced deliverables for the first year. While the County did reduce the deliverables based on the fact that we started in Sept rather than July, it is appropriate to also take into consideration on-boarding, developing relationships with partners, all of which take time. While agencies have trusted relationships with the community, mental health is a stigmatizing topic and more time is needed for communities to understand the mental health services and see themselves in need and for organizational partnerships to build.

**Forms and Protocols:** KCCEB developed protocols and forms for one-on-one mental health preventive services and outreach materials including program flyers and mental health topic flyers in English, Chinese and Korean.

**Partner Outreach:** A large component of our work in Quarter 2 and 3 involved developing referral relationships and networks with partners including schools, senior centers, youth programs and other agencies that work with East Asian populations. These were critical in helping us to find referrals for our preventive counseling work. After Year 1, our most successful referral partnerships included working with high schools to see East Asian and other youth of color.

**We met all deliverables: Some are highlighted below**

**Support Groups:** Our two support groups included Jikimee Senior Leadership Group and undocumented youth support group with ASPIRE. The Jikimee group met for two quarters (15 weeks + 11 weeks) with a total of 9 - 12 participants. These seniors learned about basic mental health topics including self-care and wellness practices, stress and coping, leadership skills and learning how to be an active listener and supporter, learning about the mental health needs of the Korean community, and learning how to be a community volunteer.
Over the program, participants have gained the power to strengthen their community and personal life goals. This support group concentrated on awareness of the mental health and then moved into the practice of how to become a strong leader of the Korean community. Throughout the session, Jikimee members created their own safe and protected space in which they naturally shared personal stories. Therefore, we were able to ascertain the mental state of each other by awakening to the Korean and Asian cultural myths and stereotypes of mental health illness. The Jikimee group learned how to raise their voice to society and how to support others. This group continues to keep practicing their leadership with diverse generations and as well as future support group participants, the potential community leaders. The group is currently in training for how to be a volunteer in the organization for community health and mental health.

The ASPIRE group met on a monthly basis with an average number of 10 participants per meeting. In these meetings, most of the discussion focused on the policies impacting the overall well-being of undocumented communities such as the proposed public health rule change and expanding Medi-Cal access to all Californians regardless of immigration status. The goal was to educate ASPIRE members of what was happening around these policies to ease the anxiety that might be associated with anything related to immigration. Activities including interactive workshops breaking down the policies and its potential effect and ways to keep the participants well by developing coping mechanisms to handle the stress generated by talking about these sensitive topics.

**Psychoeducational Workshops:** We offered a caregiver's workshop on the sign of depression to Family Bridges caregivers (Vietnamese, Cantonese, Mandarin groups). Each workshop had up to six participants to attend. Two major lessons gained from the workshops are recognizing the urgent needs for attention and support in especially senior caregiver community and strengthening the foundation of our programs and services to the Chinese community. The workshops incorporated cultural sensitivity into the western idea of mental health concept for seniors to understand and further relate to their own experience. From engaging senior caregivers with activities designed to remind their identity as an individual before they took on the caregiver role to creating a warm and secure space where they found comfort and resonation, these seniors undoubtedly broke the stereotype and shared their vulnerability in public.

We also provided a workshop discussing the intersection of academic stress and parenting communication skills. We partnered with IWAY (Improving the Wellness of Asian Youth) and presented the topic of academic stress to English, Spanish, and Chinese speaking community at Oakland Charter High School. The workshop provided signs of getting stressed and burnout as well as methods to navigate the struggle with internal and external support. This workshop generated an opportunity where parents and students shared their perspectives face to face, learned to recognize systemic and cultural impact on academic achievement and its potential risk, empathized struggles from both sides, and brainstormed ideas to support themselves as well as each other.

**Education Workshops:** We co-hosted a technology workshop for seniors with the Korean American Community Foundation. This workshop provided technology assistance for seniors in Korean language through a mental health framework. We discussed issues of isolation and loneliness and the role that technology can play to support connection and then learned how to use the mobile phone. We had 20 participants and they were eager to learn a practical topic. While new community members did not understand the mental health framework, our longstanding Jikimee leaders were able to discuss the importance of mental health for communities. We also provide a "Compassion Fatigue & Self Care" educational workshop to our collaborative partner Helping Hand of the East Bay (HHEB) to providers working with family members with developmental disability. Through this workshop, we educated providers on mental health signs and symptoms of compassion fatigue and burn out, including developing strategies to reduce burn out risks and promote self- care and setting healthy boundaries in the work environment in order to better support the providers themselves and their client's long term.

**Community Events:** KCCEB's community events included: Halmoni Movie Screening, KCCEB Open House, World Refugee Day, and Legal Clinic. The **Halmoni Movie Screening** was an opportunity for Korean seniors and Korean American community members to learn about the impact of immigration on intergenerational family dynamics. Seniors and members were able to hear a personal immigration story and learn about the current immigration system and how it impacts the health and well-being of families. During the **Open House**, Korean and Chinese community members learned about mental health symptoms and feelings through cultural food metaphors. This innovative method allowed people to connect to mental health in a physical way as they could try the food from their culture and connect with how the food feels and how that is related to mood. Community members also had an opportunity to make mental health bookmarks. KCCEB was one of the planning committee members of **World Refugee Day**.

We made an immigration timeline for community members to learn about how their arrival coincided with historic US events. We also tabled and shared information on our services. We collaborated with International Rescue Committee (IRC) and East Bay Sanctuary Convent to host a **Legal Clinic event** to support API community members to apply for naturalization and promote mental health awareness to the community. We had an opportunity to discuss with immigrant and refugee community members current political stressors that impact their wellness. In additional, we shared with community members about available mental health services to support individuals and family members struggling with multiple stressors and traumas due to the current political climate.

**Materials distributed:** This year, we developed new materials including a program flyer, MH topic flyers (stress, anxiety, anger management, depression, sexual consent, and loneliness, etc.), and community events posters. All flyers were available in English, Korean and Chinese. They were distributed at churches, schools, local community and senior center outreach events, senior housing visits, support groups, World Refugee Day, Legal clinic events, KCCEB newsletters, and Facebook. While noticing an increased number of community members searched resources online, we utilized Facebook to disseminate resources, opportunities, and education information to the community. Our goal is to create a resource hub for people to gain access to resources not only within our organization but also from other local organizations in Alameda County.

**Prevention Visits (34 Clients):** Our clients are predominantly East Asian youths. We have developed a referral partnership with IWAY, Alameda Science and Technology Institute, San Leandro High School, and Peralta Community College School District. Our youth clients face challenges with family relationships, historical and intergenerational traumas, depression, anxiety, anger management, school and relational conflicts. We also provided counseling support to monolingual Chinese and Korean speaking adults struggling with depression, grief and loss, marital conflicts, and family stressors. These individuals came from referrals from legal services, community based and faith-based organizations, senior housing facilities, and through our community outreach events throughout Alameda County.

2. What were the challenges and how did your agency mitigate challenges?

**Case Management Needs:** Many of our East Asian adults and older adult clients struggle with an array of stressors as they walked through KCCEB door, leading them to have symptoms of anxiety or depression.
As monolingual speaking Chinese or Korean clients, they often feel a lack of trust with the system and neglected by the public. It is challenging to reach out and build trust with the community when we have a limited number of staff and funding. Staff has to weight between quality and quantity, and sometimes in order to meet the deliverables they might not be able to provide a more comprehensive care, namely housing, social services, physical assistance, and emotional support, for each client.

**Mental Health Preventative Counseling Needs:** The biggest challenge we learned from community members and local schools is that the support for MH needs targeting at API community is insufficient. API community constitutes approximately 30% of the population in Alameda County. Yet API youth often encountered biased judgment or mistreatment due to their model minority while reaching out to seek MH support. It is difficult for them to relate to school staff or MH providers when they lack cultural competency. We look forward to the County initiating more conversations in the system and at schools to raise awareness regarding stereotypes, labels, and each unique individual challenges API youth are facing.

**Undocumented youth work:** It has been a challenge to outreach to the undocumented community living in the East Bay mostly because of the current political landscape that has undone a lot of progress that undocumented communities have achieved.

There's not an adequate way to assess the needs of the undocumented youth needs in Alameda County because this is a population that is often challenging to reach out to due to its diversity such as cultural differences and language spoken. In addition, the lack of visibility of undocumented issues and the stigma within their own communities are often the larger obstacles to outreach to undocumented API youth. It's a necessary more long-term investment in the efforts and strategies to continue outreaching in these communities.

**Community Need:** The major structural challenge with the UELP program is that the staffing is limited and the community need is great. This results in frustration from staff and stretching staff in different directions. For example, our Korean language staff focuses her work on seniors including the support group, doing community outreach providing one-on-one resource and referrals and supporting volunteers for our senior program. With only a half time position it would be very hard to also add other age groups (youth, families, parents, etc.). We have seen that struggle with our Chinese language staff who also has an MFT. This staff member sees mental health clients in schools, as well as families, adults and seniors. They conduct trainings and outreach with youth, parents and caregivers of seniors. It is hard to say "no" when the community need is great. This structural challenge due to set funding guidelines creates an environment where burnout is very likely. Thus, to better support the diverse Asian communities, a more robust funding is needed for capacity building.

3. Please describe the innovative ways your program has weaved the topics of mental health/emotional well-being into your activities. Please give at least one example.

**Technology workshop**: KCCEB staff often hear Korean senior clients inquire about the inconvenience of using technology device. According to them, these new devices affect their life including communication with others, self-education and opportunity for the future. We also had a number of jikimee support group members who expressed their emotional stress from struggles of lack of technology skills and intergenerational conflicts. We decided to host a technology workshop for a 3-hour event in KCCEB to allow Korean seniors to share their barriers and ambition to learn modern technology skills. The main activity was to bring together the relationship between technology use and our life with family and friends. This was a collaboration between Korean American Community Foundation, Asian Health Services, KCCEB and six volunteers. Asian Health Services offered a presentation linking mental health with healthy way of using devices.

Overall, the participants gained skills and practiced using device applications and understanding a mental health framework with technology usage. Following the workshop, we received several requests to repeat the similar workshop.

In partnership with ASPIRE, the first pan-Asian undocumented youth group in the country. We hosted the Halmoni Screening which was an event to allow Korean seniors to understand immigration through the lens of an undocumented person. It consisted of the 20 participants to explore their own immigration history in the context of what was happening in their home countries and what current U.S. policies either allowed or prevent them to immigrate here. This created a unique perspective that their stories were part of something much bigger than themselves. It also provided an open forum to discuss mental health consequences of immigration. The main activity was the screening of the short-documentary Halmoni, which translates to a grandmother in Korean. It follows a story of an ASPIRE member, an undocumented Korean young adult living in Alameda. As a DACA recipient, the protagonist is allowed to temporarily travel to Korean to visit his aging grandmother. The story focuses on family and love in the context of immigration being a barrier to achieving them. In this event, the audience was able to learn common myths about undocumented immigrants and debunking these stereotypes with facts and opening up conversation about the mental health impacts of immigration that are rarely discussed in a public setting. Overall, the audience appreciated the learning opportunity to expand their mind and hearts.

**Food and MH tasting**: While we struggled about how to present MH concept to the general public about in a very short time, the idea of incorporating what people feel the closest to, namely food, into the message came out. Recognizing both Korean and Chinese communities share similar food item, we used various styles of rice cake into five different emotions. From the taste, smell, and the look of the rice cake to the similarities each emotion brings to us physically, mentally, and emotionally, members read through the description and learned to recognize their feelings and further provoked their interest in self-reflection and generating awareness.

4. Please describe how your program has encouraged access to your services and your strategies for successful linkage for mental health treatment.

For the past year, ACWP provided multiple mental health workshops, educational trainings and wellness outreach throughout Alameda County. Through these activities, we actively shared the importance of seeking mental health services prior to the individual symptoms worsening to individual community members, leaders, and providers in faith based, school based, and community-based organizations. We also provide individual consultation to family members, community leaders, faith leaders at churches, providers at community-based organization and school-based programs partners, to help screen and detect signs and symptoms of mental health problems. Through our outreach and education strategies efforts, and with trusted collaboration and partnerships with school based, faith based, and community organizations, community members were referred to ACWP preventive counseling services where our Mental Health Specialist and Wellness Coordinator provided mental health screening, assessment, case management and counseling services to engage clients to help address and manage their mental health symptoms. While receiving preventive counseling services, staff monitor the clients' mental health symptoms, help clients develop coping skills to manage their symptoms, provided psycho-education to better understand their symptoms and reduce mental health stigma, thus being able to successfully referred clients to treatment program when necessary due to the trust and rapport building between staff and client. Thus far, we had one client in need to mental health treatment services that we were able to successfully referred. The Mental Health Specialist assisted the client to contact the ACCESS line for mental health intake, help the client schedule the initial visit for mental health intake and psychological evaluation, and ensure that the client attended the initial psychiatric session for the psychotropic medication evaluation. As a result, this client was able to receive services to address his depressive symptoms with psychotic features.

5. Describe how your program interacted with various other ACBH funded programs such as school-based programs, other prevention programs, the stigma and discrimination reduction campaign, 10 x 10 campaign etc.

This year, KCCEB partnered with other UELP providers in three ways. First, we met with other partners (AHS, CERI, FAJ, Tri-City) to support our on-boarding and trouble-shooting as new providers. It was helpful to learn how other providers have been doing the work and also share lessons learned. Second, we partnered with CERI and Asian Refugees United to develop a grant proposal to serve Asian youth for mental health using the arts for a City of Oakland OFCY grant. While we were not awarded for that grand, we did receive some funding from the City of Oakland do this work. Third we partnered with CERI, DHTI, Asian Refugees United, BRFN and Refugee Transitions to do Census Outreach this coming year. We believe working together we can address similar challenges our communities face and also increase the visibility of immigrants and refugees in Alameda County.

In partnership with IWAY, we created a referral system that IWAY will refer students from their summer programs or internship to our preventative counseling services as needed and work to engage youth in reducing stigma in order to seek mental health services in the community and schools. IWAY started outreaching to community since 2017 and has been connecting with local schools to recruit API youth for leadership building ever since.

Through our partnership with IWAY, we were able to support IWAY to expand services to API youth and be able to provide MH education to promote MH awareness, MH resources, and provide preventative counseling to API youth to reduce the risk of them falling through the cracks in the school system. Through the collaboration with Alameda Science and Technology Institute, San Leandro HS, and Peralta Community College District, we were invited to their MH committee meetings, COST meetings, and MH school events. We addressed MH concerns API youth are facing, provided consultation to staff members on how to support API students considering the nature of repressing their feelings and hiding their struggles from the school and parents as well as helped them create a safety net where API youth can reach out or be referred to in response to the needs.

6. What are your goals for your program for the upcoming fiscal year?

   This year we will continue to provide

- Combining outreach and counseling roles for each outreach worker to promote mental health awareness and increase capacity to provide preventive counseling services for the diverse East Asian communities.

- **School-based work (continue to build and strengthen our collaborative partnership with school-based programs)**
  - IWAY
  - Alameda Science and Technology Institute
  - San Leandro HS
  - Peralta Community College District

- **Wellness and Leadership Support Group**
  - Koreans (Jikimee leadership) to support elder to promote mental health awareness in the community, engage community members to seek mental health services, and advocate for culturally responsive MH services for Korean and other API communities.
  - Growing with Chinese South County - expanding services to Chinese community in Central and South County.
  - Korean Elder Support Group (to reduce social isolation, strengthen their knowledge in access essential community resources, develop coping skills to manage acute stress, depression, and anxiety symptoms, and strengthen inter-generational relationships).
  - Taichi support group for East Asian adult and elders to improve their physical and mental health wellbeing. To help address anxiety and fear of falling and support each other in the community.

**ACCESS & LINKAGE TO MENTAL HEALTH TREATMENT (QUESTION 1 AND 3 ARE REQUIRED PER YOUR EXHIBIT A - QUALITY MEASURES)**

1. Number of individuals with serious mental illness (SMI) or exhibit symptoms of a SMI who received a paper referral (i.e. referrals via phone do not apply) from your program…
   a. To an ACBH-funded mental health treatment program: 1
   b. To a non-ACBH-funded mental health treatment program: n/a

   Because we are a newly BCHS sub-contracted organization, we are currently providing preventive counseling to our clients. Of the 34 clients, only one needed MH treatment referral.

We were able to successfully support the client to access mental health treatment services (i.e. securing appointment for initial assessment, completing visit with therapist, psychotropic medication evaluation with psychiatrist) prior to discharging him from our preventive counseling program. The remaining 33 clients are still in our preventive counseling program.

2. List type(s) of mental health treatment programs the individual was referred to (i.e. outpatient, inpatient, etc.): 1 client was successfully referred to an outpatient MH treatment program

3. Number of individuals who were successfully referred and linked (i.e. client has been seen at least once in person by a treatment provider):
   a. To an ACBH mental health treatment program:1
   b. To a non-ACBH-funded mental health treatment program: n/a

4. Average duration in weeks of signs of untreated mental illness (per client self-report) *(write "n/a" or "unknown" when applicable): 2 weeks to 2 months on average*

5. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with a mental health treatment provider *(write "n/a" or "unknown" when applicable)*: 2 weeks

**TIMELY ACCESS (TO OTHER PEI-FUNDED PROGRAMS)**

1. Number of separate paper referrals to another ACBH **PEI-funded** program. *(write "n/a" or "unknown" when applicable)*: n/a

2. Number of individuals followed through on referral & engaged in an ACBH PEI-funded program *(write "n/a" or "unknown" when applicable)*: 1 for MH treatment program, 33 for PEI preventive counseling, 12 for Wellness leadership and support group.

3. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with the ACBH PEI-funded provider *(write "n/a" or "unknown" when applicable)*: 2 weeks to one month due to client's cancellation.

**MHSA Program #: PEI 6**

**PROVIDER NAME: RAMS Pacific Islander Wellness Initiative**

**PROGRAM NAME: Outreach, Education & Consultation for Asian Pacific Islander Community**

**Program Description**: RAMS Pacific Islander Wellness Initiative provides culturally responsive prevention and early intervention mental health services to Alameda County's Pacific Islanders, including Native Hawaiians. RAMS, in collaboration with long-standing and trusted Pacific Islander community-based organizations, Taulama, Samoan Community Development Center, and Regional Pacific Islander Taskforce implements an array of culturally and linguistically responsive outreach/engagement and psycho-education services, mental health consultation, preventive counseling, and mental health referrals. Our priority populations are all ethnicities and communities, with a special focus on **Pacific Islanders, including Native Hawaiians** in the Northern and Southern regions of Alameda County.

Program Outcomes & Impact: UELP Data Report FY18/19

**PERFORMANCE INDICATORS: How Much Did We Do?**

| Total Numbers Served through PEI MHSA | |
|---|---|
| Number of unduplicated individuals your program serves who are **at-risk** of developing a mental health problem or serious mental illness (SMI) | 273 |
| Number of unduplicated individuals your program serves who show **early signs** of forming a more severe mental illness | 8 |
| Number of unduplicated individual family members served indirectly by your program: | |
| Grand TOTAL of unduplicated individuals served in the Quarter that you are reporting about. [This number (D) should = A+B+C.] | 281 |

**PERFORMANCE INDICATORS: How Well Did We Do?**

Demographics

**Age Group (Unduplicated)**

| | |
|---|---|
| Children/Youth (0--15) | 21 |
| Transition Age Youth (16--25) | 70 |
| Adult (26--59) | 164 |
| Older Adult (60+) | 18 |
| Unknown/ Declined to Answer | |

**Race (Please mark only one choice)**
*If Hispanic or Latino, choose "Another race not listed."*

| | |
|---|---|
| American Indian or Alaska Native | |
| Asian | 160 |
| Black or African American | |
| Native Hawaiian or other Pacific Islander | 109 |
| White | 4 |
| More than one race | |
| Another race not listed | |
| Unknown/ Declined to Answer | |

**Sexual Orientation (Please mark only one choice)**

| | |
|---|---|
| Gay or Lesbian | 18 |
| Heterosexual or Straight | 21 |
| Bisexual | |
| Questioning or unsure of sexual orientation | |
| Queer | |
| Another sexual orientation not listed | |
| Unknown/Decline to Answer | 40 |

**Ethnicity /Cultural Heritage (Please mark only once choice)**

| | |
|---|---|
| **If Hispanic or Latino, please specify:** | |
| Caribbean | |
| Central American | |
| Mexican/Mexican--American/Chicano | |
| Puerto Rican | |
| South American | |
| Another Hispanic/Latino ethnicity not listed | |
| Unknown/Declined to Answer | |
| **If Non-Hispanic or Non-Latino, please specify:** | |
| African | |
| African American | |
| Asian Indian/South Asian | |
| Cambodian | 1 |
| Chinese | 2 |
| Eastern European | |
| European | |
| Filipino | 6 |
| Japanese | |
| Korean | |
| Middle Eastern | |
| Vietnamese | |
| Other Non-Hispanic or Non-Latino ethnicity not listed Fijian – 7<br>Native Hawaiian – 1<br>Samoan - 93<br>Tongan – 150<br>Other Pacific Islander - 8 | 259 |
| **More than one ethnicity** | |
| **Unknown /Declined to Answer** | |

**Primary Language (Please mark only one choice)**

| | |
|---|---|
| English | |
| Spanish | |
| Farsi | |
| Cantonese | |
| Mandarin | 2 |
| Other Chinese Dialects | |
| Vietnamese | 1 |
| Korean | |
| Tagalog | 6 |
| Other Filipino Dialect | |
| Japanese | |
| Laotian | |
| Cambodian | 1 |
| Mien | |
| Hmong | |
| Samoan | |
| Thai | |
| Russian | |
| Polish | |
| German | |
| Italian | |
| Turkish | |
| Hebrew | |
| French | |
| Portuguese | |
| Armenian | |
| Arabic | |
| Sign ASL | |
| Other primary language not listed Fijian – 7<br>Hawaiian – 1<br>Tongan- 150<br>Other - 12 | 170 |
| Unknown/ Decline to Answer | |

**Gender Identity (Please mark both parts A & B)**

| | |
|---|---|
| A) Assigned sex at birth: (Please mark only one | |
| Male | 11 |
| Female | 16 |
| Other sex not listed (e.g. Intersex) | |
| Unknown/Decline to Answer | |
| B) Current Gender Identity: (Please mark only one choice) | |
| Male | |
| Female | |
| Transgender | |
| Genderqueer | |
| Questioning or Unsure of Gender Identity | |
| Another Gender Identity not listed | |
| Unknown/Decline to Answer | 273 |

**Disability Status** (Please mark all that apply)

| | |
|---|---|
| None | 21 |
| Yes. If yes, please specify (choose from list below): | |
| Difficulty Seeing | 4 |
| Difficulty hearing, or having speech | |
| Mental Domain | |
| Physical/Mobility Domain | 3 |
| Chronic Health Condition | 1 |
| Another disability not listed | |
| Unknown/Decline to Answer | 49 |

**Veteran Status (Please mark only one choice)**

| | |
|---|---|
| Yes | 16 |
| No | 19 |
| Unknown/Decline to Answer | 64 |

**PROGRAM OVERVIEW**

1. What were the successes/accomplishments of the past year? Please provide one example or case study of success your agency is most particularly proud.
   PIWI accomplished the following:
   - Established a mental health, prevention and early intervention activities and services for Pacific Islanders in Alameda County
   - On-boarding of the Mental Health Specialist who also identifies as a PI, albeit temporarily, while we continue to search for a permanent candidate; this enabled us to visualize the true potential of this type of program for underserved, hard to reach populations
   - Within one month of on-boarding the Mental Health Specialist, 6 clients were referred by community partners for preventive counseling
   - Hiring of health navigators who are bicultural and bilingual

2. What were the challenges, and how did your agency mitigate challenges?
   PIWI program experienced several challenges in the first six months of implementation:
   - Recruitment of the Mental Health Specialist – this position is filled temporarily by a Pacific Islander (Psy.D) candidate until August and had started in the first week of June. We had identified and interviewed another Pacific Islander (master's level psychology) individual who will be starting in August, and his availability is limited to 6-8 hours per week. We are continuing to screen and interview candidates to support this position at full capacity.
   - Staff turnover with RAMS and community partners. Two staff left their positions in April. One due to health matters and the other due to schedule conflicts. RAMS has hired a replacement for the program/data clerk position and due to start mid-July.
   - Acclimating and learning Alameda County Health Systems and Behavioral Health Systems landscape and systems – Staff attended training on InSyst, Clinician Gateway, and MAA Billing. We are gradually learning the flow of our work and using these data systems. We are attending grantee meetings and other ancillary meetings to learn and explore more about county systems and also existing resources and services in the county, as well as professional development opportunities. We are learning about Administrative nuances and so forth.
   - Identifying and learning about the county of Alameda – we are learning about Alameda County; about existing resources and services to support individuals in their healing and recovery. We are learning more about Pacific Islanders that live here.

3. Please describe the innovative ways your program has weaved the topics of mental health/emotional well-being into your activities. Please give at least one example.

   PIWI used the "Talanoa" method to facilitate group dialogue around mental health and wellness/emotional well-being. The group is called Talanoa4Wellness. PIWI conducted one-cycle of four weeks (weekly), averaging 8 – 10 participants per group. Talanoa is based on the Pacific concept of "Talanoa," which is dialogue between two or more people formally or informally. The process is designed to allow for participants to share their stories in an open, safe, and inclusive setting to open up about mental health and mental illness; and thus, creating an opportunity to breakdown stigma. The shared space lets people share their vulnerability and also showcased resiliency in overcoming or coping with mental health and stigma associated with mental illness they face as individuals and members of family and community. The group was facilitated by an experience bilingual and bicultural facilitator. The majority of adult participants had never shared their stories or experience about mental health and mental illness before; and would have never did without Talanoa4Wellness.
   Another activity PIWI conducted was *Hot Siva* (dance), which is a physical activity that uses Samoan/Pacific Islander movements combined with Samoan/Pacific/contemporary beats/music for a low-moderate intensity exercise routine.

4. Please describe how your program has encouraged access to your services and your strategies for successful linkage for mental health treatment.
   Most of the PIWI staff are Alameda County residents who have wide networks of contacts via church membership, familial relations, schools and college affiliates, community members and providers from other sectors, for which to tap into to reach the community. Staff and partners are actively promoting the program via social media postings, newsletters, etc., as well as attending various community events directed to the Pacific Islander community. In addition, PIWI staff followed up with members who attended the community events via phone call and email and personally offered services.

5. Describe how your program interacted with various other ACBH funded programs/projects such as school-based programs, other prevention programs, the stigma, and discrimination reduction campaign, 10 x 10 campaign, etc.
   RAMS is new to Alameda County, and we are learning about and familiarizing with the various other ACBH funded programs/projects. PIWI staff made contacts with Logan High School and Hayward High School. PIWI staff has also regularly attended grantee meetings to learn and know more about the diverse communities and their activities to promote mental health. PIWI developed a working relationship with the Bay Area Community Services (BACS) in Hayward to utilize their space for community convening. PIWI partners have also been in communication with the Alameda Health Consortium to participate in their monthly peer network conversations around behavioral/mental health and facilitating the opportunity to partner with those community health centers serving the priority population within the mental health work.

6. What are your goals for your program for the upcoming fiscal year?
   PIWI's goals for the next fiscal year are: hiring of mental health specialist and filling all positions required, outreach and engage more Pacific Islanders, particularly Melanesians and Micronesians, with faith-based of all denominations, student groups on college campus, providers, among others; provide training and mentoring to health navigators (aka outreach workers); and continuing to build upon partnerships with other Alameda County groups.

**ACCESS & LINKAGE TO MENTAL HEALTH TREATMENT (QUESTION 1 AND 3 ARE REQUIRED PER YOUR EXHIBIT A - QUALITY MEASURES)**

1. Number of individuals with serious mental illness (SMI) or exhibit symptoms of an SMI who received a paper referral (i.e., referrals via phone do not apply) from your program…
   a. To an ACBH-funded mental health treatment program: 0
   b. To a non-ACBH-funded mental health treatment program: 0

2. List type(s) of mental health treatment programs the individual was referred to (i.e., outpatient, inpatient, etc.):
   PIWI community partner (TOLU) referred clients needing mental health support to RAMS mental health specialist. No clients were referred to treatment programs. It is anticipated that there would be #s in the next fiscal year as more community members and providers know about the program and the services/activities offered.

3. Several individuals who were successfully involved and linked (i.e., the client has been seen at least once in person by a treatment provider):
   a. To an ACBH mental health treatment program: 0
   b. To a non-ACBH-funded mental health treatment program: 0

4. The average duration in weeks of signs of untreated mental illness (per client self-report) *(write "n/a" or "unknown" when applicable): n/a*

5. Average time in weeks between when a paper referral was given to an individual by your program and the individual's first in-person appointment with a mental health treatment provider *(write "n/a" or "unknown" when applicable)*: n/a

**TIMELY ACCESS (TO OTHER PEI-FUNDED PROGRAMS)**

1. Several separate paper referrals to another ACBH PEI-funded program. *(write "n/a" or "unknown" when applicable)*: n/a

2. A number of individuals followed through on referral & engaged in an ACBH PEI-funded program *(write "n/a" or "unknown" when applicable)*: 8

3. Average time in weeks between when a paper referral was given to an individual by your program and the individual's first in-person appointment with the ACBH PEI-funded provider *(write "n/a" or "unknown" when applicable)*: n/a

**MHSA Program #: PEI 6**

**PROVIDER NAME: Tri-City Health Center Arise Asian Wellness Project**

**PROGRAM NAME: Outreach, Education & Consultation for Asian Pacific Islander Community**

**Program Description:** Arise: Asian Wellness Project. Target population is East Asians (Chinese, Korean, Japanese, Taiwanese) in South Alameda County.

Program Outcomes & Impact: UELP Data Report FY18/19

**PERFORMANCE INDICATORS: How Much Did We Do?**

| Total Numbers Served through PEI MHSA | |
|---|---|
| Number of unduplicated individuals your program serves who are **at-risk** of developing a mental health problem or serious mental illness (SMI) | 1,134 |
| Number of unduplicated individuals your program serves who show **early signs** of forming a more severe mental illness | 32 |
| Number of unduplicated individual family members served indirectly by your program: | |
| Grand TOTAL of unduplicated individuals served in the Quarter that you are reporting about. [This number (D) should = A+B+C.] | 1,166 |

**PERFORMANCE INDICATORS: How Well Did We Do?**
Demographics

**Race (Please mark only one choice)**
*If Hispanic or Latino, choose "Another race not listed."*

American Indian or Alaska Native
Asian
Black or African American
Native Hawaiian or other Pacific Islander
White
More than one race
Another race not listed
Unknown/ Declined to Answer

**Age Group (Unduplicated)**

| | |
|---|---|
| Children/Youth (0--15) | 60 |
| Transition Age Youth (16--25) | 195 |
| Adult (26--59) | 1,019 |
| Older Adult (60+) | 161 |
| Unknown/ Declined to Answer | |

**Primary Language (Please mark only one choice)**

| | |
|---|---|
| English | 79 |
| Spanish | |
| Farsi | |
| Cantonese | |
| Mandarin | 43 |
| Other Chinese Dialects | |
| Vietnamese | |
| Korean | |
| Tagalog | |
| Other Filipino Dialect | |
| Japanese | |
| Laotian | |
| Cambodian | |
| Mien | |
| Hmong | |
| Samoan | |
| Thai | |
| Russian | |
| Polish | |
| German | |
| Italian | |
| Turkish | |
| Hebrew | |
| French | |
| Portuguese | |
| Armenian | |
| Arabic | |
| Sign ASL | |
| Other primary language not listed Other - 207 | 207 |
| Unknown/ Decline to Answer | |

**Ethnicity /Cultural Heritage (Please mark only once choice)**

| | |
|---|---|
| **If Hispanic or Latino, please specify:** | |
| Caribbean | |
| Central American | |
| Mexican/Mexican--American/Chicano | |
| Puerto Rican | |
| South American | |
| Another Hispanic/Latino ethnicity not listed | |
| Unknown/Declined to Answer | |
| **If Non-Hispanic or Non-Latino, please specify:** | |
| African | |
| African American | |
| Asian Indian/South Asian | |
| Cambodian | |
| Chinese | 661 |
| Eastern European | |
| European | |
| Filipino | |
| Japanese | |
| Korean | 3 |
| Middle Eastern | |
| Vietnamese | |
| Other Non-Hispanic or Non-Latino ethnicity not listed | 469 |
| Other Asian- 469 | |
| **More than one ethnicity** | |
| **Unknown /Declined to Answer** | |

**Sexual Orientation (Please mark only one choice)**

| | |
|---|---|
| Gay or Lesbian | |
| Heterosexual or Straight | 2 |
| Bisexual | |
| Questioning or unsure of sexual orientation | |
| Queer | |
| Another sexual orientation not listed | |
| Unknown/Decline to Answer | 1,433 |

**Veteran Status (Please mark only one choice)**

| | |
|---|---|
| Yes | 1 |
| No | 64 |
| Unknown/Decline to Answer | 1,435 |

**Disability Status** (Please mark all that apply)

| | |
|---|---|
| None | 3 |
| Yes. If yes, please specify (choose from list below): | |
| Difficulty Seeing | |
| Difficulty hearing, or having speech | |
| Mental Domain | |
| Physical/Mobility Domain | |
| Chronic Health Condition | |
| Another disability not listed | |
| Unknown/Decline to Answer | 1,433 |

**Gender Identity (Please mark both parts A & B)**

| | |
|---|---|
| A) Assigned sex at birth: (Please mark only one choice) | |
| Male | 585 |
| Female | 850 |
| Other sex not listed (e.g. Intersex) | |
| Unknown/Decline to Answer | |
| B) Current Gender Identity: (Please mark only one choice) | |
| Male | |
| Female | |
| Transgender | |
| Genderqueer | |
| Questioning or Unsure of Gender Identity | |
| Another Gender Identity not listed | |
| Unknown/Decline to Answer | 1,435 |

**PROGRAM OVERVIEW**

1. What were the successes/accomplishments of the past year? Please provide one example or case study of a success your agency is particularly proud of.

   One of our successes was being able to reach underserved seniors with no services or way of communicating with staff at their apt complex. We are also proud of being able to set up partnerships with local high schools and senior housing complexes and providing services to their students and residents respectively.
   We reached out to a senior apt complex called Avelina in Fremont. Each time we have been there, we've noticed that it's made a significant impact on the mood of the seniors. They were very enthusiastic and seem uplifted after each support group or workshop. They seemed very appreciative of our services and the fact that we were able to communicate with them in their own language. They seem to look forward to every group. The staff were also very happy to have us and appreciated that we could help them communicate with the residents.

2. What were the challenges and how did your agency mitigate challenges?

   One of the challenges was staffing. We weren't able to get a Mental Health Specialist onboard until April 2019. This delayed the preventative counseling and prevention visits services. We kept a wait-list of patients who would be ready to be scheduled and seen once the MHS came onboard.
   Another challenge was getting interest from the community to attend groups or events, due to stigma and being a new program. Once we collaborated with the schools, we had support of their staff to help promote our services and make referrals to us for the support groups and preventative counseling.

3. Please describe the innovative ways your program has weaved the topics of mental health/emotional well-being into your activities. Please give at least one example.

   During a youth support group, we had the participants create their own self-care kits and provided education on importance of self-care. All participants were engaged and gave feedback that they enjoyed the activity. It was also a good reminder for them to practice self-care outside of the group.

4. Please describe how your program has encouraged access to your services and your strategies for successful linkage for mental health treatment.

   We had partnerships with some of the local high schools and made prevention visits to the school when there was a referral. Our goal of going out to meet them in the community was to reduce access to care for the students. We've also tried to encourage referred individuals to meet w/ the MHS by informing them we could meet them where they felt comfortable. Our partnerships and collaborative effort with school staff, community leaders, and Primary Care Providers have assisted with encouraging participants to be linked to mental health treatment.

5. Describe how your program interacted with various other ACBH funded programs/projects such as school-based programs, other prevention programs, the stigma and discrimination reduction campaign, 10 x 10 campaign etc.

   We have invited Hume Center's UELP program to a tabling event at a high school that has majority Asian and South Asian students, so students and parents could learn about both of our services. I have also been in contact with Korean Community Center of the East Bay staff to help find resources for participants since we serve the same ethnic populations but in different parts of the county. Our UELP programs also invite each other to our respective programs' events to provide support.

6. What are your goals for your program for the upcoming fiscal year?

   Our goals are to expand the type of workshops. We hope to include yoga classes as another method to help participants increase their protective factors. We also hope to utilize volunteers and contracted speakers to provide different topic workshops. Another goal is to expand services to college aged students by creating a partnership with colleges. We have already started the conversation with a local community college.

**ACCESS & LINKAGE TO MENTAL HEALTH TREATMENT (QUESTION 1 AND 3 ARE REQUIRED PER YOUR EXHIBIT A - QUALITY MEASURES)**

1. Number of individuals with serious mental illness (SMI) or exhibit symptoms of a SMI who received a paper referral (i.e. referrals via phone do not apply) from your program…
   a. To an ACBH-funded mental health treatment program: 2, all other referrals were via phone
   b. To a non-ACBH-funded mental health treatment program: 0

2. List type(s) of mental health treatment programs the individual was referred to (i.e. outpatient, inpatient, etc.): Outpatient mental health treatment, inpatient psychiatric hospital, outpatient psychiatric services

3. Number of individuals who were successfully referred and linked (i.e. client has been seen at least once in person by a treatment provider):
   a. To an ACBH mental health treatment program: 6
   b. To a non-ACBH-funded mental health treatment program: 0

4. Average duration in weeks of signs of untreated mental illness (per client self-report) *(write "n/a" or "unknown" when applicable): unknown*

5. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with a mental health treatment provider *(write "n/a" or "unknown" when applicable)*: unknown

**TIMELY ACCESS (TO OTHER PEI-FUNDED PROGRAMS)**

1. Number of separate paper referrals to another ACBH **PEI-funded** program. *(write "n/a" or "unknown" when applicable)*: 0, all referrals via phone

2. Number of individuals followed through on referral & engaged in an ACBH PEI-funded program *(write "n/a" or "unknown" when applicable)*: 0

3. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with the ACBH PEI-funded provider *(write "n/a" or "unknown" when applicable)*: n/a

**MHSA Program #: PEI 7**

**PROVIDER NAME: Afghan Wellness Center**

**PROGRAM NAME: Outreach, Education & Consultation for South Asian/Afghan Community**

**Program Description:** Afghan Wellness Center is a project of The Afghan Coalition, a non-profit, community- b a s e d organization located in Fremont. We consist of a bilingual/bicultural staff that supports the underserved Afghan community. The AWC works with individuals that are isolated or trauma-exposed, immigrants, families under stress or grieving, at risk children and youth as well as any individual at risk of early onset of a serious mental health issue by providing prevention and early intervention services in Dari, Pashto and English. AWC provides advocacy and screening, educational workshops, support groups, outreach and resources and referrals to families and refugees.

Program Outcomes & Impact: UELP Data Report FY18/19

**PERFORMANCE INDICATORS: How Much Did We Do?**

| Total Numbers Served through PEI MHSA | |
|---|---|
| Number of unduplicated individuals your program serves who are **at-risk** of developing a mental health problem or serious mental illness (SMI) | 3,010 |
| Number of unduplicated individuals your program serves who show **early signs** of forming a more severe mental illness | 46 |
| Number of unduplicated individual family members served indirectly by your program: | |
| Grand TOTAL of unduplicated individuals served in the Quarter that you are reporting about. [This number (D) should = A+B+C.] | 3,056 |

**PERFORMANCE INDICATORS: How Well Did We Do?**
Demographics

**Age Group (Unduplicated)**

| | |
|---|---|
| Children/Youth (0---15) | 228 |
| Transition Age Youth (16---25) | 556 |
| Adult (26---59) | 1,414 |
| Older Adult (60+) | 812 |
| Unknown/ Declined to Answer | |

**Race (Please mark only one choice)**
*If Hispanic or Latino, choose "Another race not listed."*

| | |
|---|---|
| American Indian or Alaska Native | |
| Asian | 2,704 |
| Black or African American | 40 |
| Native Hawaiian or other Pacific Islander | |
| White | 114 |
| More than one race | |
| Another race not listed | 119 |
| Unknown/ Declined to Answer | 33 |

**Sexual Orientation (Please mark only one choice)**

| | |
|---|---|
| Gay or Lesbian | |
| Heterosexual or Straight | 53 |
| Bisexual | 28 |
| Questioning or unsure of sexual orientation | |
| Queer | |
| Another sexual orientation not listed | 2,92 |
| Unknown/Decline to Answer | |

**Ethnicity /Cultural Heritage (Please mark only once choice)**

| | |
|---|---|
| **If Hispanic or Latino, please specify:** | |
| Caribbean | |
| Central American | |
| Mexican/Mexican-American/Chicano | |
| Puerto Rican | |
| South American | |
| Another Hispanic/Latino ethnicity not listed | |
| Unknown/Declined to Answer | |
| **If Non-Hispanic or Non-Latino, please specify:** | |
| African | |
| African American | |
| Asian Indian/South Asian | |
| Cambodian | |
| Chinese | |
| Eastern European | |
| European | |
| Filipino | |
| Japanese | |
| Korean | |
| Middle Eastern | |
| Vietnamese | |
| Other Non-Hispanic or Non-Latino ethnicity not listed-AFGHAN | 2,704 |
| **More than one ethnicity** | |
| **Unknown /Declined to Answer** | |

**Primary Language (Please mark only one choice)**

| | |
|---|---|
| English | 30 |
| Spanish | |
| Farsi | 38 |
| Cantonese | |
| Mandarin | |
| Other Chinese Dialects | |
| Vietnamese | |
| Korean | |
| Tagalog | |
| Other Filipino Dialect | |
| Japanese | |
| Laotian | |
| Cambodian | |
| Mien | |
| Hmong | |
| Samoan | |
| Thai | |
| Russian | |
| Polish | |
| German | |
| Italian | |
| Turkish | |
| Hebrew | |
| French | |
| Portuguese | |
| Armenian | |
| Arabic | |
| Sign ASL | |
| Other primary language not listed Dari - 1684 Pashto - 362 Unknown/ Decline to Answer | 2,046 |

**Gender Identity (Please mark both parts A &**

| | |
|---|---|
| A) Assigned sex at birth: (Please mark only one | |
| Male | 1,356 |
| Female | 1,654 |
| Other sex not listed (e.g. Intersex) | |
| Unknown/Decline to Answer | |
| B) Current Gender Identity: (Please mark only one choice) | |
| Male | |
| Female | |
| Transgender | |
| Genderqueer | |
| Questioning or Unsure of Gender Identity | |
| Another Gender Identity not listed | |
| Unknown/Decline to Answer | |

**Disability Status** (Please mark all that apply)

| | |
|---|---|
| None | 34 |
| Yes. If yes, please specify (choose from list below): | |
| Difficulty Seeing | |
| Difficulty hearing, or having speech | |
| Mental Domain | 3 |
| Physical/Mobility Domain | 1 |
| Chronic Health Condition | 1 |
| Another disability not listed | |
| Unknown/Decline to Answer | 2,971 |

**Veteran Status (Please mark only one choice)**

| | |
|---|---|
| Yes | |
| No | 73 |
| Unknown/Decline to Answer | 2,937 |

**PROGRAM OVERVIEW**

1. What were the successes/accomplishments of the past year? Please provide one example or case study of a success your agency is particularly proud of.

Some of our successes were implementing a weekly afterschool program to support youth, several cultural events bringing the community together and reducing isolation, reaching isolated clients through home visits and establishing seven monthly support groups. We were honored when our Executive Director, Rona Popal, and our Associates Dr. Valerie Smith, Dr. Nilofar Sami and Mizgon Darby, were named the recipients of the 2019 Ulysses Medal for Leadership in Refugee Health from the UC Davis School of Medicine.

One case we are particularly proud of is when we were able to help an extremely depressed client. Our client, with a pending Asylum case, married a recently divorced man who later left to reunite with his ex-wife. We were able to provide her with culturally sensitive emotional support, a home visit, linked her to our mental health prevention counseling and encouraged her to attend other mental health wellness events. The client attended a Spiritual Healing presentation by Dr. Masoud Ghafoer. She later said, "It was like a spark which changed me overnight. After that, I definitely know how to take care of myself." The client continues to come to the office with renewed hope about her future. Another case involved an Afghan man who had severe symptoms of PTSD and we were able to help him learn how to regulate his emotions, help him reduce his symptoms and connect him with a psychologist who helped him with more in-depth trauma work.

2. What were the challenges and how did your agency mitigate challenges?

One challenge we faced was starting our youth program. We began with the expectation that families would come to our office for events but quickly learned that it was difficult for the parents to transport their children. To mitigate this, we hosted a Parent Workshop as a listening forum and discovered that the best way to reach the youth would be to host events at their apartment recreation rooms and at schools. Our After-School Club has grown to more than 17 weekly participants. Additionally, we have attended a Wellness Fair at Searles Elementary in Union City and are hoping to have a future presence at that school and others with after school programs. This year we have interacted with 7 schools in the Fremont and Union City school districts.

A second obstacle we faced was reaching Afghan men who typically do not want to engage in counseling services. We started a monthly men's support group, a men's ESL class and held a Father's Day Celebration. We used these events to de-stigmatize Mental Health issues and promote overall wellbeing and encourage prevention services.

3. Please describe the innovative ways your program has weaved the topics of mental health/emotional well-being into your activities. Please give at least one example.

There are several ways our programs weave the topics of mental health/emotional well-being into our activities through: art therapy, cultural events such as Barat and Nowruz, cooking lessons, jewelry making, sewing classes and reciting and creating poetry to name a few. The classes give our clients a safe place to learn a new skill, discover their creative side, share their personal stories and meet others in the community. The workshops are a vehicle for enhancing self-esteem and building community, both important ingredients for positive mental health.

At the Barat Celebration (Festival of Lights) our clients were invited to a night filled with food, raffles, dancing and a presentation by our Prevention Counselor on the importance of Self-Care during Ramadan. By creating a fun, inviting event people are more apt to come and learn about Wellness topics therefore increasing their knowledge about mental health and further breaking down the stigma. Clients are encouraged at these events to meet with our Prevention Counselor, Dr. Masoud Ghafoer, if they are experiencing any mental health issues and to participate in our support groups as a way to be connected to their community.

4. Please describe how your program has encouraged access to your services and your strategies for successful linkage for mental health treatment.

Our office is a one stop shop for many Afghan refugees and immigrants. Many times, we see clients for the first time for reasons such as housing, employment and social services. An assessment is done at the first visit to the office. We determine what their needs are and refer them to different Afghan Coalition programs and community resources. Through our intake process we are able to discern who may benefit from preventative counseling and also refer clients to our on-going support groups. Through social media, community outreach events, Consortium Meetings and our youth program we encourage access to our Wellness Center.

Additionally, our partnerships with Afghan Community groups allow us to leverage our resources to provide outreach and engagement to our targeted population. Some of these outreach events include Poetry Night, Cultural Night and Soccer Night. Partners refer clients to our wellness programs through these events.

5. Describe how your program interacted with various other ACBH funded programs/projects such as school-based programs, other prevention programs, the stigma and discrimination reduction campaign, 10 x 10 campaigns etc.

We encouraged other agencies to attend our Consortium Meetings, which we consider one of the highlights of our program, so that we can train each other on cross cultural issues. We also referred people to other agencies when applicable and have shared information. In the future, we hope to schedule a site visits with other prevention programs as well as host them at our office as a means to provide a cross cultural training. Additionally, one of our goals for next year is to host an event with another UELP program.

This year we presented our program at Catholic Charities and participated in International Refugee in June.

6. What are your goals for your program for the upcoming fiscal year?

- Finding innovative ways to outreach and engage more Men in our targeted populations for mental health services.
- Partner with another UELP prevention program on an outreach event
- Continue to educate our community that having a mental health challenge is similar to a physical health challenge and to seek help sooner.
- Expand outreach efforts to reach more isolated people.
- Grow our youth program to include two more after school programs
- Establishing a weekly drop in meeting spot in Little Kabul, Fremont with outreach workers
- Family counseling for new refugee families to include effective and healthy parenting boundaries and communication for healthy relationships.

**ACCESS & LINKAGE TO MENTAL HEALTH TREATMENT (QUESTION 1 AND 3 ARE REQUIRED PER YOUR EXHIBIT A - QUALITY MEASURES)**

1. Number of individuals with serious mental illness (SMI) who received a paper referral (i.e. referrals via phone do not apply) from your program…
    a. To an ACBH-funded mental health treatment program: N/A
    b. To a non-ACBH-funded mental health treatment program: We made 6 (six) referrals to non-ACBF-funded agencies/mental health providers this Fiscal year.

2. List type(s) of mental health treatment programs the individual was referred to (i.e. outpatient, inpatient, etc.):

   Five individuals were referred to an outpatient program (psychologist) and one individual to an outpatient program at a non-profit agency for a psychological evaluation.

3. Number of individuals who were successfully referred and linked (i.e. client has been seen at least once in person by a treatment provider):
   a. To an ACBH mental health treatment program: N/A
   b. To a non-ACBH-funded mental health treatment program:

      Three clients were successfully referred and linked to the above-mentioned providers.

4. Average duration in weeks of signs of untreated mental illness (per client self-report) *(write "n/a" or "unknown" when applicable): N/A*

5. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with a mental health treatment provider *(write "n/a" or "unknown" when applicable)*:

   The average time between a paper referral given to an individual by the Afghan Coalition and the individual's first in person appointment was approximately three weeks.

**TIMELY ACCESS (TO OTHER PEI-FUNDED PROGRAMS)**

1. Number of separate paper referrals to another ACBH **PEI-funded** program. *(write "n/a" or "unknown" when applicable)*: N/A

2. Number of individuals followed through on referral & engaged in an ACBH PEI-funded program *(write "n/a" or "unknown" when applicable)*: N/A

3. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with the ACBH PEI-funded provider *(write "n/a" or "unknown" when applicable)*: N/A

**MHSA Program #: PEI 7**

**PROVIDER NAME: Filipino Community Wellness Program**

**PROGRAM NAME: Outreach, Education & Consultation for South Asian/Afghan Community**

**Program Description**: Filipino Community Wellness Program aims to engage young people, immigrants and low- wage workers in healthy, positive, culturally relevant, and inclusive activities that prevent isolation, disconnection, anxiety, fear and hopelessness, and reduces the stigmas associated with use of mental health services. Activities will focus on helping community members understand the twin impacts of colonial/post- colonial trauma and the marginalization of immigrants in the US on help-seeking behaviors. Services will be concentrated on Filipinos in the central and southern regions of Alameda County.

Program Outcomes & Impact: UELP Data Report FY18/19

**PERFORMANCE INDICATORS: How Much Did We Do?**

| **Total Numbers Served through PEI MHSA** | |
|---|---|
| Number of unduplicated individuals your program serves who are **at-risk** of developing a mental health problem or serious mental illness (SMI) | 1,415 |
| Number of unduplicated individuals your program serves who show **early signs** of forming a more severe mental illness | 22 |
| Number of unduplicated individual family members served indirectly by your program: | |
| Grand TOTAL of unduplicated individuals served in the Quarter that you are reporting about. [This number (D) should = A+B+C.] | 1,437 |

**PERFORMANCE INDICATORS: How Well Did We Do?**
Demographics

### Age Group (Unduplicated)

| | |
|---|---|
| Children/Youth (0---15) | 42 |
| Transition Age Youth (16---25) | 1,103 |
| Adult (26---59) | 131 |
| Older Adult (60+) | 122 |
| Unknown/ Declined to Answer | 17 |

### Race (Please mark only one choice)

*If Hispanic or Latino, choose "Another race not listed."*

| | |
|---|---|
| American Indian or Alaska Native | |
| Asian | 1,360 |
| Black or African American | |
| Native Hawaiian or other Pacific Islander | |
| White | 6 |
| More than one race | |
| Another race not listed | 34 |
| Unknown/ Declined to Answer | 4 |

### Sexual Orientation (Please mark only one choice)

| | |
|---|---|
| Gay or Lesbian | 25 |
| Heterosexual or Straight | 905 |
| Bisexual | 1 |
| Questioning or unsure of sexual orientation | |
| Queer | |
| Another sexual orientation not listed | |
| Unknown/Decline to Answer | 375 |

### Ethnicity /Cultural Heritage (Please mark only once choice)

| | |
|---|---|
| **If Hispanic or Latino, please specify:** | |
| Caribbean | |
| Central American | |
| Mexican/Mexican--American/Chicano | 1 |
| Puerto Rican | |
| South American | |
| Another Hispanic/Latino ethnicity not listed | 6 |
| Unknown/Declined to Answer | |
| **If Non-Hispanic or Non-Latino, please specify:** | |
| African | |
| African American | |
| Asian Indian/South Asian | 1 |
| Cambodian | |
| Chinese | |
| Eastern European | |
| European | |
| Filipino | 1,318 |
| Japanese | |
| Korean | |
| Middle Eastern | |
| Vietnamese | 24 |
| Other Non-Hispanic or Non-Latino ethnicity not listed | |
| **More than one ethnicity** | |
| **Unknown /Declined to Answer** | |

**Primary Language (Please mark only one choice)**

| | |
|---|---|
| English | 1,20 |
| Spanish | |
| Farsi | |
| Cantonese | |
| Mandarin | |
| Other Chinese Dialects | |
| Vietnamese | |
| Korean | |
| Tagalog | 19 |
| Other Filipino Dialect | |
| Japanese | |
| Laotian | |
| Cambodian | |
| Mien | |
| Hmong | |
| Samoan | |
| Thai | |
| Russian | |
| Polish | |
| German | |
| Italian | |
| Turkish | |
| Hebrew | |
| French | |
| Portuguese | |
| Armenian | |
| Arabic | |
| Sign ASL | |
| Other primary language not | 19 |
| Unknown/ Decline to Answer | |

**Gender Identity (Please mark both parts A &**

| | | |
|---|---|---|
| A) | Assigned sex at birth: (Please mark only one choice) | |
| | Male | 539 |
| | Female | 839 |
| | Other sex not listed (e.g. Intersex) | |
| | Unknown/Decline to Answer | 7 |
| B) | Current Gender Identity: (Please mark only one choice) | |
| | Male | |
| | Female | |
| | Transgender | 1 |
| | Genderqueer | |
| | Questioning or Unsure of Gender Identity | |
| | Another Gender Identity not listed | |
| | Unknown/Decline to Answer | 1,377 |

**Disability Status** (Please mark all that apply)

| | |
|---|---|
| None | 455 |
| Yes. If yes, please specify (choose from list below): | |
| Difficulty Seeing | |
| Difficulty hearing, or having speech understood | 1 |
| Mental Domain | 1 |
| Physical/Mobility Domain | 20 |
| Chronic Health Condition | 26 |
| Another disability not listed | |
| Unknown/Decline to Answer | 912 |

**Veteran Status (Please mark only one choice)**

| | |
|---|---|
| Yes | |
| No | 18 |
| Unknown/Decline to Answer | 1,23 |

**PROGRAM OVERVIEW**

1. What were the successes/accomplishments of the past year? Please provide one example or case study of a success your agency is particularly proud of.

Three support groups were initially provided: a high school-aged youth group began in July 2018; a transition-aged (TAY) group for adults 18 to 23 years old began in January 2019; and a low wage worker/caregiver support group that serves mainly elderly adults began in July 2018. A group for queer/LGBTQIA+ youth spun off in June 2019 and a young women's group will follow. Activities focused on around mental well-being and self- care. Outreach via social media was particularly effective for TAY. The low wage worker group was particularly responsive to the incorporation of art and movement into the psychoeducation workshops. For youth at James Logan High School in Union City, a structured referral system has been developed to link at-risk Filipino students to FAJ for preventative counseling services. Two of the adolescent clients who were provided individual preventative counseling services agreed to family counseling. The parents, very reluctant to receiving services, were invited to attend a few of the sessions. As a result, the parents realized their need for mental health support and requested to be seen separately for their own individual counseling.

2. What were the challenges and how did your agency mitigate challenges?

   - Challenges with program on-ramping prevented us from reaching our Preventative Counseling goals. Full staffing and strategic planning have resolved these issues going forward.
   - For TAY, challenges were mostly in attendance and having consistency in regular attendees for events. By building more strategies to do more in-person outreach on college campuses, resource fairs, and conferences, these challenges were slowly overcome. Consistency with follow-ups and check-ins with participants from each workshop/event improved attendance over time.
   - Elderly workers and caregivers often have transportation challenges. Rotating program locations in areas most convenient to participants helped mitigate this challenge.
   - For youth participants, challenges were mostly logistical. Securing regular meeting space at the school for workshops and meetings was made possible by strengthening relationships with administration to secure a multiyear MOU. Language barriers for immigrant youth were mitigated by providing space to express themselves in their preferred dialect. Materials, videos, pictures incorporated bilingual or in-language audio/words.
   - Finding a Tagalog-speaking mental health provider to triage with for non-English speaking Filipino clients who will require extensive and regular psychotherapy has been challenging. Filipino Advocates for Justice (FAJ) continues to collaborate with Asian Health Services for potential client referrals, and a translator will be hired to assist if needed.
   - The goal to de-stigmatize counseling and mental health posed some challenges in the beginning. Many of the Filipinos in the community appeared to have very little interest in participating at mental-health related events. FAJ reframed the concept of mental health and counseling to empower the community through psycho-education workshops on topics that are focused on self-care, stress management, and wellness.

3. Please describe the innovative ways your program has weaved the topics of mental health/emotional well-being into your activities. Please give at least one example.

   - Individual and group sessions circle back to mental health, such as stress relief practices, mindfulness workshops through creative/artistic outlets, activities that debunk daily stressors such as family, housing conditions, and financial stressors. We have also held recreational outings such as nature hikes to demonstrate the effect physical wellness has on mental health.
   - Participants saw the connection between their emotional well-being and challenging social conditions to help them understand their experiences in a holistic way.
   - Art and movement were incorporated into workshops to allow participants to better express themselves.

- Meditations were provided in Tagalog during workshops.
- We incorporated mental health stigma and societal norms into Filipino folklore to discuss ideas of empowerment, demonization, mental health and indigenous values
- We normalized discussion of oppressive cultural norms and healthy cultural values, leading to critical analysis of culture that does not frame Filipino culture as deficient, but a source of strength. Filipino culture seen as dynamic vs stagnant, something they have power over. They influence it as much as they have influence

4. Please describe how your program has encouraged access to your services and your strategies for successful linkage for mental health treatment.

- School campus and online/social media outreach has increased visibility of the program and available resources for youth and TAY populations.
- A partnership with the Department of Labor Standards and Enforcement provides referral of Filipino workers who need support in dealing with anxiety and other MH concerns.
- De-stigmatized seeking mental health resources via normalizing discussion around mental health in meetings and workshops
- Mental health and emotional stability were tied to indigenous values of *kapwa*, relating them to the collective health of community.
- Outreach workers provided monthly check-in/one-on-ones with peer leaders and other members, or as needed, normalizing help-seeking.
- Participants who required more in-depth preventative care were provided a warm hand-off to in house mental health specialist, acclimate them to seeing mental health professionals
- Relationships with schools' onsite health clinic and COST made for easy, efficient referrals.

5. Describe how your program interacted with various other ACBH funded programs/projects such as school-based programs, other prevention programs, the stigma and discrimination reduction campaign, 10 x 10 campaign etc.

- Participation in school site COST for program outreach and cross-referral.
- Provided consultations with other providers such as Union City Youth and Family Services.
- Provided access to existing SUD PPv clients who can benefit from preventative mental health counseling.
- Provided support pipeline for existing youth participants to TAY support groups.
- Collaborated with school counselors and health clinic for case management of youth?
- Participation of UELP staff in monthly trainings provided by Wellness in Action.

6. What are your goals for your program for the upcoming fiscal year?

- Expand the number of participants in TAY groups.
- Provide continued curriculum refinement for workshops and
- Increase collaborations with other providers and community stakeholders
- Provide male & female support youth sub-groups. Study and implement effective support strategies for non-binary and gender non-conforming participants.
- Replicate the systematic referral procedure developed at James Logan High School to other school sites.

**ACCESS & LINKAGE TO MENTAL HEALTH TREATMENT (QUESTION 1 AND 3 ARE REQUIRED PER YOUR EXHIBIT A - QUALITY MEASURES)**

1. Number of individuals with serious mental illness (SMI) or exhibit symptoms of a SMI who received a paper referral (i.e. referrals via phone do not apply) from your program…
    a. To an ACBH-funded mental health treatment program: 0
    b. To a non-ACBH-funded mental health treatment program: 0
2. List type(s) of mental health treatment programs the individual was referred to (i.e. outpatient, inpatient, etc.): n/a
3. Number of individuals who were successfully referred and linked (i.e. client has been seen at least once in person by a treatment provider):
    a. To an ACBH mental health treatment program: 0
    b. To a non-ACBH-funded mental health treatment program: 0
4. Average duration in weeks of signs of untreated mental illness (per client self-report) *(write "n/a" or "unknown" when applicable): n/a*
5. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with a mental health treatment provider *(write "n/a" or "unknown" when applicable)*: n/a

**TIMELY ACCESS (TO OTHER PEI-FUNDED PROGRAMS)**

1. Number of separate paper referrals to another ACBH **PEI-funded** program. *(write "n/a" or "unknown" when applicable)*: n/a
2. Number of individuals followed through on referral & engaged in an ACBH PEI-funded program *(write "n/a" or "unknown" when applicable)*: n/a
3. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with the ACBH PEI-funded provider *(write "n/a" or "unknown" when applicable)*: n/a

**MHSA Program #: PEI 7**

**PROVIDER NAME: Afghan Path toward Wellness (International Rescue Committee (IRC))**

**PROGRAM NAME: Outreach, Education & Consultation for South Asian/Afghan Community**

**Program Description**: Afghan Path towards Wellness (APTW) : Providing wellness and psychosocial support services to the Afghan community of North Alameda County. Primary services include preventative counseling, psycho-educational and educational workshops, community events, socials support groups, wellness assessments, and community provider and leader trainings.

Program Outcomes & Impact: UELP Data Report FY18/19

**PERFORMANCE INDICATORS: How Much Did We Do?**

| Total Numbers Served through PEI MHSA | |
|---|---|
| Number of unduplicated individuals your program serves who are **at-risk** of developing a mental health problem or serious mental illness (SMI) | 690 |
| Number of unduplicated individuals your program serves who show **early signs** of forming a more severe mental illness | 45 |
| Number of unduplicated individual family members served indirectly by your program: | |
| Grand TOTAL of unduplicated individuals served in the Quarter that you are reporting about. [This number (D) should = A+B+C.] | 735 |

**PERFORMANCE INDICATORS: How Well Did We Do?**
Demographics

**Age Group (Unduplicated)**

| | |
|---|---|
| Children/Youth (0--15) | 224 |
| Transition Age Youth (16--25) | 70 |
| Adult (26--59) | 395 |
| Older Adult (60+) | 1 |
| Unknown/ Declined to Answer | |

**Race (Please mark only one choice)**
*If Hispanic or Latino, choose "Another race not listed."*

| | |
|---|---|
| American Indian or Alaska Native | |
| Asian | 663 |
| Black or African American | |
| Native Hawaiian or other Pacific Islander | |
| White | |
| More than one race | |
| Another race not listed | 27 |
| Unknown/ Declined to Answer | |

**Sexual Orientation (Please mark only one choice)**

| | |
|---|---|
| Gay or Lesbian | |
| Heterosexual or Straight | 586 |
| Bisexual | |
| Questioning or unsure of sexual orientation | |
| Queer | |
| Another sexual orientation not listed | |
| Unknown/Decline to Answer | 104 |

**Ethnicity /Cultural Heritage (Please mark only once choice)**

| | |
|---|---|
| **If Hispanic or Latino, please specify:** | |
| Caribbean | |
| Central American | |
| Mexican/Mexican--American/Chicano | 14 |
| Puerto Rican | |
| South American | |
| Another Hispanic/Latino ethnicity not listed | |
| Unknown/Declined to Answer | |
| **If Non-Hispanic or Non-Latino, please specify:** | |
| African | |
| African American | |
| Asian Indian/South Asian | |
| Cambodian | |
| Chinese | |
| Eastern European | |
| European | |
| Filipino | |
| Japanese | |
| Korean | |
| Middle Eastern | |
| Vietnamese | |
| Other Non-Hispanic or Non-Latino ethnicity not listed | 646 |
| Afghan - 599<br>Burmese – 14<br>Other Asian/Pacific Islander - 33 | |
| **More than one ethnicity** | |
| **Unknown /Declined to Answer** | |

**Primary Language (Please mark only one choice)**

| | |
|---|---|
| English | |
| Spanish | 14 |
| Farsi | 40 |
| Cantonese | |
| Mandarin | |
| Other Chinese Dialects | |
| Vietnamese | |
| Korean | |
| Tagalog | |
| Other Filipino Dialect | |
| Japanese | |
| Laotian | |
| Cambodian | |
| Mien | |
| Hmong | |
| Samoan | |
| Thai | |
| Russian | |
| Polish | |
| German | |
| Italian | |
| Turkish | |
| Hebrew | |
| French | |
| Portuguese | |
| Armenian | |
| Arabic | |
| Sign ASL | |
| Other primary language not listed | 63<br>4 |
| Burmese – 30<br>Dari – 292<br>Pashto -266<br>Other -46 | |
| Unknown/ Decline to Answer | |

**Gender Identity (Please mark both parts A & B)**

| | |
|---|---|
| A) Assigned sex at birth: (Please mark only one | |
| Male | 25 |
| Female | 43<br>3 |
| Other sex not listed (e.g. Intersex) | |
| Unknown/Decline to Answer | |
| B) Current Gender Identity: (Please mark only one choice) | |
| Male | |
| Female | |
| Transgender | |
| Genderqueer | |
| Questioning or Unsure of Gender Identity | |
| Another Gender Identity not listed | |
| Unknown/Decline to Answer | 69 |

**Disability Status** (Please mark all that apply)

| | |
|---|---|
| None | 57 |
| Yes. If yes, please specify (choose from list below): | |
| Difficulty Seeing | |
| Difficulty hearing, or having speech | |
| Mental Domain | |
| Physical/Mobility Domain | |
| Chronic Health Condition | |
| Another disability not listed | |
| Unknown/Decline to Answer | 11 |

**Veteran Status (Please mark only one choice)**

| | |
|---|---|
| Yes | |
| No | 69 |
| Unknown/Decline to Answer | |

**PROGRAM OVERVIEW**

1. What were the successes/accomplishments of the past year? Please provide one example or case study of a success your agency is particularly proud of.

   One particular client has significantly benefited from the wrap-around services offered by the IRC's Afghan Path towards Wellness program. This individual had been enrolled in IRC's intensive case management program prior to the start of our UELP project, but given her vast number of needs, still required additional support. APTW's preventative counselor was able to work with the client to identify her primary source of depression, which was an element of her living situation. The preventative counselor worked alongside the client to successfully advocate with her low-income housing unit to be transferred to a different apartment. Another need the client identified was social isolation. The preventative counselor was able to connect her to the Pathways to Wellness women's support group at Refugee Transitions (subcontractor), where she was able to meet and socialize with other women. While the client continues to work through her mental health needs with a licensed specialist, the client states that the holistic services offered to her under the Afghan Path towards Wellness program have done more to improve her social/emotional wellbeing than her psychiatrist was able to accomplish in over 2 years.

2. What were the challenges and how did your agency mitigate challenges?

   APTW faces the continued challenge of clients not being ready or willing to access formalized mental health care. In year one APTW focused on building connections with different providers in the area and established a concrete understanding of the referral process. The preventative counselor also focused on one-on-one coaching around the stigmatization of mental health and benefits of seeking mental health support services. The IRC looks forward to continuing this work into year 2 and believe that as more trust is established in the community, there will be correlated successes in referring clients to ACBH mental health providers.

   One challenge APTW faced, as is common with pilot projects, is that some of the interventions the program planned to utilize were not found to be effective. For example, according to IRC's initial proposal, APTW planned to implement the Refugee Health Screener-15 (RHS-15) document with all new clients in their first meeting with wellness promoters. The RHS-15 is a non-clinical assessment of depression, anxiety, and PTSD. The wellness promoters quickly learned that clients were not comfortable answering these intensive questions when they had not yet established substantial trust and rapport with the assessor. The Health & Wellness Manager therefore consulted with the county and agreed to adapt program implementation to include the possibility of utilizing the RHS-15 when appropriate, but to no longer mandate it upon intake.

3. Please describe the innovative ways your program has weaved the topics of mental health/emotional well-being into your activities. Please give at least one example.

   The IRC has utilized the Pathways to Wellness (P2W) support group curriculum to increase social support and connection, while simultaneously breaching the topic of mental health and emotional wellbeing. The IRC's P2W group and curriculum is modeled after an evidence-generating Pathways to Wellness project designed specifically for refugees by Lutheran Community Services Northwest, Asian Counseling and Referral Services, Public Health Seattle & King County, and Michael Hollifield, M.D. P2W is an adaptable and scalable model and it is currently being implemented across the U.S. These support groups increase social support systems, decrease isolation, promote personal empowerment of group members, and encourage health-promoting and coping behaviors. The eight-week community social adjustment support group focuses on acculturation issues and coping skills of clients, and builds off of the existing skills and qualities of the group participants to create change within themselves and their communities. The session topics are as follows:

   Week 1 – Introduction to the group
   Week 2 – Culture Shock

Week 3 – The Refugee Experience
Week 4 – Mental Health
Week 5 – The Mind & Body Connection
Week 6 – Goals and Dreams
Week 7 – Creating Wellness
Week 8 – Creating a Community of Wellness

We have found that the timing of the Mental Health and Mind & Body Connection sessions are ideal, as they allow the group to first gain a level of comfort with both each other and the facilitator. Of the three P2W cycles administered by the IRC prior to our UELP contract, 100% of participants who completed the cycle report feeling more adjusted to life in the U.S. and more connected to the community.

4. Please describe how your program has encouraged access to your services and your strategies for successful linkage for mental health treatment.

In order to ensure clients and providers learn about the APTW Program, the Health & Wellness (H&W) team started internally by conducting a presentation to the full IRC staff on all of the different components of the program and the referral process. This ensured that any refugee or Special Immigrant Visa holder (SIV) who was enrolled in other IRC programming (case management, employment, ESL, immigration, etc.) and exhibiting signs of emotional stress would be referred to the H&W team. This same presentation has also been conducted with external partner providers. Additionally, the APTW team is present at the bi-weekly IRC Case Consultation meetings to inquire about potential referrals and offer support.

IRC's partnership with the sub-contractor, Refugee Transitions (RT), has been invaluable. The Refugee Transitions team also advertises the program to partner providers and clients. RT conducts client wellness assessments at their office, and when an issue is identified, the team immediately makes a referral to the Health & Wellness Manager at IRC, who identifies the most appropriate APTW program(s) for the client in need.

The APTW strategies for successful linkage to mental health treatment revolve around one-on-one coaching on resources, and education around myths of the risks of seeking mental health treatment. A common concern in the Afghan community is that if someone seeks mental health treatment, this may put them at risk with their employer, with CPS, and with other governmental agencies. The APTW preventative counselor works diligently with each client to dispel these myths and offer input on what mental health care truly looks like in the United States. If and when a client is willing to seek mental health treatment, the Preventative Counselor offers to accompany the client to the first session to support with transportation, registration, and other logistical stressors that can discourage someone from getting connected. Further, the APTW psycho-educational workshops aim to inform the Afghan community about different mental health and emotional support resources available to them, and to dispel myths about seeking such care.

5. Describe how your program interacted with various other ACBH funded programs/projects such as school-based programs, other prevention programs, the stigma and discrimination reduction campaign, 10 x 10 campaign etc.

In year one of APTW, the IRC looked to other UELP PEI providers for their wisdom, guidance, and client support. We attended trainings health by the Afghan Coalition in Fremont – the veteran holder of the UELP PEI project for the Afghan Community of South Alameda County. We networked with their team members to learn about the challenges and successes they faced in implementing wellness programming. APTW also worked closely with the Oakland Unified School District to identify Afghan families who would be eligible for wellness programming.
Two psycho-educational workshops were conducted within the school system to better reach these families and youth. Further, APTW connected directly with Multilingual Counseling, an ACBH-funded

specialty mental health provider with language capacity in Dari. Of the two successful mental health referrals APTW was able to make, one was connected with Multilingual Counseling.

6. What are your goals for your program for the upcoming fiscal year?

   In addition to our contract deliverables, the IRC's APTW project has the following goals for FY19-20:

   - Continue to decrease stigma associated with mental health in the Afghan community, and in turn, increase mental health referrals to ACBH providers.
   - Build deeper connections and referral systems with ACBH-funded providers
   - Expand the psycho-educational workshop curriculums and bring in more community experts to teach these sessions
   - Offer mental health skills trainings to the larger Oakland non-profit community, beyond our current partner base
   - Audio-record the mental health trainings offered by our clinical provider for posterity and the benefit of those who cannot attend in person.
   - Build stronger data-collection systems to evaluate the impact of APTW programming, as identified through client satisfaction surveys and wellness assessments.
   - Ensure client participants have a strong voice in communicating their wishes for program elements, structure, and adaptations.
   - Continue to respond not only to concrete mental health concerns, but also to other needs that impact social wellbeing

**ACCESS & LINKAGE TO MENTAL HEALTH TREATMENT (QUESTION 1 AND 3 ARE REQUIRED PER YOUR EXHIBIT A - QUALITY MEASURES)**

1. Number of individuals with serious mental illness (SMI) or exhibit symptoms of a SMI who received a paper referral (i.e. referrals via phone do not apply) from your program…
   a. To an ACBH-funded mental health treatment program: 2
   b. To a non-ACBH-funded mental health treatment program: 0

   This component of APTW's work was the most challenging in year one as the program is just beginning to address the stigma associated with seeking mental health support in the Afghan community. One outcome of note is that the Preventative Counselor has been able to successfully connect many clients to a Primary Care Doctor for depression and anxiety medication. Clients enrolled this fiscal year have been more willing to talk about their emotional stressors with a primary care doctor as opposed to a mental health clinician. The preventative counselor has worked with 6 clients who have successfully been prescribed an appropriate medication regiment through their PCP. Also, of note is that 4 preventative counseling clients were already seeing specialty mental health providers when referred to us, but had identified that they needed additional, culturally relevant support to address all of their psychosocial needs.

2. List type(s) of mental health treatment programs the individual was referred to (i.e. outpatient, inpatient, etc.):
   Outpatient

3. Number of individuals who were successfully referred and linked (i.e. client has been seen at least once in person by a treatment provider):
   a. To an ACBH mental health treatment program: 1
   b. To a non-ACBH-funded mental health treatment program: 1

4. Average duration in weeks of signs of untreated mental illness (per client self-report) *(write "n/a" or "unknown" when applicable):* Unknown – we did not track this data in year one.

5. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with a mental health treatment provider *(write "n/a" or "unknown" when applicable)*: Unknown – we did not track this data in year one.

**TIMELY ACCESS (TO OTHER PEI-FUNDED PROGRAMS)**

1. Number of separate paper referrals to another ACBH **PEI-funded** program. *(write "n/a" or "unknown" when applicable)*: Unknown – we did not track this data in year one.

2. Number of individuals followed through on referral & engaged in an ACBH PEI-funded program *(write "n/a" or "unknown" when applicable)*: Unknown – we did not track this data in year one.

3. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with the ACBH PEI-funded provider *(write "n/a" or "unknown" when applicable)*: Unknown – we did not track this data in year one.

**MHSA Program #: PEI 7**

**PROVIDER NAME: The Hume Center**

**PROGRAM NAME: Outreach, Education & Consultation for South Asian/Afghan Community- South Asian Community Health Promotion Services Program**

**Program Description**: Every person experiences challenges at different stages in their life, such as falling in love, marriage, divorce, parenting, the developmental challenges following the birth of a child, a child's first day of school, work relationships, aging, and retirement. Other types of challenges can be unpredictable, such as accidents and sicknesses. Working with the South Asian population has shown us that these challenges may increase remarkably if you are an immigrant. In order to help people, cope with such challenges successfully, The Hume Center has developed the South Asian Community Health Promotion Services Program.

This program provides short term, culturally sensitive and language specific services aimed at developing knowledge and skills to work through life challenges effectively. These services are provided not only at our clinic but we have the flexibility of providing home visits and of offering services at schools, religious establishments and other community locations. These services include prevention, preventative counseling, workshops and presentations. In order to address the significant amount of stigma around emotional wellness this program also provides outreach in the community to educate and increase utilization of services by the South Asian Community.

Program Outcomes & Impact: UELP Data Report FY18/19

**PERFORMANCE INDICATORS: How Much Did We Do?**

| **Total Numbers Served through PEI MHSA** | |
|---|---|
| Number of unduplicated individuals your program serves who are **at-risk** of developing a mental health problem or serious mental illness (SMI) | 96 |
| Number of unduplicated individuals your program serves who show **early signs** of forming a more severe mental illness | 6,502 |
| Number of unduplicated individual family members served indirectly by your program: | |
| Grand TOTAL of unduplicated individuals served in the Quarter that you are reporting about. [This number (D) should = A+B+C.] | 6,598 |

**PERFORMANCE INDICATORS: How Well Did We Do?**

Demographics

**Age Group (Unduplicated)**

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

**Race (Please mark only one choice)**
*If Hispanic or Latino, choose "Another race not listed."*

| | |
|---|---|
| American Indian or Alaska Native | 3 |
| Asian | |
| Black or African American | |
| Native Hawaiian or other Pacific Islander | |
| White | |
| More than one race | |
| Another race not listed | |
| Unknown/ Declined to Answer | |

**Sexual Orientation (Please mark only one choice)**

| | |
|---|---|
| Gay or Lesbian | 1 |
| Heterosexual or Straight | 1,61 |
| Bisexual | 5 |
| Questioning or unsure of sexual orientation | |
| Queer | |
| Another sexual orientation not listed | |
| Unknown/Decline to Answer | 4,88 5 |

**Ethnicity /Cultural Heritage (Please mark only once choice)**

| | |
|---|---|
| **If Hispanic or Latino, please specify:** | |
| Caribbean | |
| Central American | |
| Mexican/Mexican -- | |
| Puerto Rican | |
| South American | |
| Another Hispanic/Latino | 209 |
| Unknown/Declined to Answer | |
| **If Non-Hispanic or Non-Latino, please specify:** | |
| African | |
| African American | |
| Asian Indian/South Asian | 697 |
| Cambodian | |
| Chinese | |
| Eastern European | |
| European | |
| Filipino | 75 |
| Japanese | |
| Korean | 6 |
| Middle Eastern | |
| Vietnamese | |
| Other Non-Hispanic or Non- Latino ethnicity not listed | 3,373 |
| Afghan – 93 Asian Pacific Islander – 8 Bangladeshi – 8 Bhutanese 984 Nepalese – 1590 Pakistani – 16 Persian Iranian – 16 Other Asian – 124 | |
| **More than one ethnicity** | |
| **Unknown /Declined to Answer** | |

**Primary Language (Please mark only one choice)**

| | |
|---|---|
| English | 3,63 |
| Spanish | |
| Farsi | 66 |
| Cantonese | |
| Mandarin | |
| Other Chinese Dialects | |
| Vietnamese | |
| Korean | |
| Tagalog | |
| Other Filipino Dialect | |
| Japanese | |
| Laotian | |
| Cambodian | |
| Mien | |
| Hmong | |
| Samoan | |
| Thai | |
| Russian | |
| Polish | |
| German | |
| Italian | |
| Turkish | |
| Hebrew | |
| French | |
| Portuguese | |
| Armenian | |
| Arabic | |
| Sign ASL | |
| Other primary language not listed Hindi – 27 Punjabi – 185 Other - 2575 | 2,78 7 |
| Unknown/ Decline to Answer | |

**Gender Identity (Please mark both parts A & B)**

| | |
|---|---|
| A) Assigned sex at birth: (Please mark only one choice) | |
| Male | 2,79 |
| Female | 3,19 |
| Other sex not listed (e.g. Intersex) | |
| Unknown/Decline to Answer | 512 |
| B) Current Gender Identity: (Please mark only one choice) | |
| Male | |
| Female | |
| Transgender | 2 |
| Genderqueer | |
| Questioning or Unsure of Gender Identity | |
| Another Gender Identity not listed | |
| Unknown/Decline to Answer | 6,50 |

**Disability Status** (Please mark all that apply)

| | |
|---|---|
| None | 1,61 |
| Yes. If yes, please specify (choose from list below): | |
| Difficulty Seeing | |
| Difficulty hearing, or having speech understood | |
| Mental Domain | |
| Physical/Mobility Domain | 13 |
| Chronic Health Condition | |
| Another disability not listed | 1 |
| Unknown/Decline to Answer | 4,87 |

**Veteran Status (Please mark only one choice)**

| | |
|---|---|
| Yes | |
| No | 1,82 |
| Unknown/Decline to Answer | 6,50 |

**PROGRAM OVERVIEW**

1. What were the successes/accomplishments of the past year? Please provide one example or case study of a success your agency is particularly proud of.
   This year we piloted our expansion to North County and our focus on the underserved Nepalese and Bhutanese communities by hiring outreach workers. We identified many successes out in North County such as the implementation of 6 different support groups focused on decreasing social isolation, addressing trauma related to immigration, and promoting youth leadership.

2. What were the challenges and how did your agency mitigate challenges?
   The biggest challenge we faced was also related to our expansion to North County. We struggled with staffing in regards to hiring a mental health consultant to provide Preventative Counseling to participants that were referred by our outreach workers. The struggle was that there was a specific language need and there was no one qualified to provide preventative counseling who also spoke Nepali. The outreach workers struggled to build rapport with community members due to the long wait list for Preventative Counseling. By identifying that many members of the Nepalese community speak Hindi we were able to mitigate the challenge towards the end of the fiscal year by having a Hindi speaking clinician provide the preventative counseling services. For 2019-2020 fiscal year we are also on boarding a Hindi speaking clinician that will be able to provide Preventative Counseling.

3. Please describe the innovative ways your program has weaved the topics of mental health/emotional well-being into your activities. Please give at least one example.
   This year we introduced some displays that talk about the Myths of Mental Health within the South Asian Community. When we display these myths on the table during outreach events, it allows community members to read and process from afar. We have offered a lot of take-away items at our outreach table that focus on coping strategies, parenting as immigrants, self-care, addressing suicide, and introducing emotional wellness phone apps to download. Talking about these things out in the open is not safe but reading it and thinking about it still allows them to learn without feeling exposed to their community.

   We have also utilized cultural and religious practices within our work with participants by making them a part of their wellness plan. Building on what they are already utilizing, rather than trying to introduce new ways of coping has really helped engage the community. For example, we offered a Chai group for Women and a Soccer Group for Bhutanese Men.

4. Please describe how your program has encouraged access to your services and your strategies for successful linkage for mental health treatment.
   The program has eliminated psychologically heavy language from their literature. Providers also refrain from using diagnostic terminology or psychological jargon when engaging with community members. For example, we refer to someone being extremely sad or extremely worried rather than saying the person is depressed or the person has anxiety. By helping the community focus on symptoms rather than diagnosis we help them normalize their experiences and decrease their feelings of hopelessness. Being able to work with individuals for up to a year allows us to build rapport with the participants to a point where we are able to help them link to other resources and often times even continue to work with them until they are fully linked and utilizing other resources. We have an internal outpatient program which allows it to be even easier to link to mental health treatment. Although the challenge has been that there are little to no linguistically or culturally appropriate providers in outpatient programs that meet our participant's needs.

5. Describe how your program interacted with various other ACBH funded programs/projects such as school-based programs, other prevention programs, the stigma and discrimination reduction campaign, 10 x 10 campaign etc.

   We collaborated with other ACBH funded programs and worked closely with school-based programs at the different school campuses that we were at by providing mental health consultations and collaborating on school-based events. We worked with other prevention programs to help refer participants that would benefit from their services based off their cultural/linguistic needs (Ex. Referring Chinese identified students to ARISE- Asian Wellness Project). We work with a lot of South Asian Domestic and Family Violence organizations in the area that also receive some funding from ACBH. We also work closely with Tri-City Health to help support the emotional needs of their South Asian participants.

6. What are your goals for your program for the upcoming fiscal year?

   Our goals this year are to continue to grow our services in North County and provide more consistency in having a Preventative Counseling provider available to participants needing the higher level of care. We have also expanded in South County by providing services at more schools in Fremont and Union City that have expressed a high level of stress in their South Asian student body. We hope to work more collaboratively with other CBO's and UELP Providers in the area to provide joint events that are focused on Prevention and Early Intervention. We are working on a project to help target parts of the South Asian community that we have not been able to engage in the past such due to high levels of stigma (ex. the elderly and South Asian Men) by hosting more culturally appropriate events. We are also beginning to provide some services in Pleasanton and Dublin and hope to be more visible county wide.

**ACCESS & LINKAGE TO MENTAL HEALTH TREATMENT (QUESTION 1 AND 3 ARE REQUIRED PER YOUR EXHIBIT A - QUALITY MEASURES)**

1. Number of individuals with serious mental illness (SMI) or exhibit symptoms of a SMI who received a paper referral (i.e. referrals via phone do not apply) from your program…
   a. To an ACBH-funded mental health treatment program: *unknown*
   b. To a non-ACBH-funded mental health treatment program: *unknown*

2. List type(s) of mental health treatment programs the individual was referred to (i.e. outpatient, inpatient, etc.):

3. Number of individuals who were successfully referred and linked (i.e. client has been seen at least once in person by a treatment provider):
   a. To an ACBH mental health treatment program: *N/a*
   b. To a non-ACBH-funded mental health treatment program: *3*

4. Average duration in weeks of signs of untreated mental illness (per client self-report) *(write "n/a" or "unknown" when applicable): On average participants have reported having signs for at least 6 months or more before they have engaged in services of any kind.*

5. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with a mental health treatment provider *(write "n/a" or "unknown" when applicable)*: *unknown*

**TIMELY ACCESS (TO OTHER PEI-FUNDED PROGRAMS)**

1. Number of separate paper referrals to another ACBH **PEI-funded** program. *(write "n/a" or "unknown" when applicable)*: *unknown*

2. Number of individuals followed through on referral & engaged in an ACBH PEI-funded program *(write "n/a" or "unknown" when applicable)*: *unknown*

3. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with the ACBH PEI-funded provider *(write "n/a" or "unknown" when applicable)*: *unknown*

**MHSA Program #: PEI 8**

**PROVIDER NAME: Native American Health Center (NAHC)**

**PROGRAM NAME: Outreach, Education & Consultation for Native American Community**

**Program Description**: Native American Health Center, Inc. (NAHC) - Native American Health Center provides culturally responsive mental health services; including preventative counseling, cultural prevention groups, outreach, psycho-education, community events, trainings, and referrals. NAHC targets Native American youth and adult populations living in Alameda County.

Program Outcomes & Impact: UELP Data Report FY18/19

**PERFORMANCE INDICATORS: How Much Did We Do?**

| Total Numbers Served through PEI MHSA | |
|---|---|
| Number of unduplicated individuals your program serves who are **at-risk** of developing a mental health problem or serious mental illness (SMI) | 1,478 |
| Number of unduplicated individuals your program serves who show **early signs** of forming a more severe mental illness | 46 |
| Number of unduplicated individual family members served indirectly by your program: | |
| Grand TOTAL of unduplicated individuals served in the Quarter that you are reporting about. [This number (D) should = A+B+C.] | 1,524 |

**PERFORMANCE INDICATORS: How Well Did We Do?**
Demographics

**Age Group (Unduplicated)**

| | |
|---|---|
| Children/Youth (0--15) | 161 |
| Transition Age Youth (16--25) | 106 |
| Adult (26--59) | 449 |
| Older Adult (60+) | 513 |
| Unknown/ Declined to Answer | 249 |

**Race (Please mark only one choice)**
*If Hispanic or Latino, choose "Another race not listed."*

| | |
|---|---|
| American Indian or Alaska Native | 705 |
| Asian | 96 |
| Black or African American | 71 |
| Native Hawaiian or other Pacific Islander | |
| White | 45 |
| More than one race | |
| Another race not listed | 285 |
| Unknown/ Declined to Answer | 276 |

**Sexual Orientation (Please mark only one choice)**

| | |
|---|---|
| Gay or Lesbian | 49 |
| Heterosexual or Straight | 84 |
| Bisexual | 1 |
| Questioning or unsure of sexual orientation | |
| Queer | |
| Another sexual orientation not listed | |
| Unknown/Decline to Answer | 58 |

**Ethnicity /Cultural Heritage (Please mark only once choice)**

| | |
|---|---|
| **If Hispanic or Latino, please specify:** | |
| Caribbean | |
| Central American | |
| Mexican/Mexican-- | |
| Puerto Rican | |
| South American | |
| Another Hispanic/Latino | |
| Unknown/Declined to Answer | |
| **If Non-Hispanic or Non-Latino, please specify:** | |
| African | |
| African American | |
| Asian Indian/South Asian | |
| Cambodian | |
| Chinese | |
| Eastern European | |
| European | |
| Filipino | |
| Japanese | |
| Korean | |
| Middle Eastern | |
| Vietnamese | |
| Other Non-Hispanic or Non- Latino ethnicity not listed | 256 |
| **More than one ethnicity** | |
| **Unknown /Declined to Answer** | |

**Primary Language (Please mark only one choice)**

| | |
|---|---|
| English | 1,45 |
| Spanish | 24 |
| Farsi | |
| Cantonese | |
| Mandarin | |
| Other Chinese Dialects | |
| Vietnamese | |
| Korean | |
| Tagalog | |
| Other Filipino Dialect | |
| Japanese | |
| Laotian | |
| Cambodian | |
| Mien | |
| Hmong | |
| Samoan | |
| Thai | |
| Russian | |
| Polish | |
| German | |
| Italian | |
| Turkish | |
| Hebrew | |
| French | |
| Portuguese | |
| Armenian | |
| Arabic | |
| Sign ASL | |
| Other primary language not | |
| Unknown/ Decline to Answer | |

**Gender Identity (Please mark both parts A & B)**

| | |
|---|---|
| A) Assigned sex at birth: (Please mark only one | |
| Male | 40 |
| Female | 81 |
| Other sex not listed (e.g. Intersex) | |
| Unknown/Decline to Answer | 26 |
| B) Current Gender Identity: (Please mark only one choice) | |
| Male | 40 |
| Female | 81 |
| Transgender | |
| Genderqueer | |
| Questioning or Unsure of Gender Identity | |
| Another Gender Identity not listed | |
| Unknown/Decline to Answer | 26 |

**Disability Status** (Please mark all that apply)

| | |
|---|---|
| None | 90 |
| Yes. If yes, please specify (choose from list below): | |
| Difficulty Seeing | |
| Difficulty hearing, or having speech understood | 9 |
| Mental Domain | 6 |
| Physical/Mobility Domain | 67 |
| Chronic Health Condition | |
| Another disability not listed | 1 |
| Unknown/Decline to Answer | 49 |

**Veteran Status (Please mark only one choice)**

| | |
|---|---|
| Yes | 47 |
| No | 1,12 |
| Unknown/Decline to Answer | 30 |

**PROGRAM OVERVIEW**

1. What were the successes/accomplishments of the past year? Please provide one example or case study of a success your agency is particularly proud of.

The NAHC was proud to have accomplished all of its program goals over the past fiscal year. One specific case study example that staff felt particularly strong about I the case of a 13-year old Native Youth (Mixed w/African American ancestry). This youth entered our program having recently lost her mother. She experienced a great deal of trauma in her life, and witnessed a great deal of violence in her community. Being an Urban Native American of mixed descent, she did not know much of her Native culture. Through the AC PEI program, she was able to be screened and connected to our Mental Health Specialist (Alaska Native) who participated in counseling, and was taught to complete a cultural genogram, how to smudge, and was introduced to certain ceremonies. After participating in services, she reported feeling less depressed, felt closure from her mother's passing, and felt connected to the Native Community. She was referred to our Youth Services program and is currently in the process of registering for participation.

`

2. What were the challenges and how did your agency mitigate challenges?

An early challenge we experienced was with indigenous youth and other community members feeling uncomfortable completing the language used on the consent form for preventative counseling. After meeting with County staff, we were able to develop language that met the County's needs, and was easily understandable to the community which increased our number of registered members.

3. Please describe the innovative ways your program has weaved the topics of mental health/emotional well-being into your activities. Please give at least one example.

NAHC's UELP Program weaves the topics of mental health into all cultural activities and community events, either by directly having a Mental Health specialist attending the event, communicating the importance and availability of mental health services, or by taking opportunities during activities to have one-to –one brief interventions. One example of this was during our Spring Gathering Event. During this event, community members gathered at the Alameda Crown Beach to celebrate the spring season and share a meal together. During the event, a traditional healer (Arnita "Grandma" Swanson) was on hand to do a traditional Native American song, prayer, and talking circle, while Behavioral Health clinicians were present to reduce the stigma of receiving Mental Health services. The clinicians and community health workers participated in in activities such as catch, flying kites, and Frisbee with youth, adults, and their families.

4. Please describe how your program has encouraged access to your services and your strategies for successful linkage for mental health treatment.

NAHC's PEI Program has encouraged access to our services and Mental Health treatment by including mental health providers in our cultural groups, community events, and workshops. At each group, a mental health topic is discussed, or information about Behavioral Health services are disseminated. Community events focus on youth or adult community members and include mental health service providers in order to build trust and familiarity between the community and staff. Our Community Health Workers also community members through intake/screening and discuss prevention services as well as treatment services if needed with each member.

5. Describe how your program interacted with various other ACBH funded programs/projects such as school-

NAHC's PEI Program provided prevention groups at the Oakland Unified School District sites in collaboration with our School Based health Center programs in the form of a Young Women's group facilitated by our Community Health Worker. We also provided training on our PEI program to the Alameda County UELP providers at a quarterly UELP Providers meeting to inform partners regarding our program.

6. What are your goals for your program for the upcoming fiscal year?

In the upcoming fiscal year, our program goal is to better coordinate and collaborate services with our Native American community partner agencies, as well as our fellow UELP Service providers. This will expand our potential reach, and assist us in contacting more community members.

**ACCESS & LINKAGE TO MENTAL HEALTH TREATMENT (QUESTION 1 AND 3 ARE REQUIRED PER YOUR EXHIBIT A - QUALITY MEASURES)**

1. Number of individuals with serious mental illness (SMI) or exhibit symptoms of a SMI who received a paper referral (i.e. referrals via phone do not apply) from your program…

   a. To an ACBH-funded mental health treatment program: 46
   b. To a non-ACBH-funded mental health treatment program: 12

2. List type(s) of mental health treatment programs the individual was referred to (i.e. outpatient, inpatient, etc.):
   MHS Referrals, Outpatient Preventative Counseling, Outreach, Stigma Reduction, Suicide Prevention, Education & Consultations**.**

3. Number of individuals who were successfully referred and linked (i.e. client has been seen at least once in person by a treatment provider):

   a. To an ACBH mental health treatment program: 46
   b. To a non-ACBH-funded mental health treatment program: Unknown

4. Average duration in weeks of signs of untreated mental illness (per client self-report) *(write "n/a" or "unknown" when applicable):* Unknown

5. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with a mental health treatment provider *(write "n/a" or "unknown" when applicable)*: Referrals typically take 24 hours for system to process, and appointments are scheduled for the following week.

**TIMELY ACCESS (TO OTHER PEI-FUNDED PROGRAMS)**

1. Number of separate paper referrals to another ACBH **PEI-funded** program. *(write "n/a" or "unknown" when applicable)*: Unknown

2. Number of individuals followed through on referral & engaged in an ACBH PEI-funded program *(write "n/a" or "unknown" when applicable)*: 46

3. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with the ACBH PEI-funded provider *(write "n/a" or "unknown" when applicable)*: The average time between a referral and an individual's first appointment is 1 week.

**MHSA Program #: PEI 10**

**PROVIDER NAME: Partnership for Trauma Recovery (PTR)**

**PROGRAM NAME: Outreach, Education & Consultation for Partnerships for African Community**

**Program Description:** Partnerships for Trauma Recovery (PTR) provides culturally reflective, trauma-informed, linguistically competent and accessible UELP PEI services to the specific underserved population of forcibly displaced children, youth, adults, and families from African countries currently residing in North and South Alameda County. PTR specializes in providing holistic care, including culturally-reflective, trauma-informed behavioral health care and case management support for those who have fled violence and persecution in their home countries and seek refuge in the Bay Area. When entire societies are affected by large- scale violence such as war and genocide, collective trauma can result. Thus, mental health concerns caused by exposure to trauma are chief among the mental health needs for the priority population, and are PTR's primary focus. Intervening early and effectively once refugees and asylum-seekers reach the U.S. is key to preventing the deleterious effects of trauma from deeply impacting the lives of future generations. PTR has served adults, families, and youth from the African countries of Cameroon, Eritrea, Ethiopia, Nigeria, DR Congo, Uganda, Kenya, Mali, Senegal, Sudan, Egypt, Burkina Faso, and the Ivory Coast.

Program Outcomes & Impact: UELP Data Report FY18/19

**PERFORMANCE INDICATORS: How Much Did We Do?**

| **Total Numbers Served through PEI MHSA** | |
|---|---|
| Number of unduplicated individuals your program serves who are **at-risk** of developing a mental health problem or serious mental illness (SMI) | 900 |
| Number of unduplicated individuals your program serves who show **early signs** of forming a more severe mental illness | 56 |
| Number of unduplicated individual family members served indirectly by your program: | |
| Grand TOTAL of unduplicated individuals served in the Quarter that you are reporting about. [This number (D) should = A+B+C.] | 956 |

**PERFORMANCE INDICATORS: How Well Did We Do?**

Demographics

**Age Group (Unduplicated)**

| | |
|---|---|
| Children/Youth (0--15) | 82 |
| Transition Age Youth (16--25) | 175 |
| Adult (26--59) | 505 |
| Older Adult (60+) | 128 |
| Unknown/ Declined to Answer | 10 |

**Race (Please mark only one choice)**
*If Hispanic or Latino, choose "Another race not listed."*

| | |
|---|---|
| American Indian or Alaska Native | 1 |
| Asian | 65 |
| Black or African American | 576 |
| Native Hawaiian or other Pacific Islander | |
| White | 60 |
| More than one race | |
| Another race not listed | 198 |
| Unknown/ Declined to Answer | |

**Sexual Orientation (Please mark only one choice)**

| | |
|---|---|
| Gay or Lesbian | 21 |
| Heterosexual or Straight | 233 |
| Bisexual | 3 |
| Questioning or unsure of sexual orientation | |
| Queer | |
| Another sexual orientation not listed | |
| Unknown/Decline to Answer | 643 |

**Ethnicity /Cultural Heritage (Please mark only once choice)**

| | |
|---|---|
| **If Hispanic or Latino, please specify:** | |
| Caribbean | |
| Central American | 3 |
| Mexican/Mexican-- | 2 |
| Puerto Rican | |
| South American | 1 |
| Another Hispanic/Latino | 85 |
| Unknown/Declined to Answer | |
| **If Non-Hispanic or Non-Latino, please specify:** | |
| African | |
| African American | |
| Asian Indian/South Asian | 30 |
| Cambodian | |
| Chinese | 4 |
| Eastern European | |
| European | |
| Filipino | |
| Japanese | |
| Korean | 1 |
| Middle Eastern | |
| Vietnamese | |
| Other Non-Hispanic or Non- Latino ethnicity not listed<br><br>Afghan – 4<br>Other Asian Pacific Islander – 25 | 30 |
| **More than one ethnicity** | |
| **Unknown /Declined to Answer** | |

**Primary Language (Please mark only one choice)**

| | |
|---|---|
| English | 39 |
| Spanish | 56 |
| Farsi | |
| Cantonese | |
| Mandarin | |
| Other Chinese Dialects | |
| Vietnamese | |
| Korean | |
| Tagalog | |
| Other Filipino Dialect | |
| Japanese | |
| Laotian | |
| Cambodian | |
| Mien | |
| Hmong | |
| Samoan | |
| Thai | |
| Russian | |
| Polish | |
| German | |
| Italian | |
| Turkish | |
| Hebrew | |
| French | |
| Portuguese | |
| Armenian | |
| Arabic | 3 |
| Sign ASL | |
| Other primary language not listed | 452 |

Arabic – 3
Other - 449
Unknown/ Decline to Answer

**Gender Identity (Please mark both parts A & B)**

| | |
|---|---|
| A) Assigned sex at birth: (Please mark only one choice) | |
| Male | 41 |
| Female | 47 |
| Other sex not listed (e.g. Intersex) | |
| Unknown/Decline to Answer | 5 |
| B) Current Gender Identity: (Please mark only one choice) | |
| Male | 41 |
| Female | 47 |
| Transgender | |
| Genderqueer | |
| Questioning or Unsure of Gender Identity | |
| Another Gender Identity not listed | |
| Unknown/Decline to Answer | 5 |

**Disability Status** (Please mark all that apply)

| | |
|---|---|
| None | |
| Yes. If yes, please specify (choose from list below): | |
| Difficulty Seeing | |
| Difficulty hearing, or having speech understood | |
| Mental Domain | |
| Physical/Mobility Domain | 4 |
| Chronic Health Condition | |
| Another disability not listed | |
| Unknown/Decline to Answer | 89 |

**Veteran Status (Please mark only one choice)**

| | |
|---|---|
| Yes | |
| No | |
| Unknown/Decline to Answer | 90 |

**PROGRAM OVERVIEW**

1. What were the successes/accomplishments of the past year? Please provide one example or case study of a success your agency is particularly proud of.

   Over the past year, PTR's UELP PEI program provided preventive counseling to 56 unique clients, provided 133 prevention visits, facilitated 12 monthly psychoeducational workshops, conducted 3 educational workshops, facilitated 3 support groups, participated in 9 community events, and distributed our UELP PEI material on 5 local listservs that reach individuals and community-based organizations throughout the San Francisco Bay Area. PTR is particularly proud of our ability to facilitate monthly psychoeducational workshops that address practical needs of the community while incorporating wellness, self-care, and mental health awareness.

   One success we would like to highlight was the facilitation of a 9-week support group with 8 African boys who attend a local public high school. The group covered topics such as expressing and managing emotions; race and racism; and healthy communication. Overall, participants from the group reported a decrease in feelings of distress. After the end of the group, one student shared, "I feel like I was in prison since I didn't have friends and nowhere to go. And now I feel like I am liberated and happy since I make many friends from this group. I have fun and spend time with them even outside of the school."

2. What were the challenges and how did your agency mitigate challenges?

   The primary challenge PTR experienced pertained to the requirement to enter personal information in the county-wide InSyst system. The majority of our clients are asylum seekers, asylees, and refugees, many of whose status is currently uncertain. This is particularly the case for asylum seekers, whose cases may not be heard for several years. Given their past histories of trauma, their persecution often at the hands of government, and their insecure legal status, consenting to have their personal information reported in InSyst caused stress and anxiety. We addressed this challenge by allowing those clients who did not feel comfortable consenting to sharing their information in InSyst to continue to receive preventive counseling services, despite our ability to report of these clients in our total clients served (please see the table below for more information). Additionally, we have created a unique consent form for UELP PEI clients—separate from the consent form that all PTR clients receive—that clearly indicates the information that is shared in InSyst and the level of protection guaranteed by Alameda County to maintain confidentiality of all PHI. This new consent form—which will be implemented in FY 19-20—allows each UELP PEI client to be fully informed of the system and given the right to choose if they wish to consent to have their information entered in InSyst. We anticipate that this new process will enable us to vastly increase the number of clients who are opened in InSyst, and subsequently allow us to report on these clients who are receiving services under the UELP PEI program.

   Regarding other UELP activities, a challenge we experienced was working with African communities that expressed reluctance to seek mental health support based on a traditionally western model of care. We found our psychoeducational workshops to be more widely accepted if we incorporated practical issues—for example: housing, employment, or nutrition—with concepts related to wellness and self-care. We adapted our language to include a focus on wellness and self-care, rather than *mental health*, to be more culturally appropriate within the African communities we serve.

3. Please describe the innovative ways your program has weaved the topics of mental health/emotional well-being into your activities. Please give at least one example.

   As mentioned above, it was more culturally appropriate to discuss wellbeing and self-care, versus using language such as 'mental health' with the communities we served. In all of our activities we integrated a wellness component.

For example, our monthly psychoeducational workshops focused on practical topics important within the community, such as employment, housing, nutrition, exercise, assimilation, and parenting. During each of these monthly workshops, the workshop facilitators weaved in a wellness component by clearly demonstrating how the topic being covered related to stress, anxiety, wellness, and self-care. One example is a psychoeducational workshop held in February 2019, whereby guest speakers from Burma Refugee and Family Network and Centro Legal de la Raza provided information on affordable housing and tenants' rights. Following the information provided by the guest speakers, the African Communities Liaisons (Outreach Workers) discussed the ways stress caused by housing instability affect overall wellbeing and provided self-care techniques, such a movement and breathing exercises, to mitigate feelings of stress and anxiety. We found that incorporating somatic experiences to help connect mind and body were very successful with the participants of our workshops.

4. Please describe how your program has encouraged access to your services and your strategies for successful linkage for mental health treatment.

   Access to services can be a challenge for some members of African communities, due to services not being offered in diverse languages or culturally appropriate ways. Additionally, there are practical challenges, such as event location and cost of transportation that also play a role in the ability for individuals to seek and receive services. PTR encourages access to our services by offering psychoeducational workshops, support groups, and preventive counseling services in languages spoken by the community. In addition to the diverse language capacity of our African Communities Liaisons and clinical staff, PTR's Refugee Voices Interpreter Coordinator recruits, trains, and supervises mental health interpreters who speak the languages of our clients to provide interpretation for psychoeducational workshops, support groups, and preventive counseling sessions. PTR also translated our electronic and hard copy materials into several different languages to reach different segments of the community who do not speak English. The material was also adapted so that it could be well understood by youth, elderly, women, men, as well as those with or without formal education.

   During this past year, our psychoeducational workshops were offered at different locations throughout the community, on different days of the week, and during different times in an effort to make them accessible to members of the community who live throughout the county and who have varying schedules. We also offered to cover the costs of transportation to and from our events for our low-income clients who could not otherwise afford the cost of travel. Additionally, psychoeducational workshop topics were tailored to the community needs and demands in order to increase their participation and access to service provision. PTR's African Communities Liaisons and clinical staff distributed survey questions to the community members, and discussed with community and religious leaders to identify the needs of the community members before conducting the workshops. Thus, as per the community feedback and suggestions, PTR tried to address different mental health issues by integrating causes of stress/stressors such as immigration issues, employment, housing, parenting, and acculturation into the workshop material. Lastly, PTR has also used language and terms that are culturally appropriate and relevant in discussing mental health issues, such as referring to our psychoeducational workshops as African Communities Gathering, talking about *wellness* rather than *mental health* issues, and when appropriate, using terms such as mental health *issues* or mental health *concerns* opposed to talking about mental *illness*.

5. Describe how your program interacted with various other ACBH funded programs/projects such as school-based programs, other prevention programs, the stigma and discrimination reduction campaign, 10 x 10 campaign etc.

   PTR's has interacted with other ACBH-funded programs through outreach activities, school-based support group interventions, community outreach events, and information dissemination that helps to reduce the stigma and discrimination against people living with mental health issues.

PTR adopted different best practices and resources—such as support group and psychoeducational workshop manuals and curriculums that incorporate different approaches and strategies to promote mental health—from ACBH-funded, as well as non-ACBH-funded, partner organizations. In addition, PTR shared psychoeducational invitation flyers at East Bay Refugee Forum and SF-CAIRs to all partner organizations working on mental health, and some ACBH-funded partner organizations sent their staff to share experiences and participate in PTR-facilitated workshops. For instance, during an affordable housing and stress management psychoeducational workshop, two staff from the IRC UELP PEI program participated. PTR also interacted with and collaborated closely with ACBH-funded partners for different community outreach activities, including for community-based events, cultural events, wellness activities, and referrals throughout the program cycle.

6. What are your goals for your program for the upcoming fiscal year?

PTR plans to continue to provide culturally responsive, strengths-based mental health outreach and education—through the provision of psychoeducational workshops, support groups, and educational workshops—as well as preventive counseling sessions and prevention visits to African communities residing in Alameda County. Our first year as a UELP PEI provider proved to be successful in many areas, and we have identified areas we are actively working to improve and expand. Specifically, a goal for the upcoming fiscal year is to expand our services to reach more culturally and ethnically diverse African communities. After receiving feedback from the communities, we serve, we are planning to provide educational workshops to community leaders, such as in churches and mosques or different African Associations, so that these leaders feel more equipped to know how to respond if one of their members is experiencing mental health challenges. This will also provide us with the opportunity to increase collaboration with community stakeholders and organizations that serve African communities, while building the individual, community, and organizational capacity, knowledge, and skills that contribute to the prevention of mental health disorders.

In addition, we also have a goal to expand our reach with younger African community members by including youth, both boys and girls, in and out of school, through a parent-inclusive approach to providing educational and supportive groups. We are also actively seeking more collaborative activities with other PEI programs during this upcoming fiscal year to increase the reach of our UELP PEI program.

Our outreach efforts will continue to work toward decreasing the stigma and discrimination toward individuals experiencing mental health issues by providing timely access to related information, services, and support to African communities. We intend to integrate healing activities, such as sewing, beading, or other art activities, into our psychoeducational workshops and community events. Additionally, we have hired a new Mental Health Specialist to support our UELP PEI program during the upcoming fiscal year. This clinician will have the capacity to more actively participate in outreach activities, engage with community leaders, and attend monthly psychoeducational workshops. Her presence within the communities and at the psychoeducational workshops will help clients feel more comfortable seeking mental health support if additional support is needed. Greater access to our Mental Health Specialist, as well as improvements to our referral process for PEI counseling, will help to prevent mental illness from becoming severe and disabling.

**ACCESS & LINKAGE TO MENTAL HEALTH TREATMENT (QUESTION 1 AND 3 ARE REQUIRED PER YOUR EXHIBIT A - QUALITY MEASURES)**

1. Number of individuals with serious mental illness (SMI) or exhibit symptoms of a SMI who received a paper referral (i.e. referrals via phone do not apply) from your program…
    a. To an ACBH-funded mental health treatment program: 0
    b. To a non-ACBH-funded mental health treatment program: 8

2. List type(s) of mental health treatment programs the individual was referred to (i.e. outpatient, inpatient, etc.):

   PTR's preventive counseling clients are referred to Mental Health treatment services when their mental health symptoms are too severe for prevention and early intervention services to be beneficial. When deemed appropriate, PTR referred clients to our in-house pro-bono psychiatrists for medication evaluations and management and provided internal referrals for mental health treatment with our staff clinicians and clinical interns. During this fiscal year, we did not encounter any clients who required a referral for inpatient or residential care or to the Emergency Room for psychiatric evaluation or hospitalization.

3. Number of individuals who were successfully referred and linked (i.e. client has been seen at least once in person by a treatment provider):
   a. To an ACBH mental health treatment program: 0
   b. To a non-ACBH-funded mental health treatment program: 8

4. Average duration in weeks of signs of untreated mental illness (per client self-report) *(write "n/a" or "unknown" when applicable):* unknown

5. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with a mental health treatment provider *(write "n/a" or "unknown" when applicable)*: 1-3 weeks

   Due to our referrals to mental health treatment being internal referrals—either to our in-house psychiatrist or PTR's mental health clinicians—the average time between the referral being made and a client's first appointment is approximately 1-3 weeks.

**TIMELY ACCESS (TO OTHER PEI-FUNDED PROGRAMS)**

1. Number of separate paper referrals to another ACBH **PEI-funded** program. (You can find the PEI funded programs here. This can be a provider's internal or external ACBH PEI-funded program) *(write "n/a" or "unknown" when applicable)*: n/a

2. Number of individuals followed through on referral & engaged in an ACBH PEI-funded program *(write "n/a" or "unknown" when applicable)*: n/a

3. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with the ACBH PEI-funded provider *(write "n/a" or "unknown" when applicable)*: n/a

**MHSA Program #: PEI 14**

**PROGRAM NAME: The Family Education and Resource Center (FERC)**

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

Program Outcomes & Impact: UELP Data Report FY18/19

**PERFORMANCE INDICATORS: How Much Did We Do?**

| **Total Numbers Served through PEI MHSA** | |
|---|---|
| Number of unduplicated individuals your program serves who are **at-risk** of developing a mental health problem or serious mental illness (SMI) | |
| Number of unduplicated individuals your program serves who show **early signs** of forming a more severe mental illness | |
| Number of unduplicated individual family members served indirectly by your program: **AT FERC, WE DIRECTLY SERVE FAMILY CAREGIVERS** | 2,948 |
| Grand TOTAL of unduplicated individuals served in the Quarter that you are reporting about. [This number (D) should = A+B+C.] | 2,948 |

**PERFORMANCE INDICATORS: How Well Did We Do?**
Demographics

**Age Group (Unduplicated)**

| | |
|---|---|
| Children/Youth (0---15) | |
| Transition Age Youth (16---25) | 3% |
| Adult (26---59) | 75% |
| Older Adult (60+) | 15% |
| Unknown/ Declined to Answer | 7% |

**Race (Please mark only one choice)**
*If Hispanic or Latino, choose "Another race not listed."*

| | |
|---|---|
| American Indian or Alaska Native | |
| Asian | 2% |
| Black or African American | 30% |
| Native Hawaiian or other Pacific Islander | |
| White | 45% |
| More than one race | 5% |
| Another race not listed | 15% |
| Unknown/ Declined to Answer | 3% |

**Sexual Orientation (Please mark only one choice)**

| | |
|---|---|
| Gay or Lesbian | 15% |
| Heterosexual or Straight | 49% |
| Bisexual | |
| Questioning or unsure of sexual orientation | 1% |
| Queer | |
| Another sexual orientation not listed | |
| Unknown/Decline to Answer | 35% |

**Ethnicity /Cultural Heritage (Please mark only once choice)**

| |
|---|
| **If Hispanic or Latino, please specify:** |
| Caribbean |
| Central American |
| Mexican/Mexican -- American/Chicano |
| Puerto Rican |
| South American |
| Another Hispanic/Latino |
| Unknown/Declined to Answer |
| **If Non-Hispanic or Non-Latino, please specify:** |
| African |
| African American |
| Asian Indian/South Asian |
| Cambodian |
| Chinese |
| Eastern European |
| European |
| Filipino |
| Japanese |
| Korean |
| Middle Eastern |
| Vietnamese |
| Other Non-Hispanic or Non- Latino ethnicity not listed |
| **More than one ethnicity** |

**Primary Language (Please mark only one choice)**

| | |
|---|---|
| English | 80 |
| Spanish | 11 |
| Farsi | 5% |
| Cantonese | 1% |
| Mandarin | 1% |
| Other Chinese Dialects | |
| Vietnamese | |
| Korean | 2% |
| Tagalog | |
| Other Filipino Dialect | |
| Japanese | |
| Laotian | |
| Cambodian | |
| Mien | |
| Hmong | |
| Samoan | |
| Thai | |
| Russian | |
| Polish | |
| German | |
| Italian | |
| Turkish | |
| Hebrew | |
| French | |
| Portuguese | |
| Armenian | |
| Arabic | |
| Sign ASL | |
| Other primary language not | |
| Unknown/ Decline to Answer | |

**Gender Identity (Please mark both parts A & B)**

| | |
|---|---|
| A) Assigned sex at birth: (Please mark only one choice) | |
| Male | 30% |
| Female | 65% |
| Other sex not listed (e.g. Intersex) | |
| Unknown/Decline to Answer | 5% |
| B) Current Gender Identity: (Please mark only one choice) | |
| Male | 29% |
| Female | 65% |
| Transgender | 1% |
| Genderqueer | |
| Questioning or Unsure of Gender Identity | |
| Another Gender Identity not listed | |
| Unknown/Decline to Answer | 5% |

**Disability Status** (Please mark all that apply)

| | |
|---|---|
| None | |
| Yes. If yes, please specify (choose from list below): | |
| Difficulty Seeing | X |
| Difficulty hearing, or having speech understood | X |
| Mental Domain | X |
| Physical/Mobility Domain | X |
| Chronic Health Condition | X |
| Another disability not listed | |
| Unknown/Decline to Answer | |

**Veteran Status (Please mark only one choice)**

| | |
|---|---|
| Yes | 15 |
| No | 75 |
| Unknown/Decline to Answer | 10 |

**REQUIRED STRATEGY: INCREASE ACCESS AND LINKAGE TO MENTAL HEALTH TREATMENT**

a. Number of individuals with serious mental illness (SMI) who received a paper referral (i.e. referrals via phone do not apply) from your program to an ACBH mental health treatment program: Difficult to answer this question; we are not a direct referral program. But we have printed out program overviews and summaries for clients to understand more about a particular program. Most of our referrals are done via phone – ACCESS.

b. List type(s) of mental health treatment programs the individual was referred to: We have helped clients get appointments through ACCESS. They were referred to: Oakland Community Supports, BACS, Telecare, IHOT, ABODE, STARS, Bonita House and La Familia.

c. Number of individuals who were successfully referred and linked to an ACBH mental health treatment program (i.e. client has been seen at least once in person by a treatment provider): <100

d. Average duration in weeks of signs of untreated mental illness (per client self-report): Average 24-48 weeks

e. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with a mental health treatment provider: We do not do direct referrals.

f. Any additional information to report on? (optional): Click here to enter text.

**REQUIRED STRATEGY: IMPROVE TIMELY ACCESS TO MENTAL HEALTH SERVICES FOR UNDERSERVED POPULATIONS**

a. Who is/are the underserved target population/s your program is serving (e.g. TAY, Southeast Asian, etc.)? TAY, Middle Eastern, African American TAY

b. Number of separate paper referrals to an ACBH PEI-funded program. (This can be a provider's internal ACBH PEI-funded prevention or early intervention program OR an external PEI-funded ACBH prevention or early intervention program): 90% of our client's loved ones are given referrals to ACBH and/or CBOs within Alameda County.

c. Number of individuals followed through on referral & engaged in an ACBH PEI-funded program: More than 50% of our clients have followed through on our referrals and had their loved one attend a meeting or meet with a provider from the other program. The challenges we experience is when they do not "connect" with the other provider(s) and do not want to participate or be a part of their program. The client's loved one's report, "not wanting to tell their story again; having their case manager leave (turn-over rates are high)."

d. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with the ACBH PEI-funded provider. 2w-4w for ACCESS; no direct paper referrals from FERC.

e. Describe ways your program encouraged access to services and follow-through on the above referrals: At FERC, we do our best to practice warm hand-offs. We connect with the provider from the other programs and request a warm hand-off meeting or ask them to come to one of our family meetings. We offer to attend their first meeting with other providers to ensure linkage.

f. Any additional information to report on (optional): Click here to enter text.

**OUTREACH. THIS SECTION IS *REQUIRED ONLY* FOR OUTREACH PROGRAMS. OTHERWISE, IT IS OPTIONAL**

Number of potential responders: Click here to enter text.

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

| **Type of Setting(s)** (ex: school, place of worship, clinic) | **Type(s) of Potential Responders** (ex: principals, teachers, parents, nurses) |
|---|---|
| **Muslim Mosque, Tri-Valley** | Community members |
| **Oakland Police Dept.** | New academy recruits / future law enforcement officers |
| **Oakland Police Dept. CIT** | Crisis Intervention Training: law enforcement; Sgts, Housing |
| **Fremont Unified School** | Principal, teachers, parents, social workers, counselors; |
| **Tri-City Youth** | Counselors, parents, therapists |
| **Hopkins Junior High School** | Parents, teachers, principal |
| **Behavioral Health Court** | Judges, DA, case managers |
| **Veterans Affairs** | Social Workers |
| **Spectrum, Hayward** | Counselors, parents, teacher(s) |
| **Union City Family Center** | Parents, teachers, TAY, counselors |
| **CSUEB** | Graduate students in nursing; professors, nurse |
| **SFSU** | Graduate students, professor(s) |
| **Rotary Club, Berkeley** | Community members, business professionals |
| **Downtown Livermore** | Community members, parents, local business owners |
| **San Jose HS, Fremont** | Counselors, parents, teachers, principal |
| **Irvington HS, Fremont** | Parents, teachers, principal |
| **Oakland Housing Authority** | Providers, community members, housing reps |
| **UHURU House Health Fair** | Community members, health providers, |
| **Crisis Support Services Walk** | Community members, health providers, locals |
| **We Move for Health 10x10** | Community members, health providers, locals |
| **Senior Expo Health Fair** | Community members, health providers, locals |
| **4 C's Annual Kid's Health Fair** | Community members, health providers, locals |
| **27th Annual Livermore Fair** | Community members, health providers, locals |
| **Juneteenth Annual Fair** | Community members, health providers, locals |
| **Allen Temple Church Health Fair** | Community members, faith-based leaders, locals |
| **Paradise Baptist Church Health Fair** | Community members, faith-based leaders, locals |
| **Out of the Darkness Suicide Prevention Walk** | Community members, health providers, locals |
| **Livermore Farmers Market** | Community members, health providers, locals |

**NARRATIVE**

a. Choose two of the above principles and describe how your program upholds or achieves those principles. Please speak to each principle separately and specifically describe how your program activities align with that corresponding principle.

Principle #1: Community Collaboration: How does your program align with this principle? At FERC, we connect our clients and their loved ones through warm hand-off meetings. We offer to attend a first meeting or we arrange it within our own offices so our clients and their loved ones feel more comfortable. In addition to warm hand-offs, we work with other agencies to provide the level of support to the family caregivers that they themselves may not have capacity for. As these providers work with the consumers, we work with their support persons, family and caregivers. We connect families to other PEI programs, ACBH, and CBOs. We support clients through various stages of where they are at with their loved one. Often times, they are calling FERC because it is the first time their loved one is experiencing a mental health challenge or crisis. This is very new and terrifying for families who are experiencing this for the first time and do not understand the confidentiality laws and HIPAA. It can be the most frustrating experience trying to help their loved one and not having someone properly educate them in a patient manner on these patient privacy laws. Many times, providers assume that families and caregivers should know HIPAA and they can be very rude and disrespectful. We often have to start from the beginning and educate families on patient privacy, confidentiality and what a Release of Information is in addition to the crisis they are enduring.

Principle #2: Client, Consumer, and Family Involvement . How does your program align with this principle? FERC is a family caregiver centered program. We work with everyone in the family, including the consumer – AKA loved ones. We believe in strengthening the family unit by including all members to have an equal voice and work towards shared goals. W provide resources and linkages to referrals for the loved ones while providing education and support to their family caregivers.

b. Please tell us about the following…

Implementation Challenges: It is still difficult to link clients to treatment services since we cannot do direct internal referrals. Sometimes providers do not return our calls and it is frustrating when we simply want to know general information – not private information regarding the clients, but they prevent us due to HIPAA and Confidentiality. They use this to shield communication and this ONLY hurts our consumer clients. Another challenge is when providers from the other agencies do not follow through with what they are supposed to do with / for the client. Often times, Family Advocates at FERC feel like we are case managers who are continuously trying to get a hold of their case manager from another program.

Successes: When providers see the benefits of working with a Family Advocate from FERC and then they start to refer their colleagues to connect with a FA; when we receive referrals from law enforcement who have given our brochure to families during a 5150 call; when consumers tell us that their relationship with their family has improved since their involvement with FERC; helping families understand mental illness, that their loved one is not doing “anything wrong” or “on purpose.”

i. Lessons Learned: Click here to enter text.

ı. Relevant Examples of Success/Impact (e.g. a client success story) Reminder: Please do not use real client names: Family success story: Family was connected to FERC b/c their son was admitted to John George; he has a diagnosis of schizophrenia, anxiety, PTSD, depression and substance use. FERC was able to educate the parents on mental illness, print fact sheets in their native language (Korean), regularly meet with the parents and talk about communication between them and their son, FERC met with their son, advocated for case management, got into Level 1 care, but eventually the son got frustrated with the service team b/c of their high turn-over rate in case management; but still continued to work with FERC, got clean and sober, eventually was accepted into the ACBH – ACAPS program via letter recommendation from FERC, client completed an accelerated peer certification program, has completed WRAP training, and FERC helped with supporting client while working at Sally’s Place (La Familia program)– while still supporting the parent’s needs. Consumer client is thriving at work and feeling like he is giving back to the mental health community. Parents cannot be happier; they get emotional talking about the past, calling it a nightmare. They cannot believe their son has a

**ADDITIONAL INFORMATION**

a. Please describe, in 1-2 sentences, your effort to collect feedback from program participants (method used). Please include the timeframes of when you survey clients. At FERC, we ask clients to complete a survey after we have met with them on average 2-3xs. We generally do not ask them to complete a survey after our first meeting, it wouldn't make sense. We provide an online option as well as: self-addressed and post marked back to FERC, or we ask them to fill it out and drop it inside a locked box located at each of our four office sites.

b. Describe the tool (i.e. MHSIP or another survey) used to collect data. We have a programmer who is currently working on this reporting aspect. Soon we will be able to enter in each survey and it will generate a report summary including comments.

c. Summarize the results if any. Majority of our client's satisfaction have reported "Highly Satisfied" and that they have experienced an improvement in their relationship with their loved one.

d. What was learned from the participant feedback (**1-2 key points**)?The challenges are with the "system" more than anything else. The barriers to receiving services are harder than the interactions with their loved ones. Another challenging area: resources. The LACK of available and appropriate resources. Not enough beds; early discharge; housing; unsafe shelters.

e. Describe how the findings were reviewed by staff. It is optional for clients to write their name and the name of their Family Advocate. However, 98% of the clients mention their FA name b/c they are pleased with their services. So, if they write an actual FA name, then a copy is given to the FA so they know how their work has impacted their client. If there is no name and something of concern in the comments and feedback, I have addressed it in a staff meeting for all to keep in mind and for us to discuss as a team.

f. What programmatic change(s) were or will be adopted as a result of the findings? When will changes be made and how will the changes impact programming? N/A

g. What issues or challenges with the Evaluation Plan are you having? What technical assistance do you need? The challenge is data entry for the reports. I do not have someone who has the time to input all of the data.

**MHSA Program #: PEI 20A**

**PROVIDER NAME**: **Beats, Rhymes and Life (BRL)**

**PROGRAM NAME: Culturally Responsive PEI Programs for the African American Community**

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

Program Outcomes & Impact: UELP Data Report FY18/19

**PERFORMANCE INDICATORS: How Much Did We Do?**

| **Total Numbers Served through PEI MHSA** | |
|---|---|
| Number of unduplicated individuals your program serves who are **at-risk** of developing a mental health problem or serious mental illness (SMI) | 4 |
| Number of unduplicated individuals your program serves who show **early signs** of forming a more severe mental illness | 0 |
| Number of unduplicated individual family members served indirectly by your program: | 56 |
| Grand TOTAL of unduplicated individuals served in the Quarter that you are reporting about. [This number (D) should = A+B+C.] | 60 |

**PERFORMANCE INDICATORS: How Well Did We Do?**
Demographics

**Age Group (Unduplicated)**

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

**Race (Please mark only one choice)**
*If Hispanic or Latino, choose "Another race not listed."*

| | |
|---|---|
| American Indian or Alaska Native | |
| Asian | |
| Black or African American | 48 |
| Native Hawaiian or other Pacific Islander | |
| White | 4 |
| More than one race | |
| Another race not listed | 12 |
| Unknown/ Declined to Answer | |

**Sexual Orientation (Please mark only one choice)**

| | |
|---|---|
| Gay or Lesbian | |
| Heterosexual or Straight | |
| Bisexual | |
| Questioning or unsure of sexual orientation | |
| Queer | 4 |
| Another sexual orientation not listed | |
| Unknown/Decline to Answer | |

**Ethnicity /Cultural Heritage (Please mark only once choice)**

| | |
|---|---|
| **If Hispanic or Latino, please specify:** | |
| Caribbean | |
| Central American | |
| Mexican/Mexican-- | 4 |
| Puerto Rican | 4 |
| South American | |
| Another Hispanic/Latino | |
| Unknown/Declined to Answer | |
| **If Non-Hispanic or Non-Latino, please specify:** | |
| African | |
| African American | 48 |
| Asian Indian/South Asian | |
| Cambodian | |
| Chinese | |
| Eastern European | |
| European | 4 |
| Filipino | |
| Japanese | |
| Korean | |
| Middle Eastern | |
| Vietnamese | |
| Other Non-Hispanic or Non- Latino ethnicity not listed | |
| **More than one ethnicity** | |
| **Unknown /Declined to Answer** | |

**Primary Language (Please mark only one choice)**

| | |
|---|---|
| English | 48 |
| Spanish | 12 |
| Farsi | |
| Cantonese | |
| Mandarin | |
| Other Chinese Dialects | |
| Vietnamese | |
| Korean | |
| Tagalog | |
| Other Filipino Dialect | |
| Japanese | |
| Laotian | |
| Cambodian | |
| Mien | |
| Hmong | |
| Samoan | |
| Thai | |
| Russian | |
| Polish | |
| German | |
| Italian | |
| Turkish | |
| Hebrew | |
| French | |
| Portuguese | |
| Armenian | |
| Arabic | |
| Sign ASL | |
| Other primary language not | |
| Unknown/ Decline to Answer | |

**Gender Identity (Please mark both parts A & B)**

| |
|---|
| A) Assigned sex at birth: (Please mark only one choice) |
| Male |
| Female |
| Other sex not listed (e.g. Intersex) |
| Unknown/Decline to Answer |
| B) Current Gender Identity: (Please mark only one choice) |
| Male |
| Female |
| Transgender |
| Genderqueer |
| Questioning or Unsure of Gender Identity |
| Another Gender Identity not listed |
| Unknown/Decline to Answer |

**Disability Status** (Please mark all that apply)

| |
|---|
| None |
| Yes. If yes, please specify (choose from list below): |
| Difficulty Seeing |
| Difficulty hearing, or having speech |
| Mental Domain |
| Physical/Mobility Domain |
| Chronic Health Condition |
| Another disability not listed |
| Unknown/Decline to Answer |

| **Veteran Status (Please mark only one choice)** | |
|---|---|
| Yes | |
| No | |
| Unknown/Decline to Answer | |

**REQUIRED STRATEGY: IMPROVE TIMELY ACCESS TO MENTAL HEALTH SERVICES FOR UNDERSERVED POPULATIONS**

a. Who is/are the underserved target population/s your program is serving (e.g. TAY, Southeast Asian, etc.)? African American Males

b. Number of separate paper referrals to an ACBH PEI-funded program. (This can be a provider's interna ACBH PEI-funded prevention or early intervention program OR an external PEI-funded ACBH preventio or early intervention program): none

c. Number of individuals followed through on referral & engaged in an ACBH PEI-funded program: n/a

d. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with the ACBH PEI-funded provider. Most of our clients go through an extensive interview/intake process. Most clients showed no sign of mental illness or had issues that were managed by our team which included a Case Manager and Social Worker

e. Describe ways your program encouraged access to services and follow-through on the above referrals: Our Outreach team travels to outreach events within Alameda to provide workshops, performances, and Mental Health panels to share best practices and available resources to families, educators and other mental health agencies.

f. Any additional information to report on (optional): none

**NARRATIVE**

a. Choose two of the above principles and describe how your program upholds or achieves those principles. Please speak to each principle separately and specifically describe how your program activities align with the corresponding principle.

Principle #1: Choose an item. How does your program align with Cultural Competence? Beats Rhymes & Life exemplifies a culturally competent agency. Our target population is African American; and a lot of African American youth listen to popular music. We centered our agency at the intersection of Hip Hop and therapy to meet the youth where they're most active. Hip-Hop aligns with our therapeutic interventions which include Self Psychology, Group work/Relational therapy, & Narrative Therapy. Hip-Hop was born in response to poverty in neighborhoods that were historically underserved as a medium of expression and engagement for community members. Our model was designed with a trauma informed relational psychodynamic social justice, youth development framework. Beats Rhymes & Life, since its inception has built its Mission, Vision, Values, and Program design to engage youth. Our mission is to cultivate culturally responsive services through community engagement and the therapeutic power of Hip-Hop that inspires youth to recognize their own capacity for healing and self-expression. BRL's vision is to utilize Hip-Hop Therapy for individual, community, and systemic change. Our Academy (peer- mentor development) model included 1:1 meetings with our social worker, and case-manager; in addition to cross training in hip hop artistry/Group work theory, resource class in which we bring in outside resources (focusing on ACBH contractors) to build with our youth based on needs reported to our case manager and Leadership class in which we use personal challenges to validate each other's experiences as well as collaborate on breaking toxic cycles.

Principle #2: Choose an item. How does your program align with Wellness and Recovery? We have a two-part interview/intake process in choosing candidates for entering BRL's peer mentorship workforce development academy. Interview process can be anywhere from 45mins to an hour and a half. We are very transparent about our agency's mission, theory of change, and program model. We let them know that it involves therapy and case management. We ask what their associations and experience are with therapists are and what works and/or doesn't work for them in those experiences. We share our model, ask for their feedback and confirm it's something they can work with.

Critical feedback from youth in regards to systems youth encounter is that they don't reflect all relevant needs of youth, they're met with demands and intrusive questions with little to no collaboration, and there is little to no engagement and genuine attempts to build connection with them. We work earnestly to develop curriculum that is relevant to their needs and solicit feedback to what could help more. We do this until they realize that their feedback is leading the learning experiences they are having. In our clinical sessions and our case management 1:1's youth set all the goals. In the last six months of the program we enter into envisioning where they want to be even if they're not hired by our agency at that time. So, if the goal is to have a better relationship with a family member, to find an affordable place to stay, to enter or re-enter school, have more friends they can trust, resolve a child custody dispute, or get their driver's license, we support them in achieving those goals.

b. Please tell us about the following…

i. Implementation Challenges: That by the time the two-year program is almost over we are just gaining

participants trust and they're just beginning to scratch the surface of their cycles of trauma.

ii. Successes: We are hiring three members of the 15-member cohort to hold part time jobs with our organization and entering the next two-year training in working in this industry.

iii. Lessons Learned: Introduce them to referral sources earlier and get those services to be part of our community in professional and personal ways earlier; to prevent them to being referred to a stranger later.

iv. Relevant Examples of Success/Impact (e.g. a client success story) Reminder: Please do not use real client names: Female enters the final year of the program looking for support with housing, employment, and depression due to loss of a family matriarch. TAY entered with aspiration of making music as it is both a validating experience to perform her original music and a therapeutic release. She got to collaborate on two albums with us and make her own solo album. She performed at two of our showcases to much success and applause. Our case manager helped her strategize and prepped her in gaining a housing and full-time employment as a security guard at Google. Her clinician helped her unravel a lot of her prior family trauma and false narratives of herself. She also started a meditation practice which continues to aid and ease negative thoughts and anxiety.

Optional: Do you give permission to BHCS to use this success story in a public forum (i.e. MHSA website, BHCS meeting)? ☐Yes ☐No

**ADDITIONAL INFORMATION**

Please include the number of clients and/or contacts you estimate to serve in:

FY 19/20: 20/45
FY 20/21: 20/45

Please tell us about any changes you intend to make to your program over the next two fiscal years and explain your rationale for making these changes: We plan to transition the Academy Workforce Preparation model to a more prevention model with the goal of reaching 80 unduplicated youth over the next two years.

**MHSA Program #: PEI 20D**

**PROVIDER NAME: Restorative Justice for Oakland Youth (RJOY)**

**PROGRAM NAME: Culturally Responsive PEI Programs for the African American Community**

**Program Description**: Restorative Justice for Oakland Youth (RJOY) that provides empowerment and healing circles incorporating Afrocentric and indigenous restorative justice-based practices for adults and youth in community and school settings.

Program Outcomes & Impact: UELP Data Report FY18/19

**PERFORMANCE INDICATORS: How Much Did We Do?**

| **Total Numbers Served through PEI MHSA** | | Total, 3rd Quarter | Total, 3rd and 4th Quarter | Survey Results |
|---|---|---|---|---|
| Number of unduplicated individuals your program serves who are **at-risk** [1]of developing a mental health problem or serious mental illness (SMI)[2] | **A** | 344 | 344+240=584 | 49 |
| Number of unduplicated individuals your program serves who show **early signs** of forming a more severe mental illness | **B** | 0 | 0 | 0 |
| Number of unduplicated individual family members[3] served indirectly by your program: | **C** | 0 | 0 | 0 |
| Grand TOTAL of unduplicated individuals served in the Quarter that you are reporting about. [This number (D) should = A+B+C.] | **D** | 344 | 344+240=584 | 49 |

**PERFORMANCE INDICATORS: How Well Did We Do?**

Demographics

| **Age Group (Unduplicated)** | 3rd Quarter | Total 3rd and 4th Quarter | Survey Results |
|---|---|---|---|
| Children/Youth (0--15) | 88 | 88 + 29=117 | 6 (12.2%) |
| Transition Age Youth (16--25) | 65 | 65 +112=177 | 23 (46.9%) |
| Adult (26--59) | 184 | 184+34= 218 | 7 (14.2%) |
| Older Adult (60+) | 7 | 7+19= 26 | 4 (8.1%) |
| Unknown/ Declined to Answer | 0 | 0+46 = 46 | 9 (18.3%) |
| Total | 344 | 344+240=584 | 49 |

| **Primary Language (Please mark only one choice)** | 3rd Quarter | Total, 3rd and 4th Quarter | Survey Results |
|---|---|---|---|
| English | 294 | 294+186= 440 | 38 (77.5%) |
| Spanish | 50 | 50+34= 84 | 7 (14.2%) |
| Farsi | 0 | 0+5=5 | 1 (2%) |
| Cantonese | 0 | 0 | 0 |
| Mandarin | 0 | 0 | 0 |
| Other Chinese Dialects | 0 | 0 | 0 |
| Vietnamese | 0 | 0 | 0 |
| Korean | 0 | 0 | 0 |
| Tagalog | 0 | 0 | 0 |
| Other Filipino Dialect | 0 | 0 | 0 |
| Japanese | 0 | 0 | 0 |
| Laotian | 0 | 0+5=5 | 1 (2%) |
| Cambodian | 0 | 0 | 0 |
| Mien | 0 | 0 | 0 |
| Hmong | 0 | 0 | 0 |
| Samoan | 0 | 0 | 0 |
| Thai | 0 | 0 | 0 |
| Russian | 0 | 0 | 0 |
| Polish | 0 | 0 | 0 |
| German | 0 | 0 | 0 |
| Italian | 0 | 0+5=5 | 1 (2%) |
| Turkish | 0 | 0 | 0 |
| Hebrew | 0 | 0 | 0 |
| French | 0 | 0 | 0 |
| Portuguese | 0 | 0 | 0 |
| Armenian | 0 | 0 | 0 |
| Arabic | 0 | 0+5=5 | 1 (2%) |
| Sign ASL | 0 | 0 | 0 |

| | | | |
|---|---|---|---|
| Other primary language not listed | 0 | 0+5=5 | 1 (2%) |
| Total: | 344 | 344+240=584 | 49 |

**Gender Identity (Please mark both parts A & B)**

| A) Assigned sex at birth: (Please mark only one choice) | 3rd Quarter | Total, 3rd and 4th Quarter | Survey Results |
|---|---|---|---|
| Male | 201 | 201+152=353 | 30 (63%) |
| Female | 143 | 143+74=217 | 15 (31%) |
| Other sex not listed (e.g. Intersex) | 0 | 0 | 0 |
| Unknown/Decline to Answer | 0 | 0+14= 14 | 3 (6%) |
| B) Current Gender Identity: (Please mark only one choice) | | | |
| Male | 199 | 199+147=346 | 30 (61.2%) |
| Female | 141 | 141+73= 214 | 15 (31%) |
| Transgender | 0 | 0 | 0 |
| Genderqueer | 4 | 4+3=7 | 1 (1.1%) |
| Questioning/Unsure of Gender Identity | 0 | 0 | 0 |
| Unknown/Declined to answer | 0 | 0+14=14 | 3 (6%) |
| Total | 344 | 344+240=584 | 49 |

| **Sexual Orientation (Please mark only one choice)** | 3rd Quarter | Total, 3rd and 4th Quarter | Survey Results |
|---|---|---|---|
| Gay or Lesbian | 8 | 8+10= 18 | 2 (4%) |
| Heterosexual or Straight | 0 | 0+170=170 | 35 (71%) |
| Bisexual | 0 | 0+10=10 | 2 (4%) |
| Questioning or unsure of sexual orientation | 0 | 0 | 0 |
| Queer | 0 | 0+5= 5 | 1 (2%) |

| | | | |
|---|---|---|---|
| Another sexual orientation not listed | 0 | 0+10= 10 | 2 (4%) |
| Unknown/Decline to Answer | 336 | 0+34= 34 | 7 (14%) |
| Total | 344 | 344+240=584 | 49 |

| **Disability Status** (Please mark all that apply) | 3rd Quarter | Total, 3rd and 4th Quarter | Survey Results |
|---|---|---|---|
| None | 0 | 0+196=196 | 40 (81.6%) |
| Yes. If yes, please specify (choose from list below): | 0 | 0+44=44 | 9 (18.3%) |
| Difficulty Seeing | 0 | 0+4=4 | 1 (2%) |
| Difficulty hearing, or having speech understood | 0 | 0 | 0 |
| Mental Domain | 0 | 0+20=20 | 4 (8.2%) |
| Physical/Mobility Domain | 0 | 0 | 0 |
| Chronic Health Condition | 0 | 0 | 0 |
| Another disability not listed (LD): | 0 | 0+20=20 | 4 (8.2%) |
| Unknown/Decline to Answer | 344 | 344+0=344 | 0 |
| Total | 344 | 344+240=58 | 49 |

| **Veteran Status (Please mark only one choice)** | 3rd Quarter | Total (3rd + 4th qtr) | Survey Results |
|---|---|---|---|
| Yes | 0 | 34 | 7 (14.2%) |
| No | 0 | 191 | 39 (79.5%) |
| Unknown/Decline to Answer | 344 | 0+15=15 | 3 (6.1%) |
| Total | 344 | 584 | 49 |

**REQUIRED STRATEGY: INCREASE ACCESS AND LINKAGE TO MENTAL HEALTH TREATMENT**

a. Number of individuals with serious mental illness (SMI) who received a paper referral (i.e. referrals via phone do not apply) from your program to an ACBH mental health treatment program: During the period between January 1 and July 31, 2019 ("Quarters 3 and 4) 9 individuals received a paper referral to a mental health treatment program.

b. List type(s) of mental health treatment programs the individual was referred to: Conscious Voices; Serenity House; Genesis; ROOTS

c. Number of individuals who were successfully referred and linked to an ACBH mental health treatment program (i.e. client has been seen at least once in person by a treatment provider): 9

d. Average duration in weeks of signs of untreated mental illness (per client self-report) 1 week

e. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with a mental health treatment provider: 1-2 weeks

f. Any additional information to report on? (Optional): We are in the process of identifying and expanding our list of ACBH mental health treatment programs and services, making direct contact with other service providers that provide different and more intensive treatment services for community members with more complex mental health challenges. We are also reevaluating and revising our referral process, based on our experience in the first 6 months of the Project.

**REQUIRED STRATEGY: IMPROVE TIMELY ACCESS TO MENTAL HEALTH SERVICES FOR UNDERSERVED POPULATIONS**

a. Who is/are the underserved target population/s your program is serving (e.g. TAY, Southeast Asian, etc.)? RJOY is serving African Americans in Alameda County who are in need of access to culturally sensitive and responsive mental health healing services, including Black Men, Women & Girls, elders, young people (11-17 years), young men and women in Juvenile Hall and Camp Sweeney (15-21 years), Community Mental Health Workers, and queer people of color.

b. Number of separate paper referrals to an ACBH PEI-funded program. (This can be a provider's internal ACBH PEI-funded prevention or early intervention program OR an external PEI-funded ACBH prevention or early intervention program): 459 individuals received referrals to Africentric Healing Circles during the first two quarters of RJOY's AA Healing Circles Project.

c. Number of individuals followed through on referral & engaged in an ACBH PEI-funded program: 484 unduplicated individuals (participants) and an additional 100 relatives, family members, parents, teachers, and community members

d. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with the ACBH PEI-funded provider. One week

e. Describe ways your program encouraged access to services and follow-through on the above referrals: RJOY engages individuals in the Alameda County community and youth in juvenile detention through an intensive process of outreach, engagement and follow-through. We have ongoing contact with our Circle participants, often doing follow up and outreach between Healing Circles. We encourage our Healing Circle participants to participate in other RJOY activities and events

f. Any additional information to report on (optional): RJOY exceeded the goals and objectives identified in our grant proposal by reaching 584 unduplicated individuals through 12 Africentric Healing Circles (271 participants), 2 additional Racial Healing Circles (188), 1 Community Celebration (35), one Community Healing event (60), and two RJ Trainings (30). We held 141 separate Africentric Community Healing Circles, which represents 1690 "duplicated" participants. We are on track to more than double our original projection of 450 unduplicated participants. Three of our Circles have already completed 21 individual Circles in the first two quarters of the grant.

RJOY Africentric Healing Circles Project 2019 Annual Report

| Type of Circle/Event | # of Circles/ Events | Participants (unduplicated) | Participants (Duplicated) | Average number of Participants |
|---|---|---|---|---|
| Black Male Circle | 21 | 50 | 183 | 8.7 |
| Sisters Rising | 12 | 27 | 77 | 6.4 |
| QPOC | 7 | 16 | 30 | 4.2 |
| Peer Circle (Rockridge) | 15 | 35 | 48 | 12 |
| Peer Circle (Cesar Chavez) | 15 | 37 | 85 | 5.6 |
| Camp Sweeney | 6 | 7 | 33 | 5.5 |
| Community MH Workers | 12 | 9 | 61 | 5.1 |
| Elders | 7 | 12 | 23 | 3.2 |
| Uplift (Juvenile Girls) | 7 | 18 | 37 | 5.2 |
| Juvenile Hall (Boys) (#1 Circle) | 21 | 21 | 252 | 12 |
| Juvenile Hall (Boys) (#2 Circle) | 21 | 21 | 252 | 12 |
| Black Men/Black Women | 3 | 12 | 20 | 6.6 |
| SPES Racial Healing Circles | 12 | 180 | 320 | 180 |
| BHCS AA Healing Circle | 1 | 8 | 8 | 8 |
| AA Healing Trainings | 2 | 15 | 30 | 15 |
| AA Healing Celebration | 1 | 35 | 35 | 35 |
| AA Community Healing Event | 1 | 60 | 60 | 60 |
| **TOTAL** | 164 | 584 | 1,815 | |

**Africentric Healing Circles:**

1. Black Male Circle: BMC is a space for Men of Color ages 15+ to heal, share, community build, navigate conflict, celebrate, collaborate, and engage in dialogue centering issues relative to the masculine POC experience. Circles are held in the RJOY office every Thursday 6pm-8pm.
2. Sisters Rising Circle is an intergenerational space for women and girls to engage in healing, the arts, movement, dialogue and expression, centering issues affecting POC femmes, especially voices across the African Diaspora.
3. QPOC Circle: Queer People of Color Circles (QPOC) is an intentional space centering queer bay area people of color to meet, community build, network, support, learn, share and heal utilizing the practice of Restorative Justice. This weekly space is made for folks of color who identify as LGBTQIA+ and allies for the sake of deeper and more nuanced conversation as it applies to our beloved community.
4. #1 Peer Circle (Rockridge Library) Peer Circles for youth is a space for ages 11+ held at the Oakland Public Library's Rockridge and Cesar E. Branches. Here, youth learn about restorative justice in circle where we use tools like Hip Hop, development of leadership skills, deep sharing, awareness, emotional intelligence, interactive activities, and a whole lot of joy and laughter. The Rockridge Library Peer Circle met for a period of 15 weeks, and, due to summer recess, the Rockridge Peer Circle is currently on hiatus, but will resume once the school year starts.
5. #2 Peer Circle (Cesar Chavez Library) (see above) At Cesar E. Branches we hold Circles currently every 1st & 3rd Friday 4pm-5pm, and are continuing to hold these Circles during the summer months.
6. #1 Juvenile Hall (Boys Circle): RJOY conducts healing Circles on a weekly basis at the Juvenile Hall (2 Circles for Boys and one for Girls) in which young people in detention learn about and practice restorative justice, making deep connections with the circle keepers and developing strong and effective strategies to deal with past trauma, accountability, and individual, family and community healing
7. #2 Juvenile Hall Boys Circle (see above)

8. Juvenile Hall (Girls Circle), now called Uplift, is a Circle for young women in Alameda County Juvenile Hall which focuses on healing and transformation for girls dealing with the trauma of incarceration, as well as life issues affecting young women in custody.
9. Camp Sweeney (Boys Circle) is a weekly circle for young men in detention at the Juvenile detention camp, addressing a variety of important life issues and giving the participants a chance to find healing and transformation. RJOY conducted 6 Healing Circles with Camp Sweeney youth, and Circles are no on hold while RJOY re-negotiates our programs with correctional staff.
10. Community Mental Health Worker Circles with African American women (many formerly incarcerated and in recovery) working in community mental health, with staff from Conscious Voices and RJOY.
11. Elder's Circle: Elder's Circle is a weekly gathering for community members to share wisdom in a restorative space. Elder's Circles are an embodied experience that can feature anything from deep breathing and music to movement and the infusion of African Spirituality through ritual.
12. The Black Men and Women's Circle is an outgrowth of the Black Male Circle, and came together specifically to address the complex and important relationships between Black Men and Women, and areas of deep healing and communication.

**Racial Justice Community Healing Circles:**

1. SPES Racial Healing Circles: RJOY conducted a series of Healing Circles for 180 8$^{th}$ grade students, teachers, administrators and parents at St. Paul's Episcopal School in Oakland, California after a racially harmful incident. Twelve Circles were conducted in total, 6 with all 8$^{th}$ graders and 6 with parents and teachers.
2. BHCS African American Women's Circle: A one-time Circle with 8 participants

**Africentric Healing Circles Curriculum Development**

RJOY is developing individual curricula for each of the Africentric Healing Circles.

**Africentric Healing Circles Celebrations**:

First Community Celebration: The first Africentric Healing Circles Celebration took place on April 11, 2019 at the Metropolitan Golf Links Center. We welcomed 35 participants who joined us for a delicious dinner and a wonderful presentation by Luisah Teish, a storyteller-writer, artist-activist and spiritual guidance counselor. She is an initiated elder (Iyanifa) in the Ifa/Orisha tradition of the West African Diaspora. Luisah led the participants in ritual, celebration, dancing and song. The second Africentric Healing Circles Community Celebration is scheduled for September 26, 2019, and will include participants from the Africentric Healing Circles as well as many community members and restorative justice practitioners. We also plan to have a 3$^{rd}$ Africentric Community Celebration in December, 2019.

**RJ Empowerment/ Healing Trainings:**

RJOY conducted one Tier One and one Tier Two Training during the first six months of the grant period. The Tier One training involved 15 community members, and the Tier Two training involved 15 community members. In addition, our community partners, Conscious Voices and Hip Hop Heals, conducted two trainings for RJOY staff, volunteers and interns. We are planning an upcoming training opportunity: free Community Restorative Justice Healing Trainings August 10 and 17, 2019.

**OUTREACH. THIS SECTION IS *REQUIRED ONLY* FOR OUTREACH PROGRAMS. OTHERWISE, IT IS OPTIONAL**

Number of potential responders: Click here to enter text.

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

| **Type of Setting(s)** (ex: school, place of worship, clinic) | **Type(s) of Potential Responders** (ex: principals, teachers, parents, nurses) |
|---|---|
| **Genesis Project and Recovery program (non-profit)** | Non-profit community staff and participants of the program |
| **St. Columba Church, Oakland (place of worship)** | Diverse community (racially and economically) |
| **North Oakland Restorative Justice** (non-profit) | Community members, including people who are formerly incarcerated, family members of people in prison, parents and students, elders and youth |
| **Restorative Justice Council (non-profit)** | Network of non-profit staff and volunteers from restorative and transformative justice programs; teachers, students, community members |
| **RJ in Schools Learning Community (schools)** | Teachers, administrators, parents, student leaders |
| **National Association of Community and Restorative Justice Conference** | Non-profit community and staff working in restorative justice, community healing and peace building |

**NARRATIVE**

a. Choose two of the above principles and describe how your program upholds or achieves those principles. Please speak to each principle separately and specifically describe how your program activities align with that corresponding principle.

**3rd Quarter:**

**Principle #1: Cultural Competence:** How does your program align with this principle? RJOY is deeply committed to provide healing services to people in our community who have, historically, been underserved by traditional mental health and health services, particularly to African American community members and other community members of color. All our programs and services emphasize authentic and deep indigenous healing practices and values, and we continue to incorporate these values and customs in all of the work that we do. We believe that, by embracing and emphasizing indigenously-rooted restorative justice healing practices in our Africentric Healing Circles, we are providing an effective and essential pathway to mental health and healing for many of our community members who have felt disconnected and alienated from traditional mental health services.

**Principle #2: Wellness and Recovery**: How does your program align with this principle? RJOY emphasizes the importance of recovery, healing and resilience by engaging our participants in every aspect of the healing process. Participants meet in circle, sharing a deep process of accountability, shared values, radical honesty, and self-care. Circle participants receive support and also give support to fellow circle members, learning restorative justice values and practices that transform the ways in which they resolve conflict and challenges in their own lives, in their families and in the community at large. Through this intensive process, our participants move toward more positive and fulfilling lives, strengthening their relationships with their families, friends and loved ones, developing stronger coping mechanisms, dealing more effectively with stressors in their lives, and learning concrete tools for health and healing.

**4th Quarter:**

**Principle #3: Community Collaboration**: RJOY has extensive relationships with community members and non-profit organizations working to promote community healing and transformation through a variety of methods. Our Africentric Healing Circles Project has enabled us to expand our networks and collaborations even further.

We have recently been awarded a grant from Oakland Unite through their Community Healing strategy, and are excited about the prospect of doing more intentional collaboration with our four other community partners (UPM, CURYJ, ROOTS and BOSS.)

We work closely with Community Works, Restore Oakland, Impact Justice, the Ahimsa Project, and other community-based non-profits doing community restorative justice. We work with an extensive network of teachers, administrators, students and parents through our RJ in Schools Project, and have been able to recruit additional participants for our Africentric Healing Circles through all of these collaborations.

**Principle #4: Client, Consumer and Family Involvement:** RJOY centers our work and our philosophy around the full involvement of, and agency of, African American community members in the process of healing and transformation. We believe that "hurt people hurt people, and healed people heal people." We involve family members and community advocates in our Healing Circle work with our young people at Juvenile Hall and Camp Sweeney, and feel that family support and involvement is critical for successful transition back into the community for our participants involved in the criminal legal system. Recently, through the leadership of one of our staff members who is formerly incarcerated, we have started developing a process of "Family Repair Beyond the Bars," where people who have served time in prison and jail come together with family members for intentional conversations and around healing relationships. We do not use the terms "client" and "consumer" and prefer the term "participant" because it implies a sense of agency and involvement in both individual and community healing for our African American community members.

b. Please tell us about the following…

i. **Implementation Challenges**: The work that we did in the first two quarters of the grant period has resulted in considerable growth and development of all of our Africentric Healing Circles. During the past six months, we have spent considerable effort in recruitment and outreach for all of the Circles. A few of the Circles presented challenges in the recruitment process (QPOC, Sisters Rising, Elders Circle) and we re-doubled our efforts in the second quarter of the grant to recruit and draw in participants for these Circles. We understand that for each of the Circles, the recruitment process must be consistent and intensive because we are dealing with a system of health and mental health care that has often failed our participants. Participants have rarely had therapeutic experiences that have been welcoming and culturally appropriate, and have often been further traumatized by these experiences rather than receiving the help and support that they need and deserve. From April 1 to July 31, 2019, we increased our total participant numbers to 359 unduplicated participants reached in a total of 12 Africentric Healing Circles, and 2 additional Racial Healing Circle processes.

ii. **Successes**: We have experienced many extraordinary successes in the first two quarters of the grant year. Overall, we served at total of 584 unduplicated individuals: 271 unduplicated participants in 12 Africentric Healing Circles and 188 unduplicated participants (through a school-based Community Healing Circles process that focuses on Racial and Community Healing and a one-time African American Women's Healing Circle) and 125 additional community members through our Africentric Healing Celebration, Community Healing event and RJ Trainings. Our Black Men's Circle continues to be our model Circle, with significant and enthusiastic participation from African American men who represent a range of experiences, ages and life challenges. The Black Men's Circle even seeded a new Circle for Black Men and Black Women who are engaging in deep dialogue with each other. Our Peer Circles for young people of color between the ages of 11-17 are done at two Oakland Libraries (Cesar Chavez and Rockridge Libraries), which has created a wonderful support structure for our young participants. The Rockridge Circle is currently on hiatus during the summer, but the Cesar Chavez Circle has continued throughout the summer. Our partnership with Conscious Voices is flourishing, and has led to a Circle for Community Mental Health Workers, primarily formerly incarcerated African American women learning to be community mental health workers. Our Circles in Juvenile Hall (2 for Boys, one for girls) remain strong, offering real opportunities for healing and transformation to some of our most vulnerable youth. Our Circle for Boys at Camp Sweeney is experiencing some challenges as we negotiate our ongoing relationship with correctional staff at that facility.

Finally, our QPOC and Sisters Rising Circles have developed strong and committed constituencies, and are growing in numbers. Our Elders Circle is fully launched and has already held 7 Circles.

iii. **Lessons Learned**: During the first two quarters of the grant, we have strengthened our recruitment and outreach processes, supported and expanded our Circle structures, and developed and improved our curricula for each of the Africentric Healing Circles.

We have significantly developed our evaluation process, creating a survey instrument that has been distributed to and completed by 49 of our Africentric Healing Circle participants, and has laid the foundation for a comprehensive evaluation process.

iv. **Relevant Examples of Success/Impact** (e.g. a client success story) Reminder: Please do not use real client names:

**4th Quarter:**

**Quotations from Africentric Healing Circle Participants:**

Through our survey instrument, we have collected a number of comments and quotes from Circle participants:

1. RJOY is extremely helpful in managing my mental and spiritual health. The facilitators are kind, honest, and powerful. Each circle has lived up to its name leaving me more joyful and more at peace. Bijon especially organically creates circles of accountability, solace, and laughter. Thank you for supporting this program. - QPOC Circle
2. Important work is done in these circles. I would be interested in similar circles being available in the Spanish-Speaking community. (I think there is a great need, especially in immigrant communities.) - Elders Circle
3. Amazing space to build community among women that look like me. - Sisters Rising
4. Enlightening - Sister's Rising
5. I feel good leaving the circle! - Sister's Rising
6. God Bless - Juvenile Hall Boys
7. I appreciate you guys! <3 - Juvenile Hall Boys
8. Good Job. Grateful for the lessons - Juvenile Hall Boys
9. It's very cool and fresh, of no disrespect - Peer Circle Cesar Chavez

**3rd Quarter:**

**QPOC Circle**: Our QPOC Queer People of Color Circles have been a safe space enabling Bay Area youth, young adults and adults to meet, build community, network, support, learn and heal using the guiding principles of restorative justice to tackle topics like “Growing Up Gay & Black” “Queering Gender” or “Unapologetic Authenticity.” This weekly space is intentionally tailored to speak to the experiences of Queer-identifying folks of color and their allies for the sake of deeper and more nuanced conversation as it applies to our beloved bay area queer community. A recent example of the effectiveness of the QPOC Circle process comes from a young, Black, lesbian couple who found that the Circle could provide them with a safe and grounding space after finding that their relationship had been tested in other spaces (clubs, bars, etc.) They found that although these social spaces offered a good time, they also led to conflict, both between one another and with others.

While in Circle, the two shared deeply about their experiences as a couple and as individuals, trying to walk the tight rope at the intersection of the queerness, Black womanhood and unique complexities as human beings. They both talked about their own experiences with mental health and anxiety. We delved into the complexities of social media culture and its effect on our social lives. This particular Circle concluded with a “write and manifest” ritual that stressed the importance of physically writing your barriers to success and identifying specific life goals.

**Peer Circle (Rockridge Branch):** Peer Circles at the Rockridge Branch of the Oakland Public Library are an opportunity for youth to connect with one another on a regular basis, learn about restorative justice and acquire life skills for their mental, emotional and spiritual health, growth, and development. In this space, youth go deep in sharing their life experiences as well as participating in exercises and activities that model restorative justice, agency and accountability. There is also always a lot of food and a lot of fun. This group primarily serves youth of color who are Latinx or African-American middle school to high school aged. They come for the gift card incentives and end up leaving with so much more.

During one Circle, participants discussed Mental Health and Support: what support looks like, how to identify a need for it and where to meet the needs you've assessed. We filled out a "pod" worksheet identifying personal circles of support, institutional resources, and community resources that are always available.

This informed youth about access, resources, and agency in when and where to make use of them. They also had the opportunity to talk about what support does or does not look like in their life and how to build or maintain strong networks.

**Camp Sweeney Community Restor-ganizing Circle** (with young African American men in juvenile detention): examines the relationship between the personal and the political. Through the use of theatre, hip hop, and other methods, youth explore the master narratives told about who they are and dream about who they want to become. During one Circle, which focused on Race and Police terrorism, we began with the song/video entitled Treat Me (Caucasian). The end of the video shows a series of video images that can be triggering. The images are of Black men and boys who have been brutalized by the police. The Circle participants were able to name many of the young men and boys, but they were also overwhelmed by the names they didn't know and the names and stories they mistook for the other. Tension rose in the room and the Circle Keeper stepped back, realizing that this was a moment of dreaming, then she asked a few specific questions. In their frustration and heaviness, participants were looking to the Circle Keeper for answers, but she urged participants to answer the questions themselves: *Will racism ever end? Why don't Africans like Black people? Why didn't the officer (who killed the young man) get convicted?* The Circles always end with the need for more time, more silence, more.

**The Sisters Rising Circle** has begun to explore our personal and collective relationships with racial identity, health, equity and healing. During one of the circles we opened with a song and a check-in question that related to the song. One of the participants started tearing up and mentioned that she always wanted to become a singer. She then began to share parts of her life story including going through the foster-care system and that now she is in a place in her life to reclaim love and power through her voice. We talked about how so many of us women of color are socialized to silence our truth and that manifests as illness in our bodies. We chose another song that was meaningful to that particular participant and she sang it while the RJOY Circle Keeper played guitar. The circle brought up a lot of past grief so we then closed the circle with a water cleansing and checked out with things we will like to call into our lives.

**ADDITIONAL INFORMATION**

Please include the number of clients and/or contacts you estimate to serve in:

FY 19/20:
From January-July, 2019, RJOY reached 584 (unduplicated) participants through 12 Africentric Healing Circles (166 individual AA Healing Circles), two Racial Justice Community Healing Circles, one Africentric Celebration, one Community Healing Celebration and one RJOY Training Process. (We served our 584 participants through 1815 duplicated participant experiences.)

Our participant figures are already significantly higher than our original projections in our BHCS Grant Proposal, in which we committed to reaching 450 unduplicated participants in the first year of the project.

We committed to conducting a total of 10 Africentric Healing Circles, and we are now conducting 12 ongoing Circles (and 2 special circle processes.) We are at 166 individual African American Healing Circles, and are on track to double the number of Circles by the end of the first grant year.

Based on these figures, we anticipate that we will reach a total of at least 750 (unduplicated) participants in the first year of the project by continuing to conduct at least 10 Africentric Healing Circles, hosting two additional Africentric Celebrations (one in September and one in December), and conducting a two-day Community Healing Training (August) and a two-day RJOY Tier 1/Tier 2 Training (September.)

FY 20/21:

We plan to continue to conduct our Africentric Healing Circles in 2020-2021 (a minimum of 10 separate Circles), as well as Africentric Healing Celebrations, RJ Trainings and Community Healing Circles, reaching a minimum of 450 additional unduplicated individuals in that grant year.

Please tell us about any changes you intend to make to your program over the next two fiscal years and explain your rationale for making these changes: Click here to enter text.

Over the next two fiscal years, we intend to expand and solidify our Africentric Healing Circles Program, bringing in additional Circle Keepers who have received RJ Training through our Training Program, and finalizing individual curricula for each of the Circles. We plan to refine and modify our evaluation process by 1.) Improving our survey instrument; 2.) Developing an "age appropriate" survey process for our younger participants; 3.) Continuing to have Circle participants complete surveys. With the assistance of graduate students from Sacramento State University and under the supervision of our Executive Director, Dr. Teiahsha Bankhead, we will analyze the survey data and plan to complete an evaluation report by the end of the three-year grant period which will provide valuable insight into the efficacy of the Africentric Healing Circles process. We will continue to develop our Ubuntu Healing Center (through separate funding sources) and will involve participants from our Africentric Healing Circles (particularly our young people coming out of juvenile detention) in this process, making the new Healing Center a source of healing and support for our most vulnerable participants.

[1] For purposes of this report, being "**at-risk**", can be widely defined your program/agency and can include various populations and groups such as TAY, being a person of color, single parent, immigrant, being over-stressed, former consumer/client, etc. Generally speaking any individual from the general public could be considered "at-risk" of developing some type of mental health issue.

[2] **Serious mental illness** per PEI regulations is defined as a mental illness that is severe in degree and persistent in duration, which may cause behavioral functioning which interferes substantially with the primary activities of daily living, and which may result in an inability to maintain stable adjustment and independent functioning without treatment, support, and rehabilitation for a long or indefinite period of time. These mental illnesses include, but are not limited to, schizophrenia, bipolar disorder, post-traumatic stress disorder, as well as major affective disorders or other severely disabling mental disorders.

[3] **Family Members** refer to family members (e.g. parents, grandparents, siblings, aunts, uncles) of the individual served by the PEI program that received some type of indirect services from your PEI funded program. For example, a parent of a child client who received information on how to follow up with a mental health treatment referral. Or a sibling who accompanied the individual to the service.

**MHSA Program #: PEI 20E**

**PROVIDER NAME: PEERS, Faith and Spirituality Based Program**

**PROGRAM NAME: Culturally Responsive PEI Programs for the African American Community**

**Program Description:** Brand, implement and market Alameda County Interfaith and Spirituality Based Mental Illness Stigma Reduction mini-campaigns, advisory board meetings, stigma reduction support groups, and educational presentations that are placed-based, culturally-congruent, and trauma- informed through the lens of African Americans.

Program Outcomes & Impact: UELP Data Report FY18/19

**PERFORMANCE INDICATORS: How Much Did We Do?**

| **Total Numbers Served through PEI MHSA** | |
|---|---|
| Number of unduplicated individuals your program serves who are **at-risk** of developing a mental health problem or serious mental illness (SMI) | 241 |
| Number of unduplicated individuals your program serves who show **early signs** of forming a more severe mental illness | |
| Number of unduplicated individual family members served indirectly by your program: | |
| Grand TOTAL of unduplicated individuals served in the Quarter that you are reporting about. [This number (D) should = A+B+C.] | 241 |

*Totals do not include email, outreach events, or community presentations/speaking engagements where people do not sign in

| **Type of Activity** (ex: accessed website) | **Number of Individuals Reached** (#) |
|---|---|
| Email blasts of ECC-related articles and updates | 2,495 subscribers |
| ECC Communications: Hard copy calendar updates | 8,000 est. reached |
| African American ECC focus groups and Action Team meetings | 29 |
| Special Messages groups | 49 |
| Spirituality groups | 30 |
| Lift Every Voice and Speak (LEVS) speaking engagements | 396 |
| Tabling/outreach events | 1,600 (approximately) |
| Community presentations | 219 |

**PERFORMANCE INDICATORS: How Well Did We Do?**

Demographics

**Age Group (Unduplicated)**

| | |
|---|---|
| Children/Youth (0---15) | |
| Transition Age Youth (16---25) | 21 |
| Adult (26---59) | 101 |
| Older Adult (60+) | 25 |
| Unknown/ Declined to Answer | 94 |

**Race (Please mark only one choice)**

*If Hispanic or Latino, choose "Another race not listed."*

| | |
|---|---|
| American Indian or Alaska Native | |
| Asian | 5 |
| Black or African American | 108 |
| Native Hawaiian or other Pacific Islander | |
| White | 40 |
| More than one race | 17 |
| Another race not listed | 30 |
| Unknown/ Declined to Answer | 41 |

**Sexual Orientation (Please mark only one choice)**

| | |
|---|---|
| Gay or Lesbian | |
| Heterosexual or Straight | 38 |
| Bisexual | 2 |
| Questioning or unsure of sexual orientation | |
| Queer | |
| Another sexual orientation not listed | 2 |
| Unknown/Decline to Answer | 19 |

**Ethnicity /Cultural Heritage (Please mark only once choice)**

| | |
|---|---|
| **If Hispanic or Latino, please specify:** | |
| Caribbean | |
| Central American | |
| Mexican/Mexican-- | 3 |
| Puerto Rican | |
| South American | |
| Another Hispanic/Latino | |
| Unknown/Declined to Answer | 17 |
| **If Non-Hispanic or Non-Latino, please specify:** | |
| African | 1 |
| African American | 108 |
| Asian Indian/South Asian | 1 |
| Cambodian | 0 |
| Chinese | 1 |
| Eastern European | 0 |
| European | 3 |
| Filipino | 3 |
| Japanese | 1 |
| Korean | 0 |
| Middle Eastern | 1 |
| Vietnamese | 0 |
| Other Non-Hispanic or Non- Latino ethnicity not listed | 3 |
| **More than one ethnicity** | 3 |
| **Unknown /Declined to Answer** | 89 |

**Primary Language (Please mark only one choice)**

| | |
|---|---|
| English | 58 |
| Spanish | 7 |
| Farsi | |
| Cantonese | 1 |
| Mandarin | |
| Other Chinese Dialects | |
| Vietnamese | |
| Korean | |
| Tagalog | |
| Other Filipino Dialect | |
| Japanese | |
| Laotian | |
| Cambodian | |
| Mien | |
| Hmong | |
| Samoan | |
| Thai | |
| Russian | |
| Polish | |
| German | |
| Italian | |
| Turkish | |
| Hebrew | |
| French | |
| Portuguese | |
| Armenian | |
| Arabic | |
| Sign ASL | |
| Other primary language not | 1 |
| Unknown/ Decline to Answer | 17 |

**Gender Identity (Please mark both parts A & B)**

| | |
|---|---|
| A) Assigned sex at birth: (Please mark only one | |
| Male | |
| Female | |
| Other sex not listed (e.g. Intersex) | |
| Unknown/Decline to Answer | 24 |
| B) Current Gender Identity: (Please mark only one choice) | |
| Male | 92 |
| Female | 10 |
| Transgender | |
| Genderqueer | |
| Questioning or Unsure of Gender Identity | |
| Another Gender Identity not listed | 1 |
| Unknown/Decline to Answer | 40 |

**Disability Status** (Please mark all that apply)

| | |
|---|---|
| None | 0 |
| Yes. If yes, please specify (choose from list below): | |
| Difficulty Seeing | |
| Difficulty hearing, or having speech | |
| Mental Domain | 19 |
| Physical/Mobility Domain | 9 |
| Chronic Health Condition | |
| Another disability not listed | |
| Unknown/Decline to Answer | 213 |

**Veteran Status (Please mark only one choice)**

| | |
|---|---|
| Yes | 4 |
| No | 56 |
| Unknown/Decline to Answer | 181 |

**REQUIRED STRATEGY: IMPROVE TIMELY ACCESS TO MENTAL HEALTH SERVICES FOR UNDERSERVED POPULATIONS**

a. Who is/are the underserved target population/s your program is serving (e.g. TAY, Southeast Asian, etc.)? Mental health consumers, primarily low-income people of color, including TAY and older adults.

b. Number of separate paper referrals to an ACBH PEI-funded program. (This can be a provider's internal ACBH PEI-funded prevention or early intervention program OR an external PEI-funded ACBH prevention or early intervention program): 1

c. Number of individuals followed through on referral & engaged in an ACBH PEI-funded program: 0

d. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with the ACBH PEI-funded provider. N/A The referrals were not for "appointments" per se. One participant, who has a TAY-aged child struggling with mental health challenges, was referred to Intensive Home Outreach Team (IHOT). Other referrals were to programs not funded by ACBH PEI, such as 2-1-1 for the Consolidated Entry System. For example, we provided one participant with referrals to BayLegal's Alameda County Tenants' Rights Hotline (and 2-1-1) for advice on negotiating with his landlord and he was able to avoid eviction.

e. Describe ways your program encouraged access to services and follow-through on the above referrals: Our primary method is to provide both information about participants' options and personal encouragement, since self-determination is a core principle of our program model.

**NARRATIVE**

a. Choose <u>two</u> of the above principles and describe how your program upholds or achieves those principles. Please speak to each principle separately and specifically describe how your program activities align with that corresponding principle.

Principle #1: Cultural Competence How does your program align with this principle? PEERS has provided culturally competent services with cultural humility for African Americans with mental health challenges for many years. One example of our practice of cultural competence is our African American Everyone Counts Campaign. FY18-19 was the planning year for this campaign, which builds on PEERS' Latino Everyone Counts Everyone Counts Campaign (FY16-17 and FY17-18) and Chinese American Everyone Counts Campaign (FY14-15 and FY15-16). The campaign is staffed and led by African Americans, all of whom have lived experience with mental health challenges. Some elements of African American culture that have been incorporated into the planning of the campaign include taking a trauma-informed approach, incorporating culturally-informed ritual into meetings and other gatherings, and making room for talking about religion and belief systems, as well as shared histories of oppression and current experiences of racism. The campaign is guided by an African American Action Team, composed of a diverse group of 16 African American community members with lived experience of mental health challenges. One of Action Team's charges this year was to identify a group with the power and influence to reduce stigma around mental health in the local African American community. The Action Team decided that people in the music and entertainment industries have that kind of influence. We are in the process of recruiting influential artists and media producers to the campaign, including Mistah Fab, So Oakland, and KPFA.

Principle #2: Wellness and Recovery How does your program align with this principle? All of the community outreach (both in-person and online) PEERS does through the Everyone Counts Campaign is strongly grounded in messages of wellness and recovery. From our "Love More, Judge Less" t-shirts, to our insistence on using non-stigmatizing recovery-based language instead of diagnostic or symptom-focused language, to the many ways that our staff act as living models of the possibility of wellness and recovery, PEERS aligns with this principle consistently. Our Lift Every Voice and Speak speakers' bureau (LEVS), promotes wellness and recovery by training people with lived experience of mental health challenges to tell their recovery stories, including how different forms of stigma have affected them. By telling their stories, LEVS speakers introduce wellness and recovery perspectives to audiences of other mental health consumers as well as to

community members who may not have similar experiences. The speakers' bureau enhances the wellness of LEVS speakers themselves by building supportive peer relationships, developing leadership, and improving their community by acting to reduce stigma.

b. Please tell us about the following…

i. Implementation Challenges: At the beginning of FY18-19, attendance at LEVS meetings was lower than we wanted, with an average attendance of eight participants during the first quarter. To increase engagement, we revamped the meetings and the speaker training curriculum. We incorporated more healing and wellness tools into the meetings, including art activities and small-group sharing. The program coordinator implemented a new system for supporting each speaker to move toward her or his own speaking goals. We also brought more structure to the speaker trainings, so that members were better able to support each other to improve their effectiveness as speakers. Additional training on the different forms of stigma related to mental health challenges (public stigma, structural stigma, and self-stigma) also deepened speakers' ability to link their personal stories to stigma reduction. On another note, at the end of FY17-18, we redesigned our spirituality program to emphasize facilitating groups at other places where people gather rather than at PEERS, because we were not satisfied with the level of attendance at our spirituality groups. To that end, we developed a new partnership with Allen Temple Arms, an affordable housing complex for low-income seniors and people with disabilities. Not only were the spirituality groups well received by the residents, but PEERS' partnership with Allen Temple Arms expanded beyond the spirituality program.

ii. Successes: The African American Everyone Counts Campaign has had some major successes in getting media coverage. In July, Bre Williams, PEERS' Programs Manager, was featured on an hour-long show on KPFA radio that explored questions including what it means to be mentally and emotionally healthy, why mental, emotional, and physical health often are understood as separate, how dominant cultural norms frame understanding of health and illness -- and more healthful and culturally relevant ways to understand mental health. In November, PEERS' Executive Director Vanetta Johnson along with staff members Bre Williams and Ashlee Jemmott were featured on the KBLX radio show "Listen Up Bay Area," which features local organizations. In a 15-minute segment, they discussed key themes related to mental health among African Americans, including the goals of the African American Everyone Counts Campaign. In the spring, the campaign was again featured on KPFA during KPFA's coverage of Oakland's Juneteenth celebration. As for Lift Every Voice and Speak, the changes to the speakers' bureau program were so successful that by the fourth quarter, average attendance at meetings increased to 18 and membership increased to 30. The program currently is at capacity and we have suspended recruitment of new members.

iii. Lessons Learned: During the planning phase for the two-year African American Everyone Counts Campaign, PEERS held a series of focus groups -- one for high-school aged young men, one for high-school aged young women, and one for elders. Each group discussed what they need in their neighborhoods to thrive and be successful; what cultural competency means to them; what supports, skills, and resources they need in order to develop healthier self-esteem; and what would help them be more prepared to respond to the daily stressors associated with racism, discrimination, and other forms of systematic oppression. Themes that emerged in all three groups included attention to the social determinants of health such as the need for good jobs, access to healthy food and grocery stores, role models, and support (e.g. "Neighborly love - someone to talk to about real stuff."). Young women strongly expressed the need for safety in many settings, especially safety from physical and sexual violence. Young men talked about needing to know more about their history and the histories of their people. When discussing cultural competency, focus group participants articulated the need to be understood. One young woman said, "Doctors need to be aware of black people's humanity." An elder participant pointed out, "Not all black people are the same." Another elder participant described how, as a black man, he has to set his mental health providers at ease and make the provider feel comfortable in order to get services. As we move into the next stage of the campaign, we will incorporate what we have heard so far, and continue to seek out the insights of more African American community members.

iv. Relevant Examples of Success/Impact (e.g. a client success story) Reminder: Please do not use real client names: The LEVS speakers' bureau program coordinator implemented a new system for supporting each speaker to move toward her or his own goals. At the beginning of the year, or upon joining LEVS, each speaker is given the option of setting an individual goal. The program coordinator then adapts the curriculum and designs opportunities to assist each participant to pursue their goal. LEVS participants recently described the group as "a speakers' bureau for healers," and "a healing community that helps spread hope." One member of the speakers' bureau said that she now is "speaking in a voice I didn't know I had."

**ADDITIONAL INFORMATION**

Please include the number of clients and/or contacts you estimate to serve in:

FY 19/20: 275 (does not include email, outreach events, or community presentations/speaking engagements where people do not sign in)

FY 20/21: 275 (does not include email, outreach events, or community presentations/speaking engagements where people do not sign in)

Please tell us about any changes you intend to make to your program over the next two fiscal years and explain your rationale for making these changes: The two primary changes to PEERS ECC programs in the next two years will be in the ethnic-specific social inclusion campaigns and in the Program Anti-Stigma Latino (PAL). In FY 19-20, we will move from planning to implementation of the African American Everyone Counts Campaign, which includes facilitating two multi-session stigma reduction support groups. In FY 20-21, we expect to be in a planning year for another culture-specific Everyone Counts Campaign. In FY 19-20, we also will begin implementation of PAL, a Latino-focused anti-stigma program that will include peer support groups and community presentations.

**MHSA Program #: PEI 23**

**PROGRAM NAME: Post Crisis Peer Mentoring**

**Program Description**: Post Crisis Peer Mentoring program offers brief low-intensity early intervention through peer support to address and promote recovery, and to prevent relapse. The program engages mentors and participants whereby each mentor serves as a facilitator with the participant on the participant's path to self-discovery and self-determination.

Program Outcomes & Impact: UELP Data Report FY18/19

**PERFORMANCE INDICATORS: How Much Did We Do?**

| Total Numbers Served through PEI MHSA | |
|---|---|
| Number of unduplicated individuals your program serves who are at-risk of developing a serious mental illness (SMI) | 132 |
| Number of unduplicated individuals your program serves who show early signs of forming a more severe mental illness | 132 |
| Number of unduplicated individual family members served indirectly by your program: | |
| Grand TOTAL of unduplicated individuals served in the Quarter that you are reporting about. [This number (D) should = A=B+C.] | 132 |

**PERFORMANCE INDICATORS: How Well Did We Do?**

Demographics

**Age Group (Unduplicated)**

| | |
|---|---|
| Children/Youth (0---15) | 0 |
| Transition Age Youth (16---25) | 35 |
| Adult (26---59) | 83 |
| Older Adult (60+) | 14 |
| Unknown/ Declined to Answer | 0 |

**Race (Please mark only one choice)**

*If Hispanic or Latino, choose "Another race not listed."*

| | |
|---|---|
| American Indian or Alaska Native | 1 |
| Asian | 9 |
| Black or African American | 42 |
| Native Hawaiian or other Pacific Islander | |
| White | 29 |
| More than one race | 2 |
| Another race not listed | |
| Unknown/ Declined to Answer | |

**Sexual Orientation (Please mark only one choice)**

| | |
|---|---|
| Gay or Lesbian | 2 |
| Heterosexual or Straight | 66 |
| Bisexual | 1 |
| Questioning or unsure of sexual orientation | 1 |
| Queer | |
| Another sexual orientation not listed | 1 |
| Unknown/Decline to Answer | 20 |

**Ethnicity /Cultural Heritage (Please mark only once choice)**

| | |
|---|---|
| **If Hispanic or Latino, please specify:** | |
| Caribbean | 1 |
| Central American | |
| Mexican/Mexican-- | 1 |
| Puerto Rican | |
| South American | |
| Another Hispanic/Latino | 13 |
| Unknown/Declined to Answer | |
| **If Non-Hispanic or Non-Latino, please specify:** | |
| African | 1 |
| African American | |
| Asian Indian/South Asian | |
| Cambodian | |
| Chinese | 4 |
| Eastern European | |
| European | |
| Filipino | |
| Japanese | |
| Korean | |
| Middle Eastern | 2 |
| Vietnamese | |
| Other Non-Hispanic or Non- Latino ethnicity not listed | |
| **More than one ethnicity** | |
| **Unknown /Declined to Answer** | |

**Primary Language (Please mark only one choice)**

| | |
|---|---|
| English | 10 |
| Spanish | 15 |
| Farsi | |
| Cantonese | 8 |
| Mandarin | |
| Other Chinese Dialects | |
| Vietnamese | |
| Korean | |
| Tagalog | |
| Other Filipino Dialect | |
| Japanese | |
| Laotian | |
| Cambodian | |
| Mien | |
| Hmong | |
| Samoan | |
| Thai | |
| Russian | |
| Polish | |
| German | |
| Italian | |
| Turkish | |
| Hebrew | |
| French | |
| Portuguese | |
| Armenian | |
| Arabic | 2 |
| Sign ASL | |
| Other primary language not listed | |
| Unknown/ Decline to Answer | 6 |

**Gender Identity (Please mark both parts A & B)**

| | |
|---|---|
| A) Assigned sex at birth: (Please mark only one choice) | |
| Male | 72 |
| Female | 60 |
| Other sex not listed (e.g. Intersex) | |
| Unknown/Decline to Answer | |
| B) Current Gender Identity: (Please mark only one choice) | |
| Male | |
| Female | |
| Transgender | |
| Genderqueer | |
| Questioning or Unsure of Gender Identity | |
| Another Gender Identity not listed | |

**Disability Status** (Please mark all that apply)

| | |
|---|---|
| None | 63 |
| Yes. If yes, please specify (choose from list below): | |
| Difficulty Seeing | 3 |
| Difficulty hearing, or having speech | 5 |
| Mental Domain | 20 |
| Physical/Mobility Domain | 22 |
| Chronic Health Condition | 5 |
| Another disability not listed | |
| Unknown/Decline to Answer | 12 |

**Veteran Status (Please mark only one choice)**

| | |
|---|---|
| Yes | |
| No | 80 |
| Unknown/Decline to Answer | 2 |

**REQUIRED STRATEGY: IMPROVE TIMELY ACCESS TO MENTAL HEALTH SERVICES FOR UNDERSERVED POPULATIONS**

a. Who is/are the underserved target population/s your program is serving (e.g. TAY, Southeast Asian, etc.)? Services are provided to transition-age youth, adults and older adults being discharged or dispositioned from John George Psychiatric Hospital inpatient hospital services.

b. Number of separate paper referrals to an ACBH PEI-funded program. (This can be a provider's internal ACBH PEI-funded prevention or early intervention program OR an external PEI-funded ACBH prevention or early intervention program): 132

c. Number of individuals followed through on referral & engaged in an ACBH PEI-funded program: 132

d. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with the ACBH PEI-funded provider. N/A

e. Describe ways your program encouraged access to services and follow-through on the above referrals: N/A However, while the participant is engaged with the peer mentor, the mentor is informed by the participant in terms of participant's needs. The mentor will then, together with the participant, assist the participant in navigating the mental health system in order to help the participant find the appropriate services that best fits the participant's needs.

**NARRATIVE**

a. Choose two of the above principles and describe how your program upholds or achieves those principles. Please speak to each principle separately and specifically describe how your program activities align with that corresponding principle.

Principle #1: Wellness and Recovery. How does your program align with this principle? For the Mentor to be able to connect with a patient while they are in a facility, and before they are discharged, provides an opportunity to eliminate the disconnect between being served in a facility and reconnecting to community. The peer mentors are dedicated to serving those who suffer from serious and persistent mental illness in order to alleviate suffering. Through partnerships with community organizations, local government entities, and public agencies, our peer mentor program works to address issues that affect overall community health. The peer mentor interacts with the patient in order to understand and help address the needs of the patient. Considering the patient is being served in a psychiatric facility, the objective of the peer mentor is to help the participants improve the quality of their life within the community once they are discharged. Our adult peer mentor program's primary focus is to serve the mentor health population in Alameda County who suffers from serious and persistent mental illness. It is an opportunity for those who have struggled with mental illness to gain confidence and to receive additional support within a one on one relationship for an extended period of time.

Principle #2: Integrated Service Delivery. How does your program align with this principle? All efforts are made to assign a peer mentor to a patient before the patient is discharged from a mental health facility. At the point of introduction, the trained peer mentor will attempt to make a meaningful connection with the patient at the facility. At the patient's request, the mentor will continue to visit the patient until the patient is discharged. And while still at the facility, the mentor and patient will agree to maintain that connection into the community where the patient lives. Before discharge, the mentor and patient will agree to contact each other on a weekly basic- both by phone and in person. The in-person meeting will be arranged by phone or text. It is an opportunity for those who have struggled with mental illness to gain confidence and to receive one on one support in addition to having a case manager and, or a therapist. At the request of the patient, the mentor is willing to share his or her individual experiences of recovery and transformation; and connecting with a peer mentor is a way for a person to connect with someone not unlike themselves, and who may have gone through similar circumstances. Parents of the patient are very welcoming to the mentor-patient relationship. Parents view such relationships as additional community support; and many parents may not have quality time to devote to this type of support, are unfamiliar with the mental health system of services. One example is: The peer mentors will assist their participants with obtaining community resources such as housing, obtain a free phone from various providers, connect to mental health support groups in addition to a one on one connection. Also, the peer mentor can assist the patient to collaborate with other community providers who offers services for both patient and family.

phone and who may refuse assistance to obtain a free phone. Another challenge is no shows: when a participant constantly decides to meet with mentor; but does not show. Mentor must then re- navigate boundaries with participant in order for the relationship to remain fruitful.

ii. Successes: Mentors have learned to better understand the many challenges faced by the participant. Such could be issues with home environment, lack of employment, the Participant not being able to think clearly and critically. The mentor, by relying on the training and personal experiences, have been able to be more empathetic toward providing services to Participants. And by being patient and caring, the Mentor is able to form a more productive relationship with the participant. In this manner of care, serving the participant has become more personable, and the Mentor has become truly invested in the well-being of the Participant. This has led to the development of more trust between the two.

iii. Lessons Learned: Mentors who are committed to the process are critical to its success; and among this process is to introduce the participant to as many community services as available to help the participant facilitate his or her own needs. Once trust is firmly established between Mentor and Participant, the participant will open up and share with the Mentor how the Mentor can be of service.

iv. Relevant Examples of Success/Impact (e.g. a client success story) Reminder: Please do not use real client names: One of the challenges I faced was a participant who was homeless. We overcame this problem when he was sent to Jay Mahler rehab facility from John George Hospital and with help from the social workers and myself, 'client' was referred to East Oakland Community Project/Crossroads which is transitional housing. He will apply for permanent subsidized housing for the next 9-12 months from that facility." One participant was connected with a mentor for a few months; and the patient was in the process of taking the CPA exam. He passed it and is now back at work doing accounting. One participant was connected with a mentor with a drinking issue; but she is now going to barber college. Drinking issue remains a challenge.

**EVALUATION PLAN UPDATE**

Each PEI program must collect information **on client/participant experience, feedback, or satisfaction** with the programming provided.

a. Please describe, in 1-2 sentences, your effort to collect feedback from program participants (method used). Please include the timeframes of when you survey clients.
Each month as the patient and mentor interact, the patient will fill out a Hope and Isolation Scale. The intent of this scale is to measure improvement of the patient's feeling of isolation and hopelessness.

b. Describe the tool (i.e. MHSIP or another survey) used to collect data.
We implemented the Hope and Isolation Scale, a 12-question survey with the goal of measuring the development of the patient while in relationship with the mentor. Going forward, we plan to use the MHSIP as mentioned above.

c. Summarize the results if any. In general, the program was successful in that it enabled patients who previously endorsed feelings of hopelessness to experience greater positive views of their future when they successfully navigated the program. A larger more focused evaluation of the program is needed to determine whether part of the success may be attributed to factors associated with those participants who remain engaged with their Mentor (remain in the program) as opposed to those who drop out early on/ those who are less connected with their Mentor. In other words, there may be some commonalities among those who experience greater success and report more hopefulness (and therefore complete the tool) as opposed to others who may not consistently complete the program or self-report measures.

d. What was learned from the participant feedback (**1-2 key points**)? Providing participants with mentorship and real time guidance navigating the system; including those which resulted in actual linkages seemed to be associated with reported feelings of increased hopefulness. Patients who also received more contact and support from their community-based programs also showed less isolation and more self-efficacy overall.

e. Describe how the findings were reviewed by staff. Findings were discussed with AHS leaders and NAMI staff during several program update meetings. Discussions revealed that the initial referrals by the social workers were successful in identifying potential matches with the program; but did also highlight that the level of engagement post-discharge could not always be predicted.

f. What programmatic change(s) were or will be adopted as a result of the findings? When will changes be made and how will the changes impact programming? Findings (described above) have been relayed to Social Work Supervisor and have been discussed with the team in relation to identifying patients who would benefit from the program. However, this contract has not been renewed for FY20.

g. What issues or challenges with the Evaluation Plan are you having? What technical assistance do you need? NONE

**ADDITIONAL INFORMATION.**

Please include the number of clients and/or contacts you estimate to serve in:

FY 19/20: Minimum 100
FY 20/21: Minimum 100

Please tell us about any changes you intend to make to your program over the next two fiscal years and explain your rationale for making these changes: Would like to focus more on improvement on the quality of life after discharge and not place a considerable emphasis simply to reduce hospital beds (which was the original intent of the mentoring program) without having the same consideration for how the mentoring improves the overall quality of life after the patient is discharged. The rational in this is: the patient comes from an environment whereby much focus should ultimately be given to where the patient will be returning (thus the focus of the Mentor). Further change would be to extend the mentoring process into PEI, and to have mentors come to each Unit on a weekly basic to inform patient of the mentoring process.

**MHSA Program #: PEI 24**

**PROGRM NAME: Sobrante Park Community Project- Roots Community Health Center**

**Program Description**: Sobrante Park Mental Illness Prevention services - increasing protective factors and decreasing risk factors for families, community beautification and career readiness and exploration for junior and senior high school students.

Program Outcomes & Impact: UELP Data Report FY18/19

**PERFORMANCE INDICATORS: How Much Did We Do?**

**PERFORMANCE INDICATORS: How Well Did We Do?**
Demographics

| | CATEGORY 1: MENTAL HEALTH & WELLNESS | CATEGORY 2: NEIGHBORHOOD BEAUTIFICATION | CATEGORY 3: CAREER EXPLORATION |
|---|---|---|---|
| **A:Number of unduplicated individuals your program serves who are at-risk of developing a mental health problem or serious mental illness (SMI)** | **33** | | **32** |
| **B: Number of unduplicated individuals your program serves who show early signs of forming a more severe mental illness** | **3** | | **0** |
| **C: Number of unduplicated individual family members served indirectly by** | **8** | | **0** |
| **D: Grand TOTAL of unduplicated individuals served in the Quarter that you are reporting** | | | |
| **Ethnicity /Cultural Heritage** | | | |
| **If Hispanic or Latino, please specify:** | | | |
| **Caribbean** | | | |
| **Central American** | | | |
| **Mexican/Mexican-American/Chicano** | **3** | | |
| **Puerto Rican** | | | |
| **South American** | | | |
| **Another Hispanic/Latino ethnicity not listed** | | | |
| **Unknown/Declined to Answer** | **12** | | **20** |
| **If Non-Hispanic or Non-Latino, please specify:** | | | |
| **African** | | | |

| | | | |
|---|---|---|---|
| African American | 14 | | 11 |
| Asian Indian/South Asian | | | |
| Cambodian | | | |
| Chinese | | | |
| Eastern European | | | |
| European | 1 | | |
| Filipino | | | |
| Japanese | | | |
| Korean | | | |
| Middle Eastern | | | 1 |
| Vietnamese | | | |
| Other Non-Hispanic or Non-Latino ethnicity not listed | | | |
| More than one ethnicity | | | |
| Unknown /Declined to Answer | 6 | | |
| Age Group (Unduplicated) | | | |
| Children/Youth (0---15) | 10 | | |
| Transition Age Youth (16---25) | 14 | | 32 |
| Adult (26---59) | 11 | | |
| Older Adult (60+) | 1 | | |
| Unknown/ Declined to Answer | | | |
| Race (Please mark only one choice) *If Hispanic or Latino, choose "Another race not* | | | |
| American Indian or Alaska Native | | | |
| Asian | 1 | | |
| Black or African American | 14 | | 11 |
| Native Hawaiian or other Pacific Islander | | | |
| White | 1 | | 1 |
| More than one race | | | |
| Another race not listed | 15 | | 20 |
| Unknown/ Declined to Answer | 5 | | |
| Primary Language (Please mark only one choice) | | | |
| English | 34 | | 32 |
| Spanish | 2 | | |
| Farsi | | | |
| Cantonese | | | |
| Mandarin | | | |
| Other Chinese Dialects | | | |
| Vietnamese | | | |
| Korean | | | |
| Tagalog | | | |
| Other Filipino Dialect | | | |
| Japanese | | | |
| Laotian | | | |

| | | | |
|---|---|---|---|
| **Cambodian** | | | |
| **Mien** | | | |
| **Hmong** | | | |
| **Samoan** | | | |
| **Thai** | | | |
| **Russian** | | | |
| **Polish** | | | |
| **German** | | | |
| **Italian** | | | |
| **Turkish** | | | |
| **Hebrew** | | | |
| **French** | | | |
| **Portuguese** | | | |
| **Armenian** | | | |
| **Arabic** | | | |
| **Sign ASL** | | | |
| **Other primary language not listed** | | | |
| **Unknown/ Decline to Answer** | | | |
| **Gender Identity** | | | |
| **Assigned sex at birth: (Please mark only one choice)** | | | |
| **Male** | **19** | | **19** |
| **Female** | **16** | | **13** |
| **Other sex not listed (e.g. Intersex)** | | | |
| **Unknown/Decline to Answer** | **1** | | |
| **Current Gender Identity: (Please mark only one choice)** | | | |
| **Male** | **19** | | **19** |
| **Female** | **16** | | **13** |
| **Transgender** | | | |
| **Genderqueer** | | | |
| **Questioning or Unsure of Gender Identity** | | | |
| **Another Gender Identity not listed** | | | |
| **Unknown/Decline to Answer** | **1** | | |
| **Sexual Orientation (Please mark only one choice)** | | | |
| **Gay or Lesbian** | | | |
| **Heterosexual or Straight** | | | |
| **Bisexual** | **1** | | |

| | | | |
|---|---|---|---|
| **Questioning or unsure of sexual orientation** | | | |
| **Queer** | | | |
| **Another sexual orientation not listed** | | | |
| **Unknown/Decline to Answer** | **35** | | **32** |
| **Disability Status (Please mark all that apply)** | | | |
| **None** | **3** | | |
| **Yes. If yes, please specify (choose from list below):** | | | |
| **Difficulty Seeing** | | | |
| **Difficulty hearing, or having speech understood** | | | |
| **Mental Domain** | | | |
| **Physical/Mobility Domain** | | | |
| **Chronic Health Condition** | | | |
| **Another disability not listed** | | | |
| **Unknown/Decline to Answer** | **33** | | **32** |
| **Veteran Status (Please mark only one choice)** | | | |
| **Yes** | | | |
| **No** | | | |
| **Unknown/Decline to Answer** | **36** | | **32** |

**REQUIRED STRATEGY: INCREASE ACCESS AND LINKAGE TO MENTAL HEALTH TREATMENT**

a. Number of individuals with serious mental illness (SMI) who received a paper referral (i.e. referrals via phone do not apply) from your program to an ACBH mental health treatment program: *0*

b. List type(s) of mental health treatment programs the individual was referred to: *N/A*

c. Number of individuals who were successfully referred and linked to an ACBH mental health treatment program (i.e. client has been seen at least once in person by a treatment provider): *N/A*

d. Average duration in weeks of signs of untreated mental illness (per client self-report): *104*

e. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with a mental health treatment provider: *N/A*

f. Any additional information to report on? (Optional): No clients have been externally referred for mental health treatment programs. One client was already connected to Roots' LCSW prior to engaging with our Sobrante Park work. Two (2) clients requiring services for mild-moderate mental illness have been referred to and seen by Roots' LCSW. Navigators are still searching for appropriate care for a Spanish-speaking client.

**REQUIRED STRATEGY: IMPROVE TIMELY ACCESS TO MENTAL HEALTH SERVICES FOR UNDERSERVED POPULATIONS**

a. Who is/are the underserved target population/s your program is serving (e.g. TAY, Southeast Asian, etc.)? Individuals and families of African and Latino/a decent living in/attending school in Sobrante Park.

b. Number of separate paper referrals to an ACBH PEI-funded program. (This can be a provider's internal ACBH PEI-funded prevention or early intervention program OR an external PEI-funded ACBH prevention or early intervention program): 8 this quarter, 78 since program inception (all for internal program)

c. Number of individuals followed through on referral & engaged in an ACBH PEI-funded program: 5 this quarter, 46 since program inception

d. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with the ACBH PEI-funded provider. 1 week

e. Describe ways your program encouraged access to services and follow-through on the above referrals: Phone calls to client and client's family members, visiting with clients in familiar spaces (home, school), offering incentives to participation

f. Any additional information to report on (optional): N/A

Number of potential responders: 249

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

| **Type of Setting(s)** (ex: school, place of worship, clinic) | **Type(s) of Potential Responders** (ex: principals, teachers, parents, nurses) |
|---|---|
| **SP Health & Wellness Fair** | Community members |
| **Neighborhood Empowerment Day** | Community members |
| **Madison Park Academy** | Students, parents, counselors |

**NARRATIVE**

a. Choose <u>two</u> of the above principles and describe how your program upholds or achieves those principles. Please speak to each principle separately and specifically describe how your program activities align with that corresponding principle.

b. Principle #1: **Cultural Competence**
How does your program align with this principle?

Our Navigators reflect the population served in Sobrante Park (1 African American man; 1 Latina and Spanish-speaking). All physical and mental health providers also reflect the demographics of the population. We provide services in the languages spoken by our clients. Staff have life experiences similar to the clients with whom they are working. Services are also provided in a comfortable, non-stigmatizing environment. Youth clients are invited to utilize our Dream Youth Clinics for adolescent and transitional age youth where staff create an inviting and safe space for youth to engage. All clients have access to Roots Community Market, where they can use a point system to select a bag of fresh groceries with a set of recipes representing the various cultures of our clients.

Principle #2: **Community Collaboration**
How does your program align with this principle?

Community Collaboration is at the foundation of this scope of work. We work closely with the Sobrante Park Resident Action Council to ensure residents are engaged in the strategies being implemented within the neighborhood. We have also been meeting with key staff at the schools to ensure that we are familiar with their challenges and adding value. We have been building strong relationships with other partners to provide services in Sobrante Park and across all sites. This includes legal services from Centro Legal de La Raza; offering clients opportunities for employment with hiring partners through our Empowerment Center; and conducting housing assessments for unhoused clients through the Coordinated Entry System. Our network of partners continues to expand, leading to a broader array of resources available to our clients and attendees at all of our community events.

b. Please tell us about the following

Implementation Challenges: In the fourth quarter, we identified significant differences in interpretation of the role of Roots on the school campus as it relates to the Center for Healthy Schools and Communities (CHSC) COST Team at MPA, school staff, and our on-campus partner Higher Ground. At some point in March, we discovered that CHSC had expressed its understanding that all referrals (including those from Higher Ground) had to come through the COST team. As a result, we did not receive any referrals from Higher Ground after that point (some time in February). In addition, the COST team agreed to send us only a small number of referrals as a "trial run," significantly limiting the number of MPA students with whom we could work. We did not realize this was happening until much later. We subsequently had a series of meetings towards the end of the fiscal year to get on one accord regarding referrals. In addition, we have met with staff on the primary campus, as well as Native American Health Center staff to further partnerships that address the needs of families and fill current service gaps.

Finally, because of the shortened period of this contract (9 months rather than a full year), our proposed numbers served should have been altered to reflect 75% of the full amount. In addition, because this was our first year doing this scope of work, the first 3 months were a start-up period and services did not fully begin until January 2019.

Successes: On June 22$^{nd}$, we had our third community engagement event, the Sobrante Park Health &Wellness Fair, with 23 attendees. This event was hosted by the Sobrante Park RAC and Roots' navigation and clinic staff attended to provide services. While the turnout for this event was lower than expected, Roots has provided outreach ideas to the RAC and will make Roots outreach staff available for outreach efforts for future events.

Partners offering services at this event included Healthy Teeth Healthy Communities, Roots' mobile clinic, Oakland Fire Dept., Oakland Police Dept., CA Highway Patrol, East Bay Moms Demand Action, Planting Justice, Sobrante Park Resident Action Council, East Oakland Neighborhood Initiative, and a backpack giveaway.

Roots also supported the Sobrante Park RAC in their hosting of an Earth Day community beautification event on April 20th. Participants cleaned up litter and planted flowers and trees throughout the neighborhood.

Roots' Navigators were approved for full access to Madison Park Academy and Lionel Wilson via a formal MOU with OUSD. This has led to an increase in students and families served as we are able to meet with clients in spaces more accessible to them. Our Navigators have also increased their skill in serving families as a unit but also as individuals, engaging multiple members of families in services.

More than 24 students (32 juniors and seniors) have been served by the stipend career paths and employment readiness and exploration program hosted by Higher Ground. For navigated students unable to participate in this program, Navigators have facilitated linkages with other summer youth employment opportunities including Youth Uprising, YEP, and Roots' Oakland Unite Summer Nights Planning Committee.

Lessons Learned: In our work with our partners, we have learned it is best to have our partners send regular (monthly) reports of their activities to maintain accountability and ensure timeliness of quarterly reporting. In our work with community members, we have recognized the need for additional legal service providers (including in Spanish) to assist with immigration, criminal, tenancy, and family legal issues that many of our clients are facing. We are actively working to bolster these existing partnerships and increase the regularity and accessibility of services.

For engaging with clients, we have found the best referrals to be those that come from existing clients. People are more likely to follow up when they know another client engaged in services. For some referrals we received from partners, we realized the clients they were referring may not have the most intense level of need as they are already engaged in other services. We have tried to focus our reach to those who are not engaged in other programs since they are most likely to be at risk of developing severe mental illnesses. Some of the students who were referred to us by Madison Park Academy have very complex needs outside the scope/training of family Navigators. We are working to match the expertise of program staff with the needs expressed by the school to ensure these students have access to all the support services (academic, health, financial, etc.) they need (see Section 8 for details).

. Relevant Examples of Success/Impact (e.g. a client success story) Reminder: Please do not use real client names: *Recounted by Roots Sobrante Park Navigator:* "'Rodney' came to Roots one day and was visibly in emotional distress. Teary-eyed, he sat down and began to explain his story to me. He started by explaining why he was so emotional. He said the one-year anniversary of his mother's death was in a couple of days and she was his world. He then went on to talk about how he was going through a rough patch in life and didn't have many social supports.

And, although he has three siblings (sisters), only one is somewhat supportive – to an extent. As our conversation went on he talked about how his life had been going in a downward spiral since a shoulder injury left him temporarily disabled. Before the injury, Rodney was a unionized sprinkle fitter and making upward of $60/hr. Rodney was also a single parent raising his only son, up until and for some time after his injury. However, the time that he raised his son after his injury was short lived. They were moving from hotel to hotel - because of his limited income (SDI), it was the only thing he could afford. He eventually realized that the best

thing for his son was to go live with his maternal grandmother out of state, a painstaking decision that has left him and his son's relationship strained. While living on his own now, Rodney was able to convince one of his sisters, who lives in Sobrante Park, to let him live in her backyard until he got on his feet; something that he'd be willing to do for himself, but not if he still had his son in his custody.

Shortly after our conversation, we began working on a plan to get Rodney back on his feet. We took care of his immediate needs which were food, clothing and a bus pass. We went to Roots Community Market (Roots' food pantry) and got him a few items to last him for a few days. We then went upstairs to our men's clothing closet and picked out a couple of slacks, blazers, collared shirts and dress shoes. I then gave Rodney a bus pass and an ID Voucher. Our next step was to get reinstated into the sprinkler fitter's union and find temporary housing. After several weeks we were able to get Rodney into "Turning Point," Roots' Emergency Bridge Housing, and pay for his union dues. To date, Rodney has been reinstated into the union and is getting together the tools, equipment and working clothes needed for his line of work."

**ADDITIONAL INFORMATION**

Please include the number of clients and/or contacts you estimate to serve in:

FY 20/21: 64

Please tell us about any changes you intend to make to your program over the next two fiscal years and explain your rationale for making these changes: (1) We will include Outreach Specialist time to increase referrals for services and outreach for events, (2) we will include a new partner, Timebanking, to implement Timebanking in Sobrante Park. This will be used as a tool to build community, increase engagement, and create an additional incentive for program participants, (3) we will incorporate a 0.5 FTE Navigator specializing in adolescent navigation in an effort to be responsive to the needs of the school as expressed by the Center for Healthy Schools and Communities. We will commensurately decrease family navigators from 2.0 FTE to 1.5 FTE resulting in no net change in navigator time, and (4) we are increasing program coordinator time given the diverse scope of work and coordination of multiple partners.

# PREVENTION & EARLY INVERVENTION PROGRAM SUMMARIES: EARLY INTERVENTION PROGRAMS

**MHSA Program #: PEI 2**

**PROVIDER NAME: Prevention and Recovery in Early Psychosis (Prep)**

**PROGRAM NAME: Early Intervention for the Onset of First Psychosis & SMI among TAY**

**Program Description:** PREP provides evidence-based treatment and support for transition age youth (TAY) experiencing an initial episode of psychosis.

Program Outcomes & Impact: PEI Data Report FY18/19

**PERFORMANCE INDICATORS: How Much Did We Do?**

| **Total Numbers Served through PEI MHSA** | |
|---|---|
| Number of unduplicated individuals your program serves who are **at-risk** of developing a mental health problem or serious mental illness (SMI) | 58 |
| Number of unduplicated individuals your program serves who show **early signs** of forming a more severe mental illness | 58 |
| Number of unduplicated individual family members served indirectly by your program: | 26 |
| Grand TOTAL of unduplicated individuals served in the Quarter that you are reporting about. [This number (D) should = A+B+C.] | 84 |

**PERFORMANCE INDICATORS: How Well Did We Do?**

Demographics

**Age Group (Unduplicated)**

| | |
|---|---|
| Children/Youth (0-••15) | 0 |
| Transition Age Youth (16-••25) | 58 |
| Adult (26-••59) | 0 |
| Older Adult (60+) | 0 |
| Unknown/ Declined to Answer | 0 |

**Race (Please mark only one choice)**

*If Hispanic or Latino, choose "Another race not listed."*

| | |
|---|---|
| American Indian or Alaska Native | 0 |
| Asian | 1 |
| Black or African American | 19 |
| Native Hawaiian or other Pacific Islander | 2 |
| White | 9 |
| More than one race | 6 |
| Another race not listed | 20 |
| Unknown/ Declined to Answer | 1 |

| Sexual Orientation (Please mark only one choice) | |
|---|---|
| Gay or Lesbian | 0 |
| Heterosexual or Straight | 42 |
| Bisexual | 6 |
| Questioning or unsure of sexual orientation | 1 |
| Queer | 0 |
| Another sexual orientation not listed | 0 |
| Unknown/Decline to Answer | 9 |

| Gender Identity (Please mark both parts A & B) | |
|---|---|
| A) Assigned Sex at Birth (Please mark only one choice) | |
| Male | 40 |
| Female | 16 |
| Other Sex Not Listed (e.g. intersex) | 0 |
| Unknown/Declined to Answer | 2 |
| B) Current Gender Identity (Please mark only one) | |
| Male | 40 |
| Female | 16 |
| Transgender | 0 |
| Genderqueer | 0 |
| Questioning or Unsure of Gender Identity | 0 |
| Another Gender Identity Not Listed | 0 |
| Unknown/Declined to Answer | 2 |

| Ethnicity /Cultural Heritage (Please mark only once choice) | |
|---|---|
| **If Hispanic or Latino, please specify:** | |
| Caribbean | 0 |
| Central American | 8 |
| Mexican/Mexican- | 9 |
| Puerto Rican | 0 |
| South American | 1 |
| Another Hispanic/Latino | 2 |
| Unknown/Declined to Answer | 0 |
| **If Non-Hispanic or Non-Latino, please specify:** | |
| African | 18 |
| African American | 0 |
| Asian Indian/South Asian | 3 |
| Cambodian | 0 |
| Chinese | 0 |
| Eastern European | 0 |
| European | 3 |
| Filipino | 1 |
| Japanese | 0 |
| Korean | 0 |
| Middle Eastern | 1 |
| Vietnamese | 0 |
| Other Non-Hispanic or Non-Latino ethnicity not listed | 3 |
| **More than one ethnicity** | 7 |
| **Unknown /Declined to Answer** | 2 |

**Primary Language (Please mark only one choice)**

| | |
|---|---|
| English | 48 |
| Spanish | 8 |
| Farsi | 0 |
| Cantonese | 0 |
| Mandarin | 0 |
| Other Chinese Dialects | 0 |
| Vietnamese | 0 |
| Korean | 0 |
| Tagalog | 1 |
| Other Filipino Dialect | 0 |
| Japanese | 0 |
| Laotian | 0 |
| Cambodian | 0 |
| Mien | 0 |
| Hmong | 0 |
| Samoan | 0 |
| Thai | 0 |
| Russian | 0 |
| Polish | 0 |
| German | 0 |
| Italian | 0 |
| Turkish | 0 |
| Hebrew | 0 |
| French | 0 |
| Portuguese | 0 |
| Armenian | 0 |
| Arabic | 0 |
| Sign ASL | 0 |
| Other primary language not | 0 |
| Unknown/ Decline to Answer | 1 |

**Disability Status** (Please mark all that apply)**

| | |
|---|---|
| None | 43 |
| Yes. If yes, please specify (choose from list below): | |
| Difficulty Seeing | 0 |
| Difficulty hearing, or having speech | 1 |
| Mental Domain | 4 |
| Physical/Mobility Domain | 3 |
| Chronic Health Condition | 0 |
| Another disability not listed | 0 |
| Unknown/Decline to Answer | 9 |

** There were two clients who had more than one disability.

**Veteran Status (Please mark only one choice)**

| | |
|---|---|
| Yes | 0 |
| No | 56 |
| Unknown/Decline to Answer | 2 |

**REQUIRED STRATEGY: INCREASE ACCESS AND LINKAGE TO MENTAL HEALTH TREATMENT**

a. Number of individuals with serious mental illness (SMI) who received a paper referral (i.e. referrals via phone do not apply) from your program to an ACBH mental health treatment program: We served a total of 58 unduplicated clients from July 1, 2018- June 30, 2019 and discharged 35 clients. During Q1 we had a total of 33 clients served and 10 clients were discharged from the program. Of the 10 clients who discharged in that quarter, 6 of the clients were given ACBHS mental health referrals. The remaining 4 clients either had private insurance, was unresponsive to engagement attempts, moved out of area or were already connected to multiple ACBHS mental health programs. In Q2, we served 38 clients and discharged 7 clients from the program. Out of the 7 clients discharged, 5 clients were given ACBHS mental health referrals. For the remaining 2 clients, one client moved out of county and the other client was not interested in services and was provided the phone number to ACCESS. In Q3, we served 35 clients and 18 clients were discharged from the program. Of the 18 clients discharged, 11 clients were given referrals to ACBHS. For the remaining 7 clients, either the client moved out of county, had private insurance, or were not interested in services and was provided with ACCESS phone number. During Q4, we had 6 clients discharged from the program. Out of the 6 clients discharged, 1 client was given a referral to ACBH mental health program, 1 client was given an out of-county referral since they relocated to Santa Clara County, and 3 clients were given ACCESS's phone number as these clients were not interested in services at this time and 1 client was already connected to several mental health providers and did not need additional referrals.

b. List type(s) of mental health treatment programs the individual was referred to: From July 1 2018- June 30, 2019, clients have been referred to various mental health programs with Alameda County for continuing care. The following is a list of all the programs that clients were referred to during this period: La Clinica, Pathway to Wellness, West Coast Children's Center, Side by Side, Fred Finch, BACS, STARS, UCSF Children's Hospital Oakland, HUME Center, Oakland Children's Clinic, FERC, Seneca, and Berkeley Comprehensive Community Treatment. Pathways to Wellness is a program that provides medication support. West Coast Children's Center provided therapy and case management services. FERC is a program that provides emotional support and resources to the families of children, youth and adults with a mental health issue. All the other mental health programs listed above are programs that provide therapy, medication support, and case management services.

c. Number of individuals who were successfully referred and linked to an ACBH mental health treatment program (i.e. client has been seen at least once in person by a treatment provider): From July 1, 2018- June 30, 2019, we had a total of 12 clients who successfully linked to ACBH mental health treatment program where the client had attended at least one treatment session in person with the new ACBH provider. This data was gathered by using Clinician's Gateway, the electronic health record system linked to several providers within Alameda County. Even though clients are referred and linked to another community provider for continued care, our clients are sometimes challenged to attend these appointments due to transportation issues, motivation for continued treatment, unfamiliarity with new provider, and mental health symptoms experienced on the day of the appointment. However, it is important to note that in Q2 we implemented plan to accompany clients to their first appointment and as a result, we continuously increased in our success rate of linking clients to a new ACBH program. In Q1 we linked 16%, Q2 we linked 40%, Q3 we linked 82% and in Q4 we linked 100%.

d. Average duration in weeks of signs of untreated mental illness (per client self-report): From July 1, 2018-June 30, 2019, out of the 58 clients served we were able to accurately assess the onset of mental illness for 48 clients. The average duration of untreated mental health illness for these clients was 40 weeks.

e. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with a mental health treatment provider: During this fiscal year we were unable to track this consistently. Using Clinician's Gateway (county database) and CIRCE (our EHR system), we tracked the time the date a paper referral was made and the date of the client's first appointment with a new provider, which on average was about 3.01 weeks.

However, it is important to note that some of the challenges that we faced to connect clients to another mental health provider within a reasonable amount of time were difficulty engaging client with the new provider; difficulty scheduling an appointment within reasonable time; or client requiring higher level of care. Clients continued to receive services from the Early
Psychosis program until the warm-handoff was conducted.

f. Any additional information to report on? (Optional): N/A

**REQUIRED STRATEGY: IMPROVE TIMELY ACCESS TO MENTAL HEALTH SERVICES FOR UNDERSERVED POPULATIONS**

a. Who is/are the underserved target population/s your program is serving (e.g. TAY, Southeast Asian, etc.)? We currently serve the TAY population and multiple minority communities which include African American, Latino, Southeast Asian and LGBTQI2-S.

b. Number of separate paper referrals to an ACBH PEI-funded program. (This can be a provider's internal ACBH PEI-funded prevention or early intervention program OR an external PEI-funded ACBH prevention or early intervention program): During this fiscal year, we had only one client who was referred to an ACBH PEI-funded program. All other clients were referred to other non-PEI funded ACBH mental health programs or out-of-county providers.

c. Number of individuals followed through on referral & engaged in an ACBH PEI-funded program: One client and their family members engaged in services offered by FERC, which was the referral we made to a PEI funded ACBH mental health program.

d. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with the ACBH PEI-funded provider. The initial referral was made to FERC four weeks before the first in-person appointment with the PEI- funded provider. It is important to note that our staff therapist had difficulty engaging the client's family with the new provider in addition to obtaining an appointment with this new provider. This client continued to receive services with the Early Psychosis program until the warm hand off was completed.to outpatient services with their private insurance and FERC to help support the family.

e. Describe ways your program encouraged access to services and follow-through on the above referrals: When making a referral, our staff discusses with the client which programs they are being referred to and how these services can help them to maintain stability. Our staff explores the client's willingness to continue treatment with the program they are being referred to as well as any other barriers to treatment. Our staff also engages the referral provider's staff to facilitate a successful warm-handoff.

f. Any additional information to report on (optional): N/A

**OUTREACH. THIS SECTION IS *REQUIRED ONLY* FOR OUTREACH PROGRAMS. OTHERWISE, IT IS OPTIONAL**

Number of potential responders: 24

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

| **Type of Setting(s)** (ex: school) | **Type(s) of Potential Responders** (ex: principals, teachers, parents, nurses) |
|---|---|
| **Agencies- PHP & non-profits:** | Mental health providers (i.e. counselors, SW, managers) |
| Fairmont Hospital | Mental health providers (i.e. counselors, SW, managers) |
| Girls Inc. | Mental health providers (i.e. counselors, SW, managers) |
| Berkeley Mental Health Dept. | Mental health providers (i.e. counselors, SW, managers) |

**NARRATIVE**

a. Choose two of the above principles and describe how your program upholds or achieves those principles. Please speak to each principle separately and specifically describe how your program activities align with that corresponding principle.

Principle #1: Integrated Service Delivery. How does your program align with this principle? The Early Psychosis programs in Alameda County provide intensive services to help the client manage psychosis early, engage in treatment and improve functioning in the community. Not only do we offer mental health services, which include individual and family therapy and medication support, but we also have an Employment and Education Specialist (EES) who helps the client engage in school and/or the workforce, family support specialist and a peer support specialist. These two roles play a critical part of our team to provide the client and their family's emotional support and case management services from staff who have lived experience with mental health issues. Within EES services, the Employment and Education Specialist (EES) works directly with individuals to develop and implement employment and or education goals in-line with the IPS model and plans activities to decrease isolation and provide opportunities for clients to gain confidence in a variety of settings related to work and school goals. In addition, the Employment and Education Specialist helps clients through all phases of seeking employment and/or education placement including evaluation, planning, and resource development. Our therapists, EES, program manager, psychiatric nurse practitioner, family support specialist, and peer support specialist work collaboratively as a team and are introduced to the client as they wrap up the diagnostic assessment interviews to determine eligibility for early psychosis services. In addition, the staff also attends a weekly Team Collaboration meeting to discuss the needs of each client, identifying how each discipline can provide person-centered care within the client's community.

Principle #2: Cultural Competence. How does your program align with this principle? Our multidisciplinary team is culturally diverse and closely representative of the populations served, which are mostly African-American, Hispanic/Latino or Asian. The Early Psychosis staff work to maintain an attitude of cultural humility, learning from clients about their culture as they experience it, so that treatment can be tailored to include their values, beliefs, norms and traditions.

This process starts at intake and continues throughout the course of the therapeutic relationships with the client. In addition, the staff provides treatment in multiple languages and settings which include the office, clients' homes, schools, and in the community to help reduce the barriers to obtaining and engaging in treatment.
Moreover, staff also participates in cultural competency trainings to maintain an up-to-date perspective on broader understandings of culture in all its forms (i.e. socio-economic, race, ethnicity, age, SOGIE, etc.). During this fiscal year, the Early

Psychosis programs provided direct services in Spanish and Gujarati in addition to English. To maintain these standards, our job descriptions list bilingual/bicultural experience as "required" for most key roles, and as "preferred" once those key positions are filled. We also list personal or family experience of mental health challenges as "highly desirable" in all our job descriptions.

b. Please tell us about the following…

i. Implementation Challenges: During most of the FY 2018-19, we operated with multiple unfilled staff positions which created challenges that resulted in smaller caseloads, less referrals and more reliance on other community resources. Due to these open positions (that included both management and line staff), as well as to transitioning out of previous contractual partnership (previous partner held the administrative oversight function for the program), we addressed pervasive quality assurance issues. Therefore, most of Q2 and Q3 focused on updating charts to meet Medi-Cal standards. During Q4, although the program was almost fully staffed, new staff onboarding and training impacted capacity to increase caseloads rapidly and we continued to rely on other community resources. Another challenge was having the need to slow down referrals in Q3 which impacted the flow of referrals in Q4 (which continued to be low). Moreover, during Q4, we also relocated to another site which required a new site certification.

ii. Successes: Despite the challenges we faced during FY 2018-19, we were able to maintain a census each quarter between 33- 38 clients. During this time, we launched the BEAM program component to provide treatment to clients experiencing symptoms of early psychosis and severe mood disorder. We also rebuilt our team and increased capacity to do research-validated diagnostic assessments and provide evidence-based treatment. We have strengthened the program by improving processes and streamlining systems from referral up to discharge. We also resumed attending the CQRT chart reviews at the ACBH and re-established our internal chart review process to ensure ongoing compliance with Medi-Cal standards. In Q4, we have successfully met the ACBH requirements for CQRT and have been released from attending the CQRT chart review meetings. Moreover, we have created standardized procedures and protocols for the referral, intake process, and onboarding new staff. As we have hired more staff, in efforts to obtain new referrals and educate the community about our services, we have reached out to multiple behavioral health providers and psychiatric hospitals. We are in the process of re-creating streamlined procedures and developing welcoming packets for new clients.

iii. Lessons Learned: Between Q1 and Q3, the long period with multiple vacant positions created challenges that resulted in low census, less referrals, and more reliance on community resources to ensure clients had access to necessary services. However, in Q4, the rapid staff increase, time needed to onboard new staff, and the effects of slowing down referrals in Q3, interfered with our ability to grow our census. The Felton Early Psychosis Programs – (re)MIND® and BEAM Alameda – will continue to address challenges related to Access to Linkage Strategy by continuing our direct outreach to treatment providers to inform them about our specialized services and re-build our referral network to facilitate engagement in outpatient services for individuals who do not meet criteria for early psychosis services, but who will, nonetheless, be engaged with us through the rigorous diagnostic assessment phase. We will also continue to strengthen our processes to ensure that transitioning clients are making at least one "successful linkage" to a community provider by lengthening warm-handoffs, including planning to attend their first appointment with the new provider.

iv. The Felton (re)MIND® and BEAM Alameda will also plan to improve access to services for underserved populations by maintaining a multidisciplinary team that is closely representative of our client population with most individuals identified as African-American and Hispanic/Latino. As we rebuild the team, we will actively recruit bilingual/bicultural individuals that are representative of the populations we serve.

v. Relevant Examples of Success/Impact (e.g. a client success story) Reminder: Please do not use real client names: Our first success story involves a high school student experiencing psychosis. Like many of the young people we serve, they had experienced multiple psychiatric hospitalizations when they enrolled in the Early Psychosis program in Alameda County. This young person's first hospitalization was due to being at-risk for self-harm and experiencing distressing auditory hallucinations and disorganized thinking and behavior. In addition to their increased psychiatric symptoms they also experienced other life stressors including the loss of their adoptive mother. Due to stressors and increased psychosis, they continued to experience multiple hospitalizations and needed support to regain stability in the community. Luckily, this young person had a supportive extended family where their adoptive grandmother and siblings sought services and helped them connect with specialized treatment. Over the course of several months this young person worked with our staff therapist and learned skills to identify triggers to symptoms and coping strategies to minimize delusions and thoughts of suicide. Through the course of treatment, they were able to gain insight into their symptoms, practice learned skills and coping strategies, and their symptoms stabilized. This young person will be graduating high school this year and will attend junior college in the fall.

The second success story involves a young person who had multiple psychiatric hospitalizations due to grave disability and suicide ideation. This young person also reported experiencing distressing auditory hallucinations, disorganized thinking, depressed mood and increased substance use. Over the course of 2 years of treatment, this young person worked with our staff therapist and learned skills to identify triggers to symptoms and coping strategies to minimize delusions and suicidal thoughts. This young person was able to gain insight into their illness, stopped using substances, practices learned skills and coping strategies and their symptoms stabilized. This young person has successfully graduated from our services, is currently working full time, is involved in advocacy work, and is planning to enroll in school in the fall.

The third success story involves a young person in high school. When this young person first arrived at our program, they were just hospitalized for aggression, command hallucinations, delusions, and bizarre behaviors. Some examples of this young person's symptoms were punching walls, verbal abuse towards family members, and cawing like an eagle. Through the course of treatment, the staff therapist was able to engage this young person by relating to their interests in Aztec and Mayan culture, such as the eagle from the Legend of Tenochtitlan. The young person and staff were able to create a plan that involved weekly psychotherapy and medication management which effectively decreased the symptoms. They were able to grow their interest in construction and enrolled in ROP classes. This young person is doing well, has successfully graduated from the program and will be graduating from high school this summer.

The last success story involves a young person experiencing a first onset of psychosis. This young person's symptoms revolved around hypercritical auditory hallucinations that impaired their ability to maintain a job. More specifically, the young person's auditory hallucinations were so intense they began yelling back at the voices while at work. In order to cope with the voices, this young person started smoking marijuana. However, this coping strategy only provided temporary relief as the voices quickly increased with greater intensity. This young person's marijuana use became a source of family turmoil as it jeopardized their housing situation. Fortunately, this young person was highly motivated to change.
The treatment team and this young person agreed to a harm reduction plan by reducing the frequency of substance use and trying a different strain of marijuana that would not exacerbate their psychosis symptoms. With the support of this young person's treatment team, this young person was able to obtain a job, speak at public venues about his recovery, complete his probation requirements, continue to have stable housing and graduate from our program.

**ADDITIONAL INFORMATION**

Please include the number of clients and/or contacts you estimate to serve in:

FY 19/20: 100 unduplicated clients.
FY 20/21: 100 unduplicated clients.

Please tell us about any changes you intend to make to your program over the next two fiscal years and explain your rationale for making these changes: In FY 2019-20 we plan to provide services to 15 years old individuals experiencing early signs and symptoms of psychosis or severe mood disorder, on a case-by-case basis. This will increase ACBH capacity to provide psychosis early intervention at a critical period closest to onset of disabling symptoms. We are also expanding our staff capacity and will increase our projected census from 80 to 100 unduplicated clients. In FY 2020-21 we plan to maintain our efforts to demonstrate the added value of psychosis early intervention to the system of care and achieve sustainability.

**MHSA Program #: PEI 3**

**PROVIDER NAME: Geriatric Assessment & Response Team (GART)**

**PROGRAM NAME: Mental Health for Older Adults**

**Program Description:** GART is a mobile geriatric behavioral health team that provides support services to older adults ages 60 and above with serious behavioral health care needs. GART provides brief voluntary behavioral health care services with the aim of resolving immediate behavioral health needs.

Program Outcomes & Impact: PEI Data Report FY18/19

**PERFORMANCE INDICATORS: How Much Did We Do?**

| Total Numbers Served through PEI MHSA | |
|---|---|
| Number of unduplicated individuals your program serves who are **at-risk** of developing a mental health problem or serious mental illness (SMI) | 89 |
| Number of unduplicated individuals your program serves who show **early signs** of forming a more severe mental illness | 24 |
| umber of unduplicated individual family members served indirectly by your p r ogram: | |
| Grand TOTAL of unduplicated individuals served in the Quarter that you are number (D) should = A+B+C.] | 89 |

**PERFORMANCE INDICATORS: How Well Did We Do?**
Demographics

| **Sexual Orientation (Please mark only one choice)** | |
|---|---|
| Gay or Lesbian | 8 |
| Heterosexual or Straight | 75 |
| Bisexual | |
| Questioning or unsure of sexual orientation | |
| Queer | |
| Another sexual orientation not listed | |
| Unknown/Decline to Answer | 20 |

**Age Group (Unduplicated)**

| | |
|---|---|
| Children/Youth (0---15) | |
| Transition Age Youth (16---25) | |
| Adult (26---59) | |
| Older Adult (60+) | 98 |
| Unknown/ Declined to Answer | |

**Race (Please mark only one choice)**
*If Hispanic or Latino, choose "Another race not listed."*

| | |
|---|---|
| American Indian or Alaska Native | |
| Asian | 14 |
| Black or African American | 34 |
| Native Hawaiian or other Pacific Islander | |
| White | 43 |
| More than one race | |
| Another race not listed | 6 |
| Unknown/ Declined to Answer | |

**Ethnicity /Cultural Heritage (Please mark only once choice)**

| | |
|---|---|
| **If Hispanic or Latino, please specify:** | |
| Caribbean | |
| Central American | |
| Mexican/Mexican--American/Chicano | 3 |
| Puerto Rican | |
| South American | 1 |
| Another Hispanic/Latino ethnicity not listed | |
| Unknown/Declined to Answer | |
| **If Non-Hispanic or Non-Latino, please specify:** | |
| African | |
| African American | 24 |
| Asian Indian/South Asian | |
| Cambodian | |
| Chinese | 12 |
| Eastern European | |
| European | 8 |
| Filipino | 1 |
| Japanese | |
| Korean | |
| Middle Eastern | 1 |
| Vietnamese | |
| Other Non-Hispanic or Non-Latino ethnicity not listed | 35 |
| **More than one ethnicity** | |
| **Unknown /Declined to Answer** | |

**Primary Language (Please mark only one choice)**

| | |
|---|---|
| English | 83 |
| Spanish | 4 |
| Farsi | |
| Cantonese | 3 |
| Mandarin | 2 |
| Other Chinese Dialects | 4 |
| Vietnamese | |
| Korean | |
| Tagalog | 1 |
| Other Filipino Dialect | |
| Japanese | |
| Laotian | |
| Cambodian | |
| Mien | |
| Hmong | |
| Samoan | |
| Thai | |
| Russian | |
| Polish | |
| German | |
| Italian | |
| Turkish | |
| Hebrew | |
| French | |
| Portuguese | |
| Armenian | |
| Arabic | 1 |
| Sign ASL | |
| Other primary language not | |
| Unknown/ Decline to Answer | |

**Gender Identity (Please mark both parts A & B)**

| | |
|---|---|
| A) Assigned sex at birth: (Please mark only one choice) | |
| Male | 25 |
| Female | 71 |
| Other sex not listed (e.g. Intersex) | |
| Unknown/Decline to Answer | |
| B) Current Gender Identity: (Please mark only one choice) | |
| Male | 22 |
| Female | 56 |
| Transgender | |
| Genderqueer | |
| Questioning or Unsure of Gender Identity | |
| Another Gender Identity not listed | |
| Unknown/Decline to Answer | |

**Disability Status** (Please mark all that apply)

| | |
|---|---|
| None | 15 |
| Yes. If yes, please specify (choose from list below): | |
| Difficulty Seeing | |
| Difficulty hearing, or having speech understood | 2 |
| Mental Domain | |
| Physical/Mobility Domain | 33 |
| Chronic Health Condition | 3 |
| Another disability not listed | |
| Unknown/Decline to Answer | 44 |

**Veteran Status (Please mark only one choice)**

| | |
|---|---|
| Yes | 5 |
| No | 58 |
| Unknown/Decline to Answer | 35 |

**REQUIRED STRATEGY: INCREASE ACCESS AND LINKAGE TO MENTAL HEALTH TREATMENT**

a. Number of individuals with serious mental illness (SMI) who received a paper referral (i.e. referrals via phone do not apply) from your program to an ACBH mental health treatment program: 100% of open cases (#23) receive a paper referral as part of their discharge process. When a client abandons services before a discharge summary can be written, GART clinicians send referral information through the mail as well as a client survey requesting feedback.

b. List type(s) of mental health treatment programs the individual was referred to: Outpatient psychotherapy, outpatient psychiatry, neuropsychology, inpatient geriatric & non-geriatric providers for additional assessment & treatment, day treatment programs and drop-in socialization and day rehabilitation centers,

field-based case management programs, peer-based support groups for older adults, friendly visitors, culturally responsive and language-specific mental health providers, recovery- oriented substance abuse programs and providers, housing & homeless resources that cater to either older adults or individuals with mental health needs. Referrals to Alzheimer's Association are made for individuals (& their families) who have co-occurring dementia diagnoses.

c. Number of individuals who were successfully referred and linked to an ACBH mental health treatment program (i.e. client has been seen at least once in person by a treatment provider): Approx. 13 of the 24 opened cases were successfully referred and linked to ACBH mental health treatment programs. This number does not include clients who are still open and receiving services with GART and who may be referred/linked at point of discharge.

d. Average duration in weeks of signs of untreated mental illness (per client self-report): ranges from 1 month to 40+ years

e. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with a mental health treatment provider: 24 to 72 hours

f. Any additional information to report on? (Optional): Click here to enter text.

**REQUIRED STRATEGY: IMPROVE TIMELY ACCESS TO MENTAL HEALTH SERVICES FOR UNDERSERVED POPULATIONS**

a. Who is/are the underserved target population/s your program is serving (e.g. TAY, Southeast Asian, etc.)? Older Adults, individuals over 60 years of age. GART is the PEI program serving this population.

b. Number of separate paper referrals to an ACBH PEI-funded program. (This can be a provider's internal ACBH PEI-funded prevention or early intervention program OR an external PEI-funded ACBH prevention or early intervention program): None. GART does not refer to PEI programs.

c. Number of individuals followed through on referral & engaged in an ACBH PEI-funded program: None. GART does not refer to PEI programs.

d. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with the ACBH PEI-funded provider. None. GART does not refer to PEI programs.

e. Describe ways your program encouraged access to services and follow-through on the above referrals: GART is a hybrid early intervention (PEI) and ACBH specialty mental health program. Clinicians refer to non-PEI programs. Once services end, GART clinicians develop a discharge plan with the client and engage their natural support systems. Together, they identify best-matched, continued care to fit a client's mental health needs. Clinicians will call providers to arrange appointments and, when appropriate and possible, accompany clients to those intake meetings. Prior to discharge, clinicians will follow up with clients and providers to confirm that a connection has been made and assist further if needed.

f. Any additional information to report on (optional): N/A

**NARRATIVE**

a. Choose two of the above principles and describe how your program upholds or achieves those principles. Please speak to each principle separately and specifically describe how your program activities align with that corresponding principle.

Principle #1: Community Collaboration. How does your program align with this principle? GART clinicians have become regular presenters for the Alameda County Social Services Training and Consulting Team (TACT). They have provided valuable information about MHSA, the GART program and the mental health needs of older adults as part of an induction class for new public guardianship & conservator staff, APS & IHSS workers. In addition to these quarterly induction meetings, between August – October 2018, GART partnered with IHSS and met with 16 of their individual units to educate about identifying mental health issues during their assessment process and increase their ability to identify mental health needs for the older adults they serve. GART has become a resource for IHSS by providing consultation and ease of connecting client to best-matched mental health services to address their needs. GART regularly presents to Cal State East Bay nursing students and Meals on Wheels. Because the above-mentioned programs serve older adults, it benefits our shared clients for us to have strong, coordinated relationships with one another. Additional outreach efforts have been made with providers such as Jay Mahler Recovery Center, John George Psychiatric Pavilion and Fairmont PHP day program to meet new staff and provide information about referrals and services that clients can expect of the GART program. The GART team participates in quarterly Multi-Disciplinary meetings with the Area Agency on Aging – this provides many opportunities to collaborate and partner with treatment, legal, medical providers.

Principle #2: Wellness and Recovery. How does your program align with this principle? The GART program utilizes a client-centered approach toward identifying short and long-term goals and designing personalized mental health services by using a collaborative treatment plan. Clinicians then accompany (vs. direct) the client during their wellness and recovery process – providing support & guidance when needed. Clinicians utilize W.R.A.P. – Wellness Recovery Action Plans to engage clients in an accessible wellness process that can be utilized well after treatment ends. The GART program makes use of a multi-disciplinary team approach which includes an RN who sees every client. Approaching mental health treatment in this way benefits the client because clinicians take a "whole person" perspective to assessment & treatment. Doing so is critical when working with an aging population due to the frequency of co-occurring medical conditions which frequently impact an individual's mental health. In spring 2019, GART supervisors participated in planning process with several community partners for Daybreak Adult Day Center's Trauma Informed Care Conference. Supervisor also served as a panel presenter representing the ways in which GART provides trauma informed services to older adults within the community.

b. Please tell us about the following…

i. Implementation Challenges: GART continues to identify ways to connect with isolated seniors in the community. In addition to the major IHSS outreach project we tackled during the first quarter, GART continues to reach out to primary care and nutritional providers - two entities that interface with seniors who are isolated or otherwise making little connection with mental health services. We continue to work toward more successful outcomes with primary care referrals. Clinicians have consistently found that while clients may agree to mental health services and GART outreach when introduced by their primary care provider, they decline when a clinician reaches out. We've attempted to mitigate this issue by working toward stronger relationships with primary care providers (PCP). We've also suggested that, when possible & appropriate, PCP coordinate with GART to meet client at doctor's office to facilitate referrals. GART moved Headquarters from Hayward to Oakland in May 2019. While it was hoped that the move will be seamless, mostly because the program is field-based vs. clinic-based, there has been a transition and adjustment. In addition, the division director and supervisor have been exploring the possibility of changing the program name & considering rebranding with the updates.

Successes: GART is a resource for ACBH and receives referrals and requests for consultation from all levels of treatment providers – including service team mangers, acute setting clinicians (e.g. John George Inpatient) and residential treatment providers (e.g. Woodroe Place, Morton Baker & Jay Mahler sub-acute facilities). This spring, University of California @ Berkeley invited supervisor to speak with intern students for information and recruiting purposes. There may be a possibility of a first-year intern joining the team in the fall. GART team continues to be invited to speak quarterly with Cal State East Bay RN students and Social Services new employees as part of their orientation/induction process. Division Director has asked the team to develop a training to provide for ACBH Crisis Team as part of its expansion of services.

ii. Lessons Learned: There are a considerable number of older adults who do not meet the criteria for Alameda County services because they are Medi-CARE only or because they have a large share of cost. This is a major barrier to treatment due to additional cost involved for seniors who want mental health treatment but who do not have full-scope Medi-CAL. There is an incredible amount of untreated (& frequently unreported) trauma within this population. Because we frequently share clients, coordinated care is critical across the multiple providers that serve this population (e.g. APS, primary care, IHSS). Although stigma and ambivalence regarding mental health treatment is very present amongst older adults, clients are more likely to engage in services within the comfort of their own home or chosen setting.

iii. Relevant Examples of Success/Impact (e.g. a client success story) Reminder: Please do not use real client names: 70-year old client with no prior history of mental illness was referred by primary care provider because she stopped attending medical appointments. In addition to chronic pain throughout her body, client also complained of signs/symptoms consistent with major depressive disorder. During her intake appointment she described herself as feeling "dead inside". Initially she was agreeable to monthly check-ins with GART at her home. After meeting with the GART LCSW & RN twice, she shared information about extensive childhood physical & sexual trauma - as well as extensive substance abuse - that she had never revealed to her primary care providers. She agreed to meet weekly with the GART team and received individual therapy as well as brokerage services over a 6-8-month period of time. Services were extended for her due to her initial reluctance to engage in treatment as well as her need to transition thoughtfully to her new mental health providers upon discharge. This client's mood and level of daily functioning improved dramatically during this short period of time - she began looking into travel, social engagements and made progress in quitting her lifelong smoking habit. Upon discharge, this client was successfully linked to an ACBH contract provider.

**ADDITIONAL INFORMATION**

Please include the number of clients and/or contacts you estimate to serve in:

FY 19/20: 25 - 35
FY 20/21: 30 - 40

Please tell us about any changes you intend to make to your program over the next two fiscal years and explain your rationale for making these changes: This Year GART has had nearly 500 individual contacts with the community, 180 of those were unduplicated. Of this number, the GART program has opened 45 who were eligible to receive specialty mental health services. Please see above (page 2) for details that explain the difference between these numbers and the ways in which GART serves the community both as a MHSA & Specialty Mental Health program. There are no plans to change the program over the next fiscal year. GART will continue to provide services in the hybrid manner described above (page 2) – serving clients who meet specialty mental health criteria and those who do not.

**MHSA Program #: PEI 17A**

**PROVIDER NAME: Youth Uprising**

**PROGRAM NAME: TAY Resource Centers**

**Program Description:** Youth Uprising (YU) provides peer group sessions, counseling for healing and health, case management and holistic wellness services to youth, ages 13-25 in an accessible community setting.

Program Outcomes & Impact: PEI Data Report FY18/19

**PERFORMANCE INDICATORS: How Much Did We Do?**

| Total Numbers Served through PEI MHSA | |
|---|---|
| Number of unduplicated individuals your program serves who are **at-risk** of developing a mental health problem or serious mental illness (SMI) | 335 |
| Number of unduplicated individuals your program serves who show **early signs** of forming a more severe mental illness | 5 |
| Number of unduplicated individual family members served indirectly by your program: | 17 |
| Grand TOTAL of unduplicated individuals served in the Quarter that you are number (D) should = A+B+C.] | 357 |

**PERFORMANCE INDICATORS: How Well Did We Do?**
Demographics

**Age Group (Unduplicated)**

| | |
|---|---|
| Children/Youth (0---15) | 94 |
| Transition Age Youth (16---25) | 245 |
| Adult (26---59) | |
| Older Adult (60+) | |
| Unknown/ Declined to Answer | 1 |

**Race (Please mark only one choice)**
*If Hispanic or Latino, choose "Another race not listed."*

| | |
|---|---|
| American Indian or Alaska Native | 7 |
| Asian | 3 |
| Black or African American | 249 |
| Native Hawaiian or other Pacific Islander | 1 |
| White | 5 |
| More than one race | |
| Another race not listed | 44 |
| Unknown/ Declined to Answer | 31 |

**Sexual Orientation (Please mark only one choice)**

| | |
|---|---|
| Gay or Lesbian | 5 |
| Heterosexual or Straight | 236 |
| Bisexual | 25 |
| Questioning or unsure of sexual orientation | |
| Queer | 5 |
| Another sexual orientation not listed | 3 |
| Unknown/Decline to Answer | 66 |

**Ethnicity /Cultural Heritage (Please mark only once choice)**

| | |
|---|---|
| **If Hispanic or Latino, please specify:** | |
| Caribbean | |
| Central American | |
| Mexican/Mexican--American/Chicano | 8 |
| Puerto Rican | |
| South American | 1 |
| Another Hispanic/Latino ethnicity not listed | 50 |
| Unknown/Declined to | |
| **If Non-Hispanic or Non-Latino, please specify:** | |
| African | |
| African American | 242 |
| Asian Indian/South Asian | |
| Cambodian | |
| Chinese | |
| Eastern European | |
| European | 3 |
| Filipino | |
| Japanese | |
| Korean | |
| Middle Eastern | |
| Vietnamese | |
| Other Non-Hispanic or Non-Latino ethnicity not listed | 12 |
| **More than one ethnicity** | 5 |
| **Unknown /Declined to Answer** | 19 |

**Primary Language (Please mark only one choice)**

| | |
|---|---|
| English | 326 |
| Spanish | 3 |
| Farsi | |
| Cantonese | |
| Mandarin | |
| Other Chinese Dialects | |
| Vietnamese | |
| Korean | |
| Tagalog | |
| Other Filipino Dialect | |
| Japanese | |
| Laotian | |
| Cambodian | |
| Mien | |
| Hmong | |
| Samoan | |
| Thai | |
| Russian | |
| Polish | |
| German | |
| Italian | |
| Turkish | |
| Hebrew | |
| French | |
| Portuguese | |
| Armenian | |
| Arabic | |
| Sign ASL | |
| Other primary language not | 2 |
| Unknown/ Decline to Answer | 9 |

**Gender Identity (Please mark both parts A & B)**

| | |
|---|---|
| A) Assigned sex at birth: (Please mark only one | |
| Male | |
| Female | |
| Other sex not listed (e.g. Intersex) | |
| Unknown/Decline to Answer | |
| B) Current Gender Identity: (Please mark only one choice) | |
| Male | |
| Female | |
| Transgender | |
| Genderqueer | |
| Questioning or Unsure of Gender Identity | |
| Another Gender Identity not listed | |
| Unknown/Decline to Answer | |

**Disability Status** (Please mark all that apply)

| | |
|---|---|
| None | 262 |
| Yes. If yes, please specify (choose from list below): | |
| Difficulty Seeing | |
| Difficulty hearing, or having speech | |
| Mental Domain | 13 |
| Physical/Mobility Domain | 3 |
| Chronic Health Condition | 2 |
| Another disability not listed | 23 |
| Unknown/Decline to Answer | 37 |

**Veteran Status (Please mark only one choice)**

| | |
|---|---|
| Yes | 1 |
| No | 337 |
| Unknown/Decline to Answer | 2 |

**REQUIRED STRATEGY: INCREASE ACCESS AND LINKAGE TO MENTAL HEALTH TREATMENT**

a. Number of individuals with serious mental illness (SMI) who received a paper referral (i.e. referrals via phone do not apply) from your program to an ACBH mental health treatment program: 3

b. List type(s) of mental health treatment programs the individual was referred to: Fred Finch, STARS,

c. Number of individuals who were successfully referred and linked to an ACBH mental health treatment program (i.e. client has been seen at least once in person by a treatment provider): 1

d. Average duration in weeks of signs of untreated mental illness (per client self-report): 52
e. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with a mental health treatment provider: 2

f. Any additional information to report on? (Optional): Click here to enter text.

**REQUIRED STRATEGY: IMPROVE TIMELY ACCESS TO MENTAL HEALTH SERVICES FOR UNDERSERVED POPULATIONS**

a. Who is/are the underserved target population/s your program is serving (e.g. TAY, Southeast Asian, etc.)? TAY

b. Number of separate paper referrals to an ACBH PEI-funded program. (This can be a provider's internal ACBH PEI-funded prevention or early intervention program OR an external PEI-funded ACBH prevention or early intervention program): 81

c. Number of individuals followed through on referral & engaged in an ACBH PEI-funded program: 28

d. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with the ACBH PEI-funded provider. 2

e. Describe ways your program encouraged access to services and follow-through on the above referrals: We continue to encourage access by contacting within the week of initial paper referral and that initial visit the clinician travels to meet the client.

f. Any additional information to report on (optional): Click here to enter text.

**SECTION 5. OUTREACH. THIS SECTION IS *REQUIRED ONLY* FOR OUTREACH PROGRAMS. OTHERWISE, IT IS OPTIONAL**

| Measure | Annual Goal | Clients Served as of Quarter (1/2/3/Annual) |
|---|---|---|
| Number of referrals to supportive services | 100 | Q1:71/Q2:60/ Q3:59/ Q4/Annual: 257 |
| Number of confirmed linkages to referrals | 50 | Q1:6/Q2:38/ Q3:52/ Q4/Annual: 155 |
| Number of group series provided | 16 | Q1:4/ Q2:4/ Q3:4/ Q4/Annual:16 |
| Clients receiving Intervention Visit | 250 | Q1:131 / Q2:372/ Q3: 117/ Q4/Annual:782 |
| Clients receiving Individual Counseling | 30 | Q1:8/Q2:3/ Q3:8 New clients per quarter Q4/Annual:30 |
| Clients receiving Group Counseling | N/A | Q1:147 /Q2:293/ Q3:188 Q4/Annual:812 members total visits |
| Clients receiving Holistic Healing Sessions | 100 | Q1:34/ Q2:75/ Q3:146/ Q4/Annual:425 total visits |

- Group Themes for 2018-2019: Self-Esteem, Self-Love, Empowerment, Healthy Relationships, Domestic Violence, Self-Reflection, Social Justice, Anti-bullying, Advocating for Self, Moving Beyond Fear, Emotional Balance, Emotional Intelligence Vulnerability, Trauma Triggers, Self-Care, and Coping Skills
- In the 2018-2019 we strengthened our Masters level clinical training model. This year 4 clinical interns (2 MSW from UC Berkeley, 1 MFTi from Holy Names University and 1 MFTi from CIIS) joined our clinical team to gain skills in the field and support our prevention model by offering direct clinical services to the members. Our intervention visit number has increase substantially due to having the additional clinical support and we are able to reach members that would not typically engage in traditional therapy.
- Many of the youth and community members are taking advantage of the YU Holistic services so our numbers have increased.
- We are strengthening our community collaboration and have a new clinical referral pipeline with EOYDC to support their youth with mental health services. We concluded our Leadership Training at EOYDC to decreased stigma around mental health services and increase access. We are now working with HHREC, another PEI funded program, to offer Healing through Art Workshops to our youth members and has an art exhibit up in the space.

**NARRATIVE**

a. Choose two of the above principles and describe how your program upholds or achieves those principles. Please speak to each principle separately and specifically describe how your program activities align with that corresponding principle.

Principle #1: Community Collaboration. How does your program align with this principle? Over the 2018-2019 fiscal year we have increased community collaboration tremendously. We have a partnership with EOYDC to decrease stigma around and increase access to mental health services. Reduced signs of trauma in TAY interns and increased awareness around triggers that impact their overall ability to function and build healthy relationships. Also, HHREC provided Health through Art workshops. This also expanded our community reach. We also have partnered with other PEI funded programs and community-based organizations to have a more diverse delivery of mental health services. This has increased our ability to provide more holistic mental health services to a population that has challenges engaging in traditional therapy.

Principle #2: Integrated Service Delivery. How does your program align with this principle? We put specialized focus on strengthening our referral and collaboration process with our Arts & Expressions and Career & Education Departments in addition to other community-based organizations such as EOYDC. Strengthening these partnerships allows the clinical team to better wrap around the entire youth and ensure that their overall needs are supported in a way that increase success and sustainability with supports such as employment, housing, and education services for TAY in a way that supports and prevents mental health challenges. This has also been proven to streamline access to mental health services for TAY.

b. Please tell us about the following…

i. Implementation Challenges: One challenge is connecting with the youth once a referral is received. Although we receive ample referrals capturing the TAY and registering them for therapeutic intervention often only takes 2 weeks however their follow through with the initial appointment is stretched due to typical TAY risk factors such as broken or no phone, moved, skipped class, etc.

ii. Successes: Strong partnerships with EOYDC and now HHREC (Health through Art), which increased our community collaboration and our ability to support more youth in the East Oakland neighborhoods. Creating a

graduate level clinical intern training program allows us to triage and provide mental health services to more TAY as well improve our visibility amongst other community stakeholders.

iii. Lessons Learned: Our highlight lesson learned this fiscal year is that partnership and multiple adult contact is important to sustaining the success and gains of our TAY client's.

iv. Relevant Examples of Success/Impact (e.g. a client success story) Reminder: Please do not use real client names: A 16-year old male was referred to YU with severe PTSD. He has been engaged in mental health services at YU for about 18 months. His PTSD symptoms impacted his ability to regulate his emotions in class and at home, leading to conflicts with his caregiver & teachers and impacting his overall academic success. During his time working with one of our clinicians he was able to obtain a 504 plan at his school. Because of this he was able to complete the school year and summer school with no incidents. He is now on track to graduating with his class. He was also able complete the summer job training at YU and was placed at a nearby café. Because of this success and his heightened confidence and ability to self-reflect he is now able to engage in family therapy to begin to repair his relationship with his caregiver.

**ADDITIONAL INFORMATION**

Please include the number of clients and/or contacts you estimate to serve in:

FY 19/20: 300
FY 20/21: 300

Please tell us about any changes you intend to make to your program over the next two fiscal years and explain your rationale for making these changes: No changes anticipated.

**MHSA Program #: PEI 17B**

**PROVIDER NAME: REACH Ashland Youth Center**

**PROGRAM NAM: TAY Resource Centers**

**Program Description**: REACH serves youth ages 11 through 24 who live throughout Alameda County with a focus on the Ashland and unincorporated area. We help our members overcome the immediate and prevalent obstacles in their lives by cultivating their own strengths and promise. In the process, they develop resiliency and the skills they need to take positive action and thrive, even amidst ongoing personal trauma and social disadvantage.

Program Outcomes & Impact: PEI Data Report FY18/19

**PERFORMANCE INDICATORS: How Much Did We Do?**

| **Total Numbers Served through PEI MHSA** | |
|---|---|
| Number of unduplicated individuals your program serves who are **at-risk**[1] of developing a mental health problem or serious mental illness (SMI)[2] | 330 |
| Number of unduplicated individuals your program serves who show **early signs** of forming a more severe mental illness | 32 |
| Number of unduplicated individual family members[3] served indirectly by your program: | 231 |
| Grand TOTAL of unduplicated individuals served in the Quarter that you are reporting about. [This number (D) should = A+B+C.] | 593 |

List Number of Individuals Reached by each Activity (ex: who accessed website, social media hits, tabling/outreach events, e-blasts, etc.): 856; the community engagement events are an estimate for youth and adults who were reached. These numbers may be duplicated, with the exception of COST referrals.

| **Type of Activity** (ex: accessed website) | **# of Individuals Reached** |
|---|---|
| COST Referrals | 82 |
| Non-clinical Health & Wellness groups and programs at REACH outside of COST | 274 |
| -Creative Writing, Gardening, Girls Group, Boys Group, Storytelling, Mindfulness, etc.. | |
| Community Events (Cinco de Mayo, Holiday Lighting, etc.) | 500 |

**PERFORMANCE INDICATORS: How Well Did We Do?**
Demographics

**Age Group (Unduplicated)**

| | |
|---|---|
| Children/Youth (0-••15) | 197 |
| Transition Age Youth (16-••25) | 126 |
| Adult (26-••59) | 0 |
| Older Adult (60+) | 0 |
| Unknown/ Declined to Answer | 7 |

**Race (Please mark only one choice)**
*If Hispanic or Latino, choose "Another race not listed."*

| | |
|---|---|
| American Indian or Alaska Native | 1 |
| Asian | 10 |
| Black or African American | 115 |
| Native Hawaiian or other Pacific Islander | 0 |
| White | 14 |
| More than one race | 34 |
| Another race not listed | 129 |
| Unknown/ Declined to Answer | 27 |

**Sexual Orientation (Please mark only one choice)**

| | |
|---|---|
| Gay or Lesbian | |
| Heterosexual or Straight | |
| Bisexual | |
| Questioning or unsure of sexual orientation | |
| Queer | |
| Another sexual orientation not | |
| Unknown/Decline to Answer | 330 |

**Ethnicity /Cultural Heritage (Please mark only once choice)**

| | |
|---|---|
| **If Hispanic or Latino, please specify:** | |
| Caribbean | 0 |
| Central American | 4 |
| Mexican/Mexican- | 87 |
| Puerto Rican | 1 |
| South American | 0 |
| Another | 0 |
| Hispanic/Latino Unknown/Declined to | 31 |
| **If Non-Hispanic or Non-Latino, please specify:** | |
| African | 42 |
| African American | 72 |
| Asian Indian/South Asian | 1 |
| Cambodian | 0 |
| Chinese | 4 |
| Eastern European | 1 |
| European | 13 |
| Filipino | 2 |
| Japanese | 0 |
| Korean | 0 |
| Middle Eastern | 0 |
| Vietnamese | 1 |
| Other Non-Hispanic or Non- Latino ethnicity not | 3 |
| **More than one ethnicity** | 34 |
| **Unknown /Declined to Answer** | 34 |

**Primary Language (Please mark only one choice)**

| | |
|---|---|
| English | 154 |
| Spanish | 63 |
| Farsi | 0 |
| Cantonese | 0 |
| Mandarin | 0 |
| Other Chinese | 4 |
| Vietnamese | 0 |
| Korean | 0 |
| Tagalog | 0 |
| Other Filipino | 0 |
| Japanese | 0 |
| Laotian | 0 |
| Cambodian | 0 |
| Mien | 0 |
| Hmong | 0 |
| Samoan | 0 |
| Thai | 0 |
| Russian | 0 |
| Polish | 0 |
| German | 0 |
| Italian | 0 |
| Turkish | 0 |
| Hebrew | 0 |
| French | 0 |
| Portuguese | 0 |
| Armenian | 0 |
| Arabic | 0 |
| Sign ASL | 0 |
| Other primar | 2 |
| Unknown/ Decline to Answer | 107 |

| **Gender Identity (Please mark both parts A & B)** | |
|---|---|
| A) Assigned sex at birth: (Please mark only one choice) | |
| Male | |
| Female | |
| Other sex not listed (e.g. Intersex) | |
| Unknown/Decline to Answer | 330 |
| B) Current Gender Identity: (Please mark only one choice) | |
| Male | 122 |
| Female | 157 |
| Transgender | 0 |
| Genderqueer | 1 |
| Questioning or Unsure of Gender Identity | 0 |
| Another Gender Identity not listed | 0 |
| Unknown/Decline to Answer | 50 |

**Disability Status** (Please mark all that apply)

| | |
|---|---|
| None | |
| Yes. If yes, please specify (choose from list below): | |
| Difficulty Seeing | |
| Difficulty hearing, or having speech | |
| Mental Domain | |
| Physical/Mobility Domain | |
| Chronic Health Condition | |
| Another disability not listed | |
| Unknown/Decline to Answer | 330 |

**Veteran Status (Please mark only one choice)**

| | |
|---|---|
| Yes | |
| No | |
| Unknown/Decline to Answer | 330 |

**REQUIRED STRATEGY: INCREASE ACCESS AND LINKAGE TO MENTAL HEALTH TREATMENT**

a. Number of individuals with serious mental illness (SMI) who received a paper referral (i.e. referrals via phone do not apply) from your program to an ACBH mental health treatment program: 19

b. List type(s) of mental health treatment programs the individual was referred to: Individual therapy at REACH, Fuente
Wellness Clinic, Youth and Family Service Bureau, Eden Children Services, Fred Finch and Willow Rock Adolescent Center

c. Number of individuals who were successfully referred and linked to an ACBH mental health treatment program (i.e.
client has been seen at least once in person by a treatment provider): 15

d. Average duration in weeks of signs of untreated mental illness (per client self-report): 4

e. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with a mental health treatment provider: 2

**REQUIRED STRATEGY: IMPROVE TIMELY ACCESS TO MENTAL HEALTH SERVICES FOR UNDERSERVED POPULATIONS**

a. Who is/are the underserved target population/s your program is serving (e.g. TAY, Southeast Asian, etc.)? REACH serves youth who live in Alameda County ages 11-24 year and specifically youth who live and attend schools in the unincorporated areas of Ashland, Cherryland and San Lorenzo. REACH also serves youth who are involved in the justice system and foster care.

b. Number of separate paper referrals to an ACBH PEI-funded program. (This can be a provider's internal ACBH PEI-funded prevention or early intervention program OR an external PEI-funded ACBH prevention or early intervention program): 63

c. Number of individuals followed through on referral & engaged in an ACBH PEI-funded program: 38

d. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with the ACBH PEI-funded provider. 2

e. Describe ways your program encouraged access to services and follow-through on the above referrals: We connected youth services by conducting brief assessment of needs, vetting of the referral and assisting them to contact potential providers. We were also able to successfully connect youth to services by providing a warm "hand off" to program providers housed within REACH. We also contacted potential providers to inquire about service availability and turnaround time to youth to be contacted.

**NARRATIVE**

a. Choose two of the above principles and describe how your program upholds or achieves those principles. Please speak to each principle separately and specifically describe how your program activities align with that corresponding principle.

Principle #1: Client, Consumer, and Family Involvement How does your program align with this principle? We envision a vibrant community in which all youth thrive. We believe that when youth thrive our community also thrive. We infused youth voices in to our programming and have a youth led leadership group called Youth ERA (Empowered Residents of Ashland). We have started surveying families to inquire about level of interests in volunteering as well as workshops and topics that they would like to learn more about. REACH now has a Family Engagement team and sub committees dedicated to implement some of our family strategies. One of these sub committees is to prepare and design a family room where caregivers can utilize for meetings and workshops.

Principle #2: Integrated Service Delivery How does your program align with this principle? In the last year, we have
continued to build out our coordination of care service delivery model. We have a variety of programs provided by different organizations housed within REACH and understand the need for all of us to be coordinated and integrated as service providers.

b. Please tell us about the following…

i. Implementation Challenges: Transitional Age Youth services continues to be a challenge, no employment provider, lack of clarity around protocols and procedures, different levels of professional development, limited understanding of adolescent/youth development, and understanding of positive youth development model.

ii. Successes: Continue to have youth leadership group (Youth ERA), Successful 2nd annual Summer Camp at REACH, Coordination of Services Team (COST), youth engagement, and youth internship.

iii. Lessons Learned: Continue to build capacity and alignment with staff by increasing professional development trainings and opportunities. Increase outreach to the community including schools in the immediate areas and increase engagement with parents, caregivers, and families.

iv. Relevant Examples of Success/Impact (e.g. a client success story) Reminder: Please do not use real client names: This last fiscal year, the Youth Leadership Council Now Youth ERA rebranded their name and became more involved with the Board of Supervisors Office and also helped with the successful implementation of a School Resource Officer (SRO) back in to REACH. Youth ERA met weekly to prepare questions and feedback for Supervisor Miley and his office in regard to the events which occurred the year prior when the proposal for the Alameda County Sheriff's Office to become the lead operator of REACH.

**ADDITIONAL INFORMATION**

Please include the number of clients and/or contacts you estimate to serve in: FY 19/20: 350
FY 20/21: 350

Please tell us about any changes you intend to make to your program over the next two fiscal years and explain your rationale for making these changes: We hope to serve more youth with the addition of 2 clinicians from the Youth and Family Service Bureau Behavioral Health Unit as well as social work intern from Smith College. We also will be working on integrating our services better with our in-house partners as well as community partners.

# PREVENTION & EARLY INVERVENTION PROGRAM SUMMARIES:
# OUTREACH FOR INCREASING RECOGNITION OF EARLY SIGNS OF MENTAL ILLNESS PROGRAMS

**MHSA Program #: PEI 1C**

**PROGRAM NAME Early Childhood Mental Health Outreach and Consultation**

**Program Descriptions:** Early Childhood Mental Health Consultation to teachers and directors in low-income preschool programs utilizing the Stands of Practice. Consultation with parents when additional support and linkages are indicated.

Program Outcomes & Impact: PEI Data Report FY18/19

**PERFORMANCE INDICATORS: How Much Did We Do?**

| Total Numbers Served through PEI MHSA | |
|---|---|
| Number of unduplicated individuals your program serves who are **at-risk** of developing a mental health problem or serious mental illness (SMI) | 392 |
| Number of unduplicated individuals your program serves who show **early signs** of forming a more severe mental illness | NA |
| Number of unduplicated individual family members served indirectly by your program: | 21 |
| Grand TOTAL of unduplicated individuals served in the Quarter that you are reporting about. [This number (D) should = A+B+C.] | 413 |

**PERFORMANCE INDICATORS: How Well Did We Do?**
Demographics

**Age Group (Unduplicated)**

| | |
|---|---|
| Children/Youth (0---15) | 291 |
| Transition Age Youth (16---25) | 10 |
| Adult (26---59) | 87 |
| Older Adult (60+) | 25 |

**Race (Please mark only one choice)**
*If Hispanic or Latino, choose "Another race not listed"*

| | |
|---|---|
| American Indian or Alaska Native | 1 |
| Asian | 79 |
| Black or African American | 144 |
| Native Hawaiian or other Pacific Islander | 2 |
| White | 57 |
| More than one race | 14 |
| Another race not listed | 116 |
| Unknown/ Declined to Answer | |

**Sexual Orientation (Please mark only one choice)**

| | |
|---|---|
| Gay or Lesbian | 1 |
| Heterosexual or Straight | 20 |
| Bisexual | |
| Questioning or unsure of sexual orientation | |
| Queer | |
| Another sexual orientation not listed | |
| Unknown/Decline to Answer | 21 |

**Ethnicity /Cultural Heritage (Please mark only once choice)**

| | |
|---|---|
| **If Hispanic or Latino, please specify:** | |
| Caribbean | 4 |
| Central American | 38 |
| Mexican/Mexican-- | 110 |
| Puerto Rican | 1 |
| South American | 3 |
| Another Hispanic/Latino | 11 |
| Unknown/Declined to Answer | |
| **If Non-Hispanic or Non-Latino, please specify:** | |
| African | 50 |
| African American | 98 |
| Asian Indian/South Asian | 8 |
| Cambodian | 1 |
| Chinese | 27 |
| Eastern European | |
| European | 3 |
| Filipino | 4 |
| Japanese | |
| Korean | |
| Middle Eastern | 3 |
| Vietnamese | 17 |
| Other Non-Hispanic or Non- Latino ethnicity not listed | |
| **More than one ethnicity** | 16 |
| **Unknown /Declined to Answer** | 19 |

**Primary Language (Please mark only one choice)**

| | |
|---|---|
| English | 14 |
| Spanish | 15 |
| Farsi | |
| Cantonese | 6 |
| Mandarin | 20 |
| Other Chinese Dialects | |
| Vietnamese | 17 |
| Korean | |
| Tagalog | 1 |
| Other Filipino Dialect | 1 |
| Japanese | |
| Laotian | |
| Cambodian | |
| Mien | |
| Hmong | |
| Samoan | |
| Thai | |
| Russian | |
| Polish | |
| German | |
| Italian | |
| Turkish | |
| Hebrew | |
| French | 1 |
| Portuguese | |
| Armenian | |
| Arabic | 5 |
| Sign ASL | |
| Other primary language not | 62 |
| Unknown/ Decline to Answer | 3 |

**Gender Identity (Please mark both parts A & B)**

| | |
|---|---|
| A) Assigned sex at birth: (Please mark only one choice) | |
| Male | 130 |
| Female | 166 |
| Other sex not listed (e.g. Intersex) | |
| Unknown/Decline to Answer | 117 |
| B) Current Gender Identity: (Please mark only one choice) | |
| Male | |
| Female | |
| Transgender | |
| Genderqueer | |
| Questioning or Unsure of Gender Identity | |
| Another Gender Identity not listed | |

**Disability Status** (Please mark all that apply)

| | |
|---|---|
| None | |
| Yes. If yes, please specify (choose from list below): | |
| Difficulty Seeing | |
| Difficulty hearing, or having speech | 4 |
| Mental Domain | 2 |
| Physical/Mobility Domain | |
| Chronic Health Condition | |
| Another disability not listed | |
| Unknown/Decline to Answer | 40 |

**Veteran Status (Please mark only one choice)**

| | |
|---|---|
| Yes | |
| No | 29 |
| Unknown/Decline to Answer | 11 |

**Primary Language (Please mark only one choice)**

| |
|---|
| English |
| Spanish |
| Farsi |
| Cantonese |
| Mandarin |
| Other Chinese Dialects |
| Vietnamese |
| Korean |
| Tagalog |
| Other Filipino Dialect |
| Japanese |
| Laotian |
| Cambodian |
| Mien |
| Hmong |
| Samoan |
| Thai |
| Russian |
| Polish |
| German |
| Italian |
| Turkish |
| Hebrew |
| French |
| Portuguese |
| Armenian |
| Arabic |
| Sign ASL |
| Other primary language not |
| Unknown/ Decline to Answer |

**Gender Identity**

| | |
|---|---|
| A) Assigned sex at birth: (Please mark only one choice) | |
| Male | |
| Female | 6 |
| Other sex not listed (e.g. Intersex) | |
| Unknown/Decline to Answer | |
| B) Current Gender Identity: (Please mark only one choice) | |
| Male | 7 |
| Female | 15 |
| Transgender | 2 |
| Genderqueer | 1 |
| Questioning or Unsure of Gender Identity | |
| Another Gender Identity not listed | |
| Unknown/Decline to Answer | |

**Disability Status** (Please mark all that apply)

| |
|---|
| None |
| Yes. If yes, please specify (choose from list below): |
| Difficulty Seeing |
| Difficulty hearing, or having speech understood |
| Mental Domain |
| Physical/Mobility Domain |
| Chronic Health Condition |
| Another disability not listed |
| Unknown/Decline to Answer |

**Veteran Status (Please mark only one choice)**

| |
|---|
| Yes |
| No |
| Unknown/Decline to Answer |

**REQUIRED STRATEGY: IMPROVE TIMELY ACCESS TO MENTAL HEALTH SERVICES FOR UNDERSERVED POPULATIONS**

a. Who is/are the underserved target population/s your program is serving (e.g. TAY, Southeast Asian, etc.)? LGBTQ community, first generation immigrant youth, youth identified as Black, Muslim, Latin-x, Asian, and Filipino. The Outreach for School-Based Health Centers program helps improve access to mental health services to a diverse population of youth across multiple schools that would otherwise be unaware and in some cases unable to obtain mental health support. By conducting outreach efforts on-campus, we provide information and resources directly to youth in a non-judgmental and easily accessible manner. By outreaching to school district and school site personnel who have relationships with all youth, our program was able to obtain referrals and connect with youth who would otherwise not seek services or support on their own.

b. Number of separate paper referrals to an ACBH PEI-funded program. (This can be a provider's internal ACBH PEI-funded prevention or early intervention program OR an external PEI-funded ACBH prevention or early intervention program): N/A

c. Number of individuals followed through on referral & engaged in an ACBH PEI-funded program: N/A

d. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with the ACBH PEI-funded provider. N/A

e. Describe ways your program encouraged access to services and follow-through on the above referrals: N/A

f. Any additional information to report on (optional):

**OUTREACH. THIS SECTION IS *REQUIRED ONLY* FOR OUTREACH PROGRAMS. OTHERWISE, IT IS OPTIONAL.**
Number of potential responders: 2,126

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

| **Type of Setting(s)** | **Type(s) of Potential Responders** (ex: principals, teachers, parents, nurses) |
|---|---|
| **Suicide Awareness &** | Students, Teachers, District Staff (367 youth & 17 adults) |
| **District LGBTQ** | Students, District Staff, Teachers, Community Members (6 youth & 4 adults) |
| **City Collaborative** | District Staff, Superintended, County Supervisor, City Staff, Program Directors of local |
| **Class Presentations** | Students & teachers (120 youth & 1 adult) + (85 youth & 6 adults)+(19youth & 6adults) |
| **Middle School Chalk event** | Students, teachers, district staff, administration (120 youth & 8 adults) |
| **Teacher Packets about** | Counselors, teachers, & administration (180 adults) *not counted |
| **Youth Development** | Students (27 youth) |
| **Youth Confidence Event** | Students, teacher (20 youth, 1 adult) |
| **School Video about Mental** | Students, school faculty (1700 youth, 78 adults) *not counted |
| **Stress Awareness &** | Students, teachers, counselors (55 youth, 15 adults) |
| **District Behavioral Health** | Director of Students Services, Program Managers (2 adults) |
| **Gratitude Tabling Event** | Students, teachers (30 youth, 5 adults) |
| **Post-vention Support Mtg.** | District Program Manager, School Psychologists, Counselors, Intervention Leads (20 |
| **BAPHR Presentation** | Physicians (22 adults) |
| **Mental Health** | Counselors, School Psychologist, Intervention Lead (10 adults) |
| **Family Night** | Students, Teachers, Administration (50 youth, 55 adults)+ (45 & 36) |

| | |
|---|---|
| **Health & Wellness Class** | Students (11) |
| **Teen Dating Violence** | Students, teachers, administration, police department (633 youth & 40 adults) |
| **Boys & Girls Club** | Board Members (8) |
| **Service Announcements** | Students (2,880 youth) *not counted |
| **Community/District Mtg.** | Parents, District Staff, Community Members (18 adults) |
| **Community Services Mtg.** | Recent graduates, City Council members, community members (4 youth, 20 adults) |
| **Mental Health Awrns Camp** | Students, City Staff, Program Director of Girls Inc. (3 youth, 9 adults) |
| **Mental Health Awrns** | Students (180 youth) |

**NARRATIVE**

a. Choose two of the above principles and describe how your program upholds or achieves those principles. Please speak to each principle separately and specifically describe how your program activities align with that corresponding principle.

Principle #1: Wellness and Recovery How does your program align with this principle? Though one of our main goals as an outreach program is to ensure those students most in need are aware and know how to access mental health services, we acknowledge that many of the students we interact with are not in crisis but are at risk of developing severe issues. Therefore, we make strong efforts in each of our outreach efforts to promote wellness and resiliency. We want our consumers to hear about and acknowledge the importance of their own mental health and identify ways that they can maintain or when needed improve their wellbeing. For example, our Suicide Prevention Awareness Month activities have a significant focus on protective factors that the youth have the ability to partially control. At our tabling event this year, youth were encouraged and supported in identifying coping techniques that they already used in their lives as well as providing examples of alternatives. This was done through a bracelet making activity where various coping skills were assigned to different color beads. The youth were then able to make a bracelet for themselves that was designed to act as a reminder for them to use their coping skills when they were experiencing troubling emotions or thoughts.

Principle #2: Client, Consumer, and Family Involvement How does your program align with this principle? Youth are the primary consumers and clients for our outreach services and as such youth are encouraged and supported in having a voice in the content, planning, implementation, and evaluation of all of our outreach efforts. We do this at multiple levels and with diverse range of students who are interacting with our program. At each of the health centers we have created an advisory board that is comprised of youth representatives from the school. This diverse group of students plays an essential role in helping ensure that our outreach efforts are properly designed to meet our target audience. They assist with the planning on how to convey the information in a manner that will be received by youth. At large events, the youth actually assist in the tabling, encouraging their peers to interact with the information that is being provided. Lastly, the youth advisory board meets after a large event to celebrate the achievements and brainstorm how to address any challenges that arose. Also, every youth that interacts with our outreach efforts is invited to take an anonymous evaluation survey that provides our program with valuable information regarding the consumers experience with our outreach efforts.

b. Please tell us about the following…

i. Implementation Challenges: Stress Management – Trying to provide additional support at a very stressful time had a competing message to youth. We made multiple attempts in our outreach and warm handoffs from school personnel and though successful for those students that attended, we had lower numbers that we had originally anticipated given our youth advisory board and our own clients' verbalization that they and other students would benefit from having events focused on stress management.

ii. Successes: Through our 3-day Stress Awareness & Management series, we successfully provided youth with space to be able to decompress and prioritize their mental health at a peak time of stress with finals, college applications, and the holidays approaching. Students who participated in the series obtained peer support, knowledge about mental health resources on-campus, and took away both physical objects and strategies to be able to manage stress. Youth also learned how to take an inventory of their own stress level and identify what internal resources they can access on their own and when to seek mental health support both for themselves and their peers.

iii. Lessons Learned: A lesson we learned from our Stress Management series was that though the concept of providing a time and space for stress management was highly desired by youth, actually stepping away from their stress to take time for themselves was actually harder for them than we all anticipated. The belief was that by providing students with strategies to take care of their own mental health the week before finals would allow them to enter finals in a better space, however many students were already too stressed at that time. We will explore doing a similar event at the end of next semester and will start it a week earlier.

iv. Relevant Examples of Success/Impact (e.g. a client success story) Reminder: Please do not use real client names: Though our efforts for the Stress Management were geared towards upper class students in the high school dealing with Finals and College Applications, we had a number of new middle schoolers come to the events. This provided us with the opportunity to develop relationships with youth who had not interacted with our Health Center. The Stress Management event led to one of the middle school students entering into individual therapy.

**EVALUATION PLAN UPDATE**

a. Please describe, in 1-2 sentences, your effort to collect feedback from program participants (method used). Please include the timeframes of when you survey clients. We created an anonymous Google Form that youth have the option of completing through our tablets when they engage in our events. We only collect data survey during the events to ensure the data is from youth who have actually participated.

b. Describe the tool (i.e. MHSIP or another survey) used to collect data. The Google Form is a 5-question survey that was created by staff with input from our Youth Advisory Boards.

c. Summarize the results if any. 87.5% of the youth who have taken the survey, responded that they had learned at least one thing about Suicide Prevention during our events. 95.2% of youth responded “Yes” to knowing at least one person/place that they can go to for help on campus. 62% of youth responded “Yes” to knowing they can access Mental Health Support at the SBHCs. 100% of the youth responded “Yes” to enjoying the events.

d. What was learned from the participant feedback (**1-2 key points**)? The most significant point to us is that 75% of the youth were knowledgeable about obtaining mental health support at the SBHC. This is a number we hope to continue to grow throughout our efforts.

e. Describe how the findings were reviewed by staff. As a Google Form, the Program Director was able to bring up the results as a Summary with graphs. This was presented during a Staff Meeting. At the staff meeting staff highlighted trends, celebrated success, and focused discussion on comments that showed needs for improvement.

f. What programmatic change(s) were or will be adopted as a result of the findings? When will changes be made and how will the changes impact programming? A change we had been discussing for a long time, but did not have the data to support, was that we need to unify the branding of the SBHC. Anecdotally, students have shared that there is some confusion about the School Based Health Center being a part of the school and not a program of Alameda Family Services. We are now being mindful of putting our logo on all of our paperwork, flyers, and posters. We also are making sure to visibly note that any of the classroom presentations or lunch time tabling events are provided the School Based Health Center. We hope that this will provide clarification

to youth and staff and eventually lead to more students both being knowledgeable about where to obtain services and seeking them out when in need.

g. What issues or challenges with the Evaluation Plan are you having? What technical assistance do you need?
No need.

**ADDITIONAL INFORMATION**

Please include the number of clients and/or contacts you estimate to serve in:

FY 19/20: 1,850
FY 20/21: 1,900

Please tell us about any changes you intend to make to your program over the next two fiscal years and explain your rationale for making these changes: We would like to explore the potential of providing outreach on a smaller scale to the middle schools. Anecdotally, youth report experiencing mental health needs in middle school, but not necessarily having the resources or autonomy to access services. With additional funding, we believe we may be able to provide outreach & awareness about relevant mental health issues and even refer youth to resources within the community.

**MHSA Program #: PEI 1F**

**PROGRAM NAME: Community-Based Mental Health Outreach and Consultation**

**Program Description**: EBAC's Fremont Healthy Start Program engages, encourages, and trains potential community responders, primarily family members of youth and children but also school staff and community members, about ways to recognize and respond to early signs of mental illness.

Program Outcomes & Impact: PEI Data Report FY18/19

**PERFORMANCE INDICATORS: How Much Did We Do?**

| Total Numbers Served through PEI MHSA | |
|---|---|
| Number of unduplicated individuals your program serves who are **at-risk** of developing a mental health problem or serious mental illness (SMI) | 1,053 |
| Number of unduplicated individuals your program serves who show **early signs** of forming a more severe mental illness | 92 |
| Number of unduplicated individual family members served indirectly by your program: | 2,526 |
| Grand TOTAL of unduplicated individuals served in the Quarter that you are reporting about. [This number (D) should = A+B+C.] | 3,672 |

**PERFORMANCE INDICATORS: How Well Did We Do?**
Demographics

**Age Group (Unduplicated)**

| | |
|---|---|
| Children/Youth (0---15) | 36 |
| Transition Age Youth (16---25) | 103 |
| Adult (26---59) | 623 |
| Older Adult (60+) | 383 |
| Unknown/ Declined to Answer | 0 |

**Race (Please mark only one choice)**
*If Hispanic or Latino, choose "Another race not listed."*

| | |
|---|---|
| American Indian or Alaska Native | 0 |
| Asian | 662 |
| Black or African American | 22 |
| Native Hawaiian or other Pacific Islander | 15 |
| White | 63 |
| More than one race | 4 |
| Another race not listed | 315 |
| Unknown/ Declined to Answer | 61 |

**Sexual Orientation (Please mark only one choice)**

| | |
|---|---|
| Gay or Lesbian | |
| Heterosexual or Straight | 37 |
| Bisexual | |
| Questioning or unsure of sexual orientation | |
| Queer | |
| Another sexual orientation not listed | |
| Unknown/Decline to Answer | 29 |

**Ethnicity /Cultural Heritage (Please mark only once choice)**

| | |
|---|---|
| **If Hispanic or Latino, please specify:** | |
| Caribbean | 1 |
| Central American | 13 |
| Mexican/Mexican--American/Chicano | 283 |
| Puerto Rican | 0 |
| South American | 12 |
| Another Hispanic/Latino ethnicity not listed | 85 |
| Unknown/Declined to Answer | 5 |
| **If Non-Hispanic or Non-Latino, please specify:** | |
| African | 0 |
| African American | 22 |
| Asian Indian/South Asian | 120 |
| Cambodian | 5 |
| Chinese | 200 |
| Eastern European | 0 |
| European | 0 |
| Filipino | 39 |
| Japanese | 0 |
| Korean | 105 |
| Middle Eastern | 79 |
| Vietnamese | 32 |
| Other Non-Hispanic or Non-Latino ethnicity not listed | 82 |
| **More than one ethnicity** | 0 |
| **Unknown /Declined to Answer** | 62 |

**Primary Language (Please mark only one choice)**

| | |
|---|---|
| English | 33 |
| Spanish | 34 |
| Farsi | 12 |
| Cantonese | 43 |
| Mandarin | 12 |
| Other Chinese Dialects | 25 |
| Vietnamese | 21 |
| Korean | 81 |
| Tagalog | 0 |
| Other Filipino Dialect | 7 |
| Japanese | 0 |
| Laotian | 0 |
| Cambodian | 5 |
| Mien | 0 |
| Hmong | 0 |
| Samoan | 0 |
| Thai | 0 |
| Russian | 0 |
| Polish | 0 |
| German | 0 |
| Italian | 0 |
| Turkish | 0 |
| Hebrew | 0 |
| French | 0 |
| Portuguese | 0 |
| Armenian | 0 |
| Arabic | 0 |
| Sign ASL | 0 |
| Other primary language not | 71 |
| Unknown/ Decline to Answer | 70 |

**Gender Identity (Please mark both parts A & B)**

| | |
|---|---|
| A) Assigned sex at birth: (Please mark only one choice) | |
| Male | 362 |
| Female | 790 |
| Other sex not listed (e.g. Intersex) | 0 |
| Unknown/Decline to Answer | 0 |
| B) Current Gender Identity: (Please mark only one choice) | |
| Male | 362 |
| Female | 790 |
| Transgender | |
| Genderqueer | |
| Questioning or Unsure of Gender Identity | |
| Another Gender Identity not listed | |
| Unknown/Decline to Answer | |

**Disability Status** (Please mark all that apply)

| | |
|---|---|
| None | 67 |
| Yes. If yes, please specify (choose from list below): | |
| Difficulty Seeing | 4 |
| Difficulty hearing, or having speech | 5 |
| Mental Domain | 23 |
| Physical/Mobility Domain | 20 |
| Chronic Health Condition | 31 |
| Another disability not listed | 7 |
| Unknown/Decline to Answer | 19 |

**Veteran Status (Please mark only one choice)**

| | |
|---|---|
| Yes | 0 |
| No | 114 |
| Unknown/Decline to Answer | 0 |

**OUTREACH. THIS SECTION IS *REQUIRED ONLY* FOR OUTREACH PROGRAMS. OTHERWISE, IT IS OPTIONAL.**

Number of potential responders: 3,672

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

| **Type of Setting(s)** (ex: school, place of worship, clinic) | **Type(s) of Potential Responders** (ex: principals, teachers, parents, nurses) |
|---|---|

| | |
|---|---|
| **Fremont Healthy Start Program Office** | Parents, caregivers, general community members |
| **Fremont Family Resource Center Welcome** | Parents, caregivers, general community members |
| **School** | School staff, teachers, parents, caregivers |
| **Client Homes** | Parents, caregivers, general community members |

**NARRATIVE**

a. Choose two of the above principles and describe how your program upholds or achieves those principles. Please speak to each principle separately and specifically describe how your program activities align with that corresponding principle.

Principle #1: Client, Consumer, and Family Involvement How does your program align with this principle? Trauma involves a loss of power and control that makes those impacted by trauma feel helpless. By giving real opportunities for parents to provide their voice and choices, they will feel empowered and can promote their own wellness. Creating and developing leadership and growth opportunities for families is a core value of our Family Resource Centers (FRC). To this end, EBAC has trained 10 parent leaders as Family Health Advocates (FHAs) to provide culturally appropriate outreach and education regarding health insurance and public benefits options to other parents. Peer to peer outreach and education has been shown to be very effective strategy when working with other parents. FHAs receive training through Alameda County and EBAC to prescreen for Medi-Cal, CalFresh, HealthPAC, and Covered California enrollment applications, including ongoing professional development throughout the school year to support their leadership development. They also receive training to conduct outreach and promote the services offered through our center within their communities. They participate in trainings and perform enrollment and outreach tasks within their communities for approximately 10 hours per month. Additionally, the FRC launched its FRC Advisory Team (FRCAT) this spring, which included one FHA. FRCAT will work on different projects and provide recommendations. FRCAT has worked on updating the Universal Intake to ensure it is family and user friendly. A program coversheet for the Intake was also developed to assist in explaining to families what to expect in the process, our values and who to contact if they have questions. An intake tip guide additionally was created with instructions on how to conduct a universal intake in a trauma-informed way and how staff can apply these techniques as they conduct intakes. It was important to include parent voice in this process to ensure that our forms and process are family friendly. We are working on a scoring guide next to help prioritize family need. It is our desire in the future to also have a parent representative on the EBAC Board, as well as to form a Parent Advisory Board.

Principle #2: Wellness and Recovery How does your program align with this principle? As part of EBAC's ongoing process to become trauma-informed, we are intentional to make improvements towards achieving this goal. For example, we have trained staff in Trauma Informed Principles, created welcoming spaces, and have implemented Trauma Informed System Principles in programming and trauma informed case management. Our objective is for staff to embody these principles by reflecting these principles in their daily work and brainstorming ways that the Family Resource Centers can develop resources to support families in this area. Some of the resources will be developed by staff while others resources will be developed in FRCAT. Examples of these resources include: developing a cultural family wellness power point that will be used for training other staff, enrollment process flow chart, mindfulness activities, and wellness resources for parents for children. Diverse social and cultural groups may experience and react to trauma differently. Our goal is to respond to them sensitively to make each other feel understood and to enhance wellness. As part of these efforts, the FRC offices are being assessed for being inclusive, trauma-informed, and family friendly. Our guiding vision is to create a calming experience as staff and families navigate the office space. Given the high volume of traffic and sometimes chaotic nature of the work, it is important ensure a grounded and tranquil physical environment. Fremont Healthy Start was the first center to pilot this process. It focused on revamping its lobby and staff lunch room and created a new Wellness Space. The Wellness Space provides a calming area for families and staff with a tranquil sitting area, nature mural, and warm lighting. We worked with our Wellness Consultant to assess the space and develop a space design. The plan was further discussed with staff and adjustments were made to customize the space. Response from staff and clients has been positive. It has changed the way they interact with this space. It has also inspired some

to look at ways of incorporating calming spaces in their homes.

b. Please tell us about the following…

i. Implementation Challenges: An ongoing challenge continues to be the lack of mental health resources in the community that are culturally and linguistically appropriate. While EBAC staff is successful in helping to de-stigmatize mental health challenges and getting clients to feel comfortable talking about them, it is challenging when there are not enough organizations to which clients can be referred. Clients express a desire to be referred for counseling services, but there are no services available in their language. Staff continues to provide information on mental health and brief education to build trust. The majority of our clients do not speak English, and this creates barriers to accessing services. This creates further challenges for our staff in providing outreach and education. The lack of insurance options for undocumented clients is also a challenge. With fears of public charge and the current immigration climate, some clients are reluctant to receive social services. Immigration fears has created a lot of emotional turbulence in some families. In particular, staff have reported the impact on young people. Hearing about ICE raids, the caravan of people coming over, children being separated from their parents, makes young people feel afraid and some put blame on parents for bringing them here. There is fear of losing work permits or the ability to renew. All of this is detrimental to the mental health of young people and immigrant families. A final challenge has been that wellness information for young children is not always received well by parents. For example, one staff referred a family to the Infant Toddler Program and a parent responded, "How do you know there is an issue with my child - he is so young?" Staff are continuing to provide education in this area.

ii. Successes: Our staff are breaking stigmas around accessing mental health services and offering support to those who might not otherwise have it. Because of staff's own experiences with mental health challenges, they are able to connect with families. They help validate and normalize experiences. They are seen as a friendly face in the community that has access to many resources; clients have shared that it is for this reason that they came to the Family Resource Center for help. While these families come to the Center seeking assistance with basic needs rather than mental health services, staff is able to begin having the sometimes-difficult conversations about mental health while connecting them to resources. Since shame related to accessing mental health services is strong in many cultures, it is advantageous to our program that clients do not view EBAC's Family Resource Center as a mental health service provider. In this way, families who come to our center know that they do not need to worry that their community will know and thus they feel free to have those confidential conversations with staff that they trust. Through these efforts, we have succeeded in having many of these resistant clients return to express interest and seek referral for services. Another success is the continued effort by FHS Family Resource Specialists to build upon partnerships with community agencies and attend mental health trainings to enhance their ability to assist the vulnerable populations we serve. Staff works closely with the 21 agencies at the Fremont Family Resource Center (FFRC), working with the Center's case managers, Youth and Family Services, Alameda County Social Services, and Tri-City Health Center, among many others. EBAC has a contract with the FFRC to staff the information desk at the Welcome Center and provide one-on-one application assistance to walk-in clients. This contract has been in effect for the last 20 years, and our staff's experience over these years has greatly increased staff's knowledge of service eligibility requirements of each of the 21 agencies housed at the FFRC. We further learned that asking about their child's behavioral health first is an effective way to begin a conversation about mental health issues in the family. Also, parents are more open to seeking help if their struggles are not framed as "mental health issues." Staff additionally participated in several mental health and wellness trainings to support and reinforce their outreach work. These include: Mental Health First Aid, Vicarious Resilience, The Practice of Mindfulness and De-Escalation Techniques, Implicit Bias, and Trauma Informed Care. Staff reported that all the trainings were helpful to their work. One staff participated in NAMI's Family-to-Family program, which is a 12-class education program for family members of adults living with mental illness. In this program the term family is viewed from a broad perspective to include parents, siblings, spouses, adult sons and daughters, partners and significant others. Participants learn about the normative stages of our emotional reactions to the trauma of mental illness; our belief system and principles; understanding mood disorders;

characteristic features of psychotic illnesses; brain science; research on functional and structural brain abnormalities in the major mental illnesses; genetic revolution in biological psychiatry; genetic transmission of mental illnesses; Problem Solving Skills; Medication Review; Early warning signs of relapses; and Self Care. Further, the Mental Health Screening tool continues to be very useful in helping to start the conversation on mental health, which can be very difficult for some families. Finally, we have found that in the moment strategies, such as breathing exercises, relaxation methods, and coloring mandalas, can help clients ground themselves if they are feeling triggered.

i. Lessons Learned: Staff are sharing supportive resources and referrals and creating conversations to shift the narrative around what support can look like, what therapy can look like, and how accessible and relatable it can be. Helping families understand what they can expect opens up a conversation about therapy and how it can be a helpful resource. We are also empowering families to access support within themselves, to recognize their own ability to grow, and to realize that they are their own expert and healer, whether or not they have access to mental health services. This is an important service in helping families who may not want or are not ready to receive mental health services in a standard setting. It helps to reframe that everyone needs a little help sometimes and that it is okay. It helps to understand why we do the things we do. That understanding alone can positively impact families with the hope of leading to more healing conversations with a trained professional. We deepened our understanding of the importance of community and connection in healing. We have learned the incredible empowerment that comes with choosing to seek these resources and insights and choosing a new path. We understand the impact it has on people's lives. Our staff feel fortunate to be able to witness it. Our goal is for our work to be destigmatizing and to provide access, which often keeps families from seeking services, and convey that services do not have to be scary, isolating or a secret. In our role, we have found a space to provide education and support beyond the walls of mental health programs and bring connection, tools, resources, and support too many. Staff has learned that creating wellness areas for people seeking supportive services helps to minimize their anxiety and positively impacts mental health. In response, and as an effort to strengthen our trauma-informed practices, staff from Fremont Healthy Start consulted with EBAC's Wellness Consultant to make changes to the program location's lobby area and breakroom and create a wellness area for clients and staff. Improvements included furniture placement changes, new plants, softer lighting, and the addition of social justice and wellness posters. Staff has deepened their understanding that being trauma-informed means that appointments may not be kept, answers may not be given, stories may not be shared, and papers may be forgotten due to the experience lived. There are ways in speaking to a client and really hearing them or looking at body language that are telltale signs of trauma. It is okay to stop doing paperwork when you see that the client has been triggered by something during the encounter, it is okay to address issues and allow clients to vent if that is what they want. It is important that staff are creating a safe place for families. Reaching out for services can be humiliating and difficult to some with a high sense of pride. Staff has an understanding that our clients are hurt but they do not treat them with pity. Being able to work with them in a way that gives them power helps with how they see the help given. Staff continue breaking taboos and preconceived notions about mental illness. Staff found that the mental health questionnaire triggers emotional responses in some people and that they need to be prepared for mindfulness or deep breathing activities. Mujeres Unidas has been a good resource for some of the Latina clients as they have support groups and a crisis hotline. One staff will be trained soon by SAVE for Project Light which will enable her to run support groups for women living in domestic violence situations.

ii. Relevant Examples of Success/Impact (e.g. a client success story) Reminder: Please do not use real client names: Story #1 An immigrant family of four was struggling with the father's recent disability, which was impacting their financial situation. The mother visited EBAC's Family Resource Center for assistance with a CalFRESH application and was given a mental health screening. She revealed her family's situation and shared that there was a great deal of conflict in the house hold, resulting in her desire to separate from her husband. She shared that her children were also frustrated. Staff validated and normalized her feelings. Even though it was her first-time meeting with our staff person, she felt comfortable talking to her and opening up about her painful situation. Our staff person was able to refer her for mental health services so that she is able to talk to someone about this transition in her family. Story #2: A mother and her teen daughter came

in for Medi-Cal application assistance. There was obvious friction between the two. The mother had been struggling with depression making it difficult to get out of bed. The teen disclosed self-esteem issues from having undocumented parents and having an inferiority complex and resentment towards her parents for putting her in this situation. The daughter made a comment about her mother being weak. Staff explained that the mind gets sick just like the body does. If we get sick we see a doctor; it is the same for the mind. This reframing helped to shift the teen's view of her mother and she began to feel more empathy towards her. Staff recommended family therapy and both the mother and the daughter were agreeable to it. While the teen initially felt that the mother was the only one of concern, there was some reflection that perhaps she could benefit from therapy as well. Story #3: Recently, a mother and her 18-year-old daughter came to Fremont Healthy Start for assistance in applying for Medi-Cal. When the Family Resource Specialist noticed that the daughter showed no emotional expression and that the mother looked sad and was crying, the Family Resource Specialist began asking questions about what happened. The daughter spoke about not wanting to go back to school because she was worried she would have charges pressed against her. The daughter was pulled aside to get more information, but she was difficult to engage. The daughter began speaking about anti-psychotic medications that she had been given, and talked about hearing voices and how she had been 5150'd by the school. The Family Resource Specialist then spoke with her mother and asked if her daughter was receiving treatment or if there was a diagnosis. The mother said no because she felt that her daughter's situation was more of a behavior issue than a mental health issue. However, the mother shared that she was becoming concerned about leaving her daughter alone after a recent incident in which her daughter was violent with her younger sister. Staff discussed the importance of getting treatment and medication. Staff encouraged the daughter to take the medication she had been issued at the emergency room and to follow-up with their doctor. Staff completed their Medi-Cal application, provided a FERC referral, and accompanied them to the FERC appointment to speak to the parent partner. Staff will continue to follow up with the mother to ensure that she feels supported and is following through on treatment goals.

**ADDITIONAL INFORMATION**

Please include the number of clients and/or contacts you estimate to serve in:

FY 19/20: 1000
FY 20/21: 1000

Please tell us about any changes you intend to make to your program over the next two fiscal years and explain your rationale for making these changes: There are no significant changes planned over the next two fiscal years. We will use our evaluation data to continue to refine our services and process.

**MHSA Program #: PEI 13**

**PROVIDER NAME: WRAP Planning**

**PROGRAM NAME: PEERS, Wellness, Recovery & Resiliency Services**

**Program Description**: 4 ongoing WRAP groups in English and Spanish at various Alameda County locations, including one for transition-age youth. Reach approximately 300 consumers and family members with WRAP orientations and promote consumer leadership by training and supporting consumers to become WRAP facilitators.

Program Outcomes & Impact: PEI Data Report FY18/19

**PERFORMANCE INDICATORS: How Much Did We Do?**

| **Total Numbers Served through PEI MHSA** | |
|---|---|
| Number of unduplicated individuals your program serves who are **at-risk** of developing a mental health problem or serious mental illness (SMI) | 1,027 |
| Number of unduplicated individuals your program serves who show **early signs** of forming a more severe mental illness | |
| Number of unduplicated individual family members served indirectly by your program: | |
| Grand TOTAL of unduplicated individuals served in the Quarter that you are reporting about. [This number (D) should = A+B+C.] | 1,027 |

**PERFORMANCE INDICATORS: How Well Did We Do?**
Demographics

**Age Group (Unduplicated)**

| | |
|---|---|
| Children/Youth (0---15) | 76 |
| Transition Age Youth (16---25) | 183 |
| Adult (26---59) | 320 |
| Older Adult (60+) | 70 |
| Unknown/ Declined to Answer | 378 |

**Race (Please mark only one choice)**
*If Hispanic or Latino, choose "Another race not listed."*

| | |
|---|---|
| American Indian or Alaska Native | 13 |
| Asian | 47 |
| Black or African American | 380 |
| Native Hawaiian or other Pacific Islander | 8 |
| White | 195 |
| More than one race | 87 |
| Another race not listed | 79 |
| Unknown/ Declined to Answer | 218 |

**Sexual Orientation (Please mark only one choice)**

| | |
|---|---|
| Gay or Lesbian | 22 |
| Heterosexual or Straight | 14 |
| Bisexual | 12 |
| Questioning or unsure of sexual orientation | 3 |
| Queer | 3 |
| Another sexual orientation not listed | 8 |
| Unknown/Decline to Answer | 83 |

**Ethnicity /Cultural Heritage (Please mark only once choice)**

| | |
|---|---|
| **If Hispanic or Latino, please specify:** | |
| Caribbean | |
| Central American | 2 |
| Mexican/Mexican--American/Chicano | 12 |
| Puerto Rican | |
| South American | |
| Another Hispanic/Latino ethnicity not listed | |
| Unknown/Declined to Answer | 102 |
| **If Non-Hispanic or Non-Latino, please specify:** | |
| African | 2 |
| African American | 3 |
| Asian Indian/South Asian | 2 |
| Cambodian | 1 |
| Chinese | 6 |
| Eastern European | 3 |
| European | 6 |
| Filipino | 20 |
| Japanese | 1 |
| Korean | 1 |
| Middle Eastern | 4 |
| Vietnamese | 5 |
| Other Non-Hispanic or Non- Latino ethnicity not listed | 23 |
| **More than one ethnicity** | 0 |
| **Unknown /Declined to Answer** | 833 |

**Primary Language (Please mark only one choice)**

| | |
|---|---|
| English | 20 |
| Spanish | 29 |
| Farsi | |
| Cantonese | 7 |
| Mandarin | 1 |
| Other Chinese Dialects | |
| Vietnamese | 4 |
| Korean | |
| Tagalog | |
| Other Filipino Dialect | |
| Japanese | |
| Laotian | |
| Cambodian | |
| Mien | |
| Hmong | |
| Samoan | 1 |
| Thai | |
| Russian | |
| Polish | |
| German | |
| Italian | |
| Turkish | |
| Hebrew | 1 |
| French | |
| Portuguese | |
| Armenian | |
| Arabic | 1 |
| Sign ASL | 1 |
| Other primary language not | 5 |
| Unknown/ Decline to Answer | 772 |

**Gender Identity (Please mark both parts A & B)**

| | |
|---|---|
| A) Assigned sex at birth: (Please mark only one choice) | |
| Male | |
| Female | |
| Other sex not listed (e.g. Intersex) | |
| Unknown/Decline to Answer | 1,02 |
| B) Current Gender Identity: (Please mark only one | |
| Male | 43 |
| Female | 44 |
| Transgender | 1 |
| Genderqueer | 2 |
| Questioning or Unsure of Gender Identity | 1 |
| Another Gender Identity not listed | 1 |
| Unknown/Decline to Answer | 13 |

**Disability Status** (Please mark all that apply)

| | |
|---|---|
| None | 98 |
| Yes. If yes, please specify (choose from list below): | |
| Difficulty Seeing | 4 |
| Difficulty hearing, or having speech understood | 2 |
| Mental Domain | 55 |
| Physical/Mobility Domain | 18 |
| Chronic Health Condition | 7 |
| Another disability not listed | 26 |
| Unknown/Decline to Answer | 817 |

**Veteran Status (Please mark only one choice)**

| | |
|---|---|
| Yes | 10 |
| No | 20 |
| Unknown/Decline to Answer | 81 |

**REQUIRED STRATEGY: IMPROVE TIMELY ACCESS TO MENTAL HEALTH SERVICES FOR UNDERSERVED POPULATIONS**

a. Who is/are the underserved target population/s your program is serving (e.g. TAY, Southeast Asian, etc.)? Mental health consumers, primarily people of color, including TAY and older adults.

b. Number of separate paper referrals to an ACBH PEI-funded program. (This can be a provider's internal ACBH PEI-funded prevention or early intervention program OR an external PEI-funded ACBH prevention or early intervention program): 8

c. Number of individuals followed through on referral & engaged in an ACBH PEI-funded program: 7

d. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with the ACBH PEI-funded provider. N/A The referrals were not for "appointments" per se. For example, one participant was referred to FERC and called the FERC Warm Line, while another participant was referred to the Pool of Consumer Champions (POCC) and became a member of the POCC's SAGA Committee. Four participants were connected to peer specialist job training programs (BestNow!) and Alameda County Accelerated Peer Specialist program). We introduced TAY Mentors to the Independent Living Skills Program, Youth Employment Project, and the Unity Council, among other community services.

e. Describe ways your program encouraged access to services and follow-through on the above referrals: Our primary method is to provide personal encouragement and information about participants' options, since self-determination is a core principle of our program model.

f. Any additional information to report on (optional): Many of the referrals our participants need are for services related to basic needs such as food and housing. For example, we have referred participants experiencing homelessness or housing crisis to 2-1-1, so that they could access the Coordinated Entry System.

**OUTREACH. THIS SECTION IS *REQUIRED ONLY* FOR OUTREACH PROGRAMS. OTHERWISE, IT IS OPTIONAL**

Number of potential responders: N/A

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

| **Type of Setting(s)** (ex: school, place of worship, | **Type(s) of Potential Responders** (ex: principals, teachers, parents, nurses) |
|---|---|
| | N/A. Our Stigma and Discrimination Reduction PEI Data Report provides information on PEERS' outreach activities. |

**NARRATIVE**

a. Choose two of the above principles and describe how your program upholds or achieves those principles. Please speak to each principle separately and specifically describe how your program activities align with that corresponding principle.

Principle #1: Wellness and Recovery How does your program align with this principle? As a diverse community of people with mental health experiences, PEERS pursue the vision of a world where people can freely choose among many mental health options that address the needs of the whole person. Wellness and recovery are central to everything we do. PEERS' keystone service is Wellness Recovery Action Planning (WRAP). WRAP is an evidence-based practice used worldwide by people dealing with mental health challenges. PEERS provide WRAP groups free of charge and open to the public in both English and Spanish in various locations in Alameda County, in addition to groups that are available to participants in programs of other ACBH providers, such as the South County Homeless Project, the East Bay Community Recovery Project, and the TRUST Clinic. We also tailor WRAP groups for transition-age youth of color, for the LGBTQ community, and for women. Because WRAP groups always are facilitated by peers – people who use WRAP in their own lives – WRAP groups not only give participants tools for wellness and recovery, but model that wellness and recovery are possible. All PEERS programming, including WRAP and the TAY program, use the language of wellness and recovery rather than clinical or diagnostic language. The focus of our groups always is on strengths, goals, and tools rather than symptoms or perceived deficits. Participants are supported to generate their own strategies to meet goals that they set for their wellness, while exchanging peer support. Moreover, participants who complete a full cycle of WRAP groups are eligible to be

trained to become WRAP facilitators, which offers them opportunities for leadership, professional development, and generating income. Our TAY Wellness workshops also communicate these same wellness and recovery principles. During FY18-19, TAY Wellness workshop topics included self-advocacy and motivation, culture and social media, foster care, racism, intimate partner violence, and eliminating mental health stigma.

Principle #2: Community Collaboration How does your program align with this principle? PEERS collaborate with different facets of the community in multiple ways. For example, through our collaborative relationships with the Alameda County Network of Mental Health Clients, BestNow! internship program, as well as the Alameda County Accelerated Peer Specialist Program (ACAPS), we connect our participants to employment training and employment support. Several of our staff members are alumni of BestNow!, and our practice of sponsoring interns and hiring BestNow! graduates also increases employment opportunities for mental health consumers. New TAY program partnerships during this fiscal year included Acta Non Verba Youth Urban Farm Project (ANV); Beats, Rhymes and Life (BRL); Youth Employment Partnership (YEP); and Oakland Unified School District (OUSD) -- Dewey Academy, Oakland High's African American Male Achievement class, and the African American Male Achievement program in particular. In the fall, the TAY mentors facilitated wellness workshops at YEP, Dewey Academy (a continuation high school), and Oakland High. Not only were the workshops very well received by the youth participants, but we were able to reach young people affected by trauma who are in settings that don't typically address mental health directly. By facilitating wellness workshops in settings like these, the PEERS' TAY program is making space for young people to understand and explore wellness outside of the medical model of mental health. In the spring, we facilitated a wellness workshop for BRL participants on community connections, and partnered with ANV to provide multi-session wellness workshops focusing on nutrition and mental health, housing, budgeting and financial literacy, housing, and community connections for the youth participants in ANV's summer program.

b. Please tell us about the following…

Implementation Challenges: PEERS WRAP program did not encounter any significant implementation challenges during this fiscal year. The primary implementation challenge we faced in our TAY program during this pilot year was attrition among the TAY mentors in the on-the-job training aspect of the program. In our recruitment and hiring, we sought out young people with lived experience of mental health challenges. Over the course of the program pilot, however, we learned that it takes more intensive staffing (including a case manager) to support young people who face not only substantial emotional and behavioral challenges, but also major family dysfunction, unstable housing, physical health crises, etc. As well, there was a mismatch between the skill level of the TAY mentors and PEERS' expectations of them as employees.

Successes: Successes include very strong results from our post-activity surveys of participants WRAP groups and TAY wellness workshops. Among the highlights were the following: 88% of participants in WRAP sessions and in TAY wellness workshops reported understanding more about their own wellness and mental health after participating. 93% of WRAP participants and 92% of TAY wellness workshop participants reported that the group or workshop was useful to them. 93% of WRAP participants and 79% of TAY wellness workshop participants agreed or strongly agreed with the statement "I see myself using what I learned today in the future." During FY18-19, two primary strategies have enabled us to take the quality of our WRAP program to the next level: creating a new staff position and increasing the skills of WRAP facilitators through WRAP Facilitator Mentoring meetings. The new staff position has increased our capacity to provide close supervision of all of our WRAP facilitators, further developing their skills. We restructured our WRAP Facilitator Mentoring meetings to increase the extent to which these meetings develop facilitators' skills, which has been well received.

i. Lessons Learned: From the attrition in our pilot cohort of TAY mentors, we learned that we need to change the design of the TAY program. Based on what we learned, we will eliminate the on-the-job training part of the program, which was not as successful, to focus on the most successful elements of the program: bimonthly TAY leadership meetings (which allow for the flexibility that young people facing substantial life challenges need), and TAY wellness workshops.

ii. Relevant Examples of Success/Impact (e.g. a client success story) Reminder: Please do not use real client names: WRAP group participants consistently report learning tools they can use to support their own wellness. Things they learn include (in their own words): "How to better care for myself." "Having an action plan to combat life's stressors is important." "How to make plans for work and my mental health." "How to have compassion for myself." "I learned about my triggers and actually came up with ways to identify and deal with my reaction to the triggers." Participants in TAY wellness workshops reported that the workshops were powerful. Responses to a question about what they learned in the workshops included: "I learned that how you grew up can affect your mental health." "Needing someone to talk to is okay." "I learned that opening up to people about your mental health can help you." "Something I learned is that it's ok to cry." "All my brothers

made me feel cool." "I learned about places you can go to if you are seeking help." "We engaged with each other. It was amazing. I just wish we had more time."

**ADDITIONAL INFORMATION**

Please include the number of clients and/or contacts you estimate to serve in:

FY 19/20: 1,040 (approximately 210 through the TAY program, 825 through WRAP, and 5 new participants through Hoarding and Cluttering)

FY 20/21: 1,040 (approximately 210 through the TAY program, 825 through WRAP, and 5 new participants through Hoarding and Cluttering)

Please tell us about any changes you intend to make to your program over the next two fiscal years and explain your rationale for making these changes: The major change we plan to our WRAP program is the addition of a second Spanish-language WRAP group. As described above, we are redesigning the TAY program based on what we learned from the attrition from on-the-job training in our pilot cohort of TAY mentors. We will eliminate the on-the-job training part of the program, to focus on the most successful elements of the program: bimonthly TAY leadership meetings (which allow for the flexibility that young people facing substantial life challenges need), and TAY wellness workshops. We will begin a new Hoarding and Cluttering project in FY 19-20, which will entail facilitating two 15-session support groups following the evidence-based curriculum, Buried in Treasures. We predict that the majority of participants in these Hoarding and Cluttering groups will already be engaged in PEERS programs through WRAP, so the groups will not be likely to increase our numbers served by a great deal.

**MHSA Program #: PEI 19**

**PROVIDER NAME: City of Fremont**

**PROGRAM NAME: Older Adults Peer Support- Peer Coaching for Older Adult LGBT Community**

**Program Description:** Providing supportive services to the LGBT older adult community. Providing outreach and prevention services to enhance existing programming in the older adult population. Reducing social isolation by providing services that encourage and support positive social support networks and relationships that reduce the risk of prolonged suffering. Increase self- confidence among target population. Increase access to needed community resources. Offering 1 to 1 time with trained LGBT Peer Coaches. Offering Support Groups and Education Resources.

Program Outcomes & Impact: PEI Data Report FY18/19

**PERFORMANCE INDICATORS: How Much Did We Do?**

| Total Numbers Served through PEI MHSA | |
|---|---|
| Number of unduplicated individuals your program serves who are at-risk of developing a serious mental illness (SMI) | 5 |
| Number of unduplicated individuals your program serves who show early signs of forming a more severe mental illness | 0 |
| Number of unduplicated individual family members served indirectly by your program: | 0 |
| Grand TOTAL of unduplicated individuals served in the Quarter that you are reporting about. [This number (D) should = A=B+C.] | 5 |

**PERFORMANCE INDICATORS: How Well Did We Do?**
Demographics

**Age Group (Unduplicated)**

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

**Race (Please mark only one choice)**
*If Hispanic or Latino, choose "Another race not listed."*

| | |
|---|---|
| American Indian or Alaska Native | |
| Asian | 1 |
| Black or African American | |
| Native Hawaiian or other Pacific Islander | |
| White | 3 |
| More than one race | |
| Another race not listed | |
| Unknown/ Declined to Answer | |

**Sexual Orientation (Please mark only one choice)**

| | |
|---|---|
| Gay or Lesbian | 3 |
| Heterosexual or Straight | 2 |
| Bisexual | |
| Questioning or unsure of sexual orientation | |
| Queer | |
| Another sexual orientation not listed | |
| Unknown/Decline to Answer | |

**Ethnicity /Cultural Heritage (Please mark only once choice)**

| | |
|---|---|
| **If Hispanic or Latino, please specify:** | |
| Caribbean | |
| Central American | |
| Mexican/Mexican-American/Chicano | 1 |
| Puerto Rican | |
| South American | |
| Another Hispanic/Latino ethnicity not listed | |
| Unknown/Declined to Answer | |
| **If Non-Hispanic or Non-Latino, please specify:** | |
| African | |
| African American | |
| Asian Indian/South Asian | 1 |
| Cambodian | |
| Chinese | |
| Eastern European | |
| European | |
| Filipino | |
| Japanese | |
| Korean | |
| Middle Eastern | |
| Vietnamese | |
| Other Non-Hispanic or Non-Latino ethnicity not listed | |
| **More than one ethnicity** | |
| **Unknown /Declined to Answer** | |

**Primary Language (Please mark only one choice)**

| | |
|---|---|
| English | x |
| Spanish | |
| Farsi | |
| Cantonese | |
| Mandarin | |
| Other Chinese Dialects | |
| Vietnamese | |
| Korean | |
| Tagalog | |
| Other Filipino Dialect | |
| Japanese | |
| Laotian | |
| Cambodian | |
| Mien | |
| Hmong | |
| Samoan | |
| Thai | |
| Russian | |
| Polish | |
| German | |
| Italian | |
| Turkish | |
| Hebrew | |
| French | |
| Portuguese | |
| Armenian | |
| Arabic | |
| Sign ASL | |
| Other primary language not | |
| Unknown/ Decline to Answer | |

**Gender Identity (Please mark both parts A & B)**

| | |
|---|---|
| A) Assigned sex at birth: (Please mark only one | |
| Male | 1 |
| Female | 4 |
| Other sex not listed (e.g. Intersex) | |
| Unknown/Decline to Answer | |
| B) Current Gender Identity: (Please mark only one choice) | |
| Male | 1 |
| Female | 4 |
| Transgender | |
| Genderqueer | |
| Questioning or Unsure of Gender Identity | |
| Another Gender Identity not listed | |
| Unknown/Decline to Answer | |

**Disability Status** (Please mark all that apply)

| | |
|---|---|
| None | |
| Yes. If yes, please specify (choose from list below): | |
| Difficulty Seeing | |
| Difficulty hearing, or having speech | |
| Mental Domain | 5 |
| Physical/Mobility Domain | 2 |
| Chronic Health Condition | 5 |
| Another disability not listed | |
| Unknown/Decline to Answer | |

**Veteran Status (Please mark only one choice)**

| | |
|---|---|
| Yes | |
| No | 5 |
| Unknown/Decline to Answer | |

**IMPROVE TIMELY ACCESS TO MENTAL HEALTH SERVICES FOR UNDERSERVED POPULATIONS**

a. Who is/are the underserved target population/s your program is serving (e.g. TAY, Southeast Asian, etc.)?
LGBT Older Adult Population

b. Number of separate paper referrals to an ACBH PEI-funded program. (This can be a provider's internal ACBH PEI-funded prevention or early intervention program OR an external PEI-funded ACBH prevention or early intervention program): N/A

c. Number of individuals followed through on referral & engaged in an ACBH PEI-funded program: N/A

d. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with the ACBH PEI-funded provider. N/A

e. Describe ways your program encouraged access to services and follow-through on the above referrals: N/A

**OUTREACH FOR INCREASING RECOGNITION OF EARLY SIGNS OF MENTAL ILLNESS**

Number of potential responders: None at this time

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

| **Type of Setting(s)** (ex: | **Type(s) of Potential Responders** (ex: principals, teachers, parents, nurses) |
|---|---|
| Various local Universities (comm. Based setting) | Met with the University School of social work Department to present LGBT senior coaching program. Discussed service collaboration i.e.: sharing resources for the LGBT |
| | clients and information and referrals. |
| Social Services | Outreached to Area on Aging to disseminate info: re: LGBT senior peer coaching |

**NARRATIVE**

a. Choose <u>two</u> of the above principles and describe how your program upholds or achieves those principles. Please speak to each principle separately and specifically describe how your program activities align with that corresponding principle.

Principle #1: Community Collaboration. How does your program align with this principle? The program strongly collaborates with various community organization/mental health providers in informing LGBT older adult population about our program and ways for easier service access. Program staff also outreached to various food pantries where seniors go for food assistance services. This quarter, writer presented the program to Social Services Area on Aging for potential service collaboration and referrals.

Principle #2: Wellness and Recovery. How does your program align with this principle? Our LGBT peer coaching program for older adults involve clients to actively participate in developing and defining their own treatment goals so they can sustain their recovery and resiliency needed to live fulfilling and productive lives and increasing their stability and optimism.

Principle # 3: Cultural Competence: The program continues to offer LGBT Senior Peer coach and Senior Mobile Mental Health staff opportunities to advance their knowledge about LGBT population via training and education. Senior Peer coach also has a direct access to the program interdisciplinary team members for consultation. The program supports collaborative team practice among staff in addressing client and family's well-being, recovery and resiliency.

b. Please tell us about the following…

i. Implementation Challenges: Prejudice and stigma continue to be a major barrier in client's help seeking behavior. The program continues to do outreach work to various community agencies (both public and private) but the response has been very slow. Periodic follow up is required to remind them of available services the program offers. LGBT older adult population continues to need strong advocacy work in order to help them access services. It has been very challenging to recruit potential clients to participate in the program. Despite active program promotions in the community, referrals have not found its way to the program.

ii. Successes: Existing clients continue to benefit from the program. Working relationship has improved making it a lot easier to work on specific goals.

iii. Lessons Learned: Identify key members of the LGBT community, support them by providing them with multiple services and resources available to LGBT population so that it will strengthen their population base.

We will continue to promote our program to establish working relationship with their population base.

iv. Relevant Examples of Success/Impact (e.g. a client success story) Reminder: Please do not use real client names: With our continued services and support, one of the program clients is now very comfortable working with his LGBT senior peer coach. In addition, client's other support person is actively coordinating and supporting the services the program provides for the client.

**EVALUATION PLAN UPDATE**

a. Please describe, in 1-2 sentences, your effort to collect feedback from program participants (method used). Senior peer coach attends weekly supervision from a licensed Clinical Social Worker staff which is an opportunity to collect feedback re: participant's satisfaction in receiving services. In addition, clients are invited to participate in different focus groups to gather feedback on the challenges they experience and recommendations on how to improve the program. Senior Peer Coach attended the Tri City Elder Coalition and presented the program to the group.

b. Describe the tool used to collect data.
Weekly supervision and attendance/ participation in various focus group.

c. Summarize the results. In weekly supervision, coach will update supervisor of status of his supportive relationship with his peers. Coach also discusses some of his challenges he may have in working with his peers. Supervisor and senior peer coach address these challenges and working on problem solving areas of concerns.

d. What was learned from the participant feedback (**1-2 key points**)?
Participants reported that his senior peer coach is dependable and empathetic. However, one of the clients stated that he feels a bit guilty using coach's time listening to him. "I feel I may be a burden to him knowing that he has his own mental health challenges as well".

e. Describe how the findings were reviewed by staff. Supervisor meets with senior peer coach and discusses status of his working relationship with his peer. Supervisor ensures that peer coach is not experiencing increase in symptoms which will lead to burn out and affect his ability to provide support to his peers. If peer coaches observe that symptoms are recurring, supervisor will sit down with the peer to discuss ways to address their concerns or supervisor will recommend peer sees his/her regular therapist to increase therapy sessions.

f. What programmatic change(s) were or will be adopted as a result of the findings? When will changes be made and how will the changes impact programming? None at this time, but will continue to provide weekly supervision to the peer coach to help him maintain /sustain his emotional stability.

Continue to offer education and training to increase his knowledge of the LGBT population.
Senior Mobile Mental Health Interdisciplinary team and the City of Fremont Case Management Team will continue to provide support to the coach.

g. What issues or challenges with the Evaluation Plan are you having? What technical assistance do you need?
The program has not been able to recruit enough senior LGBT clients to receive services from peer.
Despite increased program promotions and outreach efforts, we haven't received referrals from the various community service providers. The program is planning to rework our marketing strategies in order to disseminate program information to the community.

**ADDITIONAL INFORMATION**

Please include the number of clients and/or contacts you estimate to serve in:

FY 19/20: Same number per program contract.
FY 20/21: Same number per program contract

Please tell us about any changes you intend to make to your program over the next two fiscal years and explain your rationale for making these changes: Client's admission to the program has been very difficult thus we haven't been able to meet contracted # of clients to be served. This year, we are going to try to change our fliers/brochures to convey more the intent of the program. We also plan to implement a different strategy for the program to become more visible in the community via attending community meetings, showing movies about LGBT to our senior population. We coordinate and collaborate these efforts with different programs within the City of Fremont.

**MHSA Program #: PEI 20B**

**PROVIDER NAME: Black Men Speak**

**PROGRAM NAME: Culturally Responsive PEI programs for the African American Community**

**Program Description:** Black Men Speak (BMS) is an inspirational speaker's bureau that aims to end the trauma, discrimination and stigma associated with mental health and substance abuse challenges.

Program Outcomes & Impact: PEI Data Report FY18/19

**PERFORMANCE INDICATORS: How Much Did We Do?**

| Total Numbers Served through PEI MHSA | |
|---|---|
| Number of unduplicated individuals your program serves who are **at-risk** of developing a mental health problem or serious mental illness (SMI) | 352 |
| Number of unduplicated individuals your program serves who show **early signs** of forming a more severe mental illness | |
| Number of unduplicated individual family members served indirectly by your program: | |
| Grand TOTAL of unduplicated individuals served in the Quarter that you are reporting about. [This number (D) should = A+B+C.] | 352 |

**PERFORMANCE INDICATORS: How Well Did We Do?**
Demographics

**Age Group (Unduplicated)**

| | |
|---|---|
| Children/Youth (0---15) | 1 |
| Transition Age Youth (16---25) | 30 |
| Adult (26---59) | 176 |
| Older Adult (60+) | 36 |
| Unknown/ Declined to Answer | 109 |

**Race (Please mark only one choice)**
*If Hispanic or Latino, choose "Another race not listed."*

| | |
|---|---|
| American Indian or Alaska Native | 2 |
| Asian | 12 |
| Black or African American | 121 |
| Native Hawaiian or other Pacific Islander | 1 |
| White | 20 |
| More than one race | 17 |
| Another race not listed | 11 |
| Unknown/ Declined to Answer | 168 |

**Sexual Orientation (Please mark only one choice)**

| | |
|---|---|
| Gay or Lesbian | 0 |
| Heterosexual or Straight | 0 |
| Bisexual | 0 |
| Questioning or unsure of sexual orientation | 0 |
| Queer | 0 |
| Another sexual orientation not listed | 0 |
| Unknown/Decline to Answer | 352 |

**Ethnicity /Cultural Heritage (Please mark only once choice)**

| | |
|---|---|
| **If Hispanic or Latino, please specify:** | |
| Caribbean | 0 |
| Central American | 0 |
| Mexican/Mexican-- | 2 |
| Puerto Rican | 0 |
| South American | 0 |
| Another Hispanic/Latino | 0 |
| Unknown/Declined to Answer | 22 |
| **If Non-Hispanic or Non-Latino, please specify:** | |
| African | 2 |
| African American | 108 |
| Asian Indian/South Asian | 1 |
| Cambodian | 1 |
| Chinese | 2 |
| Eastern European | |
| European | 1 |
| Filipino | 3 |
| Japanese | |
| Korean | |
| Middle Eastern | |
| Vietnamese | 3 |
| Other Non-Hispanic or Non- Latino ethnicity not listed | 2 |
| **More than one ethnicity** | 3 |
| **Unknown /Declined to Answer** | 202 |

**Primary Language (Please mark only one choice)**

| | |
|---|---|
| English | 0 |
| Spanish | 0 |
| Farsi | 0 |
| Cantonese | 0 |
| Mandarin | 0 |
| Other Chinese Dialects | 0 |
| Vietnamese | 0 |
| Korean | 0 |
| Tagalog | 0 |
| Other Filipino Dialect | 0 |
| Japanese | 0 |
| Laotian | 0 |
| Cambodian | 0 |
| Mien | 0 |
| Hmong | 0 |
| Samoan | 0 |
| Thai | 0 |
| Russian | 0 |
| Polish | 0 |
| German | 0 |
| Italian | 0 |
| Turkish | 0 |
| Hebrew | 0 |
| French | 0 |
| Portuguese | 0 |
| Armenian | 0 |
| Arabic | 0 |
| Sign ASL | 0 |
| Other primary language not listed | 0 |
| Unknown/ Decline to Answer | 35 |

**Gender Identity (Please mark both parts A & B)**

| | |
|---|---|
| A) Assigned sex at birth: (Please mark only one choice) | |
| Male | 18 |
| Female | 2 |
| Other sex not listed (e.g. Intersex) | 0 |
| Unknown/Decline to Answer | 332 |
| B) Current Gender Identity: (Please mark only one choice) | |
| Male | 93 |
| Female | 71 |
| Transgender | 0 |
| Genderqueer | 1 |
| Questioning or Unsure of Gender Identity | 0 |
| Another Gender Identity not listed | 0 |
| Unknown/Decline to Answer | 187 |

**Disability Status** (Please mark all that apply)

| | |
|---|---|
| None | |
| Yes. If yes, please specify (choose from list below): | |
| Difficulty Seeing | 2 |
| Difficulty hearing, or having speech | 2 |
| Mental Domain | 15 |
| Physical/Mobility Domain | 2 |
| Chronic Health Condition | 2 |
| Another disability not listed | 0 |
| Unknown/Decline to Answer | 32 |

**Veteran Status (Please mark only one choice)**

| | |
|---|---|
| Yes | 1 |
| No | 0 |
| Unknown/Decline to Answer | 35 |

**OUTREACH. THIS SECTION IS *REQUIRED ONLY* FOR OUTREACH PROGRAMS. OTHERWISE, IT IS OPTIONAL**

Number of potential responders: 218

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

| **Type of Setting(s)** (ex: school, place of worship, clinic) | **Type(s) of Potential Responders** (ex: principals, teachers, parents, nurses) |
|---|---|
| **Wellness Centers** | Caseworkers, client reps, managers, consumers, family members, directors |
| **Recovery Centers** | Caseworkers, managers, client reps, consumers, directors, family members, support |
| **Conditional Release** | Caseworkers, managers, client reps, consumers, directors, family members, support |
| **Religious Organizations** | Spiritual leaders, pastors, families, Consumers, directors, general public |
| **Festivals** | General public, families, consumers, directors, organization reps |

**NARRATIVE**

a. Choose two of the above principles and describe how your program upholds or achieves those principles. Please speak to each principle separately and specifically describe how your program activities align with that corresponding principle.

Principle #1: Community Collaboration How does your program align with this principle? BMS has developed some unique partnerships with organizations in media and broadcasting to increase our reach and influence in our targeted community, as well as with housing advocates and job centers to stay updated on information related to employment openings and housing options for individuals, the homeless, low-income families, and seniors. Through the Alameda County Community Corrections Partnership Advisory Board (CAB Committee), we have also established a solid partnership with re-entry programs that provide housing, resources, counseling, computer training, and job referrals for individuals returning into society. BMS hopes that by working together with these various organizations we will increase our reach to those impacted and help create healthier communities.

Principle #2: Wellness and Recovery How does your program align with this principle? BMS encourages and supports individuals through recovery by meeting each individual right where they are and working with them without stigma, judgment, or discrimination. We have integrated resources for alternative therapies that focus on the whole person, including mental, physical, and spiritual aspects. We promote positive self- talk, help clients develop WRAP plans, and encourage individuals to help others by sharing their journeys to wellness and recovery. BMS members, by sharing our own unique personal stories, inspire clients and prove that wellness and recovery are possible. We strategically promote the concept that the power of recovery lies in everyone and that clients have the power to make choices that support their own greater well-being.

b. Please tell us about the following…

i. Implementation Challenges: Member participation in in speaking engagements was down and has been one of our biggest challenges throughout the past two quarters. Members' work schedules continue to conflict with dates and times of scheduled activities. In an effort to rectify this we have increased our outreach efforts and established new partnerships with community-based organizations outside of our current network of partners, that offer flexibility in days, times, and locations to allow BMS members to engage in events and activities outside of normal business hours.

ii. Successes: BMS has been dedicated to enlightening and reducing stigma and discrimination against those with mental health and substance abuse challenges. We are pleased to have successfully exceeded our objectives: the number of speakers on our roster, and speakers' reports of satisfaction, empowerment, and increased hopefulness. Our audience member objectives were also exceeded.

iii. Lessons Learned: Offer flexible times and locations and provide transportation for members to and from events when needed.

iv. Relevant Examples of Success/Impact (e.g. a client success story) Reminder: Please do not use real client names: "I am truly thankful to BMS for their support in my employment endeavors and for their help giving me the confidence I need to share my story and encouragement to pursue my dreams. BMS truly is a brotherhood, a family, a group of individuals working together to help one another. I don't know where I would be if I had not become a member. I am grateful that they were able to meet me where I was in my journey to recovery. Today I feel much better about myself, I am working, I'm taking care of my kids and I am doing awesome at maintaining my Wellness and Recovery."

**ADDITIONAL INFORMATION**

Please include the number of clients and/or contacts you estimate to serve in:

FY 19/20: 250
FY 20/21: 300

Please tell us about any changes you intend to make to your program over the next two fiscal years and explain your rationale for making these changes: BMS will continue to grow our partnerships and impact in an effort to increase our target population's knowledge of resources and services available to them within the community. BMS is currently in the planning stages of developing additional services. In the coming fiscal year 2019-20 we are looking to facilitate a weekly Re-Entry Support Group with a focus on individuals returning to society and those who have suffered/suffer with mental health and substance abuse challenges. Also, through audience feedback we are actively recruiting women to be a part of the women's section of Black Men Speak speaker's bureau. Over the next two fiscal years BMS plans to offer additional support groups for our target population and open up a women's chapter of our organization. Through our outreach efforts we have discovered that in order to break the stigma associated with mental health within the communities of African American Males and Men of Color we need strategic groups that deal with issues that confront targeted issues. At each speaking event we have had a mixed crowd and after reviewing audience responses, there has been numerous positive feedback regarding our women speakers. We'd plan on exploring ways that we can support this demographic in the future.

**MHSA Program #: PEI 20C**

**PROGRAM NAME: Culturally Responsive PEI Programs for the African American Community-African American Family Support**

Free quarterly workshops offer help to family members who seek support and care for those living with mental illness and/or who are substance addicted. The program provides opportunities to talk with mental health and substance use professionals and share stories with peer families.

**GENERAL INFORMATION & TOTAL NUMBERS SERVED**

| Total Numbers Served through PEI MHSA | |
|---|---|
| Number of unduplicated individuals your program serves who are **at-risk** of developing a mental health problem or serious mental illness | |
| Number of unduplicated individuals your program serves who show **early signs** | |
| Number of unduplicated individual family members served indirectly by your program: | 88 |
| Grand TOTAL of unduplicated individuals served in the Quarter that you are reporting about. [This number (D) should = A+B+C.] | 200 |

**PERFORMANCE INDICATORS: How Well Did We Do?**
Demographics

### Age Group (Unduplicated)

| | |
|---|---|
| Children/Youth (0---15) | 2 |
| Transition Age Youth (16---25) | 3 |
| Adult (26---59) | 26 |
| Older Adult (60+) | 30 |
| Unknown/ Declined to Answer | 1 |

**Race (Please mark only one choice)**
*If Hispanic or Latino, choose "Another race not listed."*

| | |
|---|---|
| American Indian or Alaska Native | 2 |
| Asian | |
| Black or African American | 59 |
| Native Hawaiian or other Pacific Islander | |
| White | |
| More than one race | |
| Another race not listed | 2 |
| Unknown/ Declined to Answer | |

**Sexual Orientation (Please mark only one choice)**

| |
|---|
| Gay or Lesbian |
| Heterosexual or Straight |
| Bisexual |
| Questioning or unsure of sexual orientation |
| Queer |
| Another sexual orientation not listed |
| Unknown/Decline to Answer |

**Ethnicity /Cultural Heritage (Please mark only once choice)**

| | |
|---|---|
| **If Hispanic or Latino, please specify:** | |
| Caribbean | 1 |
| Central American | |
| Mexican/Mexican-American/Chicano | 1 |
| Puerto Rican | |
| South American | |
| Another Hispanic/Latino ethnicity not listed | |
| Unknown/Declined to Answer | 1 |
| **If Non-Hispanic or Non-Latino, please specify:** | |
| African | 5 |
| African American | 36 |
| Asian Indian/South Asian | |
| Cambodian | |
| Chinese | |
| Eastern European | 1 |
| European | 1 |
| Filipino | |
| Japanese | |
| Korean | |
| Middle Eastern | |
| Vietnamese | |
| Other Non-Hispanic or Non- Latino ethnicity not listed | |
| **More than one ethnicity** | |
| **Unknown /Declined to Answer** | |

**Primary Language (Please mark only one choice)**

| |
|---|
| English |
| Spanish |
| Farsi |
| Cantonese |
| Mandarin |
| Other Chinese Dialects |
| Vietnamese |
| Korean |
| Tagalog |
| Other Filipino Dialect |
| Japanese |
| Laotian |
| Cambodian |
| Mien |
| Hmong |
| Samoan |
| Thai |
| Russian |
| Polish |
| German |
| Italian |
| Turkish |
| Hebrew |
| French |
| Portuguese |
| Armenian |
| Arabic |
| Sign ASL |
| Other primary language not |
| Unknown/ Decline to Answer |

**Gender Identity (Please mark both parts A & B)**

| | | |
|---|---|---|
| A) | Assigned sex at birth: (Please mark only one choice) | |
| | Male | |
| | Female | |
| | Other sex not listed (e.g. Intersex) | |
| | Unknown/Decline to Answer | |
| B) | Current Gender Identity: (Please mark only one choice) | |
| | Male | 10 |
| | Female | 53 |
| | Transgender | |
| | Genderqueer | |
| | Questioning or Unsure of Gender Identity | |
| | Another Gender Identity not listed | |
| | Unknown/Decline to Answer | |

**Disability Status** (Please mark all that apply)

| |
|---|
| None |
| Yes. If yes, please specify (choose from list below): |
| Difficulty Seeing |
| Difficulty hearing, or having speech understood |
| Mental Domain |
| Physical/Mobility Domain |
| Chronic Health Condition |
| Another disability not listed |
| Unknown/Decline to Answer |

**Veteran Status (Please mark only one choice)**

| |
|---|
| Yes |
| No |
| Unknown/Decline to Answer |

**OUTREACH. THIS SECTION IS *REQUIRED ONLY* FOR OUTREACH PROGRAMS**

Number of potential responders: ***A total 88 family caregivers and friends attended the two meetings.***

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

| **Type of Setting(s)** (ex: school, place of worship, | **Type(s) of Potential Responders** (ex: principals, teachers, parents, nurses) |
|---|---|
| North Oakland Senior | Family caregivers and friends of people with mental illness and/or substance abuse |
| Center | Family caregivers and friends of people with mental illness and/or substance abuse |
| Charles Porter Golden | Family caregivers and friends of people with mental illness and/or substance abuse |
| Recreation Center | Family caregivers and friends of people with mental illness and/or substance abuse |

**NARRATIVE**

Choose two of the above principles and describe how your program upholds or achieves those principles. Please speak to each principle separately and specifically describe how your program activities align with that corresponding principle.

Principle #1: Cultural Competence How does your program align with this principle? The AAFOP believes that there are core elements of African American culture. Among them are the belief in a common history, and values placed on communal activity and the extended family. Call and response is an appreciated verbal form in music and in areas of public association. The workshops open with recitation of a poem, using call and response to begin building group cohesion. The workshops close with the group singing the Negro National Anthem, another cohesion-building experience calling up a common historical reality as well as hope for the future. The facilitator and key speakers validate participants' expressions of racial conditions, whether they are cultural constraints, social limitations or traditional strengths.

Principle #2: Client, Consumer, and Family Involvement How does your program align with this principle? Having information about the service systems is an essential first step in family involvement and we are providing information including where to turn to get help in utilizing the systems (the Family Education and Resource Center is a prime source of help). Participants in the meetings are also invited to attend the monthly African American Family Support Group meetings which offer a way for families to become involved and to provide mutual support.

a. Please tell us about the following…

i. Implementation Challenges: Finding time to cover more topics and a way to have someone on site to help family caregivers and friends.

ii. Successes: We have developed a successful meeting format, recruited several very good presenters and made progress in identifying the main challenges these family caregivers and friends face. It is clear to us that those who attend these meetings have very positive feelings about sharing and learning together with others who are facing similar challenges.

iii. Lessons Learned**:** Meeting attendees would like to learn about more topics than we can cover in the allotted time. We need to secure additional resources in order to hold additional meetings and have someone present at meetings who can help those with questions.

iv. Relevant Examples of Success/Impact (e.g. a client success story) Reminder: Please do not use real client names: **N/A**

**ADDITIONAL INFORMATION**

Please include the number of clients and/or contacts you estimate to serve in:

FY 19/20: We hope to serve many additional family caregivers, but doing so will require additional resources.
FY 20/21: We hope to continue to increase the number of family caregivers and friends we serve; this will require additional resources.

Please tell us about any changes you intend to make to your program over the next two fiscal years and explain your rationale for making these changes:

**MHSA Program #: PEI 22**

**PROGRAM NAME: LGBT Support Services- Older & Out Adult LGBT Peer Supports**

**Program Description:** Older and Out provides drop-in therapy groups for LGBTQ older adults, age 60+ in north, central and east Alameda County. Groups are free, run for 90 minutes, welcome new members at any time, and refreshments are provided. Groups are facilitated by clinical interns assisted by local LGBTQ 60+ older adults.

Program Outcomes & Impact: PEI Data Report FY18/19

**PERFORMANCE INDICATORS: How Much Did We Do?**

| **Total Numbers Served through PEI MHSA** | |
|---|---|
| Number of unduplicated individuals your program serves who are **at-risk** of developing a mental health problem or serious mental illness (SMI | 7 |
| Number of unduplicated individuals your program serves who show **early signs** of forming a more severe mental illness | 0 |
| Number of unduplicated individual family members served indirectly by your program: | NA |
| Grand TOTAL of unduplicated individuals served in the Quarter that you are reporting about. [This number (D) should = A+B+C.] | 80 |

**PERFORMANCE INDICATORS: How Well Did We Do?**
Demographics

**Age Group (Unduplicated)**

| | |
|---|---|
| Children/Youth (0-••15) | 0 |
| Transition Age Youth (16-••25) | 0 |
| Adult (26-••59) | 7 |
| Older Adult (60+) | 73 |
| Unknown/ Declined to Answer | |

**Race (Please mark only one choice)**
*If Hispanic or Latino, choose "Another race not listed."*

| | |
|---|---|
| American Indian or Alaska Native | 2 |
| Asian | 4 |
| Black or African American | 12 |
| Native Hawaiian or other Pacific Islander | 0 |
| White | 51 |
| More than one race | 7 |
| Another race not listed | 1 |
| Unknown/ Declined to Answer | 3 |

**Sexual Orientation (Please mark only one choice)**

| | |
|---|---|
| Gay or Lesbian | 66 |
| Heterosexual or Straight | 1 |
| Bisexual | 4 |
| Questioning or unsure of sexual orientation | 1 |
| Queer | 4 |
| Another sexual orientation not listed | 2 |
| Unknown/Decline to Answer | 2 |

**Ethnicity /Cultural Heritage (Please mark only once choice)**

| | |
|---|---|
| **If Hispanic or Latino, please specify:** | |
| Caribbean | |
| Central American | |
| Mexican/Mexican-American/Chicano | 1 |
| Puerto Rican | |
| South American | |
| Another Hispanic/Latino ethnicity not listed | |
| Unknown/Declined to Answer | 7 |
| **If N on-Hispanic or Non-Latino, please specify:** | |
| African | |
| African American | 12 |
| Asian Indian/South Asian | 1 |
| Cambodian | |
| Chinese | 1 |
| Eastern European | 3 |
| European | 3 |
| Filipino | |
| Japanese | |
| Korean | |
| Middle Eastern | |
| Vietnamese | |
| Other Non-Hispanic or Non- Latino ethnicity not listed | 2 |
| **More than one ethnicity** | 2 |
| **Unknown /Declined to Answer** | 48 |

**Primary Language (Please mark only one choice)**

| | |
|---|---|
| English | 76 |
| Spanish | 1 |
| Farsi | |
| Cantonese | 8 |
| Mandarin | |
| Other Chinese Dialects | |
| Vietnamese | |
| Korean | |
| Tagalog | |
| Other Filipino Dialect | |
| Japanese | |
| Laotian | |
| Cambodian | |
| Mien | |
| Hmong | |
| Samoan | |
| Thai | |
| Russian | |
| Polish | |
| German | |
| Italian | |
| Turkish | |
| Hebrew | |
| French | |
| Portuguese | |
| Armenian | |
| Arabic | |
| Sign ASL | |
| Other primary language not | |
| Unknown/ Decline to Answer | 3 |

**Gender Identity (Please mark both parts A & B)**

| | |
|---|---|
| A) Assigned sex at birth: (Please mark only one | |
| Male | 47 |
| Female | 30 |
| Other sex not listed (e.g. Intersex) | 2 |
| Unknown/Decline to Answer | 1 |
| B) Current Gender Identity: (Please mark only one choice) | |
| Male | 45 |
| Female | 29 |
| Transgender | 1 |
| Genderqueer | 4 |
| Questioning or Unsure of Gender Identity | |
| Another Gender Identity not listed | 1 |

**Disability Status** (Please mark all that apply)

| | |
|---|---|
| None | 42 |
| Yes. If yes, please specify (choose from list below): | |
| Difficulty Seeing | 4 |
| Difficulty hearing, or having speech | 6 |
| Mental Domain | 5 |
| Physical/Mobility Domain | 11 |
| Chronic Health Condition | 5 |
| Another disability not listed | 1 |
| Unknown/Decline to Answer | 1 |

**Veteran Status (Please mark only one choice)**

| | |
|---|---|
| Yes | 9 |
| No | 46 |
| Unknown/Decline to Answer | 25 |

**OUTREACH. THIS SECTION IS *REQUIRED ONLY* FOR OUTREACH PROGRAMS. OTHERWISE, IT IS OPTIONAL**

Number of potential responders: 374

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

| **Type of Setting(s)** (ex: school, place of worship, clinic) | **Type(s) of Potential Responders** (ex: principals, teachers, parents, nurses) |
|---|---|
| **Senior Center** | LGBTQ public, their peers, providers of older adult services |
| **Non-profit** | LGBTQ public, their peers, providers of mental health and other social services |
| **Coffee shop** | LGBTQ activists & allies |

**NARRATIVE**

a. Choose two of the above principles and describe how your program upholds or achieves those principles. Please speak to each principle separately and specifically describe how your program activities align with that corresponding principle.

Principle #1: Cultural Competence. How does your program align with this principle? We are continually looking at ways we can improve our cultural competence by hiring therapists who represent the LGBTQ community and are versed in how to approach each client and situation with cultural humility so that, even if the therapist or peer specialist doesn't share the values, customs and beliefs with one other or the other clients, each person is treated with respect and positive regard. At this time, we are monolingual in our Older & Out program.

Principle #2: Wellness and Recovery. How does your program align with this principle? Our Older & Out groups are dedicated to promote resiliency and recovery in that the therapists and peer specialists don't dictate the topics for discussion or the goals for each client but instead use active listening skills to hear what topics they want to discuss and what goals they want to pursue.

b. Please tell us about the following…

i. Implementation Challenges: We continue to reach out to find people willing and able to facilitate the new peer groups in the East County, the groups that replaced the Older & Out Livermore therapy group while at the same time, pay attention to the chance that folks might want to have a therapy group in that region again. We also continue to watch for early signs of mental illness in group members with resources in place to make any needed referrals. We have developed a procedure on how to split a group into two smaller groups when the attendance is high, as often happens at the group located in Berkeley.

ii. Successes: Older &Out - Berkeley is very well attended, averaging 14 members. This creates a challenge and opportunity. The therapists and group members have a procedure on when and how they split into two rooms so that everyone has the opportunity to share. Outside of the Older & Out Berkeley group, community members are regularly socializing, led by 3 group members who are skilled at planning and bringing people together.

iii. Lessons Learned: Despite the low attendance at the Older & Out Hayward group, the current group members express the need for the group's presence at that senior center in that region, to continue to be visible to the

larger community and, in addition, express their appreciation for the opportunity to have access to therapy services.

iv. Relevant Examples of Success/Impact (e.g. a client success story) Reminder: Please do not use real client names: One Older & Out group members reported: “My expectations [of the group] were to bring out a side of me I have kept in the closest, hiding part of how I was, was really painful and hard. It [group] has allowed me a safe place to explore the part of me that has been taboo for most of my life except for [a] brief affair and childhood years when I was not yet afraid to express my gayness.”

**ADDITIONAL INFORMATION**

Please include the number of clients and/or contacts you estimate to serve in:

FY 19/20: We estimate we will serve 80 – 100 unduplicated clients.
FY 20/21: We estimate we will serve 80 – 100 unduplicated clients

Please tell us about any changes you intend to make to your program over the next two fiscal years and explain your rationale for making these changes: We are looking at expanding our outreach efforts, especially in East and Central County regions and also specifically to the queer and trans people of color in Alameda County to improve the attendance at our services provided in the East & Central regions of our county and to improve the attendance of queer and trans people of color in all our groups. We will be developing a short-term case management component to better meet the access, referral and linkage needs of our group members to improve the quality of their lives. We are increasingly aware from our therapists and peer specialists about the ways that the LGBTQ older adults are struggling.

**MHSA Program #: PEI 22**

**PROGRAM NAME: Pacific Center Technical Assistance Program**

**Program Description**: This program provides cultural humility trainings to service providers in Alameda County. We provide both clinical and nonclinical trainings. Our trainings focus on how organizations can be more culturally responsive the LGBTQ+ community, both internally and externally.

Program Outcomes & Impact: PEI Data Report FY18/19

**PERFORMANCE INDICATORS: How Much Did We Do?**

| **Total Numbers Served through PEI MHSA** | |
|---|---|
| Number of unduplicated individuals your program serves who are at-risk of developing a serious mental illness (SMI) | **N/A** |
| Number of unduplicated individuals your program serves who show early signs of forming a more severe mental illness | **N/A** |
| Number of unduplicated individual family members served indirectly by your program: | **N/A** |
| Grand TOTAL of unduplicated individuals served in the Quarter that you are reporting about. [This number (D) should = A=B+C.] | **N/A** |

**PERFORMANCE INDICATORS: How Well Did We Do?**
Demographics

**Age Group (Unduplicated)**

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

**Race (Please mark only one choice)**
*If Hispanic or Latino, choose "Another race not listed."*

| | |
|---|---|
| American Indian or Alaska Native | |
| Asian | |
| Black or African American | |
| Native Hawaiian or other Pacific Islander | |
| White | |
| More than one race | |
| Another race not listed | |
| Unknown/ Declined to Answer | X |

**Sexual Orientation (Please mark only one choice)**

| | |
|---|---|
| Gay or Lesbian | |
| Heterosexual or Straight | |
| Bisexual | |
| Questioning or unsure of sexual orientation | |
| Queer | |
| Another sexual orientation not listed | |
| Unknown/Decline to Answer | X |

**Ethnicity /Cultural Heritage (Please mark only once choice)**

| | |
|---|---|
| **If Hispanic or Latino, please specify:** | |
| Caribbean | |
| Central American | |
| Mexican/Mexican-American/Chicano | |
| Puerto Rican | |
| South American | |
| Another Hispanic/Latino ethnicity not listed | |
| Unknown/Declined to Answer | X |
| **If Non-Hispanic or Non-Latino, please specify:** | |
| African | |
| African American | |
| Asian Indian/South Asian | |
| Cambodian | |
| Chinese | |
| Eastern European | |
| European | |
| Filipino | |
| Japanese | |
| Korean | |
| Middle Eastern | |
| Vietnamese | |
| Other Non-Hispanic or Non- Latino ethnicity not listed | |
| **More than one ethnicity** | |
| **Unknown /Declined to Answer** | X |

| Primary Language | |
|---|---|
| English | |
| Spanish | |
| Farsi | |
| Cantonese | |
| Mandarin | |
| Other Chinese Dialects | |
| Vietnamese | |
| Korean | |
| Tagalog | |
| Other Filipino Dialect | |
| Japanese | |
| Laotian | |
| Cambodian | |
| Mien | |
| Hmong | |
| Samoan | |
| Thai | |
| Russian | |
| Polish | |
| German | |
| Italian | |
| Turkish | |
| Hebrew | |
| French | |
| Portuguese | |
| Armenian | |
| Arabic | |
| Sign ASL | |
| Other primary language not listed | |
| Unknown/ Decline to Answer | X |

| Gender Identity (Please mark both parts A & B) | |
|---|---|
| A) Assigned sex at birth: (Please mark only one choice) | |
| Male | |
| Female | |
| Other sex not listed (e.g. Intersex) | |
| Unknown/Decline to Answer | X |
| B) Current Gender Identity: (Please mark only one choice) | |
| Male | |
| Female | |
| Transgender | |
| Genderqueer | |
| Questioning or Unsure of Gender Identity | |
| Another Gender Identity not listed | |
| Unknown/Decline to Answer | X |

**REQUIRED STRATEGY: IMPROVE TIMELY ACCESS TO MENTAL HEALTH SERVICES FOR UNDERSERVED POPULATIONS**

a. Who is/are the underserved target population/s your program is serving (e.g. TAY, Southeast Asian, etc.)? **LGBTQ+ Communities**

b. Number of separate paper referrals to an ACBH PEI-funded program. (This can be a provider's internal ACBH PEI-funded prevention or early intervention program OR an external PEI-funded ACBH prevention or early intervention program): **N/A**

c. Number of individuals followed through on referral & engaged in an ACBH PEI-funded program: **N/A**

d. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with the ACBH PEI-funded provider. **N/A**

e. Describe ways your program encouraged access to services and follow-through on the above referrals: **N/A**

**SECTION 5. OPTIONAL STRATEGY: OUTREACH FOR INCREASING RECOGNITION OF EARLY SIGNS OF MENTAL ILLNESS**

Number of potential responders: 1 organization; 1 full-day conference; 10 facilitated workshops; 150 participants

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

| **Type of Setting(s)** (ex: school) | **Type(s) of Potential Responders** (ex: principals, teachers, parents, nurses) |
|---|---|
| Community Non-Profit | Executive Director, Program Manager, Direct Service Staff, Volunteers |
| Cal Endowment | Program Managers, Therapists, Social Workers, Students, Executive Directors |

**NARRATIVE**

a. Choose two of the above principles and describe how your program upholds or achieves those principles. Please speak to each principle separately and specifically describe how your program activities align with that corresponding principle.

Principle #1: **Cultural Competence** How does your program align with this principle? The Technical Assistance Program provides LGBTQ+ cultural humility trainings to organizations working in Alameda County. We work with a variety of service providers, and offer both clinical and non-clinical trainings. Our trainings enable providers to interact with members of the LGBTQ+ community in a more culturally responsive, inclusive way. While our trainings focus on the challenges/needs facing the LGBTQ+ community, we also take intersectionality into consideration when tailoring our trainings. This means that we also consider the specific challenges of QTPOC within the larger framework of the LGBTQ+ community and beyond. To that end, The Pacific Center sponsored a day-long conference entitled, Mental Health at The Intersections.

This was our second such conference in two years. The focus was on the ways in which QTPOC can be better served by mental health practitioners and service providers. Workshop facilitators focused on the societal and personal traumas often faced by Trans/Non-Binary, Disabled POC, Immigrant and Intersex clients. They offered new frameworks for working with clients who identify in any of these groups, psycho-education, and specific cultural considerations. The conference was sold out and received positive feedback.

Principle #2: **Community Collaboration** How does your program align with this principle? The Technical Assistance Program Director works collaboratively with participating organizations to provide trainings that target specific service concerns as they relate to the LGBTQ+ community, and LGBTQ+ people of color. Pre-workshop assessments and site visits allow us to tailor each workshop to the particular needs, concerns, and/or challenges of each service provider. In addition to the workshops and evaluations themselves, we also offer collateral materials, such as handouts, articles and resource guides in order to support workshop participants with client needs that may be outside their immediate scope of practice.

Principle #3: **Wellness and Recovery** How does your program align with this principle? Under the TA Contract the Pacific Center also continued to offer grief and loss therapy groups to members of the LGBTQ+ community who are experiencing grief associated with loss. In this reporting period, 2, 8-week groups have been run, for a total of 16 unduplicated clients. (8 per group).

There was a change in leadership this quarter in that a new co -facilitators joined the group with the experienced, licensed therapist as a training ground for new clinicians. Group members worked on expressions of grief and building tolerance for painful emotions associated with loss, particularly anger, confusion, and despair. Members were invited to use weekly themes as a platform for exploring their grieving process and connecting with one another over shared experiences. Through expressions of compassion and empathy for one another, members were able to develop compassion and empathy for themselves.

b. Please tell us about the following…

i. Implementation Challenges: While we had one successful LGBTQ+ cultural humility training at the ABHCS offices, and planned for 3 others, we struggled to successfully complete all 4/one per quarter due to many factors. Our goal this fiscal year will be to complete at least three trainings at the county office.

ii. Successes: Pacific Center trainings were well attended and well received. Post-training evaluations indicated that workshop participants left with increased knowledge about the LGBTQ+ community (e.g. – terminology, life stressors, etc.) and concrete tools for engaging LGBTQ+ clients with more sensitivity. Additionally, The Pacific Center hosted a day-long conference on intersectional identities (see above section).

iii. Lessons Learned: Conducting follow-up trainings and/or trainings that are longer than the standard two-hour training allows for deeper levels of participation, learning and integration of the material. Ideally, we would like to be able to provide tiered, or leveled, trainings for all of the organizations we collaborate with. This will allow us to move beyond “LGBTQ+ 101” and have a greater impact. Additionally, being aware of and integrating an intersectional framework consistently will allow us to reach a wider audience and have a greater impact.

iv. Relevant Examples of Success/Impact (e.g. a client success story) Reminder: Please do not use real client names: Our Mental Health at the Intersections conference had a deeply positive impact on the providers who attended. Many responded with statements such as:

"I will continue to deeply reflect on the shades & layers of privilege and oppression that I carry and that impact me personally and professionally." "I'll apply what I learned with my work with university student at a counseling center and with my volunteer community." "I really enjoyed Phoenix Jackson's presentation on complex PTSD and "mostly tool-less interventions" Theory DX Treatment very useful."

**EVALUATION PLAN UPDATE**

a. Please describe, in 1-2 sentences, your effort to collect feedback from program participants (method used). Please include the timeframes of when you survey clients. Post-workshop evaluations are administered immediately following each workshop. Evaluations outline learning outcomes, and include both open ended questions and a 1-5 rating system in order to get a comprehensive overview of the levels of participant satisfaction.

b. Describe the tool (i.e. MHSIP or another survey) used to collect data. We use a paper evaluation developed by the Pacific Center. We also get qualitative input during post workshop conversations.

c. Summarize the results if any. In relation to our questions ranked 1-5, with 5 being the highest score, participants scored predominantly 4s & 5s across the following measurable categories: Met Learning Objectives, Instructor, Course Content, and Overall Satisfaction. The following quotes are representative of the majority sentiment expressed in answers to the open-ended questions: "I have an increased sensitivity to issues facing my LGBTQ+ clients, specifically my transgender clients." "I have a better understanding of the difference between sexual orientation and gender expression." "I learned A LOT about ableism." "I have a more nuanced understanding of micro-aggressions." "This made me reflect on some micro-aggressions I may have used with clients." "I learned to not make assumptions based on appearance." "I need to recognize my own biases."

d. What was learned from the participant feedback (**1-2 key points**)? Overall we have received very positive feedback to date. The feedback reflects the need for introductory LGBTQ+ workshops, and also participants' desire for additional, follow-up workshops that are more in-depth and comprehensive. This is in alignment with Pacific Center training goals.

e. Describe how the findings were reviewed by staff**. Evaluation findings were reviewed by the Director of Diversity, Equity and Inclusion, and trainer(s).**

f. What programmatic change(s) were or will be adopted as a result of the findings? When will changes be made and how will the changes impact programming? The Program Director and trainers are actively encouraging partner agencies to pursue additional, deeper trainings via additional outreach, site visits and conversations. As of this reporting, one agency has devoted 3 consecutive PD trainings to LGBTQ+ concerns during Q1 of FY 2019-2020. Currently, the Pacific Center hosts one, full-day conference on intersectional identity markers and mental health. We would like to begin offering two of these conferences in FY 2020-2021 as a way to provide deeper, more integrated levels of learning around issues facing the LGBTQ+ communities of color. Finally, the Pacific Center allocated funds to expand the program coordinator's role to a director level. Along with working with outside agencies to increase cultural humility and awareness, the Director of Diversity, Equity and Inclusion (DEI) will also be charged with developing and implementing a comprehensive DEI strategy to address issues of inclusivity and equity within the organization's staffing, collateral materials and messaging, and across programs (ex. – clinical training program, peer support group program, therapy group program).

g. What issues or challenges with the Evaluation Plan are you having? What technical assistance do you need? We are having a difficult time collecting demographic data consistently and comprehensively. Workshop participants are often reluctant to include such identifying information on their evaluations because the workshops happen in the context of work where hierarchical power dynamics are present.

**ADDITIONAL INFORMATION**

Please include the number of clients and/or contacts you estimate to serve in:

FY 19/20: Our goal is to conduct 6 trainings per quarter, along with a day-long conference. Each quarter, our goal is for at least one partner organization to conduct scaffolded trainings.

FY 20/21: Our goal is to conduct 6 trainings per quarter, along with two, day-long conferences. Each quarter, our goal is for at least two partner organizations to conduct scaffolded trainings.

Please tell us about any changes you intend to make to your program over the next two fiscal years and explain your rationale for making these changes:

# PREVENTION & EARLY INVERVENTION PROGRAM SUMMARIES: ACCESS & LINKAGE TO MENTAL HEALTH TREATMENT PROGRAMS

**MHSA Program #: PEI 1B**

**PROGRAM NAME: School-Based Mental Health Access and Linkage in Elementary, Middle and High Schools**

**Program Description:** School-based Mental Health consultation and access and linkage program providing services in 14 of 18 Alameda County school districts. A partnership between ACBH and the Center for Healthy Schools and Communities (CHSC). Coordination of service teams (COST) help refer and connect students to prevention and early intervention or treatment services

Program Outcomes & Impact: PEI Data Report FY18/19

**PERFORMANCE INDICATORS: How Much Did We Do?**

| Total Numbers Served through PEI MHSA | |
|---|---|
| Number of unduplicated individuals your program serves who are **at-risk** of developing a mental health problem or serious mental illness (SMI) | 15,833 |
| Number of unduplicated individuals your program serves who show **early signs** of forming a more severe mental illness | 8,732 |
| Number of unduplicated individual family members served indirectly by your program: | 0 |
| Grand TOTAL of unduplicated individuals served in the Quarter that you are reporting about. [This number (D) should = A+B+C.] | 24,565 |

**PERFORMANCE INDICATORS: How Well Did We Do?**
Demographics

**Age Group (Unduplicated)**

| | |
|---|---|
| Children/Youth (0---15) | |
| Transition Age Youth (16---25) | |
| Adult (26---59) | |
| Older Adult (60+) | |
| Unknown/ Declined to Answer | 15,833 |

**Race (Please mark only one choice)**
*If Hispanic or Latino, choose "Another race not listed."*

| | |
|---|---|
| American Indian or Alaska Native | 226 |
| Asian | 2,013 |
| Black or African American | 2,677 |
| Native Hawaiian or other Pacific Islander | 248 |
| White | 1,969 |
| More than one race | 676 |
| Another race not listed | 5,646 |
| Unknown/ Declined to Answer | 627 |

**Sexual Orientation (Please mark only one choice)**

| | |
|---|---|
| Gay or Lesbian | 40 |
| Heterosexual or Straight | 385 |
| Bisexual | 3 |
| Questioning or unsure of sexual orientation | 5 |
| Queer | 0 |
| Another sexual orientation not listed | 1 |
| Unknown/Decline to Answer | 9,678 |

**Ethnicity /Cultural Heritage (Please mark only once choice)**

| | |
|---|---|
| **If Hispanic or Latino, please specify:** | |
| Caribbean | 1 |
| Central American | 30 |
| Mexican/Mexican--American/Chicano | 507 |
| Puerto Rican | 1 |
| South American | 18 |
| Another Hispanic/Latino ethnicity not listed | 202 |
| Unknown/Declined to Answer | 4,141 |
| **If Non-Hispanic or Non-Latino, please specify:** | |
| African | 48 |
| African American | 541 |
| Asian Indian/South Asian | 392 |
| Cambodian | 20 |
| Chinese | 245 |
| Eastern European | 12 |
| European | 41 |
| Filipino | 300 |
| Japanese | 20 |
| Korean | 22 |
| Middle Eastern | 64 |
| Vietnamese | 65 |
| Other Non-Hispanic or Non- Latino ethnicity not listed | 343 |
| **More than one ethnicity** | 1,689 |
| **Unknown /Declined to Answer** | 1,998 |

**Primary Language (Please mark only one choice)**

| | |
|---|---|
| English | 6,309 |
| Spanish | 2,626 |
| Farsi | 56 |
| Cantonese | 115 |
| Mandarin | 111 |
| Other Chinese Dialects | 19 |
| Vietnamese | 79 |
| Korean | 12 |
| Tagalog | 68 |
| Other Filipino Dialect | 6 |
| Japanese | 14 |
| Laotian | 7 |
| Cambodian | 32 |
| Mien | 15 |
| Hmong | 1 |
| Samoan | 2 |
| Thai | 3 |
| Russian | 9 |
| Polish | 1 |
| German | 0 |
| Italian | 0 |
| Turkish | 4 |
| Hebrew | 0 |
| French | 13 |
| Portuguese | 3 |
| Armenian | 2 |
| Arabic | 148 |
| Sign ASL | 4 |
| Other primary language not | 566 |
| Unknown/ Decline to Answer | 5,865 |

**Gender Identity**

| | |
|---|---|
| A) Assigned sex at birth: (Please mark only one | |
| Male | 6,035 |
| Female | 4,869 |
| Other sex not listed (e.g. Intersex) | 54 |
| Unknown/Decline to Answer | 5,015 |
| B) Current Gender Identity: (Please mark only one choice) | |
| Male | 1,704 |
| Female | 1,370 |
| Transgender | 4 |
| Genderqueer | 0 |
| Questioning or Unsure of Gender Identity | 0 |
| Another Gender Identity not listed | 1 |
| Unknown/Decline to Answer | 7,000 |

**Disability Status** (Please mark all that apply)

| | |
|---|---|
| None | 964 |
| Yes. If yes, please specify (choose from list below): | |
| Difficulty Seeing | 7 |
| Difficulty hearing, or having speech | 236 |
| Mental Domain | 255 |
| Physical/Mobility Domain | 5 |
| Chronic Health Condition | 692 |
| Another disability not listed | 917 |
| Unknown/Decline to Answer | 8,851 |

**Veteran Status (Please mark only one choice)**

| | |
|---|---|
| Yes | |
| No | |
| Unknown/Decline to Answer | 15,833 |

**REQUIRED STRATEGY: INCREASE ACCESS AND LINKAGE TO MENTAL HEALTH TREATMENT**

a. Number of individuals with serious mental illness (SMI) who received a paper referral (i.e. referrals via phone do not apply) from your program to an ACBH mental health treatment program: 4,780 individuals

b. List type(s) of mental health treatment programs the individual was referred to: Mental health treatment programs that individuals were referred to primarily consisted of the following school-based health services: individual counseling or therapy, group counseling, crisis intervention, individualized behavior support, family counseling and parent workshops. Additionally, linkages to other services outside of school-based health resources were made when needed.

c. Number of individuals who were successfully referred and linked to an ACBH mental health treatment program (i.e. client has been seen at least once in person by a treatment provider): 4,837

d. Average duration in weeks of signs of untreated mental illness (per client self-report): n/a

e. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with a mental health treatment provider: The average time in weeks between when a paper referral was given to an individual and when that individual had their first appointment with a mental health treatment provider varied across the 14 school districts receiving MHSA funding support. Below is a table with the average times of referral to first appointment by district.

| *School District* | *Average Time between Referral and Treatment* |
|---|---|
| Alameda USD | 1-2 weeks |
| Castro Valley USD | 1-2 weeks |
| Emeryville USD | 1-2 weeks |
| Fremont USD | 3-4 weeks |
| Hayward USD | 3-4 weeks |
| Livermore USD | 3-4 weeks |
| New Haven USD | 3-4 weeks |
| Newark USD | 3-4 weeks |
| Oakland USD | 2-4 weeks |
| Piedmont USD | 3-4 weeks |
| Pleasanton USD | 1-2 weeks |
| San Leandro USD | 3-4 weeks |
| San Lorenzo USD | 3-4 weeks |

f. Any additional information to report on? (Optional): n/a

**REQUIRED STRATEGY: IMPROVE TIMELY ACCESS TO MENTAL HEALTH SERVICES FOR UNDERSERVED POPULATIONS**

a. Who is/are the underserved target population/s your program is serving (e.g. TAY, Southeast Asian, etc.)?
   - Transitional-aged youth
   - Foster youth
   - LGBTQ-identifying youth
   - Boys and young men of color
   - Unaccompanied immigrant youth
   - Food and shelter insecure youth and families
   - English as a second language youth

b. Number of separate paper referrals to an ACBH PEI-funded program. (This can be a provider's internal ACBH PEI-funded prevention or early intervention program OR an external PEI-funded ACBH prevention or early intervention program):

   A majority of referrals are primarily to school-based mental health treatment with service providers that collaborate with the schools. Given that only a minority of paper referrals are to an ACBH PEI-funded programs, we do not separate ACBH PEI-funded and non-funded referrals in our data collection process.

c. Number of individuals followed through on referral & engaged in an ACBH PEI-funded program: n/a

d. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with the ACBH PEI-funded provider. n/a

e. Describe ways your program encouraged access to services and follow-through on the above referrals:
   Alameda County School Districts are implementing a Coordination of Services Team (COST) strategy to increase early identification of students who may need support services as well as access and linkage to behavioral and mental health care. Through COST implementation teachers, staff, students (self-referral) and families may submit referrals for students they are concerned about and a multidisciplinary group of staff and internal/external service providers (i.e. COST Team) meets weekly or biweekly to triage student needs. During COST team meetings, members take responsibility for following up with the student and their guardian to ensure linkage to care is offered. Furthermore, the COST coordinator documents when follow-up occurred, if linkage to care was accepted, and the initiation date of the care that the student received.

f. Any additional information to report on (optional): n/a

**NARRATIVE**

a. Choose <u>two</u> of the above principles and describe how your program upholds or achieves those principles. Please speak to each principle separately and specifically describe how your program activities align with that corresponding principle.

   Principle #1: Client, Consumer, and Family Involvement
   How does your program align with this principle?

Emphasis on client, consumer and family involvement is high across each Alameda County school district that CHSC supports. All of the schools implement a service model that prioritizes clients, consumers and families in all aspects of the mental health system from planning and service delivery to evaluation and policy development.

Service plans are created in collaboration with the client and/or caregiver(s) as well as teachers and other key individuals in order to ensure that the services they receive reflects their goals and needs. In addition, an informed consent process is always provided to students and their families when they are being referred to a service.

Furthermore, many Alameda County school districts collaborate with multiple parent organizations and committees (i.e. PTAs, ELACs, SSCs, Parent Leadership Councils, etc.) to gather input on how to best serve students and their families.
As a result, some schools have increased Wellness Centers within their districts, hosted regular parent cafes that provide caregivers a space where they can speak openly with school administrators, presented at family partnership events, and included parents their special education strategic planning processes.

Principle #2: Integrated Service Delivery. How does your program align with this principle?

Implementation of a Coordination of Services Team (COST) strategy utilizes a diverse team of school staff and representatives from service providers to take a holistic approach to assessing student needs, integrating internal and external support services and linking students and/or their families to the appropriate support system.

COST has been integral to increasing and streamlining service delivery to students throughout Alameda County. Districts have noted that the cross-site integration of students transitioning from either elementary to middle school or middle to high school supports the continuity of care for students, especially those with the highest needs, while also preparing the receiving site with information in advance that allows them to better serve transitioning students and their families. Collaboration between schools and behavioral and mental health service providers (whether internal or external) is continuously encouraged and many of the districts are in the process of developing or integrating the implementation of their COST model to work in tandem with their Positive Behavior Interventions and Support programming as well as their Multi-tiered Systems of Support Strategies.

b. Please tell us about the following…

i. Implementation Challenges:

- Many of our school-based services are primarily for Medi-Cal eligible individuals. At times, it can be challenging to quickly link students the appropriate service either due to high volumes of individuals who are ineligible for Medi-Cal or limited availability of resources that they are eligible for. However, implementation of COST has allowed us to triage students' needs and decrease the duration of time between when a student is identified as potentially being in need, assessed, and connected to a service provider.

- Successful implementation of the COST model is contingent upon support from district and site-level leadership as it cultivates "buy-in" from the rest of the school staff. When school sites change Principals and COST coordinators, the Center for Healthy Schools and Communities usually has to establish new relationships and orient new leadership to the COST model. During times of district turnover, it can be challenging to streamline the process of connecting students to behavioral health care services as new leadership acclimates to the COST model.

- As many districts are seeing changes in their population's demographics, especially those that historically have not had many students of color and/or unaccompanied immigrant youth, they have to reassess the services they provide to their students. This includes increased trainings on trauma awareness, cultural competency, and restorative practices – all of which often takes time and capacity that not all schools have.

ii. Successes:

- More schools have reported training their staff and adopting restorative practices at their sites. Restorative Practices are a form of student support that focus on improving relationships and community over punitive actions. Given that students of color are often disproportionately suspended, restorative practices provide an alternative to suspension and an avenue to identify students who may need mental health treatment. Another success and positive impact of the implementation of COST among Alameda County schools is the expansion of Restorative Practices training and programming.

- Over the last academic year both COST referrals and linkage to care have increased across all 14 CHSC supported school districts. In addition, duration of time between referrals and connection to services has decreased at most districts.

iii. Lessons Learned:
Establishing relational trust and buy-in of strategies and services with new district leadership and staff members is vital to increased implementation and uptake of mental health treatment services for students and their families. CHSC continuously strives to establish and maintain positive relationships with school districts as well as to foster positive relationships between schools and service providers.

iv. Relevant Examples of Success/Impact (e.g. a client success story) Reminder: Please do not use real client names: Mike, an elementary school student, was referred to COST after teachers reported he was chronically absent and further investigation discovered he had an attendance rate of 51%. The school's attendance social worker contacted Mike's mother and discovered that the Mike had an older sibling who suffered from a mental illness and had begun enacting on threats previously made to harm their family. Both Mike and his mother were exhibiting PTSD symptoms, which is why Mike had been missing school. The social worker connected the family to an outside provider that was able to place his sibling in a residential treatment program, connected Mike to a therapist, connected Mike's mother to Victims of Crime services, and met with both parents to come to an agreement that Mike would live with his father because he had a more stable schedule and could take Mike to school every day. Mike currently sees a therapist weekly and has made drastic improvements including depicting happiness, participating in school events, and his attendance rate has increased to 87%.

**ADDITIONAL INFORMATION**

Please include the number of clients and/or contacts you estimate to serve in:
FY 19/20: 26,500
FY 20/21: 29,000

# PREVENTION & EARLY INVERVENTION PROGRAM SUMMARIES: STIGMA & DISCRIMINATION REDUCTION PROGRAMS

**MHSA Program #: PEI 4**

**PROVIDER NAME: PEERS**

**PROGRAM NAME: Stigma and Discrimination Reduction Campaign-Everyone Counts Campaign (EEC)**

**Program Description:** The EEC aims to reduce stigma and discrimination against people with mental health challenges and promotes social inclusion through three strategies: Empowerment (Healing Arts and Spirituality Groups), Outreach Lift Every Voice and Speak, Action Teams, Outreach and Communications (website, email, social media).

Program Outcomes & Impact: PEI Data Report FY18/19

**PERFORMANCE INDICATORS: How Much Did We Do?**

| Total Numbers Served through PEI MHSA | |
|---|---|
| Number of unduplicated individuals your program serves who are **at-risk** of developing a mental health problem or serious mental illness (SMI) | 241 |
| Number of unduplicated individuals your program serves who show **early signs** of forming a more severe mental illness | |
| Number of unduplicated individual family members served indirectly by your program: | |
| Grand TOTAL of unduplicated individuals served in the Quarter that you are reporting about. [This number (D) should = A+B+C.] | 241 |

*Totals do not include email, outreach events, or community presentations/speaking engagements where people do not sign in

List Number of Individuals Reached by each Activity (ex: who accessed website, social media hits, tabling/outreach events, e-blasts, etc.): Click here to enter text.

| **Type of Activity** (ex: accessed website) | **Number of Individuals Reached** (#) |
|---|---|
| Email blasts of ECC-related articles and updates | 2,495 subscribers |
| ECC Communications: Hard copy calendar updates | 8,000 est. reached |
| African American ECC focus groups and Action Team meetings | 29 |
| Special Messages groups | 49 |
| Spirituality groups | 30 |
| Lift Every Voice and Speak (LEVS) speaking engagements | 396 |
| Tabling/outreach events | 1,600 (approximately) |
| Community presentations | 219 |

**PERFORMANCE INDICATORS: How Well Did We Do?**
Demographics

**Age Group (Unduplicated)**

| | |
|---|---|
| Children/Youth (0---15) | |
| Transition Age Youth (16---25) | 21 |
| Adult (26---59) | 101 |
| Older Adult (60+) | 25 |
| Unknown/ Declined to Answer | 94 |

**Race (Please mark only one choice)**
*If Hispanic or Latino, choose "Another race not listed."*

| | |
|---|---|
| American Indian or Alaska Native | |
| Asian | 5 |
| Black or African American | 108 |
| Native Hawaiian or other Pacific Islander | |
| White | 40 |
| More than one race | 17 |
| Another race not listed | 30 |
| Unknown/ Declined to Answer | 41 |

**Sexual Orientation (Please mark only one choice)**

| | |
|---|---|
| Gay or Lesbian | |
| Heterosexual or Straight | 38 |
| Bisexual | 2 |
| Questioning or unsure of sexual orientation | |
| Queer | |
| Another sexual orientation not listed | 2 |
| Unknown/Decline to Answer | 19 |

**Ethnicity /Cultural Heritage (Please mark only once choice)**

| | |
|---|---|
| **If Hispanic or Latino, please specify:** | |
| Caribbean | |
| Central American | |
| Mexican/Mexican--American/Chicano | 3 |
| Puerto Rican | |
| South American | |
| Another Hispanic/Latino ethnicity not listed | |
| Unknown/Declined to Answer | 17 |
| **If Non-Hispanic or Non-Latino, please specify:** | |
| African | 1 |
| African American | 108 |
| Asian Indian/South Asian | 1 |
| Cambodian | 0 |
| Chinese | 1 |
| Eastern European | 0 |
| European | 3 |
| Filipino | 3 |
| Japanese | 1 |
| Korean | 0 |
| Middle Eastern | 1 |
| Vietnamese | 0 |
| Other Non-Hispanic or Non- Latino ethnicity not listed | 3 |
| **More than one ethnicity** | 3 |
| **Unknown /Declined to Answer** | 89 |

**Primary Language (Please mark only one choice)**

| | |
|---|---|
| English | 58 |
| Spanish | 7 |
| Farsi | |
| Cantonese | 1 |
| Mandarin | |
| Other Chinese Dialects | |
| Vietnamese | |
| Korean | |
| Tagalog | |
| Other Filipino Dialect | |
| Japanese | |
| Laotian | |
| Cambodian | |
| Mien | |
| Hmong | |
| Samoan | |
| Thai | |
| Russian | |
| Polish | |
| German | |
| Italian | |
| Turkish | |
| Hebrew | |
| French | |
| Portuguese | |
| Armenian | |
| Arabic | |
| Sign ASL | |
| Other primary language not | 1 |
| Unknown/ Decline to Answer | 17 |

**Gender Identity (Please mark both parts A & B)**

| | |
|---|---|
| A) Assigned sex at birth: (Please mark only one | |
| Female | |
| Other sex not listed (e.g. Intersex) | |
| Unknown/Decline to Answer | 24 1 |
| B) Current Gender Identity: (Please mark only one choice) | |
| Male | 92 |
| Female | 10 |
| Transgender | |
| Genderqueer | |
| Questioning or Unsure of Gender Identity | |
| Another Gender Identity not listed | 1 |
| Unknown/Decline to Answer | 40 |

**Disability Status** (Please mark all that apply)

| | |
|---|---|
| None | 0 |
| Yes. If yes, please specify (choose from list below): | |
| Difficulty Seeing | |
| Difficulty hearing, or having speech | |
| Mental Domain | 19 |
| Physical/Mobility Domain | 9 |
| Chronic Health Condition | |
| Another disability not listed | |
| Unknown/Decline to Answer | 21 |

**Veteran Status (Please mark only one choice)**

| | |
|---|---|
| Yes | 4 |
| No | 56 |
| Unknown/Decline to Answer | 18 1 |

**REQUIRED STRATEGY: IMPROVE TIMELY ACCESS TO MENTAL HEALTH SERVICES FOR UNDERSERVED POPULATIONS**

a. Who is/are the underserved target population/s your program is serving (e.g. TAY, Southeast Asian, etc.)? Mental health consumers, primarily low-income people of color, including TAY and older adults.

b. Number of separate paper referrals to an ACBH PEI-funded program. (This can be a provider's internal ACBH PEI-funded prevention or early intervention program OR an external PEI-funded ACBH prevention or early intervention program): 1

c. Number of individuals followed through on referral & engaged in an ACBH PEI-funded program: 0

d. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with the ACBH PEI-funded provider. N/A The referrals were not for "appointments" per se. One participant, who has a TAY-aged child struggling with mental health challenges, was referred to Intensive Home Outreach Team (IHOT). Other referrals were to programs not funded by ACBH PEI, such as 2-1-1 for the Consolidated Entry System. For example, we provided one participant with referrals to BayLegal's Alameda County Tenants' Rights Hotline (and 2-1-1) for advice on negotiating with his landlord and he was able to avoid eviction.

e. Describe ways your program encouraged access to services and follow-through on the above referrals: Our primary method is to provide both information about participants' options and personal encouragement, since self-determination is a core principle of our program model.

**NARRATIVE**

a. Choose <u>two</u> of the above principles and describe how your program upholds or achieves those principles. Please speak to each principle separately and specifically describe how your program activities align with that corresponding principle.

Principle #1: Cultural Competence. How does your program align with this principle? PEERS has provided culturally competent services with cultural humility for African Americans with mental health challenges for many years. One example of our practice of cultural competence is our African American Everyone Counts Campaign. FY18-19 was the planning year for this campaign, which builds on PEERS' Latino Everyone Counts Everyone Counts Campaign (FY16-17 and FY17-18) and Chinese American Everyone Counts Campaign (FY14-15 and FY15-16). The campaign is staffed and led by African Americans, all of whom have lived experience with mental health challenges. Some elements of African American culture that have been incorporated into the planning of the campaign include taking a trauma-informed approach, incorporating culturally-informed ritual into meetings and other gatherings, and making room for talking about religion and belief systems, as well as shared histories of oppression and current experiences of racism. The campaign is guided by an African American Action Team, composed of a diverse group of 16 African American community members with lived experience of mental health challenges. One of Action Team's charges this year was to identify a group with the power and influence to reduce stigma around mental health in the local African American community. The Action Team decided that people in the music and entertainment industries have that kind of influence. We are in the process of recruiting influential artists and media producers to the campaign, including Mistah Fab, So Oakland, and KPFA.

Principle #2: Wellness and Recovery. How does your program align with this principle? All of the community outreach (both in-person and online) PEERS does through the Everyone Counts Campaign is strongly grounded in messages of wellness and recovery. From our "Love More, Judge Less" t-shirts, to our insistence on using non-stigmatizing recovery-based language instead of diagnostic or symptom-focused language, to the many ways that our staff act as living models of the possibility of wellness and recovery, PEERS aligns with this principle consistently. Our Lift Every Voice and Speak speakers' bureau (LEVS), promotes wellness and recovery by training people with lived experience of mental health challenges to tell their recovery stories, including how different forms of stigma have affected them. By telling their stories, LEVS speakers introduce wellness and recovery perspectives to audiences of other mental health consumers as well as to community members who may not have similar experiences. The speakers' bureau enhances the wellness of LEVS

speakers themselves by building supportive peer relationships, developing leadership, and improving their community by reducing stigma.

b. Please tell us about the following…

i. Implementation Challenges: At the beginning of FY18-19, attendance at LEVS meetings was lower than we wanted, with an average attendance of eight participants during the first quarter. To increase engagement, we revamped the meetings and the speaker training curriculum. We incorporated more healing and wellness tools into the meetings, including art activities and small-group sharing. The program coordinator implemented a new system for supporting each speaker to move toward her or his own speaking goals. We also brought more structure to the speaker trainings, so that members were better able to support each other to improve their effectiveness as speakers. Additional training on the different forms of stigma related to mental health challenges (public stigma, structural stigma, and self- stigma) also deepened speakers' ability to link their personal stories to stigma reduction. On another note, at the end of FY17-18, we redesigned our spirituality program to emphasize facilitating groups at other places where people gather rather than at PEERS, because we were not satisfied with the level of attendance at our spirituality groups. To that end, we developed a new partnership with Allen Temple Arms, an affordable housing complex for low-income seniors and people with disabilities. Not only were the spirituality groups well received by the residents, but PEERS' partnership with Allen Temple Arms expanded beyond the spirituality program.

ii. Successes: The African American Everyone Counts Campaign has had some major successes in getting media coverage. In July, Bre Williams, PEERS' Programs Manager, was featured on an hour-long show on KPFA radio that explored questions including what it means to be mentally and emotionally healthy, why mental, emotional, and physical health often are understood as separate, how dominant cultural norms frame understanding of health and illness -- and more healthful and culturally relevant ways to understand mental health. In November, PEERS' Executive Director Vanetta Johnson along with staff members Bre Williams and Ashlee Jemmott were featured on the KBLX radio show "Listen Up Bay Area," which features local organizations. In a 15-minute segment, they discussed key themes related to mental health among African Americans, including the goals of the African American Everyone Counts Campaign. In the spring, the campaign was again featured on KPFA during KPFA's coverage of Oakland's Juneteenth celebration. As for Lift Every Voice and Speak, the changes to the speakers' bureau program were so successful that by the fourth quarter, average attendance at meetings increased to 18 and membership increased to 30. The program currently is at capacity and we have suspended recruitment of new members.

iii. Lessons Learned: During the planning phase for the two-year African American Everyone Counts Campaign, PEERS held a series of focus groups -- one for high-school aged young men, one for high-school aged young women, and one for elders. Each group discussed what they need in their neighborhoods to thrive and be successful; what cultural competency means to them; what supports, skills, and resources they need in order to develop healthier self-esteem; and what would help them be more prepared to respond to the daily stressors associated with racism, discrimination, and other forms of systematic oppression. Themes that emerged in all three groups included attention to the social determinants of health such as the need for good jobs, access to healthy food and grocery stores, role models, and support (e.g. "Neighborly love - someone to talk to about real stuff."). Young women strongly expressed the need for safety in many settings, especially safety from physical and sexual violence. Young men talked about needing to know more about their history and the histories of their people. When discussing cultural competency, focus group participants articulated the need to be understood. One young woman said, "Doctors need to be aware of black people's humanity." An elder participant pointed out, "Not all black people are the same." Another elder participant described how, as a black man, he has to set his mental health providers at ease and make the provider feel comfortable in order to get services. As we move into the next stage of the campaign, we will incorporate what we have heard so far, and continue to seek out the insights of more African American community members.

iv. Relevant Examples of Success/Impact (e.g. a client success story) Reminder: Please do not use real client names: The LEVS speakers' bureau program coordinator implemented a new system for supporting each speaker to move toward her or his own goals. At the beginning of the year, or upon joining LEVS, each speaker is given the option of setting an individual goal. The program coordinator then adapts the curriculum and designs opportunities to assist each participant to pursue their goal. LEVS participants recently described the group as "a speakers' bureau for healers," and "a healing community that helps spread hope." One member of the speakers' bureau said that she now is "speaking in a voice I didn't know I had."

**ADDITIONAL INFORMATION**

Please include the number of clients and/or contacts you estimate to serve in:

FY 19/20: 275 (does not include email, outreach events, or community presentations/speaking engagements where people do not sign in)

FY 20/21: 275 (does not include email, outreach events, or community presentations/speaking engagements where people do not sign in)

Please tell us about any changes you intend to make to your program over the next two fiscal years and explain your rationale for making these changes: The two primary changes to PEERS ECC programs in the next two years will be in the ethnic-specific social inclusion campaigns and in the program's Anti-Stigma Latino (PAL). In FY 19-20, we will move from planning to implementation of the African American Everyone Counts Campaign, which includes facilitating two multi-session stigma reduction support groups. In FY 20-21, we expect to be in a planning year for another culture-specific Everyone Counts Campaign. In FY 19-20, we also will begin implementation of PAL, a Latino-focused anti-stigma program that will include peer support groups and community presentations.

*Special note regarding the use of validated methods to measure changes in attitudes, knowledge, and behavior related to mental illness or seeking mental health services for this Stigma and Discrimination program:*

ACHB's Stigma and Discrimination Reduction programs, implemented by PEERS (Peers Envisioning and Engaging in Recovery Services), evaluates the Everyone Counts Campaign (EEC) (including the African American-focused campaign and Lift Every Voice and Sing (LEVS) program) and Hope & Faith Program using questionnaires and a Consumer Program Survey, administered twice per year. PEERS' instruments have been validated using the following methods to measure changes in attitudes, knowledge, and or behavior related to mental illness or seeking mental health services:

- ACBH and PEERS participated in the MOQA Stigma and Discrimination Reduction pilot in 2019. Several measures on the LEVS audience member survey are adapted from the measures MOQA pilot-tested. Some of these measures were also adapted for use in the Hope & Faith anti-stigma event evaluation.
- The ECC anti-stigma support groups used an evaluation tool developed by Dr. Lawrence Yang, which also has been validated.
- The Consumer Program Survey is composed of measures borrowed from other validated sources.

# PREVENTION & EARLY INVERVENTION PROGRAM SUMMARIES: SUICIDE PREVENTION PROGRAMS

**MHSA Program #: PEI 12**

**PROVIDER NAME: Crisis Support Services of Alameda County Text Line Program**

**PROGRAM NAME: Suicide Prevention**

**Program Description:** Offer the ability for Alameda County residents – emphasis on youth and young adults – to contact the Crisis Line via text message between 4pm – 11pm 7 days a week: Text "SAFE" to 20121. Free crisis texting for suicide prevention.

Program Outcomes & Impact: PEI Data Report FY18/19

**PERFORMANCE INDICATORS: How Much Did We Do?**

| Total Numbers Served through PEI MHSA | |
|---|---|
| Number of unduplicated individuals your program serves who are **at-risk** of developing a mental health problem or serious mental illness (SMI) | 333 |
| Number of unduplicated individuals your program serves who show **early signs** of forming a more severe mental illness | |
| Number of unduplicated individual family members served indirectly by your program: | |
| Grand TOTAL of unduplicated individuals served in the Quarter that you are reporting about. [This number (D) should = A+B+C.] | 333 |

NOTE: Because this is a text crisis line we have limited ability to get much general information during a crisis conversation, and we do not have enough contextual information to accurately report on individuals showing signs of forming a mental illness later. Therefore, we categorize all unduplicated individuals as "at risk". We do know that the symptoms expressed combined with the crisis situation could create "risk for SMI" for individuals.

435 individuals contacted our Text Line Program. Not all had a text session – often individuals will opt in to the program during off hours to test the system out in case they want to use it in the future. 333 individuals had text sessions with counselors.

List Number of Individuals Reached by each Activity (ex: who accessed website, social media hits, tabling/outreach events, e-blasts, etc.): Click here to enter text.

| **Type of Activity** (ex: accessed website) | **Number of Individuals** |
|---|---|
| Opting in to the program but not having a text session – usually off hours – to try it out | 102 |
| | |
| Opting in and had text session | 333 |
| | |

| | |
|---|---|
| Offer the ability for Alameda County residents – emphasis on youth and young adults – to contact the Crisis Line via text message between 4pm – 11pm 7 days a week: Text "SAFE" to 20121. The service is free. Most major cell carriers do not charge their customers to text to 20121. | 435 |
| Engage in text sessions – reaching individuals who prefer to text rather than to talk to a counselor | 1115 text sessions with 333 individuals |

**PERFORMANCE INDICATORS: How Well Did We Do?**

Demographics

**Age Group (Unduplicated)**

| | |
|---|---|
| Children/Youth (0---15) | 115 |
| Transition Age Youth (16---25) | 21 |
| American Indian or Alaska Native | |
| Asian | 2 |
| Black or African American | |
| Native Hawaiian or other Pacific Islander | 2 |
| White | 2 |
| More than one race | |
| Another race not listed | |
| Unknown/ Declined to Answer | |

**Gender Identity (Please mark both parts A & B)**

| | |
|---|---|
| A) Assigned sex at birth: (Please mark only one | |
| Male | |
| Female | |
| Other sex not listed (e.g. Intersex) | |
| Unknown/Decline to Answer | |
| B) Current Gender Identity: (Please mark only one choice) | |
| Male | 26 |
| Female | 92 |
| Transgender | 2 |
| Genderqueer | |
| Questioning or Unsure of Gender Identity | 6 |
| Another Gender Identity not listed | |
| Unknown/Decline to Answer | |

**Ethnicity /Cultural Heritage (Please mark only once choice)**

| |
|---|
| **If Hispanic or Latino, please specify:** |
| Caribbean |
| Central American |
| Mexican/Mexican--American/Chicano |
| Puerto Rican |
| South American |
| Another Hispanic/Latino ethnicity not listed |
| Unknown/Declined to Answer |
| **If Non-Hispanic or Non-Latino, please specify:** |
| African |
| African American |
| Asian Indian/South Asian |
| Cambodian |
| Chinese |
| Eastern European |
| European |
| Filipino |
| Japanese |
| Korean |
| Middle Eastern |
| Vietnamese |
| Other Non-Hispanic or Non-Latino ethnicity not listed |
| **More than one ethnicity** |
| **Unknown /Declined to Answer** |

**Primary Language (Please mark only one choice)**

- English
- Spanish
- Farsi
- Cantonese
- Mandarin
- Other Chinese Dialects
- Vietnamese
- Korean
- Tagalog
- Other Filipino Dialect
- Japanese
- Laotian
- Cambodian
- Mien
- Hmong
- Samoan
- Thai
- Russian
- Polish
- German
- Italian
- Turkish
- Hebrew
- French
- Portuguese
- Armenian
- Arabic
- Sign ASL
- Other primary language not listed
- Unknown/ Decline to Answer

**Sexual Orientation (Please mark only one choice)**

- Gay or Lesbian 2
- Heterosexual or Straight
- Bisexual 3
- Questioning or unsure of sexual orientation
- Queer
- Another sexual orientation not listed
- Unknown/Decline to Answer

**Disability Status** (Please mark all that apply)

- None
- Yes. If yes, please specify (choose from list below):
  - Difficulty Seeing
  - Difficulty hearing, or having speech understood
  - Mental Domain
  - Physical/Mobility Domain
  - Chronic Health Condition
  - Another disability not listed
- Unknown/Decline to Answer

**Veteran Status (Please mark only one choice)**

- Yes
- No
- Unknown/Decline to Answer

**REQUIRED STRATEGY: IMPROVE TIMELY ACCESS TO MENTAL HEALTH SERVICES FOR UNDERSERVED POPULATIONS**

a. Who is/are the underserved target population/s your program is serving (e.g. TAY, Southeast Asian, etc.)? Middle to high school students in Alameda County. We can also serve TAY and adults, but our target population are school age people.

b. Number of separate paper referrals to an ACBH PEI-funded program. (This can be a provider's internal ACBH PEI-funded prevention or early intervention program OR an external PEI-funded ACBH prevention or early intervention program): N/A

c. Number of individuals followed through on referral & engaged in an ACBH PEI-funded program: N/A

d. Average time in weeks between when a paper referral was given to individual by your program and the individual's first in person appointment with the ACBH PEI-funded provider. N/A

e. Describe ways your program encouraged access to services and follow-through on the above referrals: N/A *although much of our crisis management is to help texters think through their next steps in staying safe and often includes discussion of who in their life they might help them to access mental health support access.

**NARRATIVE**

a. Choose two of the above principles and describe how your program upholds or achieves those principles. Please speak to each principle separately and specifically describe how your program activities align with that corresponding principle.

Principle #1: Cultural Competence. How does your program align with this principle?

The last two years we have lowered the age requirement to be trained as a text line counselor. This means that the youngest volunteers have been 19 years old. The younger cohort of volunteers has helped all of us to understand the people we are serving better as well as enlivened our conversations during training as we sift through assumptions and other misunderstandings that can occur between older adults and youth. We have also had more understanding of the nature of the online lives of youth from our younger counselors.

Principle #2: Wellness and Recovery How does your program align with this principle? In each text session we try to accomplish a post text care plan. Sometimes this can look like discussing what music the texter will listen to, or their homework assignments, or more involved post text care involving safety planning. In all these conversations we are building in an awareness of texter's own self efficacy and personal wellness tools. We often share a pdf created by Your Life Your Voice, 99 coping tools, and discuss which items the texter resonates with. We also share a Safety Planning template from Your Life Your Voice or the My3app.org. In all these instances, the main goal is to affirm the texter's own sense of agency and explore ways to take care of their emotional needs.

b. Please tell us about the following…

i. Implementation Challenges: Texts take a long time. Often if we do not have proper staffing we are unable to adequately answer the incoming texts. On the other hand, there are times when we are not getting that many texts because we need to expand our outreach – but there is not enough staffing to do this as the current staff is focusing on training and being a responder.

ii. Successes: It is amazing the wonderful and expert counseling that trainees and volunteers and other staff can accomplish without letters after their names. The quality of care is constantly being attended to, and texters often express their gratitude. "Thank you so much for talking to me. You made me feel really comfortable, and I actually wish I'd done this sooner, lol. Thank you!"

iii. Lessons Learned: We are continually challenged with building rapport and asking assessment questions. What we have found over time is that assessment questions paired with empathic statements can be successfully integrated in to a session. We also have grown in our ability to be "transparent" about the counselor's experience texting with such messages such as "I'm hearing that today things are ok, and so I hope it's not weird that I'm asking this, but even when people are doing great they sometimes think about dying. I'm wondering have you been experiencing any thoughts of suicide lately?"

iv. Relevant Examples of Success/Impact (e.g. a client success story) Reminder: Please do not use real client names: We engaged in several emergency rescues this year where the texter felt comfortable enough to text us and let us know they had acted on their suicidal ideation and did not believe they would be able to stay safe.

**ADDITIONAL INFORMATION**

Please include the number of clients and/or contacts you estimate to serve in:

FY 19/20: 1115
FY 20/21: 1115

Please tell us about any changes you intend to make to your program over the next two fiscal years and explain your rationale for making these changes: We need to find a way to increase our capacity to take texts. They are longer than taking phone calls, however sometimes we can take more than one text at a time. Increase training modules that focus on youth related issues.


INNOVATION

# Innovation
## *"Solution Focused Activities"*

*Innovation (INN) Programs* are intended to provide mental health systems with an opportunity to learn from innovative approaches. Innovations Programs are not designed to support existing or ongoing programs or services, but rather to provide the mental health system with innovative demonstration projects that will support system change in order to increase access to services and improve client/consumer outcomes.

An Innovations Project may introduce a novel, and/or ingenious approach to a variety of mental health practices. Innovations Projects can contribute to learning at any point across the spectrum of an individual or family's needs relating to mental health, from prevention and early intervention to recovery supports which includes supportive housing.

An Innovative Project must meet the following criteria:

1. It is new, meaning it has **not** previously been done in the mental health field; Innovation Projects must promote new approaches to mental health in one or more of the following ways:

    - Introducing a new mental health practice or approach, or
    - Adapting an existing mental health practice or approach, so that it can serve a new target population or setting, or
    - Modifying an existing practice or approach from another field, to be used for the first time in mental health.

2. It has a learning component, which will contribute to the body of knowledge about mental health.

    - The learning component is represented in the application's Learning Question.

Before INN funds can be spent on an INN project, the project idea must be vetted through a 30-day public review process, approved by the County Board of Supervisors and then approved by the Mental Health Services Oversight and Accountability Commission (MHSOAC). The first two steps may take place as part of a Three-year Plan or Plan Update or may be implemented as a stand-alone process.

**Budget Summary**

| INNOVATION PROJECTS | | |
|---|---|---|
| **Project Name** | **Fiscal Year** | **Projected Budget** |
| CATT | 2019-2020 | $2,672,826 |
| Mobile Technology App Project | 2019-2020 | $365,000 |
| Land Trust | 2020-2021 | $500,000 |
| INN CPPP Project | 2020-2021 | $150,000 |

# INN Project Goals

**Community Assessment Treatment Team (CATT)**: San Leandro is first city in County to be pilot tested.

| *Pilot Project Community* | *5150/year* | *Services/year 1* | *Services/year 2* | *Services/year 3* |
|---|---|---|---|---|
| San Leandro | 1,200 | 840 | 840 | 840 |
| | **San Leandro represents 15%** of all people in County experiencing behavioral health crisis. | **70%** of persons to be served who do not require emergency medical services. | **70%** of persons to be served who do not require emergency medical services. | **70%** of persons to be served who do not require emergency medical services. |

**Mental Health Technology:** Each grantee has their own specific goals in accordance to their targeted populations. The following is a broad overview of the project's goals:

| *Targeted Population →* | *Caregivers of SMI/SED Family Members* | *Youth/TAY Victims of Trauma by Multiple Form of Violence* | *Attempted Suicide Survivors* | *Immigrants, Asylees, and Refugees* |
|---|---|---|---|---|
| **Identified issues to Resolve →** | Outreach engagement and education for emotional support. | Early intervention after trauma; Prevention of further trauma; Promote mental health wellness in youth/TAY. | Reduce isolation, stigmatization surrounding suicidal thoughts; Prevention. | Reduce stigma; Increase access; Reduce isolation and fear. |

**Supportive Housing Community Land Alliance** (project will begin after September, 2020)

| *Community* | *Goals for FY20-21* | *Goals for FY21-22* | *Goals for FY22-23* |
|---|---|---|---|
| **SMI** individuals whose income is 200% below federal poverty level. | Create CLT; Develop board of directors; Funding partners identified | First consumers to be housed; Property/Housing stock investments completed | Additional consumers to be housed; Financing models for sustainability identified/in procurement process |

# INN PROGRAM SUMMARIES

**PROJECT NAME: COMMUNITY ASSESSMENT TREATMENT TEAM (CATT)**

**Project Description:** Alameda County's existing system for responding to behavioral health crises in the community is inefficient in terms of expense, time and connecting clients to appropriate services. A vast majority of transports for individuals on a psychiatric hold are conducted by ambulance, which is expensive and requires law enforcement to wait for an ambulance to arrive. These calls are lower priority since they are generally not life-threatening, therefore increasing the wait time. In addition, the existing system transports an individual who qualifies for a 5150 involuntary hold, but those who do not qualify are left on site without a connection to services. The goal of CATT is to improve access to services in Alameda County by Combining efforts to significantly transform the response to behavioral crises in the community:

- Develop a crisis response team that includes Behavioral Health Clinicians and an Emergency Medical Technicians (EMT) in order to provide both medical and behavioral assessments in the field, including in a medical emergency department. This team would initially be available 16 hours a day, 7 days a week, and focus on two communities that are identified as underserved. The team would be able to provide transport to the appropriate services, including psychiatric hospital, emergency department, crisis residential, sobering center or other site, for clients on 5150 holds or not requiring a hold.

- Enhance the bed availability software program (Reddinet) to show availability of psychiatric, crisis stabilization units, and sobering center beds and provide alerts when the psychiatric emergency services are reaching capacity in order to provide real time information about the availability of disposition options.

- Provide access to tele-psychiatry for the crisis response team in the field.

- Provide the crisis response team with access to a Community Health Record through AC Care Connect, which enables them to send an alert about the episode to other providers involved with the client.

By bringing together the right staffing and the right technology, this innovative crisis response team will *reduce unnecessary 5150 holds, transportation to medical facilities for medical clearance, and the many hours of waiting for clients and first responders.* In addition, it will increase access to appropriate services by connecting and transporting clients whether or not they are on a 5150 hold.

**CATT Summary of Challenges & Resolutions**

The CATT project currently is in the process of developing the project's infrastructure. An evaluator for the project has been procured and begun their supportive collaboration with the CATT project management team. Transportation vehicles for the crisis response teams are being procured. Training for the CATT teams began in February, 2020.

As the CATT project infrastructure is being developed, a need for additional CATT team shifts has been identified to ensure coverage for the present needs of the County. Due to this new challenge, and delays

in the development of the project's infrastructure, ACBH will be requesting not only more time, but additional funding for these teams. This request for more funding will include an extension, under the recently approved SB 79, for the project's AB 114 funding which is set to revert July 1, 2020.

SB 79 makes changes to existing law that would have reverted funds that counties received and not spent before July 1, 2017. SB 79 reallocates these funds to the county of origin for the purposes for which they were originally allocated. Under SB 79, counties can encumber INN funds without fear of reversion so long as the funds are expended before the end of the MHSOAC approved project plan timeline, or three years for large counties/five years for small counties, whichever is later.

**Project Name: Mental Health Technology (MH TECH 2.0)**

**Project Description:** Technology is on the forefront of innovation for health monitoring, be it physical or mental health. Alameda County is fortunate to be located on these front lines of technology. The County's unique location in the Bay Area provides residents close proximity to not only Silicon Valley, but numerous other technology companies, big, small, and emerging. This parity provides the County with a community that tends to embrace new technology with enthusiasm.

Mobile apps that focus on mental health can be used for a variety of purposes. They show great promise in promoting healthy behavior changes, increasing adherence to treatment programs, providing immediate psychological support, facilitating self-monitoring and reducing the demand for clinician time.[1] As mobile applications grow in popularity among the general public, so does the potential to increase the quality of care and access to evidence-based treatments through this technology.

Technology also brings with it a source of anonymity. Anyone with a smartphone is able to access technology, and in most instances, able to maintain their anonymity due to encryption methods. This can give the user a feeling of less loneliness, isolation, or the feeling of being judged; a sense of empowerment; and reduction in distress, anxiety or fatigue. These are all benefits of being in a support group according to the Mayo Clinic.[2]

This two and half years (2.5) project was approved by the MHSOAC on April 25, 2019 and intends to provide a platform for individuals who reside in isolation, anonymity, or feel they have no place to go because of their situation. This project offers new opportunities for outreach, and engagement, and support to these communities by testing a technology-based delivery system for mental health solutions.

**MHT Summary of Challenges & Resolutions**

Set to begin on December 1, 2020, the MH Tech 2.0 did not officially begin until April 1, 2020 after several months of delay due to a prolonged contracting process with grantees. At this time, a quarterly meeting has not been held. Therefore, challenges and possible resolutions that grantees may be facing are currently an unknown.

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1 https://www.mayoclinic.org/healthy-lifestyle/stress-management/in-depth/support-groups/art-20044655 2 Spurgeon JA, Wright JH. Computer-assisted cognitive-behavioral therapy. *Current Psychiatry Reports*, 2010; 12:547–552.

**PROJECT NAME: Supportive Housing Community Land Alliance (SHCLA)**

Across the Bay Area, an inadequate supply of housing stock, particularly affordable housing, has contributed to rising home prices, rental rates, evictions, displacement and homelessness. Over the past five years, there have been significant declines in the number of licensed board and care facilities, residential hotels, and room and board facilities frequently utilized by individuals living on fixed incomes. Individuals with severe mental illness living on fixed Social Security disability incomes experience some of the greatest challenges in finding and maintaining housing in this region.

**Project Description:**

A Community Land Alliance (CLA), which will be based on a community land trust model, would be a nonprofit, community-based organization designed to ensure community stewardship of land. Community land trusts are often associated with conservation efforts, but there is also a significant effort to ensure affordable long-term housing through this form of ownership. The alliance will acquire land and maintain ownership of it permanently. The CLA enters into a long-term, renewable lease with residents. When the resident leaves, they earn a portion of the increased property value. The remainder is kept by the trust, preserving the affordability and purpose of the property for future households.

The proposed Innovation Project will promote interagency collaboration to create an **Alameda County Supportive Housing Land Alliance to develop and maintain supportive housing units.** ACBH will partner with Alameda County Housing and Community Development Department, housing and real estate legal and financial experts, consumer/client representatives, family member representatives, and existing nonprofit affordable housing developers to develop a land trust focused on supportive housing that incorporates unique aspects in order to address local conditions.

The Supportive Housing Land Alliance is a five (5) year project approved by the MHSOAC August 22, 2019. The Request for Proposal (RFP) process was completed in March, 2020, and a bidder has been awarded.

**SHCLA Summary of Challenges & Resolution**

Currently, the service agreement for the CLA is in the negotiation with the awarded bidder. The projected start date is September, 2020.

**PROJECT NAME: Community Planning**

**Project Description:** Alameda County Behavioral Health (ACBH) continues to be fully invested in having a dynamic community process that is inclusive of all communities within the County. Community involvement from the residents of the county is essential to Innovation planning and program development. ACBH has had challenges in its outreach to many of its diverse populations. These challenges include outreach and engagement to unserved and underserved individuals in both urban and rural areas. The County is dedicated to developing a revitalized and improved approach to ensure more meaningful input from all individuals living in the county.

Alameda County requested to use INN funds for fixed annual allocation for community planning activities involving stakeholders, especially individuals in unserved and underserved communities of the county. This annual allocation will be specific in its support of design, development, and implementation of INN ideas brought forth through the community planning process. Presently, under MHSA regulations, counties may use up to 5% of their total MHSA budget to fund community program planning, and designate positions for oversight and support.

The County received approval from the Mental Health Services Oversight and Commission (MHSOAC) May 13, 2020 to utilize a total of $750,000 ($150,000 per year) over the next five (5) years to conduct innovation-related community planning. These funds will be dedicated to redesigning a more informed, community planning process that will allow the County to revitalize its current process.

Additionally, as part of ACBH's plan, a dedicated INN Coordinator has been added to the County's MHSA Division. The addition of a dedicated staffer brings the County more in line with MHSA regulations with the cost of 1 FTE at the program specialist level which is $100,006, plus benefits calculated at 50% for a total of $150,000.

**Community Program Planning Process (CPPP) Summary of Challenges & Resolution**

CPPP innovation plan begins July 1, 2020. No current challenges to report.

# FUTURE INN PROSPECTS

MHSA's Three-Year Plan Community Program Planning Process (CPPP) took place during the spring of 2020 ending on May 31, 2020. During the process, MHSA staff provided updates, information, and held focus groups on current MHSA programs. The local community-based organization (CBO), Health and Human Resource Education Center (HHREC), collaborated with MHSA staff in providing outreach. Additionally, the members of the Pool of Consumer Champions (Alameda County's mental health consumer organization) provided outreach to and engaged with community members, including individuals who were homeless, to provide input through surveys.

From the CPPP, MHSA received many suggestions from a number of sources including, but not limited to, CBOs, consumers, faith-based organizations, and family members, all of whom identified current gaps and needs. The community feedback provided a fuller understanding of the community's view of underserved groups leading us to potential areas of innovation.

MHSA core values of community collaboration, cultural responsiveness, being consumer and family driven, system integration and resiliency and recovery focused all steer the direction that INN projects are to follow. MHSA staff has been vetting the many suggestions received to identify potential successful INN projects that will meet these core values, address the community priorities, and meet INN requirements. These potential projects will be presented to ACBH Systems of Care for further screening to ensure the potential projects additionally address external factors such as rates of crisis, substance use trends, community violence, trauma, staffing capacity and alignment with ACBH core values of **A**ccess, **C**onsumer & Family Empowerment, **B**est Practices and **H**ealth & Wellness.

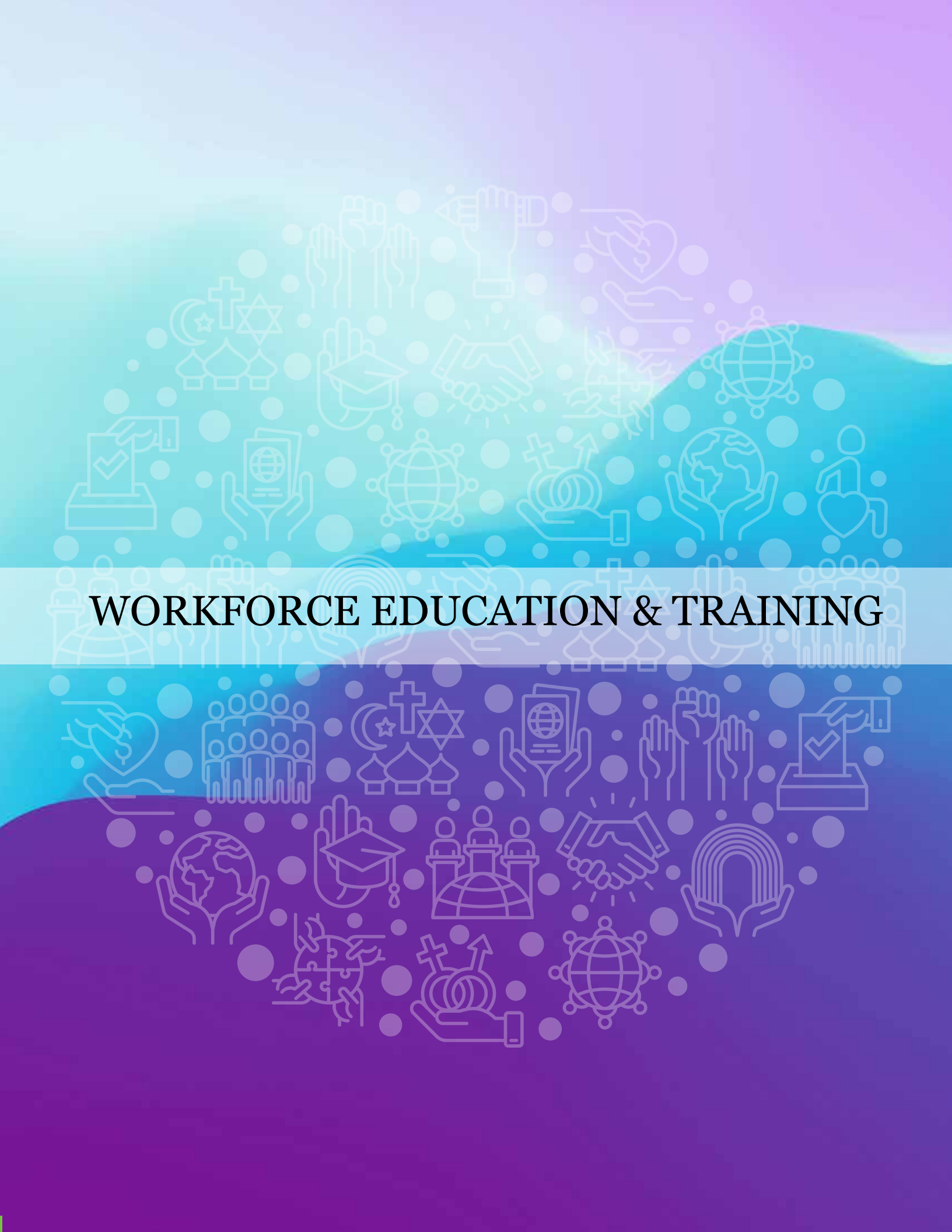
A number of broad themes have been identified during the CPPP. The themes recurring most often include:

- Youth/TAY services for addressing trauma, anti-bullying, and violence;
- Outreach/Engagement to individuals in social isolation;
- Nutrition and mental health;
- Housing/homelessness;
- Telehealth;
- Homecare visits, especially for physically disabled individuals;
- Grief and trauma navigation post Covid-19;
- Non-traditional led services: faith-based, culturally inclusive, peer led;
- Music, dance, arts therapy, and
- Asian Pacific Islander (API) and Underserved Ethnic and Language Populations (UELP) programs.

ACBH is looking to embark on new INN programs that will provide opportunities to engage more with consumer and family members, local nonprofit stakeholders and our diverse communities here in Alameda County. At the same time, it is important to acknowledge the effects of the pandemic, the extensive unemployment and current social movements. The pandemic has created a new landscape for service delivery with potentially new opportunities for innovation within these identified themes. Telehealth for example has been on the rise since the shelter-in-place order began in March, 2020. INN programming in this area has promise and potential.

A number of these themes could be joined together to address grief and trauma occurring right now as a result of COVID-19. Innovative programming in music, dance and arts therapy, nutrition and mental health and non-traditional led service delivery can all join with culturally specific programming addressing grief and trauma as well as the social isolation that has increased during the pandemic. In addition, the social movements shine an important light on innovative programming opportunities that could address the effects of historical systems that have brought about disproportionate mental health issues across many racial and ethnic populations.

There have been many unexpected changes as a result of the pandemic. Simultaneously, there is much to appreciate in terms of the effects of grief, trauma, social isolation, increased panic and depression, and what programming will be needed to address these challenges. There may be many opportunities to be examined in the next three years for innovation. Alameda County looks forward to working collaboratively with the community to uncover potential ideas to move the mental health field ahead.


WORKFORCE EDUCATION & TRAINING

# Workforce Education and Training
## *"Equity in Action"*

*Workforce Education and Training (WET)* develops a workforce for ACBH that is sufficient in size, diverse, and linguistically capable to deliver services and supports that are culturally responsive to clients and family members.

**Client Vignette (Success Story)**

A solid internship can be a major turning point for a student's career journey. Shabana Ali, age 23, knows this well. She's grateful to have experienced that kind of internship at Alameda County Behavioral Health (ACBH) in summer 2019.

*"I really liked it because it was different than some of the other internships that I've had in the past,"* said Shabana, a senior majoring in public health at CSU East Bay.

Shabana's big summer assignment was to create online career surveys for high school and undergraduate college students who've participated in one of Behavioral Health Care's career exploration activities or internships within the past five years.

"The surveys asked them what their interests were, if they were still interested in the behavioral health field, what challenges or struggles they were facing, and what kinds of supports they would need to reach their career goals," she explained.

Taking on this task excited Shabana because she enjoys working as a research assistant on her campus. Shabana interned for the Workforce Development, Education and Training (WET) unit. WET works to ensure that ACBH'S workforce is diverse, multilingual and culturally competent so that they're able to serve the county's multicultural population. WET partnered on the career follow-up survey with the program FACES for the Future at the Public Health Institute at their Oakland branch. FACES mentors youth from diverse backgrounds into health careers. The FACES team and Shabana collaborated on the project but empowered her to initiate and make final decisions on the project.

"They allowed me to make decisions on my own and gave me the freedom to take control," she says enthusiastically. That experience helped me to be more confident collaborating with programs as a researcher."

The data Shabana collected will help ACBH and their partners create future programs tailored to aid teens in career pathway programs who are aspiring to be healthcare professionals. These future participants have a lot in common with Shabana, which made the project even more significant for her.

*"I thought it was awesome, especially as a first-generation college student, because it can be really difficult navigating the system,"* she said.

Shabana also researched and designed a resource guide for ACBH staff and community providers that includes a wide variety of behavioral health services in the Alameda County.

Shabana contributed to the community through her internship but she says she gained a lot as well. She made professional connections and attended career conferences. She learned even more about mental health directly from mental health consumers at the annual Pool of Consumer Champions (POCC) Conference. The POCC is an active peer-run, grass roots group of consumers that provides a point of connection, engagement, and a strong voice for consumers in the mental health system and in the community; it's staffed by ACBH's Consumer Empowerment Team. "That program specifically has helped a lot of people feel like they belong", says Shabana. The conference attendees were welcoming, and being around people from the community enlightened her.

She witnessed this kind of peer-to-peer support outside of the POCC when attending a criminal justice training on how some formerly-incarcerated people struggle with mental health issues. Shabana listened to one man who served over 20 years in prison. "It's hard for them to get back into the system because they've been gone for so long," she said. "Something that I learned about mental health is that there's a lot of stigma behind it, but people are actually really trying to improve."

Thanks to funding from the Mental Health Services Act, students like Shabana can work in internships that will help prepare them for careers in the mental health field, and beyond.

After finishing college, Shabana Ali will pursue a master's degree in public health. She wants to work with mothers and children, research health disparities in the Indo-Fijian community, and educate Indo-Fijians about mental health. Shabana's Alameda County Behavioral Health internship gave her valuable work experience and mentorship. However, there's another important lesson she took away when it comes to supporting consumers - hope.

"It was really great to see that there's always going to be people to help them out, who are empathetic," she said. "It gives you a lot of hope."

# WORKFORCE, EDUCATION & TRAINING PROGRAM SUMMARIES:

Alameda County Behavioral Health (ACBH), Workforce Education & Training (WET) uses multiple strategies to build and expand behavioral health workforce capacity including:

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

**1. Workforce Staffing & Support**

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

**FY 18/19 Outcomes, Impact & Challenges:**

- In February 2019, the WET manager was invited to participate in the ongoing planning process for the 2020-2025 Mental Health Services Act Workforce Education and Training (MHSA WET), Statewide Plan facilitated by the Office of the Statewide Health Planning and Development (OSHPD). The WET manager has been participating in the ongoing discussion of the proposed program framework and the Regional Partnerships role to implement the 2020-2025 WET Plan supporting locally-defined workforce needs and interventions.

- The WET manager provided oversight of the High School Career Pathways contract with FACES forthe Future, eight Innovation and WET High School and Undergraduate Pathways contracts as well as the Bay Area Regional Workforce Partnership contract.

- ACBH continues to serve as the fiscal sponsor for the Bay Area Regional Partnership program as outlined in the OSHPD Agreement Number 14-5004, which includes passing through the funds to California Institute for Behavioral Health Solutions (CIBHS). The WET manager continued to provide contract oversight.

- The WET team administered and implemented the Graduate Intern Stipend Program, High School and Undergraduate Career Pathways activities and provided or collaborated on a total of 78 training activities, thereby training 2,614 staff and providing 381continuing education hours to ACBH and contracted provider staff.

- ACBH WET and MHSA Innovation (INNWET) provided funding to eight grantees to implement mental/behavioral health career pathways pilot projects for eighteen months from October 2017 through March 2019. The total allocation for the project was $2,129,203. These pilot projects provided educational and training opportunities to underrepresented and disadvantaged high school and community college students to gain experience in the Public Mental/Behavioral Health.

- INNWET Learning Conference was held on February 15, 2019. All grantees had an opportunity to share their learning experiences, successes and challenges with stakeholders, institutions and policymakers. Short videos were produced to highlight the projects, speakers connected the grantees' work to broader strategies to develop the mental/behavioral health workforce in California, and presentations were given by each grantee group. Table displays were set up and project participants were able to speak to stakeholders about their personal experience in the programs.

- The WET team collaborated with various applicant organizations including the FACES for the Future and Diversity in Health Training Institute on their applications for State Grants as a collaborative partner.

- The WET Staff continued to provide administrative functions for Children and Youth Systems of Care (CYSOC), and Criminal Justice Mental Health Services/Conditional Release Program (CONREP) internships.

- The WET Training Officer served on the ACBH Training RFP Review Committee. Reviewed and scored grant applications.

- The WET team attended, presented and actively participated in the Bay Area WET Collaborative meetings and WET coordinator conference calls.

- The WET manager and staff continued to serve on various ACBH advisory committees, such as the ACBH Training Committee, Latinx Behavioral Health Workforce Action Group, Immigrant and Refugee Workforce Workgroup, WET Regional Partnership Steering Committee, Alignment Bay Area Health Pathways, East Bay Behavioral Health Workforce Workgroup, Alameda County Health Pathway Partnership (ACHPP) and the Berkeley City College Human Services Program Advisory Committee.

**FY 19-20 Progress Report:**

- ACBH is committed to continue WET activities and WET is currently funded through the MHSA Community Support Services (CSS) component. WET is focusing on workforce capacity building through behavioral health career pipeline development, training opportunities, and addressing strategies to recruit and retain hard to fill positions, increasing diversity, bridging gaps in skills set and improving language capacity.

- The WET team continues to prioritize, develop and implement projects based on the 2017 workforce needs assessment survey outcomes. They also continue to evaluate WET program impact and needs based on program outcomes and informational data.

**2. Staff Development, Training/Conference and Consultants**

**Program Description**: MHSA WET funds are used in a variety of ways to support staff development, provide additional trainings to targeted communities and utilize consultants to implement community or school-based projects on a one-time basis.

**FY 19/20 Progress Report:**

ACBH WET provided funding to the program FACES for the Future (FACES) at the Public Health Institute to provide follow up and continued engagement services to underrepresented students interested in pursuing a career in public mental and behavioral health. FACES has been working on the development and implementation of the following activities:

- FACES staff in collaboration with an ACBH WET undergraduate intern from California State University East Bay designed and distributed an alumni survey to the high school and undergraduate interns and event participants as an outreach effort. Results were limited and tended to be connected most to the Behavioral Health Undergraduate Summit and Bright Young Minds conference participants than the Life Academy program. Respondents reported needing continued assistance in navigating the pathway to behavioral health careers. In response, the FACES team designed a timeline of events and professional development opportunities to engage alumni. Currently phone outreach is set to begin late October, 2019 with offers of events in November, February and May as well as Mental Health First Aid certification for free during December and February for any alumni who are interested. Staff have also begun designing an alumni newsletter specifically for those alumni interested in mental and behavioral health that can be distributed quarterly and become another outreach tool to get alumni engaged in activities and data capture. One of the resounding messages during an alumni event held in August was that alumni need consistency in outreach, so all efforts are being made to ensure outreach is scheduled routinely and remains sustainable.

- FACES staff hosted graduation event for Life Academy seniors (OUSD School) in May, 2019. The event was attended by students, family and supporters. An alumna of the program, Nubia Flores Miranda, was honored with a scholarship from the Alameda Council of Community Mental Health Agencies in honor of Leslie Preston.

- FACES and the ACBH WET Manager have begun outreach to Merritt College and Laney College to support ongoing regional dialogue about pathway development as well as to offer trainings to develop skill sets in staff and faculty. Mental Health First Aid (MHFA) is one of those potential trainings and both sites are working to schedule trainings with faculty staff. FACES was able to meet with the Director of the CalWORKs program at Laney College – this is a County subsidized work/school program for very high need students including those facing homelessness, newly arrived populations and system involved students. FACES is also presenting on the connection between community-based work and mental/behavioral health skills development at Berkeley Adult School for a class of Community Health Workers (CHW) in training. These are adults coming from multi-lingual, multi-cultural backgrounds who have an interest in CHW certification and continued skills development. The intention is to further engage this population in connecting to community based mental health pathway opportunities while building their understanding of how to work in community-based centers.

- FACES has provided Adult Mental Health First Aid certification trainings to Berkeley City College and Merritt College. In total, 54 participants were certified in MHFA.

In the summer of 2019:

- ACBH WET staff and FACES staff participated in the Oakland Unified School District (OUSD) Project Based Learning (PBL) Institute supporting teachers building pathways to health careers for Public Mental Behavioral Health (PMBH). In particular, Rusdale Continuation School was highlighted as a potential partner. Serving newcomer students who are academically at-risk, Rusdale is working to build out its pathway on-site as well as beginning to plan for work-based learning. This high need population would need direct intermediary assistance and supportive services in order to be successful.

- ACBH WET provided educational services to 37 high school and undergraduate students at Mentoring in Medicine and Science (MIMS).

**3. Internship Program**

**Program Description**: Coordinates academic internship programs across the ACBH workforce. Outreaches to educational institutions to publicize internship opportunities.

**FY 18-19 Outcomes/Impacts/Challenges:**

**Initiated re-launch planning to develop more efficient onboarding process for Adult & Older adult Systems of Care, Adult Forensic Behavioral Health and Vocational Rehabilitation Programs**

- Consult with program administrators to identify shared outcomes;
- Assess program's needs, determine HR requirements and create system process to support flow, timely approvals, effective communication, end users and external institutions;
- Use the existing Intern Recruitment Timeline for structure.
- Efficient processes streamline onboarding, thereby maximizing intern's experiential learning time, creating a single lean internal process (across the system of care) and positively *impacting* the workforce development pipeline.

**9 interns were placed with the Children's and Young Adults System of Care, 9 with the Adult and Older Adult System of Care, and 6 with CONREP.**

- The creation of the Intern Recruitment Timeline and a process flowchart as well as ongoing relationship building efforts between the internship coordinator, HR, Finance and clinical teams positively *impacts* efficiency and value add of the Internship Program. (see bullet #1).

**Nine interns were exposed to a total of 25 trainings, including:**

- Working with Schools and Special Education, CBT/DBT; Expressive Arts, Healthy Nutrition and Lifestyle; Working with Latino Immigrant Families; HANDLE (Holistic Approach to Neuro Development and Learning Efficiency); Career Advancement; Working with African American Families; Asian American and Immigrant Perspective on MH; Strive Program; Strengthening Relationships Through Partnerships; Documentation Training; Transformational Coaching; Objective Arts/CANS; Play Therapy; Pediatric Psychopharmacology; Suicide Assessment and Intervention; Bullying and Suicide; Early Childhood Assessment; Autism, and Eating Disorders
- In-service evaluations indicate a positive *impact*. Trainings and the trainers were extremely beneficial and well received by the interns;

Coordinate and facilitate annual internship fairs and internship orientations.

- Orientations at bay area colleges and universities give potential interns a first impression of ACBH in welcoming, low-pressure and informative settings. These are marketing impact activities, publicizing various learning opportunities and offering information and materials about ACBH's systems of care.
- Represented ACBH at 4 internship and health fairs at Cal State East Bay, UCSF, San Jose State; Holy Names College.

Launched and administered the 7th cycle of the Graduate Intern Stipend Program in August 2018.

- Awarded 20 stipends in the amount of $6,000 each for 720 internship hours. Of the 20 awardees, 70% represent the diverse communities of Alameda County.

2018-19 Graduate Intern Stipend Awardees – Ethnicity (Number of awardees =20)

| | |
|---|---|
| African American | 4 – 20% |
| Asian Pacific Islanders | 3 – 15% |
| Caucasian | 2 – 10% |
| Hispanic/Latino | 7 – 35% |
| South East Asian | 4 – 20% |

2018-19 Graduate Intern Stipend Awardees – Language (Number of applicants=20)

| | |
|---|---|
| English | 4 – 20% |
| Cantonese | 1 – 5% |
| Mandarin | 0 |
| Spanish | 9 – 45% |
| Tagalog | 0 |
| Vietnamese | 2 – 10% |
| Other | 4 – 20% |

**Challenges:**

- Creating bandwidth across the systems of care impacted teams pose *challenges* as individual staff will take on new functions to manage tasks, responsibilities and people within their programs to keep the new process functioning with integrity.
- While diversity is promoted as an essential priority, there continues to be a *challenging* lack of Latino and especially African American male intern applicants.
- Increased cultural competence training for interns and intern supervisors is a need that is has been *challenge* to fulfil with existing internal training capacity. Additional funding (coordination and collaboration with WET Institute and Ethnic Services Department) by ACBH would allow content expertise (outside of Alameda County staff) to train on cultural competence and other subject matter.
- Recruitment *challenges* include identifying potential interns who speak ACBH's threshold languages and who reflect Alameda County's cultural diversity and committing adequate staff to cover two-day orientation events

**FY 19-20 Progress Report:**

- Launched 8th cycle of Graduate Intern Stipend Program in August 2019 with a focus on increasing interns who speak one or more threshold languages: Spanish, Cantonese, Mandarin, Vietnamese and Tagalog.
- Developing system to collect and manage training and program evaluation results
    - Introduced a new post-internship program evaluation for interns to complete.
    - Continuing re-launch efforts, in conjunction with system leaders, to create standard guidelines, practice and protocol for onboarding interns in the Adult System of Care.

**FY 20-21 Anticipated Changes:** The department does not anticipate any changes at this time.

**4. Educational Pathways**

**Program Description:** Develops a mental health career pipeline strategy in community colleges, which serve as an academic entry point for consumers, family members, ethnically and culturally diverse students, and individuals interested in human services education, and can lead to employment in the ACBH workforce.

**FY 18/19 Outcomes, Impact & Challenges:**

ACBH has developed and implemented the following activities:

- **ACBH hosted nine high school students from June 18 through July 19 for 40 hours/week.** At ACBH, the students were paired with intern preceptors/mentors for 20 hours/week, and given project-based learning opportunities such as: learning to network, communicate and dress professionally, presentation skills, resume building, attending stakeholder and/or staff meetings, research and program evaluation, contracting procedures, and creating a resource guide for the Mental Health Service Act website. By doing work in an office setting, students gained valuable insight from an administrative perspective about key program development elements such as planning, coordination, team work and continuous quality improvement.

- High School interns spent 20 hours/week in the classroom sessions to gain foundational learning about behavioral health concepts, and to explore and gain tools about their own health and wellness strategies. Classroom topics included: Mental Health 101, College prep and Career Pathways in mental health, recognizing and balancing life's stressors between school and home, participating in a healing circle, Trauma-Informed Care, and becoming a trained and certified Youth Mental Health First Aider.

- **Bright Young Minds (BYM) conference** is a one-day, highly intensive day of structured activities for high schools that introduces students to careers in behavioral health. The WET Team, along with the organization called FACES and Oakland Unified School District planned, organized, and hosted the Bright Young Minds (BYM) conference on April 18, 2019 at the Cal State East Bay. It was a ground-breaking conference with 65 high school students from diverse and under-represented communities participating to explore behavioral health care career options.

- WET is currently working in collaboration with the Ohlone College STEP Up Mental Health Program to support the development of the **Mental/Behavioral Student Advocacy Training Pilot Program**. Ohlone College will recruit a cohort of up to eight students from three key programs: Puente Program Learning Community, Umoja Scholars Program, and the Genders and Sexualities Alliance Student Club. Students will be trained using the "Wellness, Recovery and Resiliency" curriculum provided by ACBH

WET. The program would include a service learning component where the students will plan and implement a service learning project that will help advance mental/behavioral health among their respective student group.
    - The WET manager is currently working in collaboration with the Ohlone College Student Health Director and the StepUp Mental Health Program Manager to possibly institutionalize the implementation of the "Wellness, Recovery and Resiliency" curriculum, developed by ACBH WET.
    - The StepUp Mental Health Program is exploring the curriculum approval process with the College Curriculum Committee Chair in response to the WET manager proposing the institutionalizing of the Wellness, Recovery and Resiliency curriculum.
    - The WET team is revising the existing mental/behavioral, 12-module curriculum, "An Introduction to Behavioral Health Care Services: Curriculum on Wellness, Recovery and Resiliency" through a contract with California Association of Social Rehabilitation Agencies (CASRA).

- The WET manager assisted Ohlone College to cultivate partnerships with ACBH Systems of Care leadership as the College applied for a state grant. One of the funding activities was to develop stronger relationships with the county behavioral health and the community based mental health services. WET manager also collaborated with the College in their application for the Peer Personnel Training and Placement through OSHPD.

- The WET team is exploring ideas and strategies regarding setting up **a non-licensed/license-eligible clinical supervision pilot project** to help eligible clinicians gain their supervision hours. The goal of this project is to increase the number of licensed bilingual and clinicians of color to fill hard-to-fill/retain positions in the County and CBO programs. In 2017, WET conducted a needs assessment survey and organizations reported an increasing demand and shortage of licensed clinicians, especially LCSWs. WET team is working with the ACBH Systems of Care leaders to identify needs for each system as well as seeking input on program design, including supervision methods to build a pipeline that can potentially address the licensed-staff shortage issue.

**ACBH WET team is currently engaged in, or completed:**

- Discussing with the Department of Health Sciences Undergraduate program at California State University East Bay, to participate in the Undergraduate Capstone Internship Project. The focus of the Capstone Project is Problem-based Learning (PBL). Students learn about a subject by working in groups to solve an open-ended problem. Instead of learning concepts and topics and then applying them to a situation, PBL courses begin with a problem statement of practical importance. In groups, students explore what they know about the issue, determine what information is still needed, and identify where relevant topics, data, and tools can found to solve the problem. ACBH WET team will provide four problem statements for the PBL projects and from early January, 2020 will start working with a cohort of twenty-four students, which is sub divided into four teams of six students.

- ACBH WET as a Bay Area Mental Health and Education Workforce Collaborative partner, coordinated, and co-hosted Adult and Youth Mental Health First Aid Instructors trainings to thirty-four people.

- ACBH WET is currently coordinating and scheduling presentations on Mental Health 101, Mindfulness, Depression and Suicide as requested by local high school teachers.

- ACBH WET funded Wellness in Action (WiA), a workforce development program, at the Center for Empowering Refugees and Immigrants (CERI). WiA works with *community leaders* from indigenous, refugee, and immigrant communities interested in promoting mental health and wellness. WiA will offer five mini-grant awards to support grassroots community leaders and provide technical and clinical consultation and skill building trainings for careers in community mental health.

**WET INN 4B Project: Behavioral/Mental Health Career Pathways for High School & Undergraduate Students FY 18/19 *Final Report* Outcomes:**

ACBH WET and INNOVATIONS (INN) provided funding to eight grantees to implement mental/behavioral health career pathways pilot projects for eighteen months from October 2017 through March 2019. The total allocation for the project was $2,129,203. These pilot projects were funded by MHSA INN to provide educational and training opportunities to underrepresented and disadvantaged high school and community college students to gain experience in the Public Mental/Behavioral Health. MHSA INN funding intended to provide the mental health system with an opportunity to learn from innovative approaches.

During the 18-month project, grantees were required to meet collaboratively on a quarterly basis where they provided updates on project progress to their colleagues, collectively addressed questions related to projects and shared lessons learned as a group to hone best practices. The quarterly meetings also allowed ACBH to address any questions related to contracts, financial reporting, reporting requirements and other key deliverables for the contract period.

- High Need Student Populations: All INN4 grantees worked with high need student populations without exception. Students in the project came from trauma backgrounds, where food and housing are insecure, care management is needed, and required safety net services to participate in projects. Oftentimes, students needed to have those basic needs met before the work of career exposure could begin. This was true regardless of age; with adults living in low socio-economic situations needing as much support as youth. As a result of this grant cycle, ACBH has a deepened appreciation for the safety net services required when targeting underrepresented student populations for workforce development and pipeline programming into Psychiatric and Behavioral Mental Health (PBMH) careers.

- Diversity in the Workforce: When properly supported, diverse students can increase their interest in professions in PBMH. The student cohorts that were served were racially, ethnically and linguistically diverse with students reporting lived experience and low socio-economic status. Examples of student populations served are newcomer and refugee populations; formerly incarcerated youth; parenting students; and those who were working toward a high school diploma. The safety net services need to be present in pipeline programming, with support in place for a wide range of young people to become interested in pursuing a career in PBMH.

- Mentorship is Key: Across the board, successful INN4 programs were projects in which mentorship was well-established and students had a caring professional to go to for support. This was not always directly related to financial need, but also related to healing, particularly for those students struggling with trauma backgrounds, community violence or refugee status. Projects utilized mentors in a variety

of ways including professional panels, internship supervisors and of course, project staff. A collective network of caring adults surrounding a student with encouragement was fundamental to seeing increases in interest in pursuing a career in PBMH.

- Employer Preparedness: All grantees reported difficulty interacting with mental and behavioral health providers in trying to support students interested in the field. A lack of diversity among professionals, a lack of understanding of how to work with students, and a lack of institutional supportive structure that allowed for work-based learning were significant barriers to the INN4 projects.

- Stigma Reduction: When students are exposed to and supported through an introduction to mental health topics and professions, stigma about accessing services, stigma about others accessing services, and reluctance to pursue a career in PBMH are reduced. This outcome is particularly encouraging as it shows there is a direct correlation between exposure and reduction of stigma for accessing services as well as career goals, which are both main areas of focus for MHSA.

The MHSA INN4 WET projects were universally successful in targeting multi-lingual, multi-cultural student populations who are historically left of out of the PMBH workforce. This is a critical requirement of the MHSA workforce development strategy to increase access to PMBH services for diverse and underserved communities in California. All INN4 projects were successful in meeting contract deliverables, staying fiscally and administratively compliant and with ensuring that students received thoughtful and well-designed programming. All INN4 projects were welcomed by the community during the INN4 Learning Community Conference and all projects successfully worked to reduce stigma in their student cohorts both in terms of accessing mental health services, as well as mental health careers.

As stated earlier, ACBH has a deepened appreciation for the types of safety net services required by this student population. Living in the Bay Area, facing economic and environmental stresses, managing trauma backgrounds; all required that supportive services be embedded in programs working on PMBH career exposure. This was universally true for both youth and adult populations. Moreover, actively working to reduce stigma supports a young person's interest in pursuing a career in PMBH. Workforce development programming operating at the high school and college level must include stigma reduction and supportive services to be successful. In addition, mental health employers interested in providing work-based learning for interested students, must be properly trained and on-boarding processes need to be streamlined in order to manage this population. Having mental health providers involved in workforce development efforts is key for ensuring that the process of interacting with mental health service organizations does not negatively impact a student's interest in the career path.

Grantees were coached on sustainability strategies for their work. This coaching enabled several grantees to find other funding mechanisms to sustain their program. Several of the grantees continue to be in the process of seeking funding or have placed the project on hiatus until an alternative funding source can be secured.

**FY 20/21 Anticipated Changes:**

- ACBH WET does not anticipate any significant program implementation changes during FY 20-21.

**5.ACBH Training Institute**

**Program Description:** Provides a coordinated, consistent approach to training and staff development. Develops, researches and provides a broad array of training related to mental health practice; wellness, recovery and resiliency; peer employment and supports and management development.

**FY 18/19 Outcomes, Impact & Challenges:**

- Provided or collaborated on a total of 78 training activities, thereby training 2,614 staff and providing 381 continuing education hours to ACBH and contracted provider staff.

- Training topics covered a variety of issues including, but not limited to, Tobacco Cessation Interventions, Adult and Youth Suicide Assessment & Intervention, Culturally Responsive Mental Health Services for Sexual Orientation and Gender Identity (SOGI), Coaching for Collaboration, Commercially Sexually Exploited & Trafficked Youth, Developing Culture-Based Wraparound for African American Transitional-Aged Youth, Navigating Systems for Adolescents with Autism Spectrum Disorder, Best Practices and Inspiration for Senior Injury Prevention Advocates, Preventing, De-Escalating, and Managing Aggressive Behavior in Behavioral Health Settings, Legal and Ethical issues, and a variety of Evidence-Based Practices.

- Provided trauma informed care related trainings including Becoming a Trauma Sensitive Workforce, Transforming Trauma - How to do this Work and Sustain, Preventing Vicarious Trauma, and Trauma-Informed Treatment for Adults, Children, & Teens.

- In collaboration with the Office of the Medical Director, a one-day Educational Summit on Cannabis was held for all health care services clinical staff including psychiatrists, physicians, and nurses.

- A full day training was provided in Farsi for County and community-based organization (CBO) staff called “Concepts of DBT and CBT as Applied to Collectivistic Culture of Farsi Speaking Populations.”

- Continue to provide trainings in both Adult and Youth Mental Health First Aid for staff and the community.

- Through a collaboration with California State University East Bay, provided the continuing education credit for their two-year post graduate Infant and Early Childhood Mental Health certificate program. Students began course work in January.

- In March 2019, ACBH contracted with East Bay Agency for Children (EBAC) to provide direction and technical support in implementing a Trauma Informed Systems (TIS) model within ACBH. One of the components of the model is the TIS 101 training, which provides foundational knowledge of TIS principles and helps participants understand how trauma and stress impact developing bodies and brains, communities, organization, and systems. A component of the model is to have TIS 101 trainers embedded in the system to train staff and support system change. EBAC will provide a train-the-trainer certification program for a cohort of 10 trainers within ACBH. The cohort will begin the certification process in August and will deliver TIS trainings to County and CBO staff beginning in October. The plan is for the trainer cohort to provide an average of two TIS trainings a month from October 2019 through June 2020 in order to complete instructor certification and then provide the trainings monthly thereafter.

- In June 2019, through a collaboration with the California Institute for Behavioral Health Solutions (CIBHS) and funding provided by the Greater Bay Area Mental Health and Education Workforce Collaborative, WET co-hosted a week-long course for an Adult Mental Health First Aid (MHFA) instructor certification. Nine persons became certified as instructors representing both ACBH and community-based organizations. These additional trainers will be able to offer MHFA training to county staff, provider agencies, and community groups.

- The Training Committee meets monthly (8 times per year). The committee is composed of representative staff and managers from county units and CBOs. The Training Committee advises the Training Officer on training activities related to both clinical and administrative staff throughout our system. In addition to the presentations and group discussion related to training outcomes and sustained learning that was discussed in the previous section, the training committee has reviewed standards of practice for trainings such as "person- first" language, fostering an inclusive environment, creating trauma informed learning environments, and using strengths-based and non-stigmatizing language. In June, Nicole Nelson, Executive Director of Training at Seneca Family of Agencies, presented to the committee on "Setting Expectations for Trainers around Equity and Inclusion" and how participants might apply these ideas to their own settings.

- Training outcomes are measured using self-administered evaluations. Each training proposes measurable learning objectives to be achieved by the end of the training. Following the training, attendees evaluate whether the objectives are met using a Likert scale from 1-5 (strongly disagree to strongly agree). At the end of every training, participants are asked to complete an evaluation and if they want continuing education credit, it is required. For all trainings, learning objectives are evaluated as being met on average as at least a 4 or 5 of the Likert scale, with 5 being "strongly agree."

- Another type of evaluation being utilized is a Post-Test, which training participants can take to test their knowledge during the training. The training instructor reviews the test with participants in order to get a sense of their learning and to address any incorrect answers and questions that may arise from taking the Post-Test.

- Another outcome measure was utilized for the trainings on Becoming a Trauma Sensitive Workforce. Two-weeks following the trainings, a post-training survey was emailed to all participants. It contained three simple questions about the impact of training and whether changes in perspective or behavior occurred/persisted as a result of the training. The survey results averaged over a three-year period indicated that between 62% of respondents (182) were positively impacted by the training and 72% made a change because of the training.

**Challenges:**

- Evaluating the impact of trainings is a challenge for any type of training in all sectors and as a way to address this, WET began scheduling presentations on related topics at the monthly Training Committee meetings. In February, Deanna Beeson, Director of Clinical Learning at Telecare, Inc., gave a presentation entitled, "Methods of Supporting Training Sustainability & Measuring Outcomes" and in October, Stella Sheldon, Training Manager from A Better Way, will present on Learner Retention Strategies.

- The training evaluations completed by participants has been administered in paper form which makes compiling, summarizing, and analyzing data very difficult. In 2019, the County purchased a new

Learning Management System which has the capacity of offering evaluations in an online format. It is planned that evaluations will be administered electronically, which will allow for much improved data analysis and trainer feedback.

- Because a number of units within ACBH host trainings for their staff and contracted providers, it has been a challenge to coordinate all that is necessary in order to provide continuing education credits for the numerous trainings being offered. Starting in July, WET formalized collaboration with other programs within ACBH who want CE credit for their trainings. The result of the collaboration has been more consistency and standardization for training participants. The established collaborations include the Office of the Medical Director, Office of Ethnic Services, Substance Use Disorders System of Care (SOC), the Child & Young Adult SOC, the Adult & Older Adult SOC, and Quality Assurance.

- All of the trainings provided have been in-person at various locations throughout the county. It is challenging for a number of the staff to attend trainings due to the added travel time needed. For this reason, among others, we are considering providing on-line trainings once the new learning management system is in place. *(To view the Training Institute's report in detail, see Appendix B.)*

**FY 19/20 Progress Report:**

- Provided or collaborated on a total of 96 training activities, thereby training 2,842 staff and providing 422.5 continuing education hours to Behavioral Health Care Services (ACBH) and contracted Community Based Organization's (CBO) staff. See the addendum for a list of trainings provided.

- Training topics were provided on a variety of issues including legal and ethical issues, Culturally Responsive Mental Health Services for Sexual Orientation and Gender Identity (SOGI), Tobacco Cessation Interventions, Adult and Youth Suicide Assessment & Intervention, Mental Health First Aid, Preventing, De-Escalating, and Managing Aggressive Behavior in Behavioral Health Settings, and a variety of evidence-based practices.

- Seventeen of the trainings were hosted by the Office of Ethnic Services and related to one or more of the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS). Trainings included a five-part intensive workshop series called "Caught in the Crossfire of Cultures", which focused on the psychological problems of the Afghan population residing in Alameda County; "Strong, Brown & Proud-Genesis of the Latina/o x Raza: The State of Latina/o x Raza in CA Today"; "Treatment & Beyond: Improving Retention and Treatment Outcomes for African Americans through Effective Case Management, Dismantling Implicit Bias, and Healing Racial Trauma"; "From Color-Blindness to Cultural Humility and Cultural Competence: Understanding Whiteness and Its Implications for Health Equity Training"; and "Behavioral Health Interpreter Training."

- Provided continuing education credit for workshops at the 2-day Asian & Pacific Islander (API) Mental Health Empowerment Conference "Unified in Resilience, Drawing Strength from our Communities", a statewide conference with 500 in attendance on the first day and 350 on the second day.

- Provided trauma informed care related trainings to County and CBO staff, including "Preventing Vicarious Trauma", "Dynamic Mindfulness", and "Trauma-Informed Treatment for Adults, Children, & Teens."
- A training "Traumatic Impact of Immigration on Children and Families" was provided in Spanish. We are planning to offer at least two more trainings in Spanish by the end of June 2020.

- Continue to maintain provider accreditation and offer required continuing education (CE) credit for Registered Nurses, Licensed Marriage and Family Therapists, Licensed Clinical Social Workers, Licensed Professional Clinical Counselors, Licensed Educational Psychologists, Licensed Clinical Psychologists, and certified Addiction Professionals.

- Continue to provide trainings in both Adult and Youth Mental Health First Aid for staff and the community.

- Continue the collaboration with California State University East Bay, WET is providing the continuing education credit for their two-year post graduate Infant and Early Childhood Mental Health certificate program.

- The Training Committee decided to take a pause starting in February during which time the Training Officer will reassess the needs of the training institute and re-evaluate the purpose and goals of hosting a training committee and the makeup of the representatives. During the pause, members will continue to share resources with each other.

**FY 20/21 Anticipated Changes:**

- In February 2019, the Alameda County Learning & Education Center received official Board approval for the purchase of a new Learning Management System. *SumTotal Systems* will be the new LMS vendor, and WET is a member of the implementation team and the representative of our department in the process. *SumTotal* will provide a data management system for self-registration and tracking of instructor-led training, online, informal, and social learning, which supports career growth and development. This new LMS includes significant additional features, improved options for managers, and has a more advanced user experience. It will continue to offer the ability for all County employees and CBO staff to register for ACBH trainings. During the remainder of 2019, WET is involved in the configuration and implementation phase with a plan to "go-live" with the new system in June 2020.

- As mentioned in the previous section, the trainings provided to date have all been in-person, which presents a challenge for a number of staff due to the added travel time needed. The new LMS system provides a platform allowing the ability to launch and learn on online and on mobile devices anytime, anywhere. We are excited about the opportunity to utilize this function to be able to provide online learning content.

**6. Post Graduate Certificate Program**

**Program Description:** MHSA WET provided funding to launch a new two-year *Infant & Early Childhood Mental Health Postgraduate Certificate Program* at Cal State University, East Bay. The overarching goal is to build capacity in a culturally diverse early childhood mental health workforce to meet the social, emotional and developmental needs of young children, ages birth to five, and families in Alameda County.

- The first year of this program has focused on the developmental foundations of infant and early childhood mental health with an emphasis on theory. Year Two is developmental foundations of relationship based clinical work with infants, young children, families and caregivers with an emphasis on application of theory to every day practice. The curriculum has a strong emphasis on working with families from diverse cultural, racial and ethnic backgrounds. This is especially important as Alameda County is exceptionally diverse in terms of socio-economic status, race, culture, ethnicity and immigration experiences.

- The program began last year and is continuing with a cohort of 15 students, 14 subsidized by MHSA WET and one private pay. Of the 15 students 11 are clinicians of color and 10 of the 15 speak a second threshold language, and all 15 are working in Alameda County early childhood community-based organizations (CBOs).

**Program Evaluation:**
The Cal State University East Bay Infant & Early Childhood Mental Health Postgraduate Certificate Program is being evaluated by UCSF Benioff Children's Hospital Oakland, Dr. Laura Frame, Director of Research, over the two-year period of implementation. The two-year evaluation will focus on evaluation of the process and methods used in the training program. To this end, the evaluation will provide ongoing feedback to program planners and teaching staff that will support continuous quality improvement during the two-year program, as well as post-pilot.

**Challenges:**
The following are challenges that the program planner and teaching team experienced in the initial phase of launching the program:

- Amount of time that was required to develop the curriculum was considerably more than had been projected. This required additional compensation for the teaching team.
- Variance of student experience and knowledge – teaching team had to revise some of the curriculum to reflect the variance of experience and knowledge of the student cohort.
- Variance of teaching team (one primary instructor and two co-instructors) experience – Primary instructor realized early on in the process that one co-instructor was considerably more prepared to develop and present curriculum. This required extra planning among the team in terms of delegation of curriculum development and instructional responsibilities, as well as differential compensation for one co-instructor.
- Although Cal State East Bay Continuing Ed staff are exceptionally collaborative and helpful, there was a learning curve on use of educational platform for teaching team.

Students received "past due tuition" notices from Cal Sate East Bay throughout the first semester although all tuition had been subsidized and completely paid for. This situation has been resolved and should not occur moving forward.

**FY 20/21 Anticipated Changes:**
ACBH WET does not anticipate any significant program implementation changes during FY 20-21.

**7. Psychiatry and Integrated Behavioral Health Care**

**Program Description:** MHSA WET provided funding to continue its partnerships with nine Federally Qualified Health Centers (FQHCs) and the University of California, San Francisco (UCSF), School of Medicine to provide behavioral health education and clinical training.

- The Office of the ACBH Medical Director funded the fifth cohort of nine FQHC primary care providers to attend the University of California Davis, School of Psychiatry, and Primary Care Psychiatry Fellowship Program. This year the ACBH Workforce Development Project includes two Safety Net primary care providers who will be attending the new UC Davis School of Psychiatry Pain Management Fellowship Program, which aims to increase the skills and knowledge base of providers to respond to the needs of patients with opioid addictions.

- ACBH WET and the University of California, San Francisco (UCSF), School of Medicine partners to provide behavioral health education and clinical training to Fellows from UCSF Public Psychiatry Fellowship (PPF) Program. However, in FY 2019-20, UCSF was unable to recruit anyone to place in the ACBH clinical education and training program.

**8. Graduate Intern Stipend Program**

**Program Description:** Offer financial incentives as workforce recruitment and retention strategies, and to increase workforce diversity. Financial Incentives are offered to individuals employed in ACACBH and to graduate interns placed in ACACBH and contracted community-based organizations, and who are linguistically and or culturally able to serve the underserved and unserved populations of the County.

**FY 18/19 Outcomes, Impact & Challenges:**

- WET continued to provide Financial Incentives to eligible graduate interns placed in ACBH and contracted community-based organizations, and who are linguistically and culturally able to serve the underserved and unserved populations of the County.

**Launched and administered the 7th cycle of the Graduate Intern Stipend Program in August 2018.**

- Awarded 20 stipends in the amount of $6,000 each for 720 internship hours. Of the 20 awardees, 70% represent the diverse communities of Alameda County.

**2018-19 Graduate Intern Stipend Awardees – Ethnicity (Number of awardees =20)**

| | |
|---|---|
| African American | 4 – 20% |
| Asian Pacific Islanders | 3 – 15% |
| Caucasian | 2 – 10% |
| Hispanic/Latino | 7 – 35% |
| South East Asian | 4 – 20% |

**2018-19 Graduate Intern Stipend Awardees – Language (Number of applicants=20)**

| | |
|---|---|
| English | 4 – 20% |
| Cantonese | 1 – 5% |
| Mandarin | 0 |
| Spanish | 9 – 45% |
| Tagalog | 0 |
| Vietnamese | 2 – 10% |
| Other | 4 – 20% |

**FY 20/21 Anticipated Changes:**

- ACBH WET does not anticipate any significant program implementation changes during FY 20-21.

**9. Loan Assumption Program**

**Program Description:** Mental Health Loan Assumption program for individuals who complete a service obligation in public behavioral health in Alameda County.

In FY17-18, Office of Statewide Health Planning and Development (OSHPD) funding supporting the State Mental Health Loan Assumption Program (MHLAP) ended. This created a service gap in providing financial incentive to hire and retain qualified, eligible employees in "hard to fill/retain" positions in Alameda County's Behavioral Health Care System. ACBH WET took necessary actions to bridge the gap, focusing on developing a local Loan repayment program, the "Alameda County Loan Repayment Program" (ACLRP), modeled after MHLAP.

**FY 20/21 Anticipated Changes:**

- After a multi-year planning process ACBH is excited to announce that WET, in partnership with The California Mental Health Services Authority (CalMHSA), will be launching the Alameda County Loan Repayment Program in July 2020.

shift from solving problems to supporting family strengths and internal resources, and increased collaboration, communication and connection between Family Partners and their Supervisors.

**FY 20/21 Anticipated Changes:**

- ACBH WET does not anticipate any significant program implementation changes during FY 20-21.

### 11. MHSA Support and Community Based Learning (CBL) Trainings

**Program Description:** Community Based Learning (CBL) Trainings are free to Alameda County Behavioral Health Care Services (ACBH) systems partners, faith-based communities and non-profit organizations that want to improve health outcomes for consumers and family members in the areas of mental health and substance use disorders.

Alameda County Behavioral Health Care Services Ethnic Services Department is able to offer trainings through funding from Prop 63, the Mental Health Services Act (MHSA). For more information on these trainings please go to: https://acmhsa.org/innovation-community-based-learning/community-based-learning-trainings/

### 10. Consumer & Family Member Training, Education and Employment

**Program Description:** Offers an integrated, coordinated approach to consumer and family member employment and supports consumer and family employees at all stages of the employment process, from recruitment to retention. The goal is to develop and retain authentic consumer and family member voices in leadership roles as we develop new wellness, recovery and resiliency practices across the system.

**FY 18/19 Outcomes, Impact & Challenges:**

- BEST Now, a program with Alameda County Network of Mental Health Clients (ACNMHC), provides peer specialist training program with 6-month internships: 19 students attended the program and graduated in June 2019. This year the training added Substance Use prevention and harm reduction courses.

- The Office of Consumer Empowerment (OCE) offered a Crisis and Peer Support Training in April 2019. 17 peer specialists completed the training.

- Pool of Consumer Champions (POCC) Latino Committee hosted and provided a Latino Empowerment Training and Event in September. 135 consumers, family members and providers attended the training.

- POCC partnered with California Association of Mental Health Peer Run Organizations (CAMHPRO) to leverage state funding to bring more trainings and employment opportunities to consumers. The POCC hired 11 peer staff from the training cohort.

- 23 on-going trainings for consumers were provided for Lift Every Voice and Speak Speakers Bureau in FY 18/19. They were trained in Toast Masters curriculum. 24 consumers were trained who are part of the Speakers Bureau.

- POCC Sexuality and Gender Alliance Committee (SAGA) presented the Supporting the Wellness of Transgender Communities Training to 30 consumers, family members and providers.

- e-CPR (Emotional CPR) train the trainer was offered in March 2019. 12 participants completed and received certificates.

- Advanced Peer Specialist trainings/educational experiences were offered to build knowledge, skills and abilities which included DBT 32-hour online training. However, DBT 32-hour online training series ended in September 2019. Many participants have experienced challenges due to technical glitches as the software is outdated and expiring.

- The Office of Family Empowerment (OFE) provided 2-day coaching skills training to support Family Partners and their Supervisors to increase communication, collaboration, connection and humility in service delivery to families and in the workplace.

- OFE implemented 18 hours of on- site technical assistance and coaching to Family Partners and Supervisors in three early childhood mental health agencies to practice and integrate coaching skills introduced at the two-day coaching training. The training and technical assistance resulted in a greater awareness and self-management of triggers especially related to trauma and high stress situations, a

# CAPITAL FACILITIES & TECHNOLOGICAL NEEDS

# Capital Facilities & Technological Needs
## *"Bringing People and Resources Together"*

The *Capital Facilities & Technological Needs (CFTN*) component of the MHSA "works towards the creation of a facility that is used for the delivery of MHSA services to mental health clients and their families or for administrative offices. Funds may also be used to support an increase in peer-support and consumer-run facilities, development of community-based settings, and the development of a technological infrastructure for the mental health system to facilitate the highest quality and cost-effective services and supports for clients and their families".

It should be noted that CFTN funding was originally a 10-year block grant, which ended on June 30, 2017. However, through Assembly Bill (AB) AB 114, ACBH was given a grace period to utilize previously reverted MHSA funding through June 30, 2020. For more information on ACBH's spending plan for AB 114 funds, please see ACBH's AB 114 Plan at https://acmhsa.org/reports-data/#mhsa-plans

In addition to the CFTN funds identified in Alameda's AB 114 Plan, ACBH began transferring CSS funds to CFTN in FY 18/19 and again in FY 19/20 and will continue in FY 20/21. Pursuant to Welfare and Institutions Code Section 5892(b), Counties may use a portion of their CSS funds for WET, CFTN, and the Local Prudent Reserve. The total amount of CSS funding used for this purpose shall not exceed 20% of the total average amount of funds allocated to that County for the previous five years.

ACBH's MHSA funded Capital Facilities projects are in alignment with Alameda County's Vision 2026. More on this vision can be seen at https://vision2026.acgov.org/index.page

**New Projects Approved for funding, implementation FY 19/20-22/23**

Through our recent CPPP the areas of housing, homelessness, culturally responsive services & programming, ability to use and increase technology (for the benefit of client care and billing purposes) and the availability of crisis services (to reduce/prevent hospitalizations) were top concerns reported by local residents. These top concerns were very similar in the previous Three-Year MHSA Plan (FY 17/18-19/20).

**CF5: African American Wellness Hub Complex**

ACBH is excited to begin work on the development of an African American Wellness Hub Complex. This Complex will be developed over the next three years and will be a beacon of hope and energy for the African American community in Alameda County.

Currently ACBH has budgeted $2 million/year for three years for a total of $6 million dollars to purchase land and/or renovate an existing space. ACBH staff are working closely with community consultants and the Alameda County General Services Agency Department on this step of the process. Once this phase is complete additional planning will take place regarding services and supports for the Hub Complex.

More information will be available on the progress of the land purchase or building purchase renovation as it becomes available and will be posted on MHSA website and in the FY 21/22 MHSA Plan Update.

## Ongoing Projects

During FY 19/20 the following CFTN projects were implemented. These projects were listed in the FY 18/19 Plan Update as new programs, however they've now transitioned to the ongoing section of this Update. Several of these projects will be completed this fiscal year and others will be continued and completed in FY 20/21 and beyond.

# CFTN PROGRAM SUMMARIES

**PROJECT NAME: CF2 Project Description: Capital Project Investments to Expand Respite Beds for Individuals with Serious Mental Illness and Physical Health Care Needs**

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

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

Due to the COVID-19 pandemic the development of additional shelter beds has been delayed, more information will be posted in the FY 21/22 Plan Update.

**PROJECT NAME: CF4. Alameda Point Collaborative**

**Project Description:** Starting in FY 18/19 ACBH utilized AB 114 CFTN funds to invest in the Alameda Point Collaborative (APC) Senior Housing and Medical Respite Center (Center) to help alleviate the homelessness crisis and address adverse health outcomes among vulnerable populations in Alameda County. This project's focus is to develop permanent supportive housing, medical respite and extended care to people experiencing homelessness, with an emphasis on medically frail and individuals with complex medical and psychiatric needs. See the FY 18/19 MHSA Plan Update for a more detailed project description at www.ACMHSA.org

**FY 19/20 Progress:** The City of Alameda held a special election in April 2019 to determine if the project could move forward. The ballot measure passed with 53% of the voters approving to move forward with the development of the Center. Once the special election was finalized ACBH released its first payment to APC, and has subsequently released its second payment to invest in the building and renovation development. In FY 20/21 ACBH will release its third and final payment. ACBH will report out additional progress as dates become available.

**PROJECT NAME: CF6. Land Purchase adjacent to the A Street Homeless Shelter**

**Project Description:** In FY 18/19 ACBH used its AB 114 CFTN funds to purchase a small plot of land next to the A Street Homeless Shelter, which ACBH has been operating in Hayward since 1988. The subject lot is located at 22385 Sonoma Street immediately adjacent to the existing A Street Shelter.

**FY 19/20 progress:** ACBH, through the General Services Agency (GSA), successfully purchased the land in January 2019. ACBH plans to use the lot as additional parking, providing approximately 20 additional spaces to augment the inadequate parking capacity needed to serve employees, residents, visitors and service vehicles. The grading and fencing of the space will take place once the contaminated soil is removed. The soil was to be removed in January 2020, however due to internal changes at GSA and the COVID-19 pandemic the project has been put on hold. ACBH is working with GSA on an updated timeline to restart the project. In the future this land may be augmented to expand the A Street Shelter capacity.

**PROJECT NAME: TN1. MHSA Technology Project**

**Program Description:** Purchase, installation and maintenance of a new Behavioral Health Management Information System, to include: billing, managed care, e-prescribing functions, data interoperability and functions as needed to support clinical and fiscal operations of BHCS. Additional expenditures for the necessary support staff during the implementation process, and other projects that provide access to consumers and family members to their personal health information and other wellness and recovery supports.

**FY 19/20 Progress:** ACBH has utilized CFTN funds to contract with an agency, XPIO, to develop a scope of services and requirements for the procurement process for a new EHR system. This system will include: billing, managed care, e-prescribing functions, data interoperability and functions as needed to support clinical and fiscal operations of ACBH.

The request for proposal (RFP) for the *billing section* of the EHR will post on August 3rd. More information will be shared with the community when available.

Additionally, under this project ACBH has been utilizing CFTN funds for the following items that have assisted ACBH in being more efficient and effective with utilization and outcome data:

- TN1: Behavioral Health Management Contracting System (to assist with the contracting process), called Apttus (phases 1-4)
- TN1: Computer/Technology Technical Assistance
- TN1:Electronic File Storage and Document Imaging (Veeam Software)
- TN2: Web-based dashboard System, called YellowFin
- TN3: County Equipment and Software Update (includes GoToMeeting software)
- TN4: Clinician's Gateway Interface
- CFTN Administration

# Performance Management Initiatives
## *"Data Driven Actions"*

*MHSA Performance Management (PM)* is a process of ensuring activities and outputs meet goals in an efficient and effective manner. The process focuses on the performance of various Alameda County Behavioral Health Care services (ACBH) units that support the administration of MHSA, MHSA funded programs and services, employees, and associated tasks. The following sections provided an overarching summary of significant quality assurance and improvement activities directed towards improving the administration of MHSA components.

### Alameda County Health Care Services Agency: Results-Based Accountability (RBA) Initiative

Project IMPACT began in July 2014 as an effort that supports programs throughout the Alameda County Health Care Services Agency (HCSA) to measure and report their outcomes[1]. The Project IMPACT team consists of a total of 17 program staff and managers from every Department in HSCA, including members who have worked closely with the RBA implementation efforts in their own Departments. The Agency Leadership Team (ALT), which includes the Agency Director of HCSA and the Directors, Deputy Directors and Finance Directors of each of the Agency's departments, is monitoring and guiding the development of Project IMPACT.

RBA is a program evaluation framework that is data-driven and uses a simple iterative process to help organizations assess current performance, identify strategies to improve, and facilitate rapid implementation of action plans. Since 2014, ACBH has been utilizing RBA in various capacities to monitor program performance and assess impacts on the clients who come into contact with department and/or contracted services. ACBH has integrated RBA into MHSA contracting efforts with Full-Service Partnerships (FSPs), adopted the framework as part of its Prevention & Early Intervention (PEI) services evaluation, and made strides to include it as part of the Juvenile Justice Center and Crisis Services program work.

### Alameda County Behavioral Health Department Initiatives

*Reorganization Efforts***.** ACBH conducted a thorough inventory of all contractual and legal obligations for the administration and delivery of behavioral health care services[2] . ACBH leaders examined the requirements included in three contracts with the California Department of Health Care Services, and interviewed ACBH managers in an effort to understand current strengths and challenges staff face in fulfilling our obligations. At the conclusion of this process, ACBH has established or plans to establish the following new key positions:

- Two Deputy Directors: Including the **Plan Administrator** who oversees and create linkages among ACBHS's core administrative functions (e.g. MHSA, quality Improvement/Quality Management, Information Systems, and financial Services) (Hired)

[1] Project IMPACT (2016). Project IMPACT FAQ. Retrieved from http://achcsa.org/hcsa/project-impact.aspx
[2] Communication from the Office of the Agency Director (2020). ACBH Departmental Reorganization-UPDATE.

- Public Information Officer: Help to promote and raise awareness of MHSA activities including community engagement efforts, development of press releases, liaison with media groups, and supporting media campaigns. (Currently vacant, delayed hiring process due to COVD-19)

- Health Equity Officer: Partner with MHSA program in the development and implementation programs to ensure they are culturally and linguistically appropriate with elements that address inequities and promotes access to care. This individual will also support the inclusion of peers and family members in the community program planning process. (Currently vacant, delayed hiring process due to COVD-19)

- Compliance and Privacy Officer: Support the MHSA program to adhere with federal, state and local guidelines. (Currently vacant, delayed hiring process due to COVD-19)

*Future strategic planning activities***.** In light of the impact of COVID-19, the MHSA program will develop more electronic platforms like social media sites to ensure our stakeholders are engaged in the program planning. The above-mentioned new positions will also: 1) support MHSA efforts; 2) develop real time dashboards to keep the community informed on the MHSA programs in Alameda County; 3) work closely with the Finance team to ensure effective budget management; 4) continue advocacy at the State level (e.g. DHCS, MHSOAC) and 5) develop new Innovation projects to inform the delivery of mental health services in Alameda County.

**Alameda County Behavioral Health: Trauma Informed Systems Initiative**

ACBH's Trauma-Informed Systems (TIS) efforts have focused primarily on the training components of the *Healing Systems of Care Conceptual* framework – establishing a cohort of embedded trainers within ACBH and training staff in the TIS 101 foundational curriculum. TIS is in the beginning stages of adapting the training so that it's more responsive to the needs of staff during this period of sheltering-in-place (**see Appendix B-4**).


Over the next three years, ACBH and Trauma Transformed (T2) will shift focus towards the practice change and leadership components of the framework. In particular, T2 will support the creation of an ACBH cohort of champions and catalysts who will gather new and existing data from ACBH to determine priorities for policy and practice change within ACBH. TIS hopes to work more directly with ACBH leadership – directors, managers and supervisors – to increase their understanding of TIS principles and implement best practices for leading others in a trauma-informed way.
The goal of all these activities is to help ACBH move closer to being a healing organization. The overarching benefit of these activities will be to improve collaboration within ACBH and with their MHSA contractors, to take more proactive steps to include contractor and community voice in decision-


making, and to anticipate and work to prevent predictable stresses, harm and trauma experienced by ACBH staff, MHSA contractors, and community members**.**

**Financial Services Division**

The MHSA Trust Fund Account (MHSA Trust) was established to maintain the MHSA monthly allocation and interest earnings. All expenditures are charged to the County General Fund (CGF) with the related MHSA program code. Finance prepares a quarterly projection report to identify the net MHSA revenue, and then develop a journal to move funds from the MHSA Trust to the CGF to offset the expenditures.

Finance has assigned a MHSA Plan number for each plan component and its projects; and have set up 29 program codes in the County financial system to associate with the MHSA projects. For community-based organizations/providers (CBO), the Division assigns a reporting unit number (RU#) for their projects. The program codes and RU#s can be used to keep track the payment status.

In each fiscal year, the Finance Division creates what is called *The Green Sheet* to identify all MHSA projects for that year including the Plan number, total budget, MHSA budget portion, estimated Medi-Cal revenue, program code and reporting unit (RU)#. The provided data helps support the preparation of the MHSA Plan and the Annual Revenue and Expenditure Report to the Department of Health Care Services.

*Communication.* Finance establishes monthly meetings with the ACBH Leadership Team to provide information, discuss issues and concerns, and communicate with the MHSA Director for relevant updates.

*Fiscal Accountability.* The Finance Division follows a set of policies and procedures to avoid supplantation of MHSA funding. All expenditures, encumbrances and revenue are reconciled every quarter, as part of the quarterly projections process. The Division requires two signatures when signing housing assistance checks over $5,000. Each Invoice and deposit require one signature.

**Procurement & Contract Compliance Activities**

The ACBH Contracts Unit operates under the auspice of the Finance Division. The Contracts Unit is undergoing an organizational restructure in which all contracts will reside within this Unit. These changes are part of an overall response to federal and state health care policy changes which affect county behavioral health in California. In order to meet the demands of these changes, ACBH is proactively preparing to adapt to and thrive in the new behavioral health environment by more fully aligning ACBH's compliance with the following federal and state requirements:

- The state-county Mental Health Plan Contract, Performance Contract, and Drug Medi-Cal Contract;

- Expanded Federal Medicaid Managed Care regulations; and
- Expanded covered services and contract requirements in Drug Medi-Cal.

The Contracts Office has seven Program Contract Managers also known as Program Specialists and eight Fiscal Contract Managers. Each Contract Manager manages between three and fifteen MHSA funded programs. The Contracts Office has one Program Contract Manager who serves as the liaison between the Contracts Unit and the ACBH MHSA Division. In this role the Contract Manager reviews the MHSA plan and updates, coordinates with the MHSA staff on reporting requirements and timelines, coordination of audit requirements on behalf of the Contracts Unit and communicates emerging changes that would impact the Contracts Unit.

*Roles & Responsibilities.* Contract Managers are responsible for monitoring programs from various aspects; Fiscal: reviewing units of services from the electronic claiming system in comparison to the allocation. Program: technical assistance (phone calls, meetings, or emails), reviewing reports (quarterly or annually) against the contracted deliverables.

*Performance Measures.* Contract Managers work in collaboration with the MHSA staff, and the provider to develop process, quality, and impact objectives for each type of program. For example, Full-Service Partnerships (FSPs) are measuring the percent of providers who can achieve a 50% reduction in the following: 1. Psychiatric hospitalization admissions 2. Psychiatric hospital days and 3. Psychiatric emergency visits 12 months prior to FSP admission and 12 months post admission. Additional metrics have been implemented more recently tied to a pay for performance fiscal model.

*Contract Compliance.* ACBH formalized a policy in June 2018, "Contract Compliance Plan and Sanctions for ACBH Contracted Providers". This policy supports ACBH in holding providers accountable for implementing County, State, and Federal requirements. Examples may include by not limited to: lack of achievement in meeting performance standards, substantive underperformance on meeting contracted deliverables, failure to meet contractual requirements such as staffing, timelines, required certifications and/or licensure. Additionally, ACBH responded to an audit finding in 2017 which resulted in the development of the MHSA Monitoring Guidelines in 2018 to strengthen the process in which ACBH are monitoring MHSA funded programs.

**MHSA Data Management Systems**

ACBH currently uses a web-based data and outcome reporting system called YellowFin. MHSA staff have partnered with System of Care staff and the ACBH Data Services team to develop costs and new FSP outcome and impact metrics that when complete will be highlighted in the FY 21/22 MHSA Plan Update. The newly created reporting dashboard will cover hospitalizations, housing, incarcerations, primary care linkage, employment, education, cost, and data quality. Below is an example of one of the draft metrics the team is designing. These systems will help move ACBH more towards payment for quality of care. All of these dashboards will be used by FSPs for program improvements and yearly reports.

The Underserved Ethnic Language Programs (UELPs), a subset of the PEI programs, have recently expanded. Because of the expansion, a workgroup will be convened to review current evaluation processes, improve the usability of the evaluation results for providers, and include the UELP Yellowfin dashboards into the evaluation.

**Prevention & Early Intervention (PEI) Unit Performance Efforts**

The MHSA PEI Unit is committed to working in collaboration with contracted providers to identify program outcomes and evaluation processes that are aligned with MHSA and the PEI system's values and regulatory requirements ( see Appendix F-4). In an effort to foster the system's "voice and choice," we're working together with providers in a trauma-informed way to:

- Create a safe space where individuals and providers can share their experiences, challenges and frustrations, and knowledge regarding data collection, reporting, and evaluation;
- Form work groups that include direct service/outreach staff to assess the utility, feasibility, propriety, and accuracy (CDC evaluation standards) of the evaluation processes and survey instruments;
- Invite accountability to ensure that evaluation activities are culturally and linguistically relevant and promote equity and accessibility;
- Explore non-Westernized, community-oriented ideas of how to invite feedback and uplift participants unique perspectives and experiences;
- Build strong relationships and transparency with providers during virtual site visits by offering support and assistance, and
- Keep providers up to date about MHSA/PEI data requirements and updated regulations.

**MHSA Audit**

The Department of Health Care Services (DHCS) conducted its abridged review of Alameda County's Mental Health Services Act (MHSA) program on March 24, 2020. Alameda County's strengths include:

- "The expansion of FSP program capacity to provide coordination and community-based care services, "
- A multitude of diverse Prevention and Early Intervention (PEI) programs specifically focused on underserved ethnic and linguistic populations, and
- The County has also shown strength in the Workforce Education and Training (WET) component offering internships, educational pathways and loan repayment programs.

Alameda County challenges include a severe lack of housing and resources to meet the needs of homeless populations within the community, merging diverse PEI programing into one system, leadership changes within behavioral health and other public agencies, and "lengthy procurement and contracting processes."

Areas where Alameda County will focus on strengthening our transparency and consistency of MHSA funded programs and their policies & procedures include:

- Increased description and documentation of the Community Program Planning Process (CPPP) within the Three-Year Plan and/or Plan Update;
- Increased description and documentation of the local review and approval process within the Three-Year Plan and/or Plan Update, and
- Tracking that 51% or more of Prevention and Early Intervention component funds are spent on youth 0 to 25 years of age, and
- Developing a policy and procedure document on the referral structure and service components of a Full-Service Partnership.

# ACKNOWLEDGEMENTS

The Alameda County Behavioral Health Department would like to acknowledge the contributions of it's staff, affiliates, consultants, and community partners, including, but not limited to:

Alameda County Behavioral Health Department

Amymade Graphic Design

Board of Supervisors, District 4

Bryan Kring Design

Financial & Contracts Division

Community & Faith-Based Organizations

District Attorney's Office

East Bay Agency for Children

Health Care Services Agency

Health & Human Resource Education Center

Human Resources Department

LA Jones & Associates

Mental Health Services Act (MHSA) Division

Mental Health Advisory Board

MHSA Stakeholder Group

MHSA Community Program Planning Process Steering Committee

Office of Ethnic Services

Pool of Consumer Champions

Public Health Department, Community, Assessment, Planning, and Evaluation

alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

# MENTAL HEALTH SERVICES ACT (MHSA)

## STAKEHOLDER GROUP MEETING CALENDAR, 2020 rv5

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

| DATE | TIME | LOCATION | MEETING THEMES |
|---|---|---|---|
| January 24, 2020 (Friday) | 2:00-4:00pm | 2000 Embarcadero Cove, 5th Floor, Oakland, CA 94606 | • MHSA Overview<br>• Annual Plan Update |
| February 28, 2020 (Friday) | 2:00-4:00pm | 2000 Embarcadero Cove, 5th Floor, Oakland, CA 94606 | • MHSA Goal Setting/Finding A Common Link<br>• Develop Operating Guidelines |
| March 27, 2020 (Friday) | 2:00-4:00pm | GoToMeeting | • MHSA Audit<br>• MHSA Community Planning Meetings (CPM) Outreach & Evaluation Design<br>• Recruitment |
| April 24, 2020 (Friday) | 2:00-4:00pm | GoToMeeting | • MHSA Community Planning Meetings (CPM) Focus Group |
| May 27, 2020 (Friday) | 2:00-4:00pm | GoToMeeting | • MHSA Community Planning Meetings (CPM)<br>• MHSA-SG Recruitment |
| June 26, 2020 (Friday) | 2:00-4:00pm | 2000 Embarcadero Cove, 5th Floor, Oakland, CA 94606 | • Quarterly Program Data Review<br>• Program Spotlight/Presentation: Innovations |
| July 24, 2020 (Friday) | 2:00-4:00pm | 2000 Embarcadero Cove, 5th Floor, Oakland, CA 94606 | • Revisit MHSA-SG Plan & Meeting Frequency<br>• Program Spotlight: COVID-19 Transit Shelter Ad<br>• MHSA Plan preview |
| August 28, 2020 (Friday) | 2:00-4:00pm | 2000 Embarcadero Cove, 5th Floor, Oakland, CA 94606 | • Program Spotlight/Presentation : Housing<br>• MHSA Policy & Legislation Review<br>• MHSA 3yr plan 20/23- Public Comment/Public Hearing |



MHSA STAKEHOLDER MEETING CALENDAR
Mariana Dailey, MPH, MCHES
Revision Date: 7/24/2020

alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

# MENTAL HEALTH SERVICES ACT (MHSA)

## STAKEHOLDER GROUP MEETING CALENDAR, 2020 rv5

| | | | |
|---|---|---|---|
| September 25, 2020 (Friday) | 2:00-4:00pm | 2000 Embarcadero Cove, 5th Floor, Oakland, CA 94606 | • Government Funding & Procurement Overview or Program Spotlight: Family Empowerment best practices<br>• PCR Report<br>• Joint Site Visit Observations |
| October 23, 2020 (Friday) | 2:00-4:00pm | 2000 Embarcadero Cove, 5th Floor, Oakland, CA 94606 | • Program Spotlight/Presentation: CFTN<br>• MHSA 3-Year Plan Posted<br>• Annual Plan Update |
| November 27, 2020 (Friday) | CANCELLED- HOLIDAY | | |
| December 25, 2020 (Friday) | 2:00-4:00pm | 2000 Embarcadero Cove, 5th Floor, Oakland, CA 94606 | • End of Year Celebration/Retreat<br>• Best Practice Review<br>• Review Operating Guidelines<br>• Renewing Commitment |

# MHSA CPPP, 2020
# *Outreach & Marketing Plan*
(Updated: July 23, 2020)

**Our vision** Expand and transform the mental health system while improving the quality of life for people living with mental health challenges.

**Our mission** Fund effective treatment, prevention, and early intervention, outreach support services, and family involvement programs to increase access and reduce inequities for unserved, underserved, and inappropriately served populations

| ACTIVITY | OBJECTIVE | DELIVERABLE | METRIC | COST | OUTCOME |
|---|---|---|---|---|---|
| **GOAL 1: Maintain administrative transparency to carry out plan objectives in order to deliver quality services to target population(s)** | | | | | |
| **MHSA CPPP Outreach & Marketing Plan** | **Create an outreach & marketing plan with visual diagram to guide planning efforts.** | **1. Develop an outreach and marketing plan which includes: outreach goals, strategies, metrics, and outcomes.** | • **Approved outreach/marketing plan** | | • **Directors letter to BOS on 4/21/20**<br>• **Sent to HCSA: 5/2020**<br>• **Sent to BOS 4: 5/2020** |
| **Convene Steering Committee Meetings** | **Host biweekly Steering Committee Meetings consisting of a cross-section of experts and community liaisons** | **1. Convene & facilitate biweekly steering committee meetings comprised of ACBH staff, consumers, and family members** | • **Steering committee roster and composition**<br>• **# meetings held** | | • **Convened 10 meetings (initiated 2/19/20 – 6/3/20)**<br>• **SM consisted of 14 individuals** |
| **MHSA Community Participation & feedback Survey** *(hyperlinked in flyer/palm card)* | **Reach 500 respondents by May 30, 2020.** | **1. Develop & translate approved CPPP SurveyMonkey**<br>**2. Embed on the MHSA webpage**<br>**3. Embed link on flyer**<br>**4. Track response rates weekly** | • **# unduplicated survey completion/each language** | | **Finalized 4/23/20**<br>**Live on 4/27/20**<br>• **# surveys: 627 which is a 14% increase from previous 3-year efforts**<br>  ○ **English: 587**<br>  ○ **Chinese: 31**<br>  ○ **Spanish: 9** |
| **3-Year CPPP Plan** | **Reach 1.2M ALCO residents with information about MHSA/Prop 63 programs/services within 5 months of CPPP activities** | **1. Develop 3 Year Plan**<br>**2. Secure approval**<br>**3. Post to MHSA website** | • **Approved MHSA 3-Year Plan**<br>• **# residents reached**<br>• **# website hits/pageviews/downloads** | | • **MHSA Plan approval date projected to 10/1/20, FY18/19 annual update approved 5/2020**<br>• **Website hit: (4/27/20 – 5/31/20): 2,145 users** |

# MHSA CPPP, 2020
# *Outreach & Marketing Plan*
(Updated: July 23, 2020)

| | | | | | |
|---|---|---|---|---|---|
| | | | | | (2,089 new users) and 10,594-page views<br>• # residents reached via surveys: 627<br>• # outreach to: at least 14,069 |
| **GOAL 2: Promote broad-level/regional awareness to Alameda County residents** | | | | | |
| Community Input Website | Centralize community input information and community feedback survey. | 1. Build a Community Input website to host the following: *Flyer, surveys, PPT video, MHSA FACT Sheets, press/media toolkit, Innovations idea web form* | • # calls to HHREC/POCC Hotline via website<br>• # completed Innovations Idea forms | | • New Community Input page, INN idea form, and Pop up message live 4/27/20<br>• # HHREC/POCC hotline calls: 177<br>• # INN forms submitted: 29 |
| Conduct Macro-level community outreach via Media/Public Relations efforts | Promote regional awareness of local MHSA efforts | 1. Develop & deliver approved Press Release, MEMOs, social media toolkit which includes a publishing schedule and topics to drive traffic to the MHSA website by May 30, 2020.<br>2. Send press release package to media outlets and post on MHSA CIP website | • # media outlets receiving press release & social media kit: *KPIX, KTVU, KRON, Tri Valley Paper, Post News Group (El Mundo paper & Oakland Post), East Bay Times, east Bay Express, Alameda Contra Costa Medical Assoc. Newsletter, Bay Areas Reporter-BAR, City of Oakland cultural Arts, Native American Health Center, Asian*<br>• # PSAs completed by ACBH staff: *Tri Valley* | • Facebook Ad (5/5/20: $490/ 2wks<br>• Post News Groups: $1840/1wk<br>• East Bay Times: $695/1/4pg/2wks<br>• Tri City Voice: $500 per 1/3pg/2wks<br>• Alameda-Contra Costa Medical Assoc: $500/2wks | • Start date: 4/27/20 (total 35 days outreach)<br>• # Media Outlets Contacted: 9<br>• # PSAs: 1 (tri-Valley)<br>• # Interviews Completed: *0* |

# MHSA CPPP, 2020
# *Outreach & Marketing Plan*
(Updated: July 23, 2020)

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|---|---|---|---|---|---|
| | | | • **# interviews completed by ACBH staff:** *0* | • Bay Area Reporter: $604/ 1/5pg/wk.<br>• East Bay Express (5/20/20): $575/wk. | |
| **Paid Advertisements** | **Reach 7,500 in Alameda County through paid advertisements and targeted outreach** | **1. Subcontract with PR Firm through HHREC**<br>**○ LaNiece Jones Media PR firm sends E-Blasts**<br>**2. HHREC pay for Facebook advertisements and paid aids in online newspapers (e.g. Oakland Post)**<br>**3. Utilize YouTube as a platform** | • **# Facebook social media hits:** *1,066 clicks/2 weeks*<br>• **PR Firm/LJ:** *3 email blasts x 7500* | **$500 for 3 blast packages to a subscriber list** | • **# PR Blasts: 3 (initiated on 4/27/20, XX, XX) with a reach of 7,500 people**<br>• **# Facebook Ads (initiated on 5/5/20 – 5/19/20): 1,066 clicks** |
| **County intranet/ internet, List Servs, and Newsletters** | **Reach Alameda County system of care providers through Countywide distribution lists, intranet/internet websites** | **1. Develop event Memorandums, flyers**<br>**2. Send messaging to County distribution lists to include:** HCSA Webmaster; *ACBH webmaster, Trauma Informed Care, MHSA, Re-entry/ AB109, Board of Supervisors (NextDoor-80,000K)*<br>**3. Post content through Alameda County CAO** | • **Complete register of distribution lists:**<br>• **Listservs:** *LANIECE JONES Listserv (7,500); POCC (1,600); MHAB (xx); ACBH Webmaster (weekly : 550-1600); MHSA Staff (11); MHSA-SH (18); MHSA CPPP_SM (13); ACBH Finance//Contracts (9); EBAC (2- XX); ACBH Leadership (11); Crisis Providers (XX); PEI (XX);* | | ○ **Memo developed 4/23/20**<br>○ **Webmaster sent 4/28/20** |

| | | | | | |
|---|---|---|---|---|---|
| | | **lists, HCSA intranet page, DA, BOS/ CAO/ Court/ MHSA/ INN distribution lists & MHSA-SG lists (NAMII, Swords to Plowshares)** | *TAY/TAY prevention (2014); PEERS (2,500); POCC-Policy (CC); District Attorney (XX); ACPD AB 109 RE-entry Listserv (CC); RHP 1400 (806); BOS 4 (8,000-800,000); HER; ACBH System of Car-,TAY ( 4 listservs); Colleges, Foster Care Collab, HCSA Dept Heads (XX); City of Oakland Culture Funding; A Touch of Life/ACBH CBL trainer; Conscious Voices/ACBH CBL Trainer; ACBH CBL Trainer; NIA Collective- Lesbians of African Descent; City of Refuge- UCCACBH CBL Trainer; Native American Health Center; St. Mary's Senior Advocates for Hope and Justice; City of Fremont- Aging & Family Services Division; HHREC; Bay Area Chapter of the Association of Black Psychologists; AECreative Consulting Partners; Nurse with Doctors without Borders; Political Community Activist NPHC* | | |
| **GOAL 3: Target and motivate the historically underserved and unserved communities/populations to participate in MHSA-funded activities** | | | | | |

# MHSA CPPP, 2020
# *Outreach & Marketing Plan*
(Updated: July 23, 2020)

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| **Convene Focus Groups** | **Identify, recruit, host 10 community focus groups by May 30, 2020.** | **1. Develop Focus Group materials**<br>**2. Coordinate focus Group Facilitator Training**<br>**3. Develop Focus group tip sheet and Questionnaire**<br>**4. Host 11 Focus Group and target:** *ACBH Leadership, MHSA-SG, MHAB, AA/Faith-Based, Latinx, UELP/ API/ immigrant/ refugee , Children/TAY, Adult, LGBTQQI+, VA, Reentry*) | • **# Focus Group Trainings**<br>• **# and name of participating agencies**<br>• **# focus groups**<br>• **# participants per agency**<br>• **# consents received**<br>• **# completed (paper only):**<br>○ *MHSA/MHAB: 1*<br>○ *POCC Volunteers*<br>○ *HHREC*<br>○ *BOS 4* | | • **Focus Group Toolkit posted: 5/2020**<br>• **# Trainings: 6**<br>○ MHSA (5/11/20): 3<br>○ SM meeting (5/20/20): 14<br>○ PEERS (5/12/20): 2<br>○ All MHAB (5/16/20): XX<br>○ MHAB Children (5/XX/20): 2<br>○ POCC (5/26/20): 7<br>• **# Focus Groups/ attendees: 12 / 186**<br>○ *ACBH Operations (4/6/20): 44*<br>○ *MHSA-SG (4/24/20): 11*<br>○ *PEERS/AA-FAITH (5/12/20):7*<br>○ *La Clinica CyB (5/13/20); 9*<br>○ *MHAB General (5/18/20): 19*<br>○ *UELP (5/22/20): 13* |

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|---|---|---|---|---|---|
| | | | | | ○ *MHAB Children's Committee/TAY (5/22/20): 34*<br>○ *MHAB Adult (5/5/20): 5*<br>○ *POCC/Camphor (5/27/20): 28*<br>○ *LGBTQIA+ HHREC/Office of Ethnic Services (5/27/20): 6 (20 preregistered)*<br>○ *MHAB Criminal Justice (5/27/20): 10*<br>○ *Family Dialogue Group (7/23/20): 12*<br>• **# consents:** ALL (verbally read)<br>• **# Paper surveys: 1** |
| **System of Care/Providers** | **Educate providers on MHSA efforts and utilize providers to facilitate information to consumers and their families** | **1. Issue MHSA-CPPP Memo to ACBH System of Care providers via webmaster blast**<br>**2. Participate in ALCO system of care meeting to include:** *POCC, FSP,* | • **# attendees** (roster)<br>• **# meetings presented**<br>• **# clinicians (55,817)** | | |

| | | | | | |
|---|---|---|---|---|---|
| | | *Adult, and Children SoC, Crisis Providers, PEI*<br>3. **Augment electronic health records and proprietary case management systems/software** *(e.g. EPIC, CalWIN, ETO, Persimmony)* **to provide information/proctor surveys**<br>4. **Contact CA Dept. of Consumer Affairs, procure Provider List & send CPPP flyer via PS Print:**<br>○ *Behavioral Science: 6,890*<br>○ *Psychology: 1,641*<br>○ *RNs: 26,734*<br>○ *LVN Psytech: 13,868*<br>○ *MedBoard:6,684*<br>5. *(Medical Board of California and Board of Registered nurses)* | | | |
| **Phone Banks/Roto Calls** | **Utilize consumer and family member word of mouth to promote awareness** | 1. **Recruit & train POCC members as call center volunteers** | • **# unduplicated calls to center**<br>• **# surveys completed with consent/assent forms** | | |

# MHSA CPPP, 2020
# *Outreach & Marketing Plan*
(Updated: July 23, 2020)

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|---|---|---|---|---|---|
| | | 2. Proctor consents/assents and surveys to respondents | | | |
| **Incentivized Street Outreach** | **Conduct street outreach activities to target transient community** | **1. POCC, Abode IHOT, HCH mobile units conduct community canvassing to proctor surveys to homeless pop.** | • # contacts per outreach worker<br>• # complete surveys<br>• #/Cost of incentives distributed | | |
| **GOAL 4: Educate community on the benefits of MHSA -funded activities to increase demand for services and build capacity through partnerships** | | | | | |
| **Community Planning Meetings** | **Convene Community Planning Meetings in each supervisorial district of the county to share information annually** | **1. Host 5, two-hour meetings with POCC in each Almeda county supervisorial district Identify satisfied MHSA-SG members to share story on MSHA website and CPM events** | • # registrants<br>• # attendees at event<br>• # surveys completed (paper-based)<br>• CPM Satisfaction rate<br>• #/cost of distributed incentivizes | | |
| **MHSA 101 Toolkit** | **Develop educational toolkit for community members, providers, and consumers** | **1. Develop/Post educational PPT, MHSA FAQ, MHSA Unit Profile Sheets, and INN web form to MHSA website.** | • # materials distributed to providers<br>• # materials distributed at CPMs (# FG participants) | | ○ See # FG participants<br>○ # INN forms: 29 web forms submitted) |

# WE WANT TO HEAR FROM YOU!

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

## Community Input Survey

for the Alameda County Mental Health Services Act 3-Year Planning Process

alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

MENTAL HEALTH SERVICES ACT · PROPOSITION 63 · CALIFORNIA

POCC

Alameda County Behavioral Health Services
invites you to take the Community Input Survey

VISIT WWW.ACMHSA.ORG

**CONTACT ADMIN LINE AT (510) 834-5990**

**SURVEY IS AVAILABLE IN SEVEN LANGUAGES**

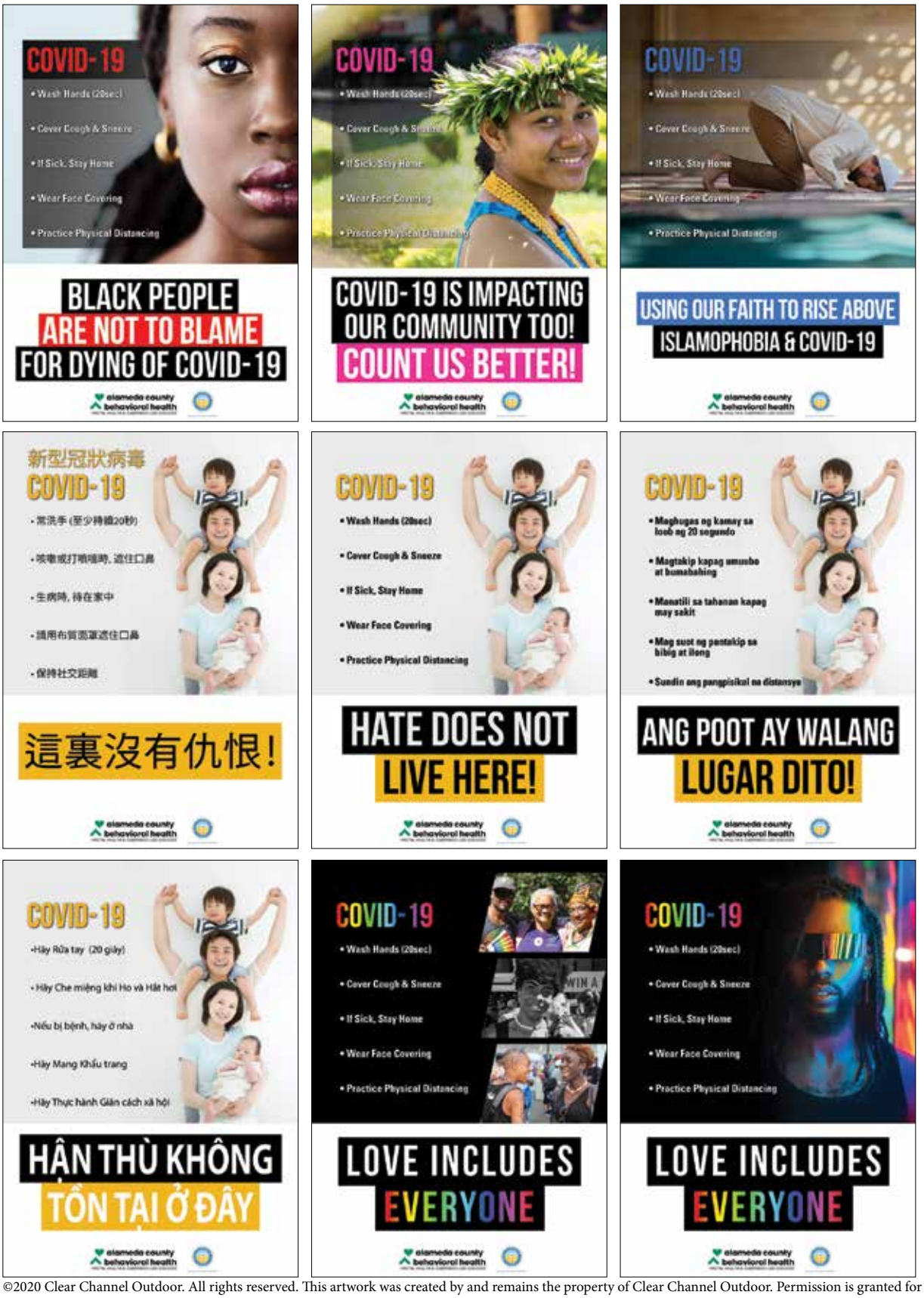
English Farsi Chinese Korean Spanish Vietnamese Tagalog

- Contribute Ideas about how to improve the county's mental health services
- Learn information about the Mental Health Services Act

**CLICK HERE TO TAKE THE SURVEY**

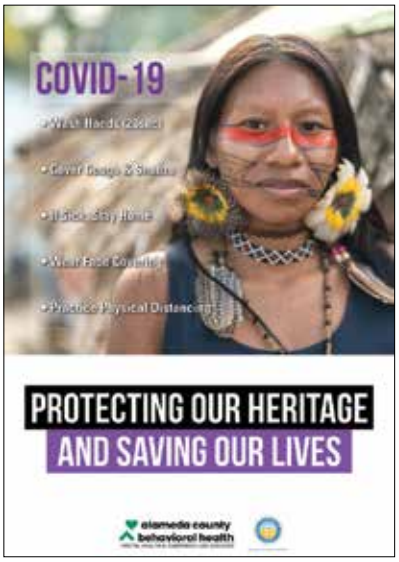
## Transit Shelter Ads

Clear Channel Outdoor

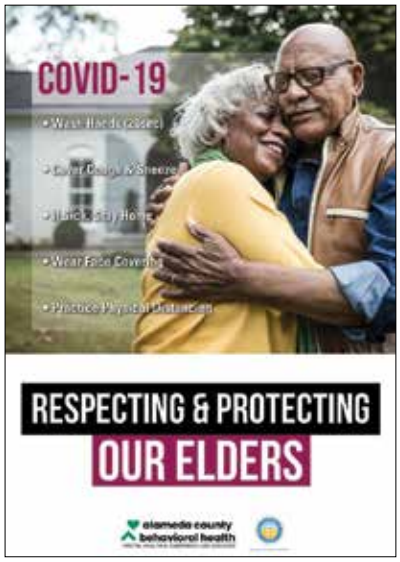


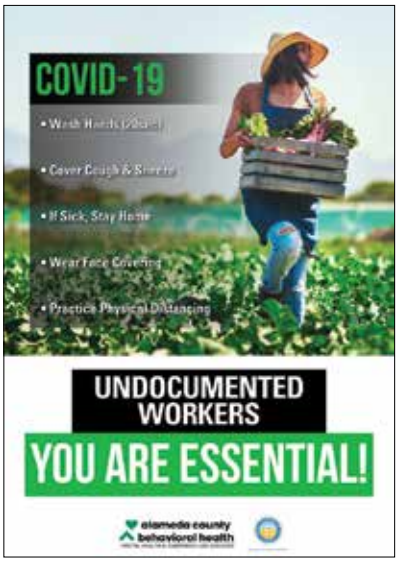
## Transit Shelter Ads

Clear Channel Outdoor







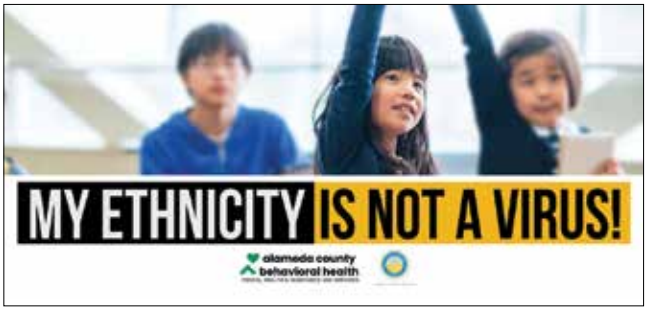




**Eco Posters**

Clear Channel Outdoor









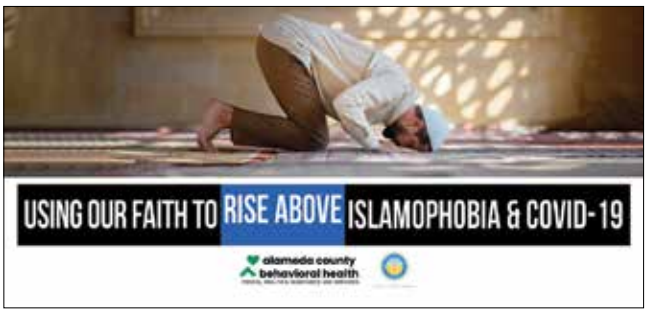


**Eco Posters**

Clear Channel Outdoor





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MENTAL HEALTH & SUBSTANCE USE SERVICES

# ACBH TIS Training Survey

## Introduction

**Alameda County Behavioral Health (ACBH) is partnering with Trauma Transformed (T2) to implement a trauma-informed systems (TIS) initiative. TIS* is an organizational change model that incorporates training, policy development, evaluation, leadership engagement, and racial justice and equity****

**The survey will help ACBH: (1) identify training needs; (2) revise the existing TIS 101 core training; and (3) identify content which addresses COVID-19 and racial equity. The survey may take 5-6 minutes to complete, and all answers are anonymous.**

**For more information on TIS principles, please visit the Trauma Transformed website after completing the survey. To participate in departmental activities, please contact Francesca Osuna (francesca.osuna@ebac.org) or Mariana Dailey (mariana.dailey@acgov.org).**

**Definitions:**

*** TIS/TIC: Terms are interchangeable. For the purpose of this initiative, we use TIS to encompass interactions between providers and communities served, as well as promote systemwide engagement.**

****Racial Equity: Eliminating policies, practices, attitudes and cultural messages that reinforce differential outcomes by race.**

alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

# ACBH TIS Training Survey

## General Feedback about TIS

**Please share your thoughts about TIS and how it can have a positive impact for you.**

1. What would it look like for Alameda County Behavioral Health (ACBH) to be trauma-informed and racially equitable? (Check all that apply)

- [ ] ACBH provides community-centered and client-centered services.
- [ ] Providers model cultural humility principles and participate in collaborative workgroups.
- [ ] Management/leadership demographics reflect the diversity of Alameda County and frontline staff.
- [ ] Leadership facilitates genuine and honest conversations with staff.
- [ ] Staff are able to work in team-based environments to provide key input on decisions impacting the Department.
- [ ] ACBH implements a quality assurance & improvement process to monitor and evaluate TIC implementation efforts.
- [ ] Other (please specify)

2. If we were to adapt the TIS training to apply the principles to the current context of the pandemics of COVID-19 and racism, what area or topic would you want to see them applied to? (check all that apply)

- [ ] Balancing working from home with caring for family members
- [ ] Working with colleagues
- [ ] Managing teams
- [ ] Supporting clients and the community
- [ ] 5 C's of Leading During a Pandemic
- [ ] Clinical guidelines for responding to COVID-19
- [ ] Understanding and addressing systemic racism in public systems of care
- [ ] Other (please specify)

3. How confident do you feel about your ability to understand racial equity and take action to make your own work and work environment more racially just?

- ◯ Very confident
- ◯ Confident
- ◯ Not sure
- ◯ Not confident
- ◯ Not at all confident

4. How important is it to you that a current or adapted version of the TIS 101 training is available to ACBH staff at this time?

- ◯ Very important
- ◯ Important
- ◯ Not sure
- ◯ Not important
- ◯ Very unimportant
- ◯ Unable to answer because I don't understand what TIS is or haven't seen the training content

alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

# ACBH TIS Training Survey

## Logistics

**Please help us understand how to build a training that would work well for you. While we continue to shelter in place, any trainings offered would be virtual.**

5. What would be the ideal length of an online training for you? (Check all that apply)

- [ ] 1 hour
- [ ] 2 hours
- [ ] 3 hours
- [ ] 4 hours
- [ ] Multiple sessions - 1 hour each
- [ ] Multiple sessions - 2 hours each
- [ ] Other (please specify other time options in minutes, ex: 90 min., instead of 1.5 hours)

6. How helpful would it be to you to receive training at the same time as your team?

- ○ Very helpful
- ○ Helpful
- ○ Not sure
- ○ Not helpful
- ○ Very unhelpful

7. How important is it to you that leadership / managers participate in trauma-informed systems training that include racial equity?

- ○ Very important
- ○ Important
- ○ Not sure
- ○ Not important
- ○ Very unimportant

8. Please choose the job category that best describes your current position.

- ○ Line Staff: *non-management/supervisory positions often performing direct services (e.g. Administrative Assistants, clerical, clinical*
- ○ First-Level Management: *e.g. Staff that manage clerical or entry level staff, such as Supervising Clerks, BHC Supervisors, etc.*
- ○ Mid-Level Management: *e.g. higher level management reporting to a Director such as Supervising Program Specialists, Financial Services Officers, etc.*
- ○ Senior (Operational) Leadership: *higher level management such as Division Director level management*
- ○ Executive Management: *System of Care level and above*

9. What support or resources would you need from your manager in order to be able to attend a trauma-informed systems training? (Check all that apply)

- ☐ Encouragement from my supervisor
- ☐ Flexibility in my work schedule
- ☐ Training times that fit with my work schedule (Please share details about this in Q.11)
- ☐ To feel that the department was prioritizing the training and that it fit with our values
- ☐ Other (please specify)

10. Given the ongoing shelter-in-place and social distancing policies, what would need to happen in an online training, or as a result of the training, for you to feel the training had a positive impact on you? (Check all that apply)

- ☐ Learning something new or in more depth than what I already know
- ☐ Changing my perception (how I understand or interpret something)
- ☐ Changing my beliefs or attitude about something
- ☐ Learning how to turn knowledge into practice

11. What else do you want us to know at this time?

alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

WELLNESS • RECOVERY • RESILIENCE

# *Mental Health Services Act "101"*

## Introduction

The Mental Health Services Act (MHSA) funds mental health services in California through a one percent tax on personal annual incomes that exceed one million dollars. The MHSA is also known as Proposition 63. It is made up of five components, described below, that are 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, Alameda County Behavioral Health (ACBH) MHSA Division is the agency that administers MHSA funding.

### ACBH's MHSA Website and Contact information

**Visit the MHSA website at https://acmhsa.org/ to find the most up-to-date information. If you have questions or want information about a speaker, please contact MHSA@acgov.org.**

## The Five MHSA Components

*Community Services and Supports* (CSS) uses funds for direct services to adults with severe mental illness and children with severe emotional disturbance.

*Prevention and Early Intervention* (PEI) services embrace an approach that engages individuals before the development of mental illness, as well as, provide services to intervene early to reduce mental health symptoms.

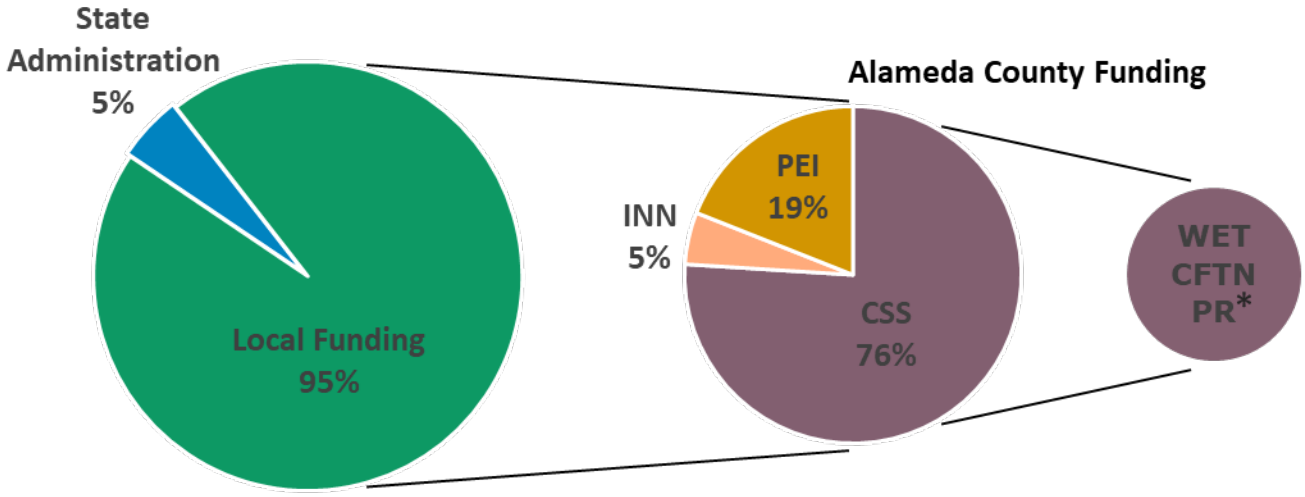
*Innovation* (INN) involves the funding and evaluation of new approaches to increase access to underserved communities, promotion of interagency collaboration, and increasing the overall quality of mental health services.

*Workforce, Education, and Training* (WET) develops a workforce for ACBH that is sufficient in size, diverse, and linguistically capable to deliver services and supports that are culturally responsive to clients and family members.

*Capital Facilities and Technological Needs* (CFTN) makes provisions for building projects and improvement of mental health services delivery by increasing technological capacity through funding.

## Funding

Funding is budgeted on a three-year cycle. The funding divisions are shown below.




*PR stand for Prudent Reserve and is explained below.

Annually, counties can dedicate up to 20% of the previous five-year CSS average allocation to the WET or CFTN components and the Prudent Reserve (PR). Counties may use **up to** five percent of their total annual MHSA revenues for their local Community Program Planning Process (CPPP). WET received funding support from the state over a ten-year period from 2008 through June 30, 2018 to implement WET program activities. Currently, ACBH WET program activities are continuing with funding support through the CSS funding stream.

### Prudent Reserve

The *Prudent Reserve* (PR) is intended for use during years when MHSA revenues are below recent averages to enable counties to continue to provide the same level of CSS and PEI services. A county's PR cannot be below 23% or exceed 33% of the average CSS revenue received in the preceding five years. [1]

The PR is different than *unallocated funds*, which are funds that have not been spent in the previous year, but that are carried over to the next fiscal year. These funds must be spent in the same component and before new funds can be allocated to the county.

### Reversion

After a certain amount of time any unspent funds, and the interest accrued on them, that have not been spent for their authorized purpose revert (go

[1] MHSUDS Information Notice No.: 19-017

back) to the state. The timing of when the funds revert depends on the MHSA component and are explained in the table below[2].

| Component | Time until Reversion |
|---|---|
| CSS and PEI | Three Years after fund distribution |
| CFTN and WET transferred from CSS | 10 Years after fund distribution |
| INN | Five years after plan approval |

## Funding Restrictions

| *Component* | *Restriction* |
|---|---|
|  *CSS* | At least 50% must be spent on activities that serve Full-Service Partnership clients. |
|  *PEI* | >50% must be spent on activities that serve clients age 25 or younger. |
|  *INN* | Must be spent on one-time projects that address learning questions. |
|  *MHSA* | Non-supplantation - MHSA may not replace (supplant) existing program funding or use for non-mental health related programs. |

## No Place Like Home Funding

In November 2018, voters approved Proposition 2 authorizing the sale of up to $2 billion of revenue bonds and the use of a portion of MHSA taxes to repay the bonds for the No Place Like Home (NPLH) funding program. The appropriations happen every year before the distribution of the MHSA funds to counties.

NPLH funds are used to invest in the acquisition, design, construction, rehabilitation, or preservation of permanent supportive housing for persons in need of mental health services and who are experiencing

[2] MHSUDS Information Notice No.: 18-033

homelessness, chronic homelessness, or who are at risk of chronic homelessness.

The permanent supportive housing must utilize low barrier tenant selection practices that prioritize vulnerable populations and offer flexible, voluntary, and individualized supportive services. Counties must commit to provide mental health services and help coordinate access to other community-based supportive services separately from the NLPH funding.

## Eligibility

| *Component* | *Eligibility* |
|---|---|
|  *CSS* | Individuals with serious mental illness (SMI) and/or severe emotional disturbance (SED). |
|  *PEI* | At risk for mental illness or emotional disturbance. |
|  *CSS + PEI* | Individuals not served or that are underserved by the current mental health system.<br>Services must be voluntary. |
|  *Not Eligible* | Those living outside of Alameda County.<br>Persons currently incarcerated in county jail or prisons and juvenile detention centers unless it is facilitating discharge for mentally ill offenders.<br>Locked or involuntary mental health services. |

## Plan Approval Process

### Community Program Planning Process

Counties are required to conduct a Community Program Planning Process (CPPP) every three years to inform its "Three Year MHSA Plan." Below are the steps for drafting and approving the plan.

| Plan Draft | Plan Review | Plan Approval |
|---|---|---|
| Drafted by engaging stakeholders, which include clients with serious mental illness and/or serious emotional disturbance, and their family members.<br>Stakeholder group should reflect the diverse demographics of the county. | 1. ACBH posts plan online for 30-day public comment period and addresses comments in plan.<br>2. At the end of the 30 days, Alameda County Mental Health Advisory Board (AC MHAB) reviews the plan and conducts a public hearing. | 1. Presented to the Alameda County Board of Supervisors (AC BOS) Health Committee.<br>2. Adopted by the full AC BOS.<br>3. Submitted to the Department of Health Care Services and the Mental Health Services Oversight and Accountability Commission (MHSOAC) within 30 days after adoption by the AC BOS. |

## Innovation Component Planning Process

Innovation planning ideas can come from ACBH staff, the community, or during the CPPP. If proposed by ACBH, they must go back to the community for input. Ideas might not be a proposed project, but instead may be an area of need that the community identifies and for which ACBH's Systems of Care will be charged with creating a plan.

| Contact MHSOAC | Submit Project to Local Oversight and Adoption | Final Adoption by MHSOAC |
|---|---|---|
| Review project with MHSOAC to ensure that it meets qualifications.<br>ACBH writes project proposal using an MHSOAC template.<br>Staff at MHSOAC provide technical assistance to ACBH Innovation Staff to ensure project proposal success. | While ACBH and MHSOAC staff are finalizing the plan, it is posted for a 30-day public review.<br>It is then submitted to the local AC MHAB for a public hearing, then to the AC BOS Health Committee, and finally to the AC BOS for adoption. | Occurs in one of the following ways:<br><$1 million: delegated to MHSOAC Executive Director (ED) and Chairperson.<br>>$1 million:<br>Reviewed by ED and Chairperson then added to consent agenda for approval during an MHSOAC meeting.<br>**OR**<br>MHSOAC Commissioner or county requests a public hearing. County presents the project during hearing and the MHSOAC votes on whether or not to approve the project. |

Once adopted by the MHSOAC, the ACBH team then conducts a request for proposal (RFP) process and contracts with the successful bidder. Funds are to be spent in the proposed project timeframe, which can be up to five years. ACBH can ask the MHSOAC for more money or time. Sustainability past funding period is written into the project proposal and must be identified as funding other than Innovation funding.

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WELLNESS • RECOVERY • RESILIENCE

# *Mental Health Services Act Community Services and Supports "101"*

## Introduction

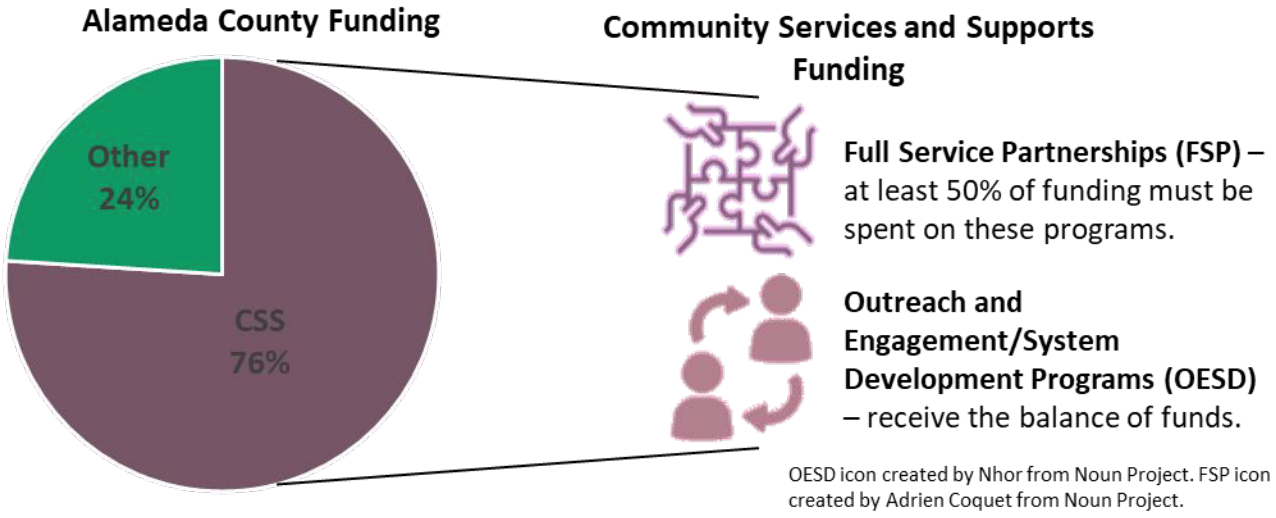
*Community Services and Supports* (CSS) uses funds for direct services to adults with severe mental illness and children with severe emotional disturbance. It is one of the five components of the Mental Health Services Act (MHSA) or Proposition 63, which funds mental health services in California. Locally, Alameda County Behavioral Health (ACBH) MHSA Division is the agency that administers MHSA funding.

### ACBH's MHSA Website and Contact information

**Visit the MHSA website at https://acmhsa.org/ to find the most up-to-date information. If you have questions or want information about a speaker, please contact MHSA@acgov.org.**

## Funding

Funding is budgeted on a three-year cycle. The funding divisions are shown below.




OESD icon created by Nhor from Noun Project. FSP icon created by Adrien Coquet from Noun Project.

### Funding Restrictions

At least 50% must be spent on activities that serve Full-Service Partnership clients. MHSA may not replace (supplant) existing program funding or use for non-mental health related programs.

## CSS Program Goals

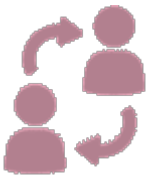
The programs address at least one of the following priorities developed in the Community Program Planning Process:

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

## Program Areas

Created by Nhor from Noun Project.

**Full Service Partnerships (FSPs)** provide voluntary wrap around services to consumers or partners. Programs are designed for individuals with serious emotional disturbance (SED) or a severe mental illness (SMI) who would benefit from an intensive service program. The foundation of Full Service Partnerships is doing "whatever it takes" to help individuals on their path to recovery and wellness. They are comprised of multidisciplinary teams that engage clients with an SED or SMI who are homeless, involved with the justice system, and/or have high utilization rates of crisis psychiatric services.



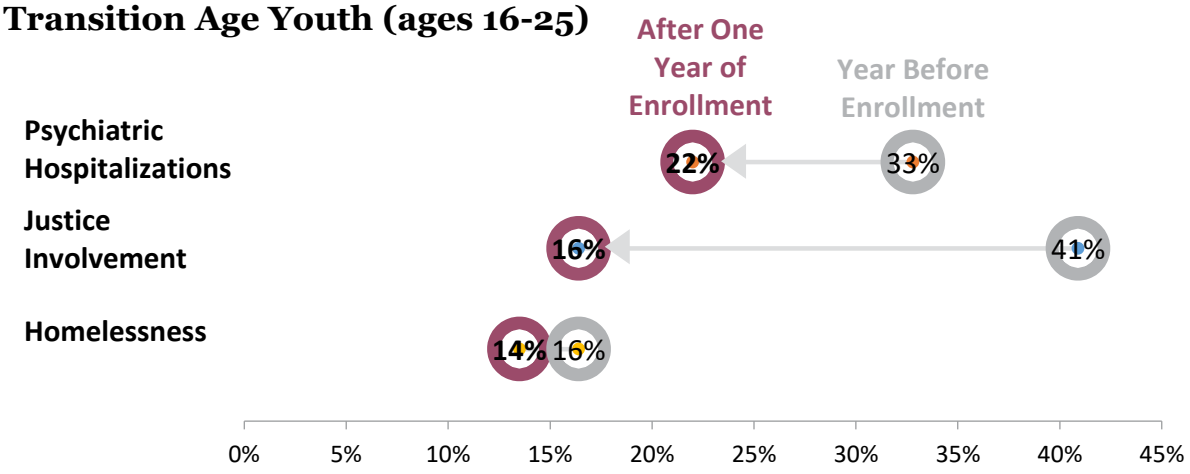
Created by Adrien Coquet from Noun Project.

**Outreach and Engagement/System Development Programs (OESD)** - System Development (SD) programs provide mental health services to those who require or are at risk of requiring acute psychiatric inpatient care, residential treatment, or outpatient crisis intervention because of a mental disorder with symptoms of psychosis, suicidality, or violence. Outreach and Engagement (OE) programs identify those in need, reaching out to target populations, and connecting those in need to appropriate treatment. Programs cover multiple treatment modalities and services including:

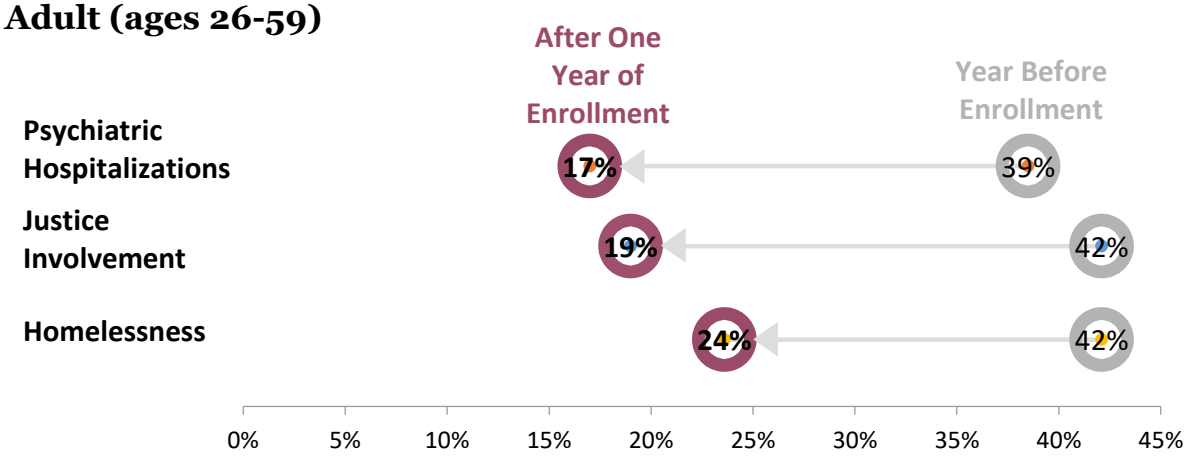
- Integrated behavioral health & primary care
- Integrated behavioral health & developmental disability services
- In-home outreach
- Outpatient treatment
- Residential care
- Behavioral health court
- Crisis response and stabilization
- Peer respite
- Co-occurring substance use disorders

## Selected FSP Outcomes Fiscal Year 2018-2019

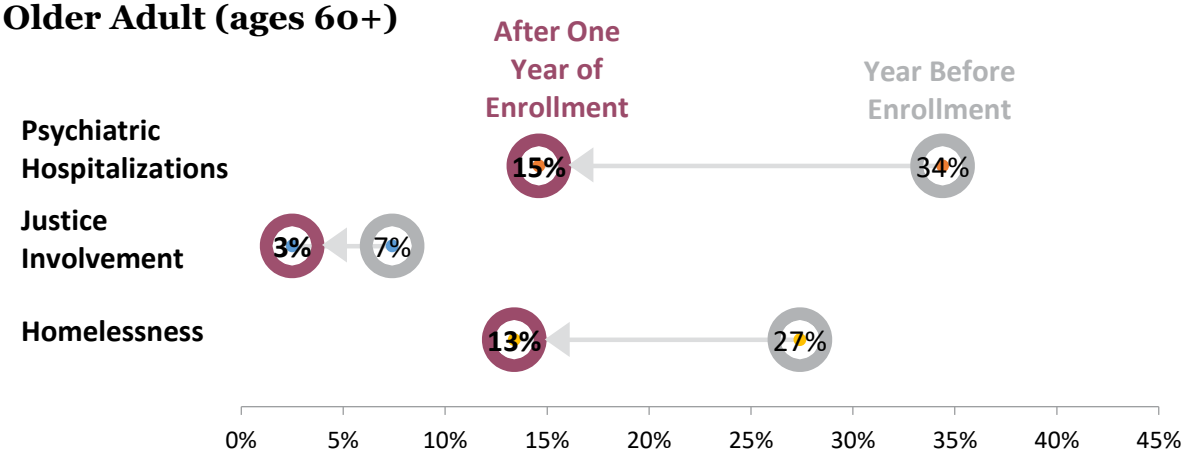
### Transition Age Youth (ages 16-25)

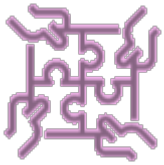



### Adult (ages 26-59)




### Older Adult (ages 60+)





# FSP Incentive Outcomes Fiscal Year 2018-2019

During Fiscal Year 2017-2018, ACBH began piloting an incentive payment program for FSPs to move toward population-based program improvement payments from fee-for-service payments. FSPs can be paid partial or full payments depending on their success.

## Post-Acute Follow-Up

| Metric Details | Episodes (#) | Follow-ups within Two Days (#) | **Success Rate (%)** | Goal for Partial Payment (%) | Goal for Full Payment (%) | FSPs Paid for this Metric (#) |
|---|---|---|---|---|---|---|
| Within Two Days (Ages 18 and up) | 1,249 | 665 | **53%** | 70% | 85% | 0 |
| Within Five Days (Ages 18 and under) | 21 | 16 | **76%** | 80% | 90% | 1 |

## FSP Initial Engagement within 7 Days (Ages 18 and older)

| Program Admits (#) | Visits within 7 days (#) | Success Rate (%) | Goal for Partial Payment (%) | Goal for Full Payment (%) | FSPs Paid for this Metric (#) |
|---|---|---|---|---|---|
| 442 | 151 | **34%** | 60% | 80% | 0 |

## Average of Four or More Visits per Month per Client

| Clients with Episode(s)* | Clients with Average of 4+ Visits Per Month | Success Rate (%) | FSPs Paid for this Metric (#) |
|---|---|---|---|
| 693 | 422 | **61%** | 7 |

*Clients must be been open to a provider for at least 30 days during the fiscal year, in order to be included in this metric.

For programs that serve partners 18 years and older, a partial payment requires 65% of partners and a full payment requires 85% of partners receive four or more visits per month. For programs that serve partners 18 years and under, a partial payment requires 65% of partners and a full payment requires 80% of partners receive four or more visits per month.

## No Service Gap of 30 Days (ages 18 and under)

| Clients (#) | Clients with No Gap Over 30 Days (#) | No Gap Over 30 Days (%) | FSPs Paid for this Metric (#) |
|---|---|---|---|
| 25 | 24 | **96%** | 2 |

This metric only includes partners that have been enrolled with a provider for at least three months. A partial payment requires 80% of partners and a full payment requires 90% of partners to not have a gap in service longer than 30 or more days.

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Karyn L. Tribble, PsyD, LCSW, Director

# MENTAL HEALTH SERVICES ACT

## Innovation Community Input Form

The Mental Health Services Act (MHSA) provides limited funding for the Innovation Component of the County's MHSA Plan. Funding will be used to increase access to underserved groups; increase the quality of services, including better outcomes; promote interagency collaboration; and increase access to services.

***Innovations are defined as*** novel, creative, and/or ingenious mental health practices/approaches that are expected to contribute to learning, which are developed within communities through a process that is inclusive and representative. The Innovation Component allows Counties the opportunity to "try out" new approaches that can inform current and future mental health practices/approaches. Innovation ideas will introduce a new practice, adapt an existing practice for a new setting, or introduce a new practice that has been successful in a non-mental health setting.

We welcome all ideas, suggestions and recommendations for Alameda County's Innovation Plan. Please use this form to submit your ideas and suggestions by **May 30, 2020.**

**1. Fundamental Concept:** Please check the primary concept below that your recommendation will address.

- ☐ Increase access to underserved groups
- ☐ Increase the quality of services
- ☐ Promote interagency collaboration
- ☐ Increase access to services

**2. Age Groups:** Please identify the age group that will be impacted by your recommendation. Please note that funds may support a project that transcends multiple age groups. Check all that apply:

- ☐ 0 to 18 years
- ☐ 16 to 25 years
- ☐ 18 to 59 years
- ☐ 60 years and above

**3. What idea (approach or practice) should the County test/try out?** Describe your idea. (Limit: 250 characters)

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Karyn L. Tribble, PsyD, LCSW, Director

**4. What challenging problem does your idea (approach or practice) address in the Alameda County mental health community?** (Limit: 250 characters)

**5. What has prevented solutions to solving this problem in the past?** Describe the barriers to resolving the problem. (Limit: 250 characters)

**6. What do we want to learn in overcoming the barriers and resolve the identified problem or issue?** (Limit: 250 characters)

**7. What should be the outcome(s) to show success?** (Limit: 250 characters)

**8. Has this idea (approach or practice) been tried elsewhere or in other populations?** If yes, please describe. (Limit: 250 characters)

**9. Contact Information** (optional)

Name: Organization:

Phone: Email:

Attach any additional information that describes your idea, such as research or other information that demonstrates how the idea can be tested and/or successful. Return input via email to: MHSA@acgov.org, fax to: (510) 567-8130, or mail to: 2000 Embarcadero Cove, Suite 400, Oakland, CA 94606, Attention: Mariana Dailey. Thank you for your participation!

# Appendix D: MHSA Focus Group Question & Answer Sheet

**Focus Group #1: ACBH Operations Meeting (Leadership) |Date: April 6, 2020| Attendee #: 44**

1. **What are the top or most pressing mental health issues right now?** (e.g. suicide, community violence, incarceration of individuals with mental illness, stigma, homelessness, substance abuse, etc.)
   - Homelessness and rapid rehousing
   - Co-occurring disorders
   - Whole person care
   - Varied API groups
   - Latinx
   - LGBTQQIA+
   - Job development strategies for re-entry
   - Children who have been out of school without IEP services since Marc will have more needs
   - Partnership with managed care plans and preparations for CalAIM
   - Mental health services in SUD programs
   - Psychiatric evaluation services
   - Psychotropic meds
   - Coordination with MH for SUD beneficiaries
   - Engaging and enticing consumers into services
   - Consumer riven services
   - Diversion programs/location for youth experiencing mental health crisis and appropriate training for law enforcement
   - Health equity
   - Isolation issues
   - Access to peer support services

2. Are there **populations** or groups of people who you believe are not being **adequately served?**
   - Miao/Hmong Guatemala indigenous group (Centrally located around Fruitvale area and serviced by La Clinica and the Native American Health Center)
   - Transgender (esp. Latinx and AA)
   - FSP services for API and Latinx, deep trauma services

3. **Questions?**
   - Will the survey be translated to ALL threshold languages specifically Tagalog? English, Farsi, Chinese, Korean, Spanish, Vietnamese, Tagalog (to be added)

**Focus Group #2: Mental Health Services Act Stakeholder Group| Date: April 24, 2020| Attendee #: 11**

1. **What are the top or most pressing mental health issues right now?** (e.g. suicide, community violence, incarceration of individuals with mental illness, stigma, homelessness, substance abuse, etc.)
   - Criminal justice system involved are walled off from services (need support with medical management) *Identified by 3 focus group participants*
   - Stigma (those who are undiagnosed who refuse services due to stigma)
   - Stigma in Asian community especially around education
   - Destigmatize asking for help (esp. for adults/older adults) *Identified by 3 focus group participants*
   - Supportive housing (for SMI and complex needs)
   - Inadequate subacute and acute beds in continuum of care/Villa (quick release of 5150 and those on holding) and short supply of licensed board and care *identified by 4 people*
   - Inadequate crisis serves and maintenance
   - Outreach to first responders/need policy around this
   - Services for children/young people seem secretive- need to disseminate information
   - System gam for those under 17 years of age who do not need to be hospitalized but have nowhere to go and are not safe alone
   - Suicide
   - Homelessness amongst veterans
2. Are there **populations** or groups of people who you believe are not being **adequately served?**
   - Criminal justice system involved/incarcerated *identified by 3 people*
   - Homeless
   - Co-occurring disorders/complex medical issues and psychosis
   - First line responders
3. **Questions?**
   - What are the PEI services?
   - Define Forensic Services
   - Average number of community responses during 30-day public hearing?

**Focus Group #3: PEERS Hope & Faith Program| Date: May 12, 2020| Attendee #: 7**

1. **What concerns related to Children/Youth/Transitional Age youth (TAY) are most important to you and your family member(s)?**
   - Depression
   - Life Skills
   - Transitioning out of foster care
   - Mental Health counselors in the schools
   - Mental Health
   - Information on Health Care and Deficiencies, Emotional Intelligence
   - Literacy
   - TAY Jobs
   - Support and Advocacy as African-American youth.
   - Suicidality and inability to connect with them at the school levels
   - Inappropriate and lack of appropriate providers that can empathize and faith-based involvement.
   - Mental Health
   - Advocacy in Schools for proper education
   - Information on Health Care and Deficiencies, Emotional Intelligence
   - Multigenerational approach that opens up to the therapy for entire families.
   - Our youth need to know that someone cares not for the money but to be there to assist them and navigating the mental and medical health care system.
   - Support and Advocacy as African American youth.

2. **What concerns related to Adults/Older Adults are most important to you and your family member(s)?**
   - Advocacy for breaking the poverty cycle
   - Mental Health
   - Education
   - Health care disparities and navigating the MH system
   - Use providers that relate to those adults. Use faith-based clinicians and create diverse support services that span into other areas of their life.
   - Health care disparities and navigating the system as adults/older adults
   - expanding on advocacy and support
   - Help for career changes due to loss of jobs
   - Financial education
   - Where to find help and support and resources. Also, Mental Health support and advocacy
   - Innovative and technology that helps adults increase their skills.
   - Financial Education

3. **Are there populations or groups of people whom you believe are not being adequately served by the behavioral system of Alameda County**?

- The PTSD of being a black male or boy
- homeless
- People who lost jobs now homeless and living in cars - need more outreach
- Black Men and TAY
- Children
- Seniors should not go to these places alone. Advocacy.
- Mothers with mental health and mothers who are impoverished
- Race and racism - institutionalism racism and interpersonal
- Mothers
- I really wanted to put in race and racism. Individuals who need the services but are turned away for various reason that other are accepted.
- Traumas are not being addressed early in our young men
- The system not having the system in place, proper cultural care for them and having black males lead this discussion. I now tons of excellent Black men who are great providers and are not connected to the community.
- Seniors are often targeted for resources. Lack of education and information
- We do not have enough practitioners of color to adequately relate to the clients
- Homeless population
- African Americans children and youth
- Outreach
- Seniors
- Teens and young adults
- Transition from being in streets to shelters
- Black men
- Children and Fathers
- African American Mothers who in impoverished communities

4. **What barriers make it more challenging for individuals and family member(s) with mental health challenges to access mental health services?**
   - Stigma and distrust of the system
   - Lack of knowledge of the services
   - Talked to family friends and community about issue of barriers and us needing healthcare, it boils down to race. 73 years old, I know what it meant to sit in the back of the bus, know what it meant to experience racism. African Americans treated differently simply based off of the color of their skin- race is the bottom line of how ppl of color is treated
   - People come into the community to try to change things for us, but race is the bottom line on how African-Americans and people of color are treated. Nothing has changed in the last 200 years.
   - It's not what is taught at school, it is what is taught at home
   - We need to leverage the African-Americans resources and services that exist - lean on behavioral health care staff who are believers to work with churches
   - We have to have multifaceted approach. We need black police, more black teachers, and healthcare providers. Education, Judicial system and Healthcare.

- We need to create a village approach, we heal in community and need to work on the digital divide in the black community. Maybe create mini Virtual Village's with the supports and resources by districts or neighborhoods.
- We (Black folks) heal in community - we need the village community because that is what works for us, may want to look at creative ways for village approach for family members - kinship network

5. **Which services or programs have been effective in addressing our local mental health concerns?**
    - PEERS
    - Peer coaching peer navigators
    - Glad Tidings International Community Outreaches
    - Real Life Groups *repeated by two participants*
    - It is with my experience with PEERS, I have liked everything that I learned about them, I like the way they do business, I really enjoy working with them. I see how they make an impact, how they involve the people. It is much easier to get people who are African-American to work with African-Americans. When you do not, they talk down to you. They can't relate, you have not walked in my shoes. What PEERS does is work with people who have experience.
    - PEERS
    - Mental Health in the Church (MHIC) and PEERS
    - Roots Community Services
- Programs that use African-American interventions or research/science developed by AA
- Peers
- Faith Based Services
- Using literature created by African-American practitioners for evidenced-based curriculum
- Beyond emancipation
- Dr. Wade Noble's agency
- Allen Temple Baptist Church in Oakland

6. **Please brainstorm any innovative ideas which would help improve mental health services in this County.**
    - Village approach
    - We are not using Social Media Effectively to educate and empower the community
    - Kinship networks
    - Virtual village
    - I would like to see Alameda County have a mobile vehicle to address individuals on the street with Mental Health Challenges.
    - Rites of passage for adolescents
    - African-Americans have historically been a trusting people, we need to build the relationship and the village and get people involved
    - "Digital village/kinship network to address digital divide
    - rites of passage

- It should be a combination of all those things. Resources, conversation, referrals. My opening is to seek the clients' desire.
- We have noticed that the use of Zoom has allowed individuals that normally would not participate in our program to join.

**Is there an audience that should drive this?**

- We should, with some of the innovation funds
- It should be us (community, faith-based community), but educate us so we know what to do when engaging with MH community
- Use organizations like PEERS that can connect to drive
- African-American health conductors
- Youth - partner with youth to have them bring in more youth
- Faith based community partnering with mental professionals
- MHIC which is connected to a lot of different systems and organizations
- Get the faith based involved in critical issues
- Book & donut drop off to let families in the neighborhood know that the community cares and to build literacy with small children lead by faith-based community
- MHIC which is connected to a lot of different systems and organizations

**7. Which stakeholder group do you primarily identify with?**

- Faith Based, Behavioral Healthcare and Educators
- Mother, social worker youth leader, administrator, connector to all things resources that deal with youth and children and life giver
- Poor people's advocate network coordinator for healthcare
- Strong connection with Millennials and Children
- Connected to Leaders in all the areas of influence.
- Jack of all trade and a master of none
- Queen, leader, teacher, mother, healer, person who is going to connect our ppl with holistic and alternative healing, other modality healer, advocate and educator, trainer, people lover, community mother

**8. Any other comments you'd like to share?**

- How to cope with new normal with the grief and loss?
- What about people dying in the hospital (isolation)?
- How do we create an awareness campaign to support community amid corona virus pandemic - how do we make sure we get to vulnerable populations?

**Focus Group #4: La Clinica/CyB | Date: May 13, 2020| Attendee #: 9**

1. **What concerns related to Children/Youth/Transitional Age youth (TAY) are most important to you and your family member(s)?**
   - Depression
   - Drug use
   - Family conflict/stress
   - Education
   - Academic support
   - Family conflict/stress
   - Community violence and trauma
   - Educational/academic support
   - Increase in community violence (Hayward)
   - Housing and homelessness
   - insecure housing
   - Inform parents around substance use related to family issues
   - Cultural barriers prevent parents from understanding kids with
   - TAY lack knowledge of how to navigate insurance and other MH services without telling parents to prevent worrying them

2. **What concerns related to Adults/Older Adults are most important to you and your family member(s)?**
   - Increased family conflict and stress due to COVID-19 (SIP, lost jobs, families sharing housing in tri valley)
   - Housing and homelessness
   - Ongoing hospitalizations employment
   - Chronic health and well-being
   - Depression
   - Parenting family issues
   - Community violence/trauma
   - Affordable health care
   - Chronic disease(s) that stress them out
   - Worrying about their children's education

3. **Are there populations or groups of people whom you believe are not being adequately served by the behavioral system of Alameda County**?
   - Undocumented Spanish speaking only communities
   - LGBTQ+
   - TAY
   - Immigrant and refugee
   - Latinx (specifically Spanish speaking only and immigrant and refugee)
   - Guatemalan families speaking native dialect
   - Unaccompanied minors
   - Need elementary school interventions
   - Undocumented Spanish speakers
   - Youth/TAY
   - Mam speakers
   - Parents (work long house and don't get chance to seek mental help)
   - Immigrant community

4. **What barriers make it more challenging for individuals and family member(s) with mental health challenges to access mental health services?**

   Challenges for Consumers:
   - Appt

- Availability
- No insurance
- Services not in their language
- Family oppression
- Safety concerns
- Services not culturally appropriate
- Not in their language
- Embarrassed to ask for help
- Communication with providers
- Service availability
- Legal concerns
- Financial
- Service not in language sometimes
- Transportation
- Stigma

Challenges for Family Members:

- Language
- Stigma
- Cultural beliefs (emotional issues not theme that should be discussed)
- Scared of new administration that's in office
- No insurance
- Services not culturally appropriate
- Their work schedules
- Stigma around mental health
- Scheduling services only during business hours and not time sensitive to their schedules
- Child often speaks English but caregivers and therapists do not
- Lack of insurance
- Stigma
- Financial
- Transportation
- No insurance
- Not everyone in family has same coverage
- Insurance doesn't cover mental health aspect and may discourage them
- Family may not want to seek MH services because they're worried this will come up later when they try to fix their legal status
- Stigma (caregivers don't understand mental health needs or why it's necessary) so they don't seek support or know how to support that person
- Some family single out the member who is having mental health challenges and do not see the need of everyone getting support

5. **Which services or programs have been effective in addressing our local mental health concerns?**
   - School-based Services
   - Housing
   - Food distribution services
   - Culturally responsive prevention programming
   - Mental health outreach
   - Health education
   - Outreach promotes awareness around mental health issues and normalizes it

- Outreach helps with emotional management, reduces stigma in Latinx population & diminishes stigma and educates around community mental health issues
- Educational workshops help people realize there are MH issues that need to be addressed
- Vicarious trauma education
- Anticipatory guidance around COVID-19 and how the virus will impact stress and tactics to cope with this.

6. **Please brainstorm any innovative ideas which would help improve mental health services in this County.**
   - Use social media (e.g. Facebook) to engage community especially due to COVID-19 we need to be more resourceful
   - Gender specific groups (esp. young men)
   - Mum speaking services
   - More media usage
   - Mental health services accessible via diff. platforms as a standard practice (e.g. telehealth, use technology to deliver services)
   - Social media toolkit

7. **Which stakeholder group do you primarily identify with?**
   - Faith-based
   - Provider
   - Immigrant
   - Family member
   - Community
   - Provider

8. **Any other comments you'd like to share?**
   - How will recent state issues re: COVID-19 impact local MHSA funding
     Answer: Our allocation is based on a two-year tax term and current funding was allocated a few years ago. Current issues would have an impact (if at all) on future allocation in the next 1-2 years. MHSA funding is stable and based on legislation PROP 63. We are committed to being your advocates. Although PEI is flexible, it has restrictions such as not being able to be used for treatment.

**Focus Group #5: Mental Health Advisory Board (MHAB) | Date: May 18, 2020| Attendee #: 40**

1. **What concerns related to Children/Youth/Transitional Age youth (TAY) are most important to you and your family member(s)?**
   - No responses

2. **What concerns related to Adults/Older Adults are most important to you and your family member(s)?**
   - No responses

3. **Are there populations or groups of people whom you believe are not being adequately served by the behavioral system of Alameda County**?
   - a) The reentry population or justice-involved population
   - b) Individuals who are stepping down from psychiatric hospitalization. It is not clear that there are community resources that network residents to behavioral health services in a supportive peer and professional environment.

4. **What barriers make it more challenging for individuals and family member(s) with mental health challenges to access mental health services?**
   - a) Not having access to smart phone, tablet etc.
   - b) Economic inequities, need more effective treatment via telehealth (Currently, treatment is done mostly via phone conference, which lacks non-verbal communication)
   - c) Many clients don't have phones, would help to stay in touch with providers
   - d) Issues with regard to IPV and accessing services and support from a home where they may not feel safe to speak freely.
   - e) Appointment availability; need more drop-in sessions; more therapists and diversity of therapists; need more resources
   - f) Consumer and family challenges - finding online (zoom, hangouts) resources for peer support and groups.
   - g) Lack supported housing board and cares to step people down from Crisis Residential facilities like Woodrow Place and Amber House (BACS)

   Challenges for Family Members
   - a) Not having many options for 5150 without involving law enforcement
   - b) Advocacy and resources to navigate health systems, particularly when a loved one is in psychiatric hospitalization

5. **Which services or programs have been effective in addressing our local mental health concerns?**
   - a) Places like Amber House
   - b) Wrap around services to stabilize youth, such as the program in Santa Clara.
   - c) Cleveland House - good programs for women and children (in East Oakland)
   - d) FERC provides so much support for families

- e) Woodrow Place - similar to Amber House, a great model
- f) PEERS
- g) Sally's Place
- h) Hayward Program with 45 beds,  wrap around services until they can get housing
- i) NAMI

**6. Please brainstorm any innovative ideas which would help improve mental health services in this County.**

- Mental Health and addiction programs in Oregon, consumer led movement, support groups, now virtual
- Housing subsidies for staff working at programs (since difficult to retain staff)
- Program in LA, works with landlords - roommate situations and services wrap around house
- More opportunities for behavioral health internships, career pathways in behavioral health, and opportunities for consumers to shadow and obtain training and education to give back and shape behavioral health services.
- Consumer-led initiatives and narrative storytelling to highlight county services that do work.
- Mental health task force.
- Supported employment opportunities for the SMI population. The current system of helping some of the people in this population find unsupported employment does not work for folks with a very severe mental illness

**7. Which stakeholder group do you primarily identify with?**

- Consumer
- Public Safety
- Family Member
- Foster care for youth

**Focus Group #6: MHAB Children's Advisory Committee | Date: May 20, 2020| Attendee #: 34**

1. **What concerns related to Children/Youth/Transitional Age youth (TAY) are most important to you and your family member(s)?**
    - Many lack awareness of existing MHSA programs such as the navigation program
    - Awareness & Accessibility to available programs
    - TAY are legally adults their families are not included in the wellness of young adults it would be nice to have families/youth working together on their wellness
    - Drug use
    - Homelessness
    - Not being prepared for adulthood or being independent
    - Lack of awareness of what programs exist
    - Transitional age needs more support (my brother was dropped after age 25 and services were really hard to find)
    - Clean, safe, healthy living environment/housing
    - I'm 16 and a junior in high school. I feel like in schools these programs are not publicized enough because if I'm being honest I didn't know that this existed until someone told me. I feel like if this program was publicized more, then teens would feel safer Housing insecurity and/or not licensed
    - Suicide statistics show children are coming in younger and younger (e.g. 10-14YO)
    - High Schools not held accountable for CA legislation AB2022
    - Schools not built to handle the crisis
    - Adulthood preparation classes
    - Unresolved stress/depression
    - Fear of expressing feelings and their parents finding out; depression considered a joke in specific cultures/machismo
    - Intimidated by counselors and teachers
    - Need classes that focus on parent education and make bullying and mental health classes mandatory
    - Need MHSA to fund school mental health clubs on campus (materials) but schools find difficulty identifying sponsors
    - Appointment availability with school counselors
    - Safety
    - We need to normalize mental illness in school
    - Figuring out how to pay for services or identify whether it's covered under insurance
    - Youth have to navigate getting help/medication while keeping it secret from their families

2. **What concerns related to Adults/Older Adults are most important to you and your family member(s)?**
    - Housing
    - Work options

- Lack of benefits
- Access to nutrition
- Lack availability to services
- Aggressive after care after acute care release
- Healthcare coverage concerns once TAY age out of their parent's insurance coverage
- High stress at home
- Lack resources of how to parent the kids aggressive after care after adult release
- Lack of education around mental health challenges and how it affects kids/biases
- No adulthood preparation
- Need financial classes
- Unresolved stress/depression
- Sensitivity/awareness about LGBTQIA+ affinities
- Transitions of children into young adult lives with new independence
- Service to support homes for parents who don't have experience or need support from unaddressed personal issues.

3. **Are there Children/TAY subpopulations or groups of people whom you believe are not being adequately served by the behavioral system of Alameda County**?
    - The age group beyond TAY (ages 25-35) because adult support groups seem to jump to an average age of 50+ when peer support groups rely on commonalities
    - African-American families
    - Teenage boys have the hardest time expressing their feelings due to the ingrained idea that it's a feminine thing to show emotion. I think that we need to tell children of all genders, and ages that it is healthy and okay to express the emotion and struggle that you go through. We also should educate kids that bottling up emotions can lead to serious issues in the future.

4. **What barriers make it more challenging for individuals and family member(s) with mental health challenges to access mental health services?**
    - Culturally appropriate services for African-American families; lack provider availability
    - Insurance coverage
    - Emotional barriers & stigma
    - Prejudice against mental illness
    - Prejudice

5. **Which services or programs have been effective in addressing our local mental health concerns?**
    - Boldly Me was helpful to an afghan student dealing with grief
    - I was unable to open up to my mother and during this age, our relationship is so rigged and I just feel like I was so alone and helpless. This went on for 3 years until I met her Boldy Me program.
    - Peer mentoring program/detection/prevention/early intervention since 2012
    - Dr. Ike Silberman (psychiatrist & neurologist) is working with Boldly Me to give children mentors and a mental health doctor

- NAMI training

6. **Please brainstorm any innovative ideas which would help improve mental health services in this County.**
    - Develop additional curriculum in schools that provides practical information and local resources for mental health and SMI
    - Team for first mental health breaks LMFT
    - Replicate boldly Me's model from Santa Clara County
    - 1:1 peer mentoring program
    - Partnering with companies who hire youth and young adults
    - Increase availability/access of programs especially peer groups
    - Senator Jim Beall's bill SB 906 Certification of Peer providers
    - Mental health services in a group setting
    - "First break team" mobile evaluation clinics similar to Planned parenthood
    - open door policy/hours for mental health clinics, a similar model to Planned Parenthood? That no judgement environment to get services/advice/etc.
    - Schools need educational assemblies that connect with teens – ask them how to run an assembly on mental illness
    - Bring AB22 to the forefront
    - Bring programs like ending the silence and boldly me to the campuses
    - Increase support for case workers
    - Increase availability
    - Bring programs to middle/elementary schools
    - Use social media to advertise  mental services
    - to incorporate mental wellness into mandatory class, I think that would be so effective toward encouraging kids and teens to seek for help
    - Incorporate mental wellness into mandatory classes

7. **Which stakeholder group do you primarily identify with?**
    - Family member
    - TAY
    - Caregiver
    - NAMI supporter of someone with mental illness
    - TAY Youth
    - Lived experience
    - Mental health advocate
    - Survivor of Alopecia Universalis
    - Founder and President of Boldly Me
    - Advocate
    - TAY

8. **Any other comments you'd like to share?**
    - No responses

**Focus Group #7: Underserved Ethnic Language Programs (UELP) | Date: May 22, 2020| Attendee #: 13**

1. **What concerns related to Children/Youth/Transitional Age youth (TAY) are most important to you and your family member(s)?**
    - Native American -->Not as many programs for the younger youth, elementary school age and babies. Native American Health Services has a lot of TAY and high school programs.
    - More early intervention to stand up to bullies and to not become bullies
    - Programs to deal with insensitive school content;
    - African Youth--> cultural shock and racial discrimination
    - Bullying
    - Korean --> higher rate of suicide issues and exposure to trauma and keeping mental health issues secret; vicarious trauma through their friends also struggling with mental illness
    - Hesitation when parental consent is needed
    - Schools not engaging parents on topics of mental health
    - I echo elementary school students, it is hard to address key areas of childhood development and engaging family which takes a lot of time and resources
    - As providers they are stretched due to limited resources
    - I echo, because schools are closed they are no longer able to engage youth and stigma to seeking services it huge
    - Notion that youth are internalizing their parent's hesitation and stigma around mental health services
    - Pacific Islander → PEI program is probably the only specific one for PI's in all of Alameda County
    - We know that we are not in all spaces they need to be (schools and CI)
    - Who has time and resources to engage youth; expand capacity of their own program
    - People are coming outside of Alameda County to receive services and trying to be in conversation with other counties
    - Trying to leverage Filipino partners to get into schools;
    - Promotion of programs and letting providers know that they exist
    - I echo everything for youth
    - Filipino → Filipino youth, 18-24 TAY feeling lost and making two different transitions of becoming an adult and working and feel isolated; feeling unmotivated and lacking of purpose
    - Youth getting involved in juvenile justice and not being able to work with them

2. **What concerns related to Adults/Older Adults are most important to you and your family member(s)?**
    - Inability to be connect with the community and feeling isolated
    - Fairly new program and one of the concerns is educating older adults in ways to support them a lot of them still have stigma the barrier for them to receive resources and making outreach that is effective and address stigma and build confidence and rapport with the community

- Getting people from outside of Alameda County and the need is great and hands are few
- Feeling unmotivated and lacking of purpose
- Feeling isolated
- Also scared to access services especially right now during COVID-19 and are undocumented but doing caretaking work of other older adults scared that they will be found out
- Currently no access to technology and need to be coached
- Stigma of coming from war or genocide and not speaking to children and children about it and the way that it manifests in abuse and substance abuse

3. **Are there populations or groups of people whom you believe are not being adequately served by the behavioral system of Alameda County**?
    - Native Americans that are hard to reach because they don't come to center because ashamed and have substance and alcohol abuse;
    - Laos, Thai, Tibetans, Mongolian, Nepalese, Khmer, Korean in mental health treatment programs;
    - Khmu
    - Undocumented Peoples
    - Pacific Islanders/Native Hawaiians
    - Native American
    - Immigrant
    - Persian/Iranian
    - Specifically, LGBTQ communities of color
    - Afghans needing more mental health services
    - LGBTQ

4. **What barriers make it more challenging for individuals and family member(s) with mental health challenges to access mental health services?**
    - Stigma
    - trust they think everything coming from the government is going to harm them because they think that they want to harm them considering the US policies on their country of origin
    - allowing for non-traditional healers
    - movement and coalition building like Filipino Mental Health Initiative in the East Bay
5. **Which services or programs have been effective in addressing our local mental health concerns?**
    - Community gatherings help to build support
    - In Long beach they created a community garden for Cambodian refugees which also connects culturally
    - Doing physical work together and then can share stories (cooking);
    - Outreach as a team also works
    - Coordinating the clinicians that have similar cultural backgrounds and resources to help expand it

6. **Please brainstorm any innovative ideas which would help improve mental health services in this County.**
    - Coalitions building of providers
    - Cultural exchange or storytelling event to get exposure to other cultures
    - Working with communities on complex trauma and specific communities need trainings

- Help paying for schooling

**7. Which stakeholder group do you primarily identify with?**

- Native American
- East Asian and Southeast Asian, community provider
- Afghan-American
- African
- Community provider and advocate
- multiple - faith community and community based and family
- ID personally closely to Khmer, Lao, Thai community
- Middle Eastern, community provider
- Community provider and advocate
- Community advocate
- Organizer
- FAJ
- Pacific islander community
- Advocate
- Southeast Asian community provider
- cultural/language specialists

**Focus Group #8: MHAB Adult Committee | Date: May 26, 2020| Attendee: #5**

1. **What concerns related to Children/Youth/Transitional Age youth (TAY) are most important to you and your family member(s)?**
    - No response

2. **What concerns related to Adults/Older Adults are most important to you and your family member(s)?**
    - Adults with serious mental illness are often homeless
    - If the most seriously ill are not to be hospitalized, they need to be in the best possible housing specifically for them--supportive, licensed, and including services for the seriously mentally ill.

3. **Are there populations or groups of people whom you believe are not being adequately served by the behavioral system of Alameda County**?
    - County's thousand sickest
    - Jail populations
    - MHSA spending needs to focus on the seriously mentally ill--people who cannot lobby or petition or agitate for their own treatment. It should not focus on stigma, employment, trauma, or non-serious mental illness.

4. **What barriers make it more challenging for individuals and family member(s) with mental health challenges to access mental health services?**
    - Denial
    - Hypocrisy
    - I do not concede that the MHSA was not intended for involuntary treatment. It did authorize involuntary treatment when it was necessary. The MHAB and the Board of Supervisors should urge the legislature to clarify this.

5. **Which services or programs have been effective in addressing our local mental health concerns?**
    - John George Hospital
    - The most important thing MHSA money can do under current restrictions is build more board-and-cares as Robert Ratner has been trying to do

6. **Please brainstorm any innovative ideas which would help improve mental health services in this County.**
    - 1) Need a place besides the Santa Rita Jail to solve SMI problems
    - 2) Agencies like Board of Supervisors and Mental Health Advisory board can talk to the state about restraints on serving SMI population, resulting in public policy and oversight
    - 3) MHSA spending needs to focus on the seriously mentally ill--people who cannot lobby or petition or agitate for their own treatment. The most important thing MHSA money can do under current restrictions is build more board-and-cares. If the most seriously ill are not to

be hospitalized, they need to be in the best possible housing specifically for them--supportive, licensed, and including services for the seriously mentally ill.

- 4) MHSA programs and others need to distinguish involuntary "treatment" in jail from involuntary treatment in locked hospitals like Villa Fairmont. The latter is sometimes necessary
- the IOP program at Fremont Hospital. They should be encouraged to apply for an "Innovation" grant

**7. Which stakeholder group do you primarily identify with?**

- MHSA programs and others need to distinguish involuntary "treatment" in jail from involuntary treatment in locked hospitals like Villa Fairmont. The latter is sometimes necessary
- (The MHSA) has been a tremendous waste of money for the most part and subject to raids by other state agencies

**8. Any other comments you'd like to share?**

- Family Member

**Focus Group #9: Health & Human Resource Education Center (HHREC) and the Office of Ethnic Services – LGBTQI2S Communities | Date: May 27, 2020| Attendee #: 6**

1. **What concerns related to Children/Youth/Transitional Age youth (TAY) are most important to you and your family member(s)?**
    - Create access and space (within systems that already exist, for example creating separate space for transgender youth who are hospitalized) for TAY who don't have privilege to speak for themselves
    - Elevate and creating space for youth to be believed & heard
    - All site should be LGTBQ+ welcoming as many youths are coming out gender non-conforming
    - Create spaces within in the systems where they are most vulnerable such as in schools & faith communities, specifically leveraging CCS funding (for example, CCHS use funding to set up ongoing services, leadership development programs that are not stigmatizing, and they served high schools, middle schools)
    - Train providers on culturally competent care for trans and gender nonconforming young people
    - Make sure forms that are filled out are inclusive
    - Educate providers on terminology
    - Take steps to not pathologize youth because of their gender identity and sexual identity
    - On the prevention side, invest by creating training programs and opportunities for young people to learn ways to be well, communicate when they are not well when wellness challenges arise
    - In terms of innovation, create family and queer trans youth DBT groups to handle reactions around young people coming out to prevent youth from carrying the burden of educating those around them
    - Lack qualified, trained adults who are there to support youth when they're questioning
    - I want to lift up TAY who are emancipated, homeless or runaways, who may be sex workers and are traumatized by family and faith-based institutions. There is a lot of self-hate, self-loathing. We need to ensure they know how to love themselves. We need to go to where they are and create a physical space for them to be
    - We need a mentorship program where adults are able to encourage resiliency and messages of love
    - There is a Family Acceptance program that works with the child and family dyad

2. **What concerns related to Adults/Older Adults are most important to you and your family member(s)?**
    - There are people out there without access to resources who are dying. They need access to skilled nursing facilities where they feel comfortable working with trans folks
    - For older adults: Isolation is an issue. We need more programs such as teams that visit people in their homes, communities, peer-to-peer phone check-ins to provide social support
    - For older adults: make sure providers are not making assumptions about their gender identify and sexual orientation

- Make sure forms make space for all people
- Adults: I think of the Pacific Center in Berkeley support adults and many won't be served unless they have a safe space to go to that specifically serves LGBTQ+, we need identified clinics in 3 regions of county using CSS.
- We need integrated services in all spaces for LGBTQ+ of all ethnicities
- Older Adults: Many must go back into the closet or hide their gender if they go into a nursing home. We need to go to them. We need people go to all the senior centers and invite others from the center to join in with them to integrate those around them and encourage acceptance. LGBTQ+ identified clinics can open up food pantries to older adults and medically comprised adults to decrease isolation
- Many see them as invisible and not part of the LGBTQ+ community. We need culturally affirming programs and LGBTQ+ clinicians. We need more workshops and make system providers attend to have a better understanding of what it means to be LGBTQ

3. **Are there populations or groups of people whom you believe are not being adequately served by the behavioral system of Alameda County**?
    - In general, we don't serve black trans women or trans women of color. We need to look at identity as intersectional. Black/brown folks will always be marginalized when it comes to access to services
    - We tend to put LGTBQ+ into a category, but gender and sexuality is different and needs to be discussed in different ways
    - Young people aren't listened to enough. They have a lot of knowledge and power
    - Average lifespan of African American trans woman is 25 or 28 years
    - Homeless- we need to go to them or they won't be served. If we don't catch them quickly they may end up in San Francisco, go into survival sex/prostitution
    - Asian LGBTQ are invisible. We know we don't serve Asian American at the penetration rate they are in Alameda County
    - Older Black lesbians can't find their space that's culturally responsive. We might have to go out the mental health system to create a system of mental health for this group. Alameda County has the Nia Collective, Women's Cancer Resource Center that aren't part of the system of care but want to be, and they have the ability to penetrate into that grouping. Many women report they are on fixed income but can't find clinicians who will take their Medi-Cal. There is an income issue when it comes to affordability
    - Trans community, and specifically, Black Trans are killed at a higher rate. I've advocated to place $1M towards this group. They need more resources and end up traveling to San Francisco for resources which seem to be drying up
    - There is a Trans Day Remembrance Day where we honor hundreds of Black transwomen who were murdered
    - MHSA should look at LGBTQ+ and they are 10% , have 1% of MHSA funding gone to this group? There is an inequity. Build this into all programs ": How are they addressing LGBTQ in the populations they are serving and will you have/hire LGBTQ+ competent clinicians?"

4. **What barriers make it more challenging for individuals and family member(S) with mental health challenges to access mental health services?**

- Stigma. Even LGBTQ+ welcoming programs, some may not use them unless you clearly state You are safe here" we need trans youth spaces, trans spaces, queer spaces in schools should be designated and available, along with integration across all programs
- Barriers based off culture and religious groups. We need to find faith-based and cultural groups and agencies willing to open up. We've had some interfaith groups funded by MHSA dollars that aren't traditional mental health programs to find affirming/prevention-like services
- Stigma
- Culturally inappropriate services
- Location. Nothing accessible for people in our county other than San Francisco
- Trans community says Alameda County doesn't have accessible services which puts them at harm's way if someone has to travel from Fremont to Oakland, etc. Local services build support
- Stigma around gender identity and expression.
- Mental Health Stigma. We need to find ways to reach them where they are at, and be able to discuss difficult decision without forcing people to self-identify with mental health problems (avoid categorizing and pathologizing, or labeling)
- Stigma
- Access. If a queer/trans calls and the clinic is using incorrect pronouns off the bat, this could promote an unsafe environment or force them to educate. Clinics should be human-centered

**5. Which services or programs have been effective in addressing our local mental health concerns?**

- Pacific Center which is self-sustaining. Some have LGBTQ integrate into their programs such as one identified clinician or the supervisors working with all the clinicians. When there is a specific focus and intent it does work, but it's not system wide.
- LGBTQ Youth Prom in Alameda County and longest running in the nation.
- GSA. A school support group for LGBTQ and allies
- Peer to Peer led support groups. This Is perhaps why the Pacific Center has had so much success. Things that build community without centering mental health issues (e.g. drag shows, etc.)
- The Pacific Center has done amazing work. We should look at where they are located and whether it reflects the population of hat Alameda County looks like. A Black trans youth in the foster care told me they wouldn't go there. Perhaps we can look at expanding what they do to different regions and groups.
- Peer to peer groups. I want to start a "Big Sibling" program like Big Brother/Sister but gender neutral
- Create jobs for people who can do this that may not have the education but have access to more resources than I do
- Drag Shows
- I think there is a huge burden placed on the Pacific Center. The county can't just look at one shop, and the County has used them as the solo demonstration site. We need this across the county that are appropriate for different folks as well.

6. **Please brainstorm any innovative ideas which would help improve mental health services in this County.**
    - There was a LGBTQ center in Oakland striving to serve African-Americans. Let's partner with them
    - We should partner with schools, faith based in all the regions in the County
    - The Oakland LGBTQ Center is off of Lakeshore. The ACBH PRIDE Committee reached out many times and hasn't received traction. The Pacific Center was providing mental health services groups at this facility.
    - The underground ballroom cultures. They deal with SUD, homeless, drugs, prostitution, HIV, and trauma. I met with them- the House of Mizrahi, they have a broad network/reach.
    - Happy Hour. Establishes a comfort zone. Create a mental health, peer support for happy hour. This would be held frequently to help them transition to the next part of their day
    - Peer support in innovative ways
    - Big Sibling
    - Ballroom culture and family. We've been supporting each other far longer than the mental health system has served us.

7. **Which stakeholder group do you primarily identify with?**
    - Black, Gay men BUT I work with/interact with/lift up ALL groups
    - Gay, Man that is transgender and a service provider and I am White. This is how people see me and it's more than who I am
    - Gay, White male. I have a PhD. There is so much more to my identity. I grew up in a poor home with a bipolar father who was an alcoholic and in/out mental institutions my whole life. That's why I want to represent and speak for so many underserved, stigmatized, unrepresented, discriminated, and murdered communities. I'm happy with- folks are speaking to their own identify but multiple pops.
    - Black Lesbian

8. **Any other questions/comments you'd like to share?**
    - I appreciate Colette and Javarre for holding this space and asking questions.
    - I echo
    - We need to advocate for these projects and should use MHSA Community Services & Support (CSS) or PEI funding, which is ongoing. It doesn't have to be an innovative project , which is one-time and doesn't count.
    - Will we be spinning our wheels? I think the PRIDE Committee should continue staying together and growing. I love the idea of Big Siblings. We have great ideas that we know would work.

**Focus Group #10: MHAB Criminal Justice Committee | Date: May 27, 2020| Attendee #: 10**

1. **What concerns related to Children/Youth/Transitional Age youth (TAY) are most important to you and your family member(s)?**
    - First psychotic break (specifically males)
    - Prevention/early intervention and primarily young men
    - Need better performance measurements to set goals
    - Suicide prevention programs for youth
    - It is difficult for the population to identify and navigate the mental health system
    - Employment
    - Education
    - Housing for all age groups

2. **What concerns related to Adults/Older Adults are most important to you and your family member(s)?**
    - Housing for all age groups
    - Employment
    - Education
    - Comorbidity/other risk factors that exist when people age
    - Substance use disorders (TAY)
    - Concerned around inmates in Santa Rita jail who are transitioning out (e.g. substance abuse, housing, transportation)
    - Family/peers concerned around continued support of impacted citizens when they're not around
    - Support for family members/caregivers
    - Family members who are aging parents have concerns. it would be great for those released from Santa Rita have had a case worker who can ensure they are connected to full services (e.g. medicine in their hands instead of script , bed, transportation, psychiatrist)

3. **Are there populations or groups of people whom you believe are not being adequately served by the behavioral system of Alameda County**?
    - Non-English speakers
    - Homeless
    - Dual Diagnosis
    - Those without an assigned/personal advocate
    - African American males in their 20s-late 30s , experience community rejection, issues living as mentally ill trying to integrate, living homeless with no connections

4. **What barriers make it more challenging for individuals and family member(s) with mental health challenges to access mental health services?**
    - Communication
    - Data

5. **Which services or programs have been effective in addressing our local mental health concerns?**
    - Services that will support family members, drive elderly and others to their doctor's appt/grocery shopping
    - La Familia has a great reentry program
    - Dementia and elderly service the city of Fremont has implemented that helps them find those who lost, or assist elderly with mental illness with other diagnosis (linkages)
    - Hospital beds (subacute and acute)

6. **Please brainstorm any innovative ideas which would help improve mental health services in this County.**
    - The county needs to hire an Industrial Engineer to adequately set goals to measure success. That could be used to assess MHSA programming
    - I hope to get more involuntary programs like Amber House for adults
    - We have so many great programs (e.g. BACS, la Familia, Bonita house) not everyone knows- we need centralized communication/ one stop shop
    - More full-service partnerships
    - People being discharged from State Hospitals but who are not being conserved or on CONREP program - they have often been in the hospital for years and need WRAP services
    - Peer navigator program

7. **Which stakeholder group do you primarily identify with?**
    - Social and criminal justice advocate & activist
    - NAMI family member advocating for caregivers and consumers
    - Patient rights advocate for mental health association
    - I'm a family member of an adult son. I have a non-profit currently in process to offer services for foster youth NMD's

8. **Any other comments you'd like to share?**
    - N/A

**Focus Group #11: Pool of Consumer Champions (POCC) Public Policy Education Committee & CAMHPRO-"Have Your Voice Heard on Innovations for Alameda County" Webinar | Date: May 27, 2020| Attendee #: 28**

1. **Please brainstorm any innovative ideas which would help improve mental health services in this County.**

**#1 Childcare for Parents in Peer Respites (Polling Vote: 11%).**

Provide in tandem Childcare Services with Peer Respite Services

- For children of people who reside in the Peer Respite.
- Childcare Services provided in the home of the parent in the Peer Respite.

Meets an INN purpose:

- Adopt existing mental health practice (Peer Respites) for new population/ setting
- Target population is adults with children.

**#2 Unique Self-Directed Tools (Polling Vote: 11%).**

- Establish a recovery plan to meet your goals for wellness
- It funds self-directed components not covered by Medi-CAL (gym membership, acupuncture, organic food…)
- Control a monthly budget and choose services and tools to help you reach those goals
- Work with a support broker to define your plan and identify tools and supports
- Often, the support broker is someone who's had their own personal experiences with the mental health system

**#3 Nutrition in Mental Health Services (Polling Vote: 0%)**

- Healthy meals and snacks in behavioral health programs
- Fresh produce distribution through behavioral health programs

**#4 Access: "2connect 2": Laptop, Internet & Peer Trainer** (Received Highest Polling Vote; 78%)

**Problem**: Post COVID-19 most POCC members, diverse BH consumers with co-morbid conditions, are excluded from participation in the County stakeholder input process, from access to online BH services, from connections with support systems to maintain their wellness. Now only the 'haves can access services due to lack of means to buy digital access, lack of know-how; poverty, lack of education in communities of color/diversity
**Solution**: Fund POCC members who lack digital access with a notebook/laptop/internet, and a peer support trainer/coach to enable online BH services & stakeholder input
**Learn**: How the provision of notebook/laptop/internet & peer training to impoverished/underserved BH consumers improve wellness measures (lack of hospitalizations, further education, employment, community involvement)

#5 **Peer Specialists Leading DBT Skills Groups (Polling Vote: 0%).**

**Problem**:

- Consumers/peer specialists do not have access to the best Evidence Based Practice for skills development such as mindfulness, emotional regulation, interpersonal effectiveness, and distress tolerance in an easy, assessable and engaging manner.
- Additionally, peer specialist from cultural, linguistic and ethnically diverse populations are not being utilized to facilitate these skills development groups.
- Furthermore, the COVID 19 pandemic and the health and safety regulations requiring physical distancing creates additional barriers to engage and enhance consumers self-efficacy.

**Solution**:

- In coordination with Behavioral Tech, the leading online Dialectical Behavioral Therapy (DBT) training program and peer specialists from cultural, linguistic and ethnically diverse communities will create customized online curriculum for peer specialists to practice mindfulness, emotional regulation, interpersonal effectiveness and distress tolerance skills.
- Provide on-going remote and in-person skills practice groups facilitated by cultural, linguistic and ethnically diverse peer specialists in Alameda County.

**Learn**:

- Does the online DBT skills trainings combined with remote/in-person peer led skills practice groups have a greater impact in improving self-efficacy in mindfulness, emotional regulation, interpersonal effectiveness and distress tolerance skills, improve engagement and reduce the need for higher levels of care vs just the online DBT skills trainings?

<u>NEW INN Ideas from polling</u>

#1 Glamping, glamorous outdoor experience team building, camping (Polling Vote: 16%).

#2 Virtual live events online with mental health speakers (Polling Vote: 26%)

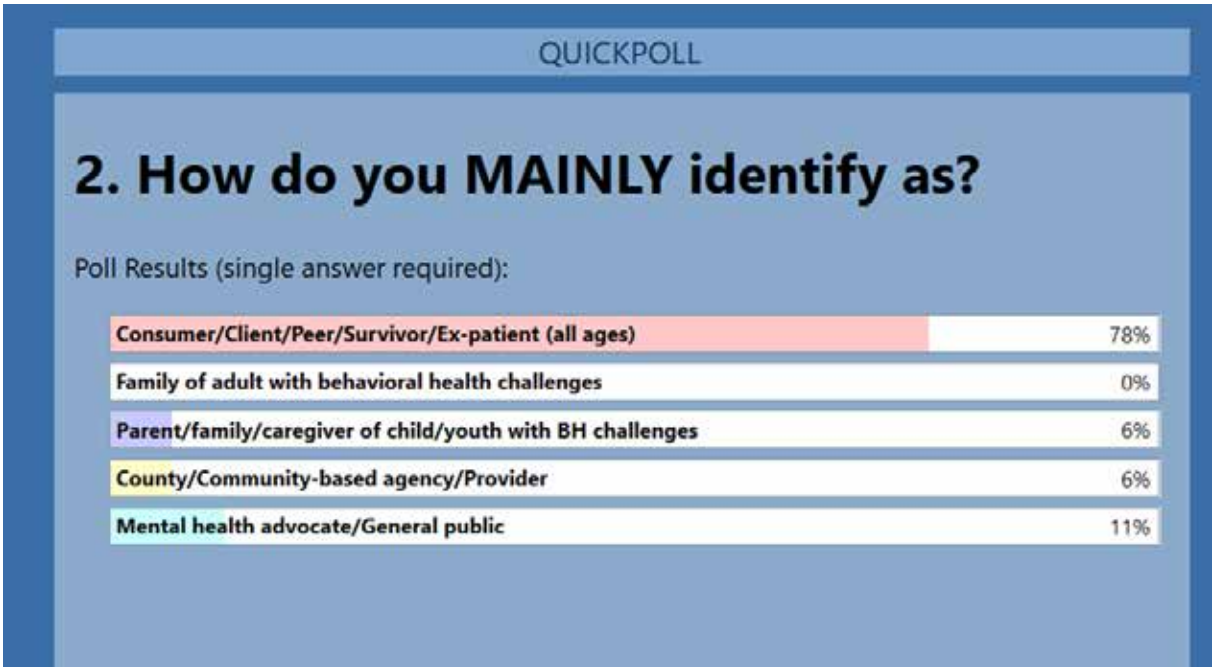
#3 Counseling for families to pick up the pieces after someone in the family has been hospitalized. It is to help heal the brokenness (Polling Vote: 11%)

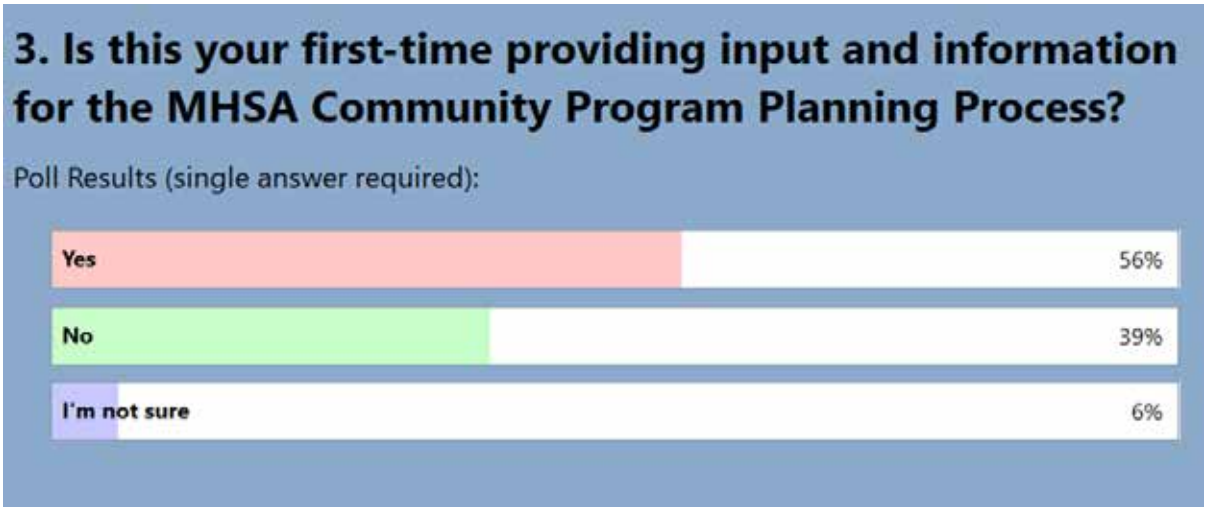
#4 Peer respite for new target population (for INN eligibility) *Received Highest Polling Vote: 47%*

#5. Continuum of care - people leaving peer respite may need additional support by participating in a longer termed program (Polling Vote: 0%)

#6. Financial Literacy (Polling Vote: 0%)

**POCC Focus Group Attendee Demographics:**


QUICKPOLL
2. How do you MAINLY identify as?
Poll Results (single answer required):
Consumer/Client/Peer/Survivor/Ex-patient (all ages) 78%
Family of adult with behavioral health challenges 0%
Parent/family/caregiver of child/youth with BH challenges 6%
County/Community-based agency/Provider 6%
Mental health advocate/General public 11%


3. Is this your first-time providing input and information for the MHSA Community Program Planning Process?
Poll Results (single answer required):
Yes 56%
No 39%
I'm not sure 6%

**Focus Group #12: Office of Family Empowerment Family Dialogue Group | Date: July 23, 2020| Attendee #:12**

1. **What concerns related to Children/Youth/Transitional Age youth (TAY) are most important to you and your family member(s)?**
    - Trauma & Education
    - Betrayal and distrust of the system.
    - Fear that adult family member will become homeless or incarcerated if the system gives up on them.
    - MHSA intended to provide involuntary services. MHSA forbids services in jails, but not in mental hospitals. Many activists are trying to get MHSA reinterpreted correctly.
    - Early childhood needs more services in pre-schools and early childhood programs, school age children receive most services from school-based programs. The programs are not staffed well enough.
    - TAY over 18 and families have no legal rights. Youth need services that support education and vocational training, peer support and family support for families.
    - Co-occurring substance use and mental illness is not well addressed and/or treated.
    - Youth's culture is frequently anti-pharmaceuticals and pro marijuana and alcohol to dampen symptoms.
    - Initial encounters when young adults first become ill, betrayal and distrust of the system
    - I'm concerned that since my child is over 24, the system might give up on her and let her be homeless or incarcerated
    - I'd like to comment about the supposed voluntary nature of services provided by MHSA. Many say MHSA was intended to provide involuntary services if they are the least restrictive services that work. MHSA explicitly forbids services in jails, but not in mental hospitals. Many activists are trying to get MHSA reinterpreted correctly.
    - Limiting services to only voluntary services leaves out a very large cohort of the most severely ill
    - The issues are so different based on the age of the person/consumer/client. Early Childhood we need more services in pre-schools and early childhood programs, school age children receive most of their services from school based programs within school systems that are not staffed well enough to serve them appropriately and where their behavior is frequently criminalized particularly if they are Black or Brown, TAY they are over 18 and families have no legal rights, and the youth need services that support education and vocational training as well as peer support and family support for families that now find themselves suddenly "out of the loop"
    - Early stage intervention is helpful like IHOT, they are more amenable
    - My then-TAY daughter had to be homeless and take meth for a couple of summers (further damaging her brain, as far as I could tell) before the system realized she was truly mentally ill and needed to be in Villa some months. They were trying to save beds by putting her out to "make choices in the community"
    - The issues are so different based on the age of the person/consumer/client. Early Childhood we need more services in pre-schools and early childhood programs, school age

children receive most of their services from school based programs within school systems that are not staffed well enough to serve them appropriately and where their behavior is frequently criminalized particularly if they are Black or Brown, TAY they are over 18 and families have no legal rights, and the youth need services that support education and vocational training as well as peer support and family support for families that now find themselves suddenly "out of the loop"

- Also, co-occurring substance use and mental illness is not well addressed and/or treated, and youth culture is frequently anti-pharmaceuticals and pro marijuana and alcohol to dampen symptoms.
- SMI self-medicate with drugs thus putting themselves in terrible danger
- We let them cycle through the system again and again and requires more subacute facilities and beds when they first enter

**2. What concerns related to Adults/Older Adults are most important to you and your family member(s)?**

- We need hospital beds and board-and-care beds or our children will be homeless or in jail as most of them are! and I'm concerned that people are reluctant to spend MHSA money on hospital beds or board-and-care beds. The system is a shamble.
- When adult children self-medicate with drugs, thus putting themselves in terrible danger.
- Concern over how we are reluctant to spend MHSA money on hospital beds or board-and-care beds.
- Once released the follow-up does not occur. Dual diagnosis is also extremely needed.
- In SF the juvenile jail was closed and the money diverted to services instead of punishment
- Lack of a clear and supported pathway as TAY are transitioning to adult forms of care. Specifically access to treatment or job supports.
- County had to spend over $100,000 before he received case management. We had to wait until he was received XX number of times. you have to be at stage 3 or 4.
- They were bragging at Villa back then that they could keep the average stay so short
- Not enough places to place people and it’s a revolving door
- The facility manager posted it on linked in that he could keep it down for five months
- First not enough beds, but once released the follow up does not occur. I heard the same thing that Tony is mentioning. Many revolving doors. Dual Diagnosis is also an extremely needed service as a follow up after hospitalization or Jail.
- Our kids take drugs and society blames their issues on that and lets government off the hook
- The loss of supportive housing and the lack of appropriate and supportive facilities- whether inpatient, day treatment, etc.
- we're excluding specific individuals. hospitals are a part of the continuum of care and shouldn’t be hell holes.
- Divert the money from mental jail to wrap around support
- Villa is less of a hellhole than Santa Rita
- We need more long-term facilities for adults and TAY (legal adults) so that people can be stabilized both medically and therapeutically. Family members are still frequently shamed

and blamed for their loved-one(s) illness even though we are usually their link to life, housing, food, etc. Families need to be included early on. After 24 years of trying to help my son and his siblings who have been so traumatized from this process, it is so clear that if he had been kept long enough to really understand what was going on with him and how to treat him, we all would have been spared so much pain.

- It's horrible to keep hoping and keep being optimistic when case managers encourage you to stay positive and exercise self-care and just hope for the best--you might hope for a day or two or a week or two or a month or two and then a call in the middle of the night, I'm in such and such a city and talking word salad and I don't know where I am
- To continue, years ago when my son's illness was escalating, and he was not interested in being compliant with medications due to his lack of insight, a psychiatrist actually told me that the best thing that could happen to him would be if his behavior landed him in jail to "get treatment".
- They were bragging; we're excluding specific individuals. hospitals are a part of the continuum of care and shouldn't be hell holes
- Deficiencies at every level in CM and other services; the loss of supportive housing and lack of appropriate and supportive facilities whether inpatient, day treatment, et.; our kids take drugs and society blames their issues on that and lets government off the hook; divert money from mental ail to wrap around support; Villa [is] less [of a] hell hole than Santa Rita
- Permanent supportive housing including Board and Care and with something meaningful for people to do
- For TAY, consumers can be "aged-out" of their housing and case management which results in destabilization at a critical time.

3. **Are there populations or groups of people whom you believe are not being adequately served by the behavioral system of Alameda County**?
    - People who have the right to refuse services; those who are cycling in and out of Santa Rita and John George
    - Who cares about serving the family members, save the life and health of the clients
    - Early Intervention for early psychosis events should include a wrap-around approach that kicks in immediately!
    - The thousand sickest, the frequent flyers are not being adequately served--they are dying, Severe mental illness (SMI)
    - Those who are cycling in and out of Santa Rita and John George
    - Those who do not have the capacity to direct their own care because they do not recognize their illness (ex. schizophrenia, schizoaffective and bipolar).
    - Those in board-and-care facilities (ex. Psynergy and Everwell).
    - TAY consumers who are "aged-out." Their housing and case management which results in destabilization at a critical time.
    - SMI

4. **What barriers make it more challenging for individuals and family member(S) with mental health challenges to access mental health services?**
    - HIPPA

- Gaslighting
- HIPAA, IMD exclusion, privileging the voice of peers over the needs of our children
- Lack of information, navigating the system can be challenging and a bit convoluted.
- Scared of physical safety; scared of loved ones when pushed to get restraining order. It's difficult to get and keep people hospitalized to get them meaningful treatment, difficult to get them wrap around services
- The criminalization of mental illness destroys the trust of family members and creates adversarial relationships within families.
- Recommendations - we need a bigger john gorge, licensed board and care, and more subacute facilities
- There are also cultural barriers based on language as well as traditional interactions with the police or medical professionals.
- Legal strangleholds to getting treatment for loved-ones who are so ill and in danger.
- We are not included and not asked for input. We need to fight to give information. Even the FSP's lack in this area. We need to keep the mentally in jail.
- Families left out when recommending policies & practices, we do not have a collaborative spirit, we don't have a centralized advocacy body, MHSA should fund an advocacy position
- Out of jail.... not in it!
- Most people don't understand the average individual living with MH challenges are with families and cant advocate the way other consumers can (who usually are recovering from drug exposure)
- The exclusion of family members -- our voices and participation are frequently kept out of the treatment of our SMI loved ones.
- Yes, in Alameda County the Consumer voice is well represented, family voice is not
- Advocacy includes access to technology, to information, to contacts, to travel, to training, to legislative bodies
- More transparency to how the gov services spends the money
- Developed better medication
- Burnout
- The county also favors consumer voices, however those consumers who can participate are not necessarily those with SMI; they are in back room, or otherwise self-isolative and can't speak for themselves, so that's why we are here giving input for them. The consumers in PEERS do not speak for my family member, in my opinion; they don't seem to reach out to those how are more ill than they are, and in fact seem to deny the severity of illness that those smaller percent with SMI suffer.
- There seems to be a group-think agreement in PEERS that anyone can make the best choices for themselves, even in the midst of severe psychosis, which is not the case
- Availability of long acting interventions (innovation) could eliminate need to be hospitalized. mandate medication in community to avoid cycling through the hospital.
- Our family members are not consistently well represented by anyone but us
- It is important to have options representing different levels of need and ability to live independently and autonomously.
- Lack of information, navigating the system can be challenge.

- Scared for loves ones when pushed to get restraining orders.
- Cultural barriers based on language, as well as traditional interactions with police or medical professionals.
- Families left our when recommending policies and practices.
- There is no collaborative spirit.
- No centralized advocacy bodies.
- Long-acting injectables that worked would be excellent; housing could be an incentive for med compliance, if there was any housing

**5. Which services or programs have been effective in addressing our local mental health concerns?**

- Psynergy and Everwell
- Russel street residence and very elementary but try to have programming like a writer's group, yoga, garden for people. Its minimum but far better
- It is important to have options representing different levels of need and ability to live independently and autonomously.
- Diversion
- Penny Bernhisel
- Community conservatorship
- Other conservatorship
- Villa Fairmont (though they fight with me)
- Gladman
- Psynergy
- Villa when you can get in
- Bonita House Residential Treatment Program
- Survivor guilt at Villa is killing me--my daughter is so happy there and I know others are dying on the street that could have that spot.
- Expand Mental Health Court like in Santa Clara, though my daughter is too sick for that
- STARS (TAY)
- West Coast Children's Center
- Various Fred Finch Programs for early intervention
- Assisted Outpatient Treatment (AOT) has been fairly effective but would be more effective if the judge was empowered to mandate needed medications. This would enable participants to live in the community rather than being continually re-hospitalized.
- FSPs but i think we have too heavy a case load for the providers. We need more FSPs with less of a case load.
- Bonita House and Psynergy are great but my daughter eloped from them
- STRIDES Community Health Center used to be a very ingenious and creative FSP
- HOST was good
- Villa as well as Willow Rock has been a very positive impact for our family

**6. Please brainstorm any innovative ideas which would help improve mental health services in this County.**

- We need a bigger john gorge, licensed board and care, and more subacute facilities

- Bring families in and quit trying to shut them up, that would be extremely innovative. Parent input is sidelined and diluted
- Laura's law
- Additional Dual Diagnosis facilities like Bonita house.
- Clubhouse Model
- Expand Mental Health Court like in Santa Clara, though my daughter is too sick for that
- Expand CC and the forensic FSPs and provide licensed beds for each client
- We need case management teams that treat folks, mony on the streets, with primary care issues primarily but underlying MI.
- Psynergy
- Have a similar plan in L.A. County – "Care First, Jail Last"
- For families, NAMI, FERC, and Family Partnership Programs (only available in CYASOC). Bonita's Co-Occurring program works for some. Villa and Jay Mahler, EBAC, AOT/CC, FSP's, Early Childhood Mental Health Consultation Programs that work with principals, directors, home visits, etc.
- Give families a voice in commitment and conservatorship proceedings, make it so they don't have to fight with the Public Defender and the PG
- Broaden services like IHOT for early intervention as an adjunct to AOT
- Diversion
- We need more from the FSP's. My son has been kept on the street by his Case Mgmt Team. Additional therapy focus.
- Massive public education with primary care people and family education to recognize the early signs
- Acknowledge that mental illness exists and is debilitating. It's not just poor mental hygiene or negative thinking.
- LA Alternatives to Incarceration Workgroup: https://lacalternatives.org/#:~:text=The%20mission%20of%20the%20Work,jail%20is%20a%20last%20resort
- FSPs without housing have no way to keep people off the street!
- Family advocates in FSPs
- Users/toniveglia/Downloads/ATI-Infographic.pdf/Users/toniveglia/Downloads/ATIRoadmapOnly_fixed.pdf
- Working within JJ and CJ since so many end up in these systems instead of getting help from clinical support.
- Long-acting injectables that worked would be excellent; housing could be an incentive for med compliance, if there was any housing
- We need a bigger john gorge, licensed board and care, and more subacute facilities

**7. Which stakeholder group do you primarily identify with?**

- I dislike being considered a stakeholder. I'm only involved in this because I had to get involved. Not because I want to make a career of this kind of advocacy. I'm in this because God made a mistake and created mental illness. I was left holding the bag
- Advocate Mom, Dad, friend, FASMI. Cheerleader.

- Mother advocate, warrior
- San Francisco Taxpayers Steering Group to help mental illness in jail and after.
- NAMI, East Bay Supportive Housing Collaborative, African American family support group, AA family member of an underserved community,
- Family Member/caregiver of an SMI individual, Family member of an African American Family involved in mental health, MHSA Stakeholder's Group.
- Frustrated, angry provider/mom
- FASMI, NSSC, Mental Illness Policy Org. I don't give money to NAMI or MHAAC because they don't on the whole get it

**8. Questions or comments?**

- What money comes from the state and federal government
  Answer: MHSA funding is stable and based on legislation PROP 63.
  Answer from Focus Group participants: Includes Medi-Cal, SAMHSA. Also, Medicare, some people have Medical and Medicare = MediMedi


ALAMEDA COUNTY BEHAVIORAL HEALTH
Mental Health Services Act (MHSA) 3-Year Program and Expenditure Plan
Community Participation and Feedback Survey

## Survey Instructions

The Alameda County Mental Health Services Act (MHSA) Division wants your input and innovative ideas to help strengthen its mental health and wellness programs to better serve you and your community over the next three years.

This survey is part of a larger community program planning process (CPPP) that may include community input meetings throughout Alameda County. To learn more about local MHSA activities, please visit https://acmhsa.org/

There are 23 questions in the survey and it takes about 15 minutes to complete. All responses are anonymous and confidential. For questions, please contact the MHSA Division at MHSA@acgov.org.

Thank you for your help with this community effort!

1. Is this your first-time providing input and information for our **MHSA Community Program Planning Process**?

- ◯ Yes
- ◯ No
- ◯ Not Sure

2. What concerns related to **Children/Youth/Transitional Age Youth (TAY)** are most important to you and/or your family member(s)? (Rate in order with 1 as "Absolutely Essential" to 5 as being "Not a Priority at this time").

| | 1=Absolutely Essential | 2=Very Important | 3=Moderately Important | 4=Somewhat Important | 5=Not a Priority at this time |
|---|---|---|---|---|---|
| a. Criminal Justice System Involvement | ○ | ○ | ○ | ○ | ○ |
| b. Community Violence & Trauma | ○ | ○ | ○ | ○ | ○ |
| c. Depression | ○ | ○ | ○ | ○ | ○ |
| d. Education/Academic Support | ○ | ○ | ○ | ○ | ○ |
| e. Employment | ○ | ○ | ○ | ○ | ○ |
| f. Family Conflict/Stress | ○ | ○ | ○ | ○ | ○ |
| g. Housing & Homelessness | ○ | ○ | ○ | ○ | ○ |
| h. Job/Vocational Training | ○ | ○ | ○ | ○ | ○ |
| i. Out-of-home Placement/Foster Care | ○ | ○ | ○ | ○ | ○ |
| j. Social Isolation/Feeling Alone | ○ | ○ | ○ | ○ | ○ |
| k. Substance Use/Abuse | ○ | ○ | ○ | ○ | ○ |
| l. Suicide | ○ | ○ | ○ | ○ | ○ |

Please identify other important health services/needs that should be prioritized for the Child/Youth/TAY age groups:

3. What concerns related to **Adults/Older Adults** are most important to you and/or your family member(s)? (Rate in order with 1 as "Absolutely Essential" to 5 as being "Not a Priority at this time").

| | 1=Absolutely Essential | 2=Very Important | 3=Moderately Important | 4=Somewhat Important | 5=Not a Priority at this Time |
|---|---|---|---|---|---|
| a. Chronic Health Condition(s) | ○ | ○ | ○ | ○ | ○ |
| b. Community Violence & Trauma | ○ | ○ | ○ | ○ | ○ |
| c. Depression | ○ | ○ | ○ | ○ | ○ |
| d. Education | ○ | ○ | ○ | ○ | ○ |
| e. Employment | ○ | ○ | ○ | ○ | ○ |
| f. Housing & Homelessness | ○ | ○ | ○ | ○ | ○ |
| g. Incarceration of Mentally Ill Adults | ○ | ○ | ○ | ○ | ○ |
| h. Job/Vocational Training | ○ | ○ | ○ | ○ | ○ |
| i. Ongoing Multiple Hospitilizations | ○ | ○ | ○ | ○ | ○ |
| j. Parenting Issues/Family Stress | ○ | ○ | ○ | ○ | ○ |
| k. Social Isolation/Feeling Alone | ○ | ○ | ○ | ○ | ○ |
| l. Substance Use/Abuse | ○ | ○ | ○ | ○ | ○ |
| m. Suicide | ○ | ○ | ○ | ○ | ○ |

Please identify other important health services/needs that should be prioritized for the **Adult/Older Adult** age groups:

4. Are there any populations or groups of people whom you believe are not being adequately served by the behavioral health system of Alameda County? **(Please select all that apply)**

- [ ] African-American/Black
- [ ] American Indian/Alaskan Native
- [ ] Asian
- [ ] Latinx
- [ ] Pacific Islander/Native Hawaiian
- [ ] Children, Young (ages 0-5)
- [ ] Children, Elementary School Aged (ages 6-12)
- [ ] Children, Middle/High Shool Aged (ages 13-17)
- [ ] Transitional Age Youth (ages 18-24)
- [ ] Adult
- [ ] Older Adult
- [ ] Criminal Justice Systems Involved Individuals
- [ ] Immigrant & Refugee
- [ ] LGBTQQI+
- [ ] Parents/Family Member
- [ ] Persons Experiencing homelessness
- [ ] Persons with disabilities
- [ ] Veteran

Other population(s), please specify:

5. Based on your answers for **Question 4**, please identify who you feel are the three most underserved groups **(please be specific)**:

(1)

(2)

(3)

6. What barriers make it more challenging for individuals and family member(s) with mental health challenges to access mental health services? **(Please select all that apply)**.

- [ ] Appointment availability
- [ ] Communication between providers
- [ ] Embarrassed to ask for help
- [ ] Did not want help
- [ ] Legal concerns
- [ ] Level of services did not match needs
- [ ] No Insurance
- [ ] Provider changes
- [ ] Resources (e.g. financial)
- [ ] Safety concerns
- [ ] Services not in my community
- [ ] Services not culturally appropriate (e.g. not in my language)
- [ ] Stigma around mental health illness in their community
- [ ] Slow response time
- [ ] Transportation

Other, please specify:

7. Which of the following MHSA Service areas do you feel have been effective in addressing our local mental health concerns? **(Please select all that apply)**.

- [ ] Crisis Services
- [ ] Consumer Wellness Centers (serves Adults with wellness/recovery services & links to community supports)
- [ ] Dual Diagnosis Services (services to improve mental health and substance use disorders)
- [ ] Culturally Responsive Prevention Programming & Supports
- [ ] Employment and Vocational Services/Supports
- [ ] Family Education & Support Centers
- [ ] Full Service Partnerships (serves Adults and TAY with mental health issues that result in homelessness, criminal justice system involvement, & frequent use of emergency psychiatric hospitalization)
- [ ] Housing Services
- [ ] Mental Health Outreach Teams
- [ ] Mental Health Services for Re-entry populations
- [ ] School-Based Mental Health Services
- [ ] Anti-Stigma & Anti-Discrimination Campaign
- [ ] Suicide prevention (crisis hotline/training & education)
- [ ] Workforce Development Projects

Other areas you feel have been effective, please specify:

8. MHSA funds **INNOVATIVE SERVICES** to improve and transform our county mental health system. The goal of the Innovations program is to contribute to learning and improving our system in three ways: (a) introduce new mental health practices & approaches that have never been done before, (b) make a change to an existing mental health service, and (c) introduce a new community-driven approach that has been successful in a non-mental health setting.

**Please list innovative ideas which help improve mental health services:**

9. MHSA funds **WORKFORCE, EDUCATION & TRAINING** activities to help develop a behavioral health workforce sufficient in size, diversity, language, and cultural responsiveness for consumers/family. Please rank the importance of the following Workforce Development strategies. (Rate in order with 1 as "Absolutely Essential" to 5 as being "Not a Priority at this time").

| | 1=Absolutely Essential | 2=Very Important | 3=Moderately Important | 4=Somewhat Important | 5=Not Priority at This Time |
|---|---|---|---|---|---|
| a. Internship Programs (e.g. High School, Undergraduate, Graduate) | ○ | ○ | ○ | ○ | ○ |
| b. Career Pathways Pipeline Programs (to promote and increase career choices in the Mental Health field) | ○ | ○ | ○ | ○ | ○ |
| c. Loan Repayment Program for Qualified Educational Loans for eligible clinical staff | ○ | ○ | ○ | ○ | ○ |
| d. Peer Support Training | ○ | ○ | ○ | ○ | ○ |
| e. Stipend Program to Support Graduate Level Behavioral Health Internships | ○ | ○ | ○ | ○ | ○ |

Please identify other important workforce development strategies:

10. My **AGE RANGE** is:

- ○ Under 16
- ○ 16-25
- ○ 26-59
- ○ 60 and over
- ○ Prefer not to answer

11. In which part of Alameda County do you **LIVE?**

Other (please specify)

12. What is your **GENDER IDENTITY**?

- Female
- Male
- Genderqueer or Gender Fluid
- Intersex
- Trans Female/ Trans Woman
- Trans Male/Trans Man
- Prefer not to answer

Other Gender Identity (please specify)

13. What is your **ETHNICITY**?

- Hispanic/ Latinx
- Non-Hispanic/ Latinx

14. What is your RACE? (Please select all that apply)

- [ ] African-American/Black
- [ ] American Indian/Alaskan Native
- [ ] Asian
- [ ] Pacific Islander/Native Hawaiian
- [ ] White/Caucasian
- [ ] Prefer not to answer

Other (please specify):

15. If you marked "ASIAN OR PACIFIC ISLANDER" under question 14, please tell us about your nationality or country of origin? (Please select all that apply)

- [ ] Asian Indian
- [ ] Cambodian
- [ ] Chinese
- [ ] Filipino/a
- [ ] Japanese
- [ ] Korean
- [ ] Samoan
- [ ] Taiwanese
- [ ] Tongan
- [ ] Vietnamese
- [ ] I am not Asian or Pacific Islander

Other (please specify):

16. Which of the following stakeholder group(s) do you primarily represent (Please select all that apply).

- [ ] Active Military/Veteran
- [ ] Consumer
- [ ] Faith Community
- [ ] Family member
- [ ] Law enforcement agency
- [ ] Provider

Other (please specify)

17. How did you learn about the **MHSA Community Participation & Feedback Survey?** (Please select all that apply).

- [ ] Community-Based Organization
- [ ] Friends/Family Member
- [ ] Hospital/Healthcare or Other Provider
- [ ] Listserv/Newsletter
- [ ] Media (e.g. Eventbrite, Facebook,Print, Radio)

Other (please specify)

18. What services are you receiving at this time? (Please select all that apply)

- [ ] Alcohol & Other Drug Services
- [ ] Community Group
- [ ] Homeless Services
- [ ] Mental Health Services
- [ ] Vocational Rehabilitation
- [ ] No Service(s) Received

Other (please specify)

19. **COMMUNITY INPUT MEETING EVALUATION SECTION: Please tell us about your recent experience (If you did not attend a recent forum, please skip questions 19-22).**

**What is your overall satisfaction with the MHSA Community Input Meeting today?**

20. Please share any comments about **strengths** of today's MHSA Community Input Meeting.

21. Please share any comments about **areas for improving** today's MHSA Community Input Meeting.

22. For those who attended a recent Community Input Meeting, was it easy for you to understand the purpose of the forum?

- Mostly Yes
- Mostly No
- I did not attend a Community Input Meeting

23.

Thank you again for taking the time to provide your input on the County of Alameda's MHSA future plans. We appreciate you! To learn about more ways to get involved, please visit our website at https://acmhsa.org/

This area is for any additional comment you would like to give us.

# APPENDIX E-2: SURVEY RESULTS

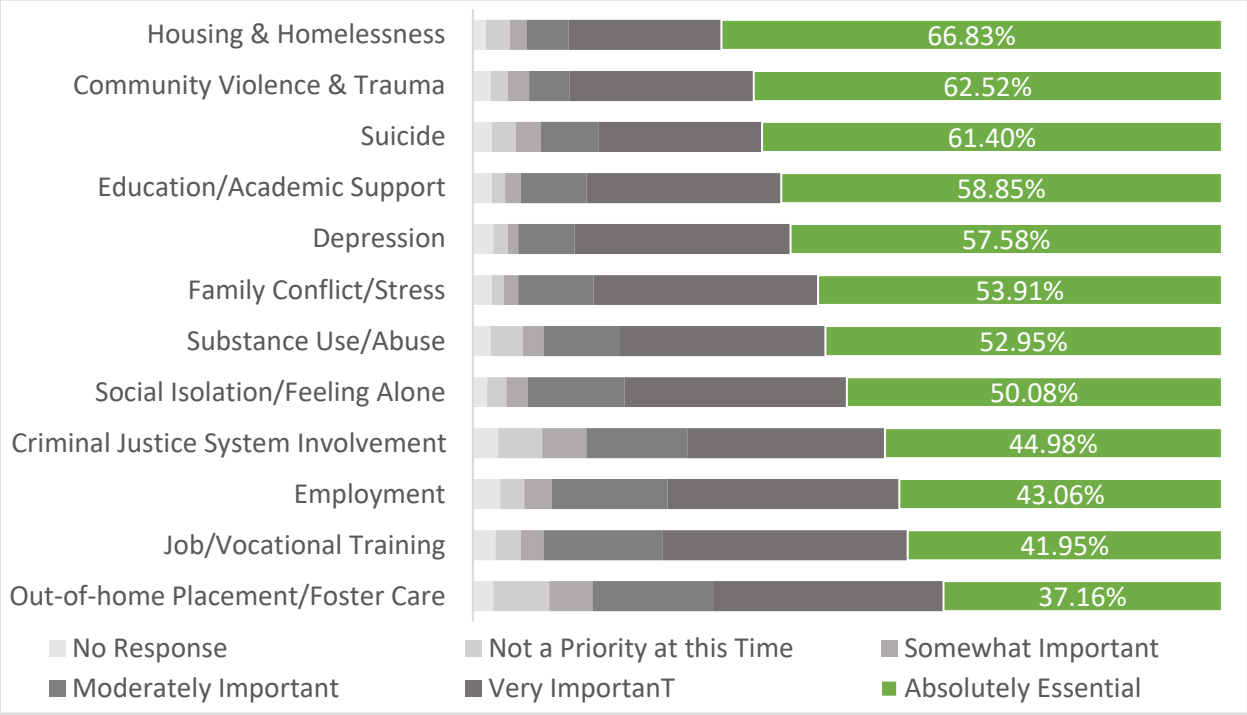
*Q1. Is this your first-time providing input and information for our MHSA Community Program Planning Process?*

**First Time Participating in MHSA Community Program Planning Process (n=627)**

| Response | Number | Percent |
|---|---|---|
| Yes | 526 | 83.89% |
| No | 51 | 8.13% |
| Not Sure | 44 | 7.02% |
| No Response | 6 | 0.96% |
| **Total** | **627** | **100.00%** |

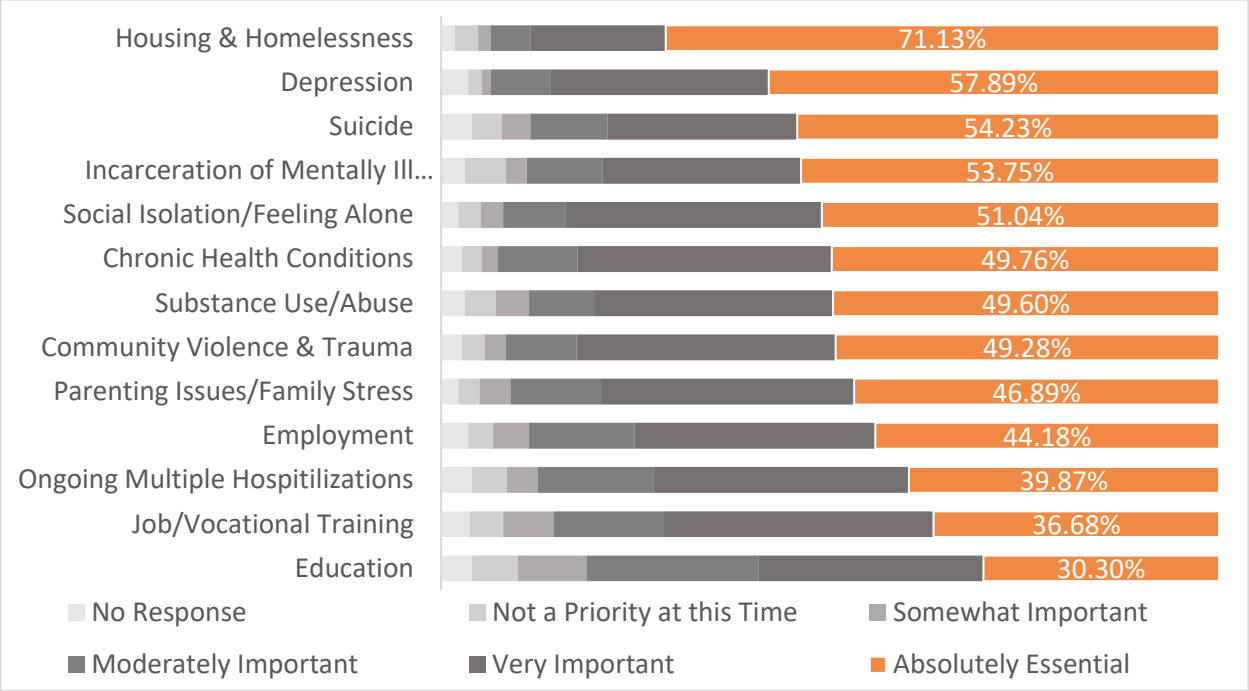
*Q2. What concerns related to Children/Youth/Transitional Age Youth (TAY) are most important to you and/or your family member(s)? (Rate in order with 1 as "Absolutely Essential" to 5 as being "Not a Priority at this time").*

**Concerns Related to Children/Youth/Transitional Age Youth (n=627)**



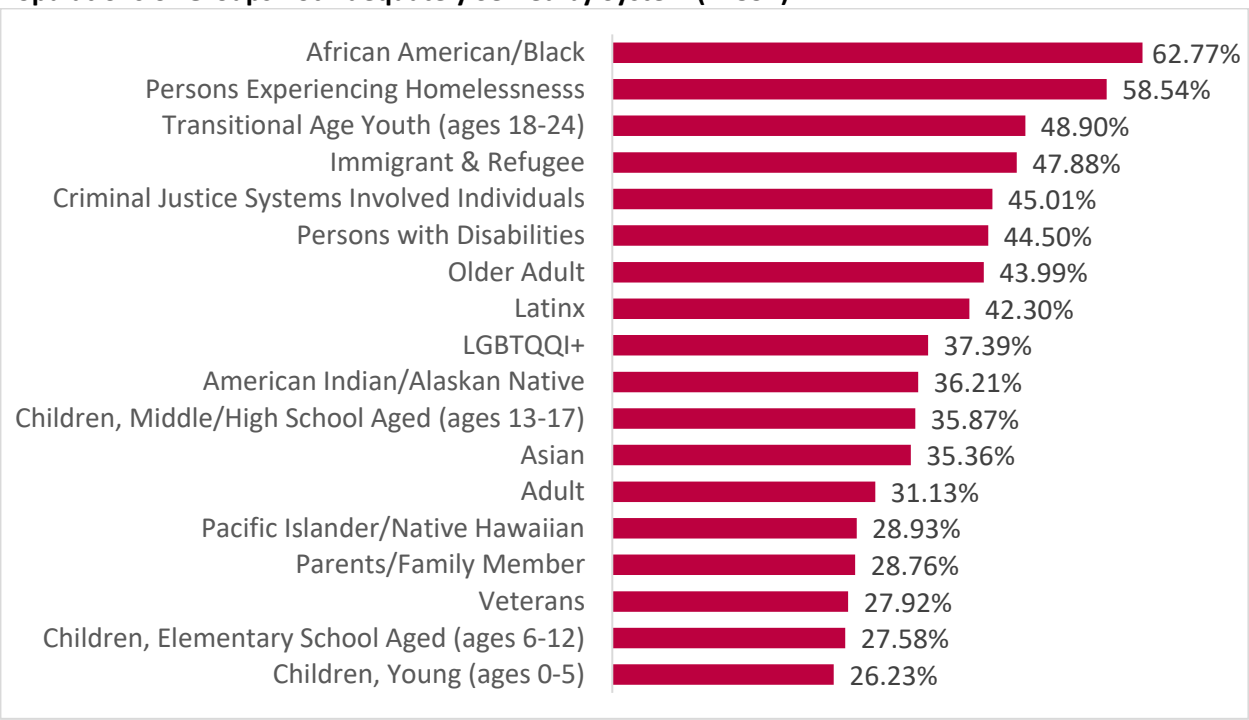
*Q3. What concerns related to Adults/Older Adults are most important to you and/or your family member(s)? (Rate in order with 1 as "Absolutely Essential" to 5 as being "Not a Priority at this time").*

**Concerns Related to Adults/Older Adults (n=627)**




*Q4. Are there any populations or groups of people whom you believe are not being adequately served by the behavioral health system of Alameda County? (Please select all that apply)*

**Populations or Groups not Adequately Served by System (n=591)**



*Q5. Based on your answers for Question 4, please identify who you feel are the three most underserved groups (please be specific).*

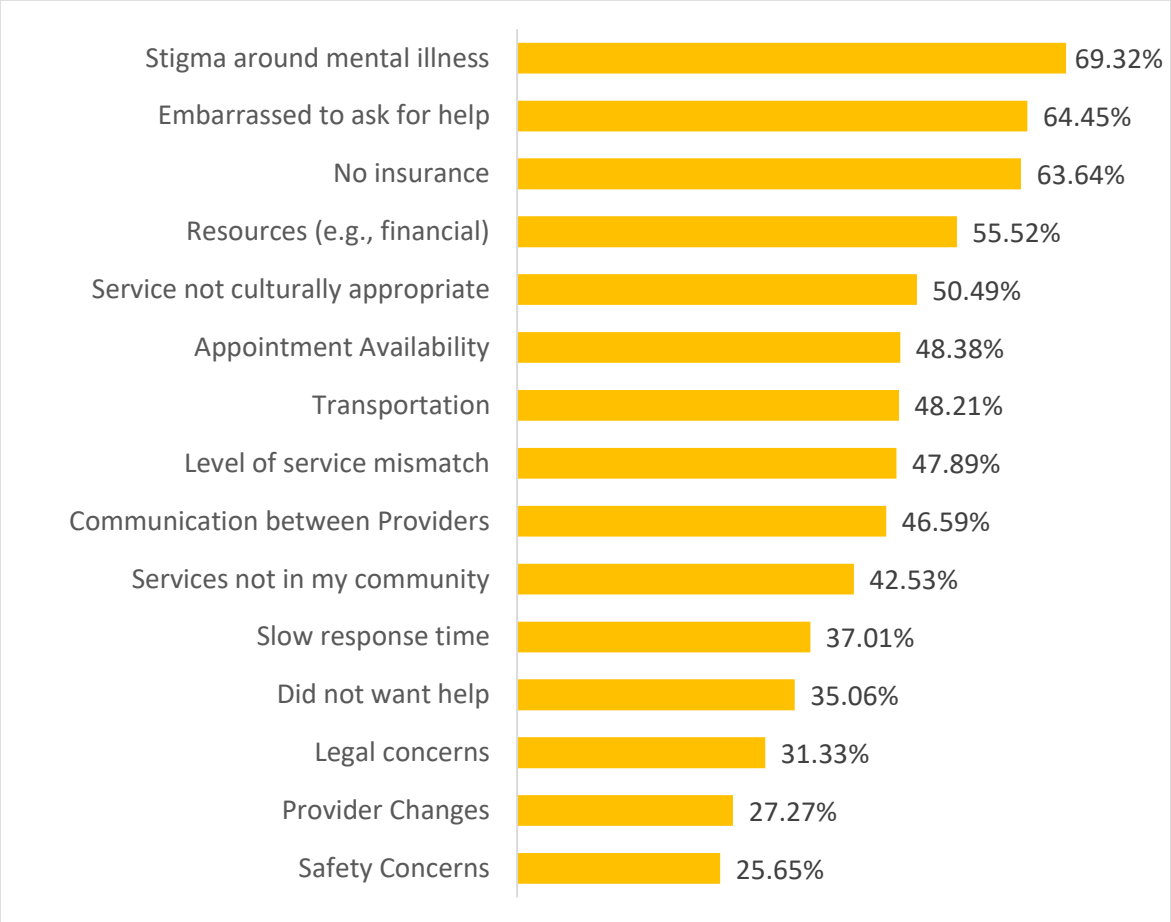
**Most Underserved Populations or Groups Free Response (n= 554)**

| Population or Group | Number | Percent |
|---|---|---|
| African American/Black | 200 | 36.10% |
| Persons Experiencing Homelessness | 130 | 23.47% |
| Older Adults | 80 | 14.44% |

*Participants wrote in more than one group/population.

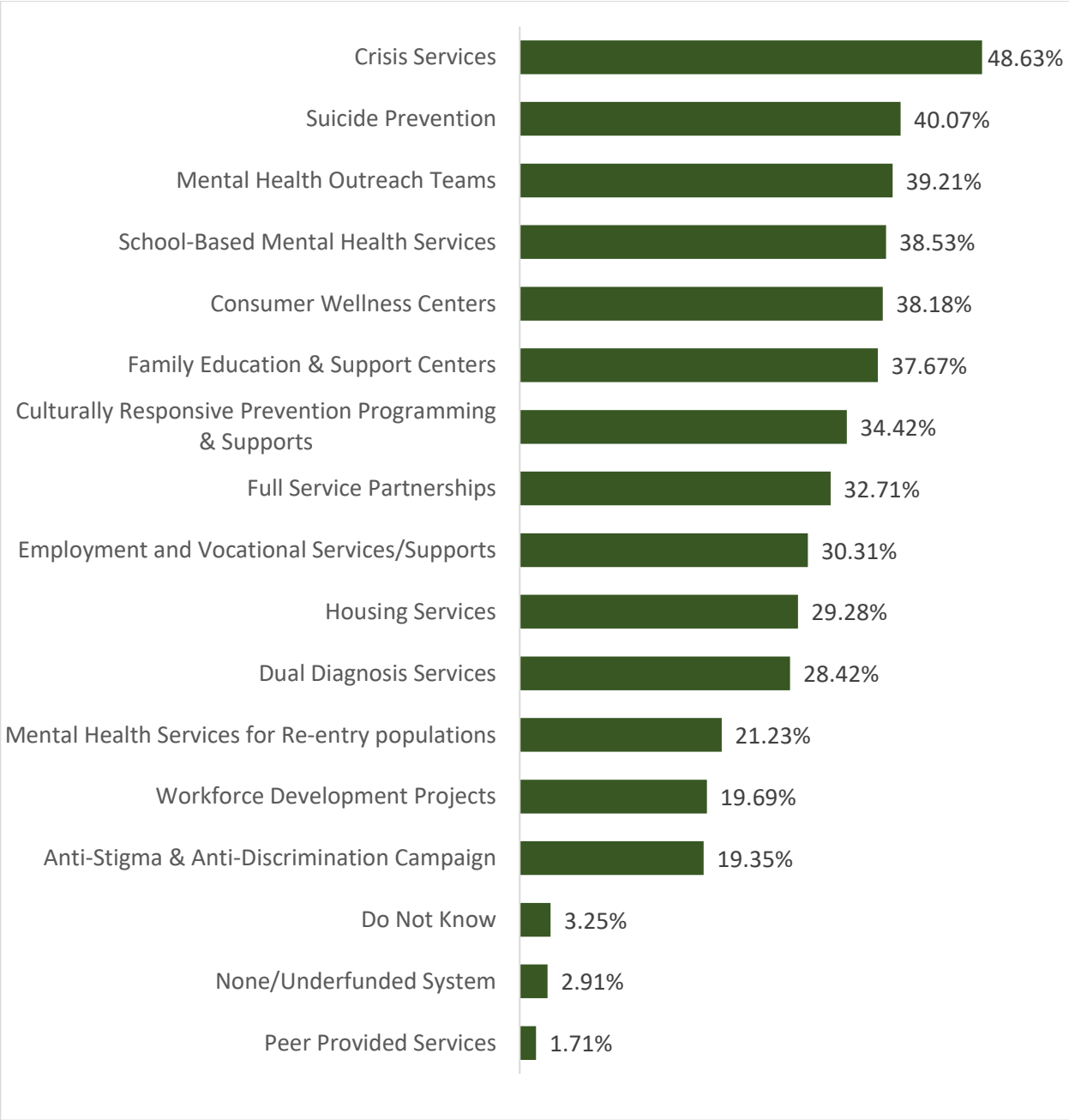
*Q6. What barriers make it more challenging for individuals and family member(s) with mental health challenges to access mental health services? (Please select all that apply)*

**Barriers to Accessing Mental Health Services (n=616)**



*Q7. Which of the following MHSA Service areas do you feel have been effective in addressing our local mental health concerns? (Please select all that apply)*

**Effective MHSA Service Areas (n= 584)**




*Q8. MHSA funds INNOVATIVE SERVICES to improve and transform our county mental health system. The goal of the Innovations program is to contribute to learning and improving our system in three ways: (a) introduce new mental health practices & approaches that have never been done before, (b) make a change to an existing mental health service, and (c) introduce a new community-driven approach that has been successful in a non-mental health setting. Please list innovative ideas which help improve mental health services:*

There were 358 respondents with 556 unduplicated ideas.

| 4

Innovative Idea 1: Community and Home-based Services

There were 69 respondents that wrote-in ideas in this area. Below are some selective responses from the survey:

> "Because of the limitations of Medi-Cal, I think more of these funds need to be utilized for Family Resource Centers and Early Childhood Mental Health Consultation. ECMHC has been proven to have positive impacts on development for children and FRC's have demonstrated impact on economic mobility of immediate neighborhood, even for those who don't directly receive services."

> "Have providers go the home, as often as necessary, like Trieste Italy does. Psychiatrists, Registered Nurses, Psychologists, etc. go to the home to PREVENT hospitalizations. This county does not have enough beds so this is the only way to help the SMI in crisis."

Innovative Idea 2: Outreach to Educate about Services and Decrease Stigma

There were 61 respondents that wrote-in ideas in this area. Below are some selective responses from the survey:

> "One idea is to have a roving mental health information vehicle. Sites and times where people can come to get more information via brochures, literature, etc, can be posted on various medias and handing out via postcards. Set times and sites with service on weekends also."

> "Create a cultural wellness center for API community with in language staff. Provide resource for outreach and engagement to reduce stigma."

Innovative Idea 3: School-based Services

There were 44 respondents that wrote-in ideas in this area. Below are some selective responses from the survey:

> "possibly adding full spectrum of services in elementary, middle, and high school similar to a full scale family resources centers; accessibility to tangible services from 7am to 5pm. Monday thru Friday. Possibly even adding a full scale family resource center at Laney, Chabot, Merritt, and Alameda community colleges."

> "Enhancing schools existing tiered support structures with tiered mental health services so that mental health providers are able to provide prevention and early intervention services. This allows schools to support students before their needs escalate to the point of medical necessity. Mental health providers are then freed up to serve all students, including those who may benefit from social skills groups that bolster protective factors and address risk factors before they escalate."

Innovative Idea 4: Integrate Culture

There were 31 respondents that wrote-in ideas in this area. Below are some selective responses from the survey:

> "Culturally accepted practices (spirituality, rituals, gatherings)."

> "More reliance on community and cultural knowledge as opposed to traditional book learning re: what's helpful for community members"

Innovative Idea 5: Care Coordination/Provider Communication

There were 27 respondents that wrote-in ideas in this area. Below are some selective responses from the survey:

> "agreements that allow for transfer of case conferencing information to allow for continuity of care."

> "Collaborative Partnerships b/tween existing organizations, e.g. schools/health centers; faith based/cbo's; city & county; primary health/behavioral health."

Innovative Idea 6: Creativity and Recreation-based Therapies

There were 23 respondents that wrote-in ideas in this area. Below are some selective responses from the survey:

> "Incorporating recreation, music, and the arts into mental health services and allowing that to be billable."

> "Engaging clients in ways that are not traditional mental health. Through culture specific healing practices, art, music, and connection to family and community."

Innovative Idea 7: Telehealth – Individual and Group

There were 23 respondents that wrote-in ideas in this area. Below are some selective responses from the survey:

> "Online community mental health sessions (e.g., mindfulness)."

> "Supporting clinical programs and consumers with greater access to telehealth. Supporting consumers with access to adequate cell phones with training to get set up with telehealth."

Innovative Idea 8: Increasing Peers in the Workforce

There were 22 respondents that wrote-in ideas in this area. Below are some selective responses from the survey:

> "Use community members such as promotoras or health educators to provide mental health support to community members that are not high need."

> "Peer specialists should be present as an option to deal with individuals who are having or been in a crisis. The peer specialist has lived experience and can assist in the wellness of the client."

Innovative Idea 9: Supporting Families

There were 14 respondents that wrote-in ideas in this area. Below are some selective responses from the survey:

> "allow billable support services to the family for collateral support, case management and

linkages. If we improve the family's health, we improve the client's mental health as well"

"Family treatment centers that are holistic- treating mental health, education, job, housing, connections, etc... with the whole family."

"there is an intervention for families who are struggling with their child's sexual orientation or gender identity; this intervention keeps kids in their family and prevents homeless youth."

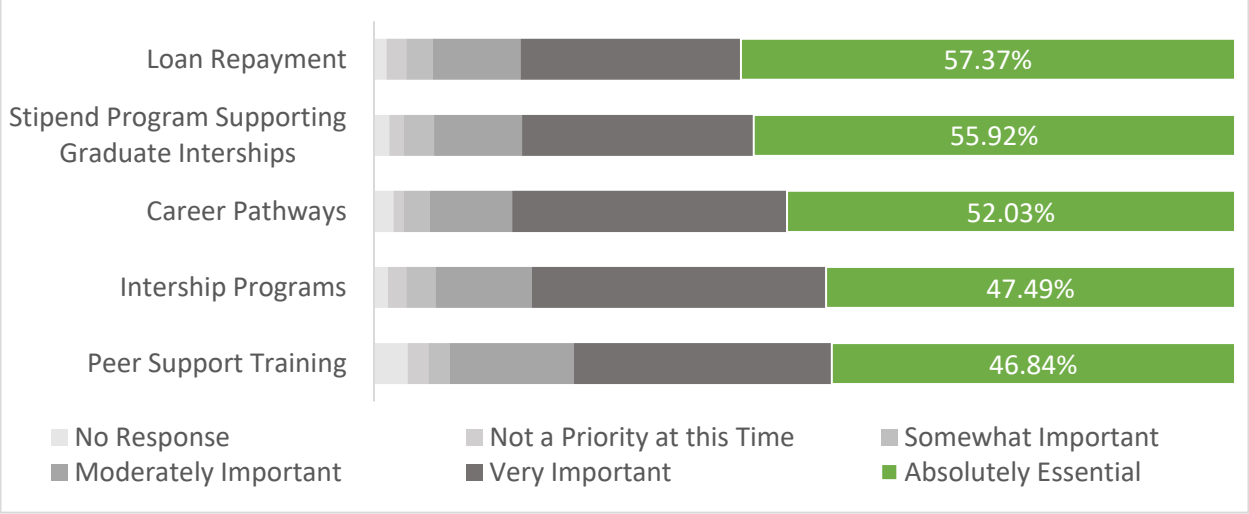
Innovative Idea 10: Evaluation

There were 5 respondents that wrote-in ideas in this area. Below are some selective responses from the survey:

"Better evaluation and follow-up on organizations who are partially or fully funded by the County, State & governmental agencies. Holding these community based programs more accountable to produce evidence base outcomes and a clear reduction in needed services for longterm mental health patients. Consequently, these programs are able to have a greater outreach to others' who may need mental health service support because there are more success stories among the mentally ill patient/ client who are no longer in need of Mental Health services and are able to re-enter the community, successfully."

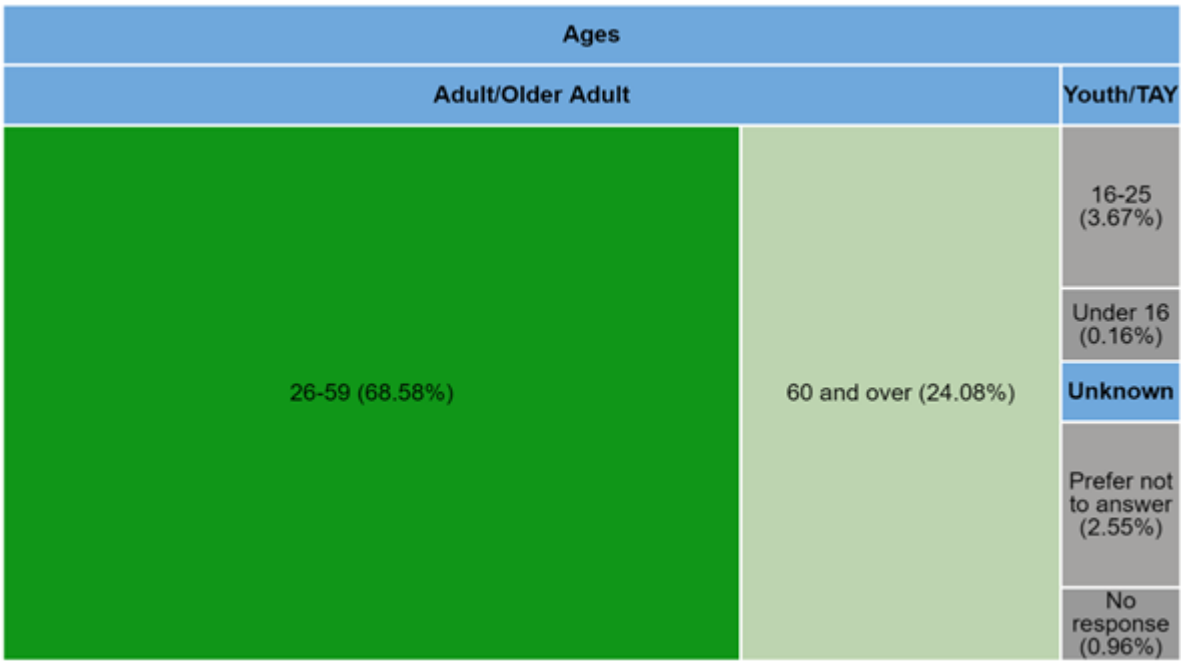
*Q9. MHSA funds WORKFORCE, EDUCATION & TRAINING activities to help develop a behavioral health workforce sufficient in size, diversity, language, and cultural responsiveness for consumers/family. Please rank the importance of the following Workforce Development strategies. (Rate in order with 1 as "Absolutely Essential" to 5 as being "Not a Priority at this time").*

**Essential WET Activities (n= 617)**



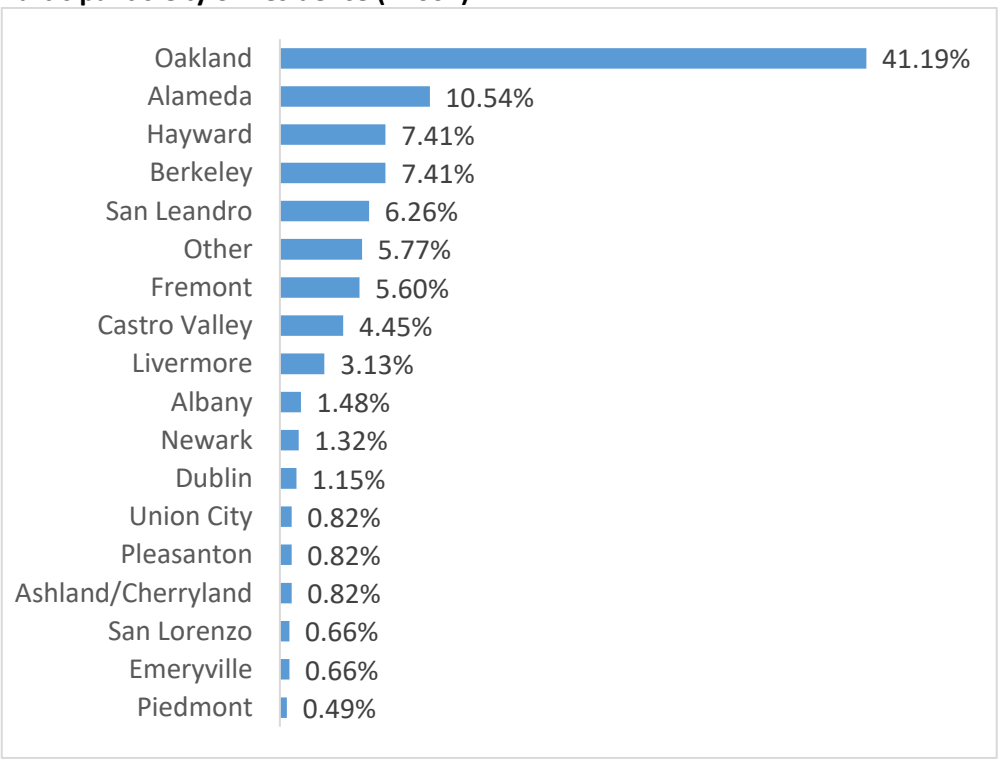
*Q10. My AGE RANGE is:*

**Participant's Age Groups (n=627)**



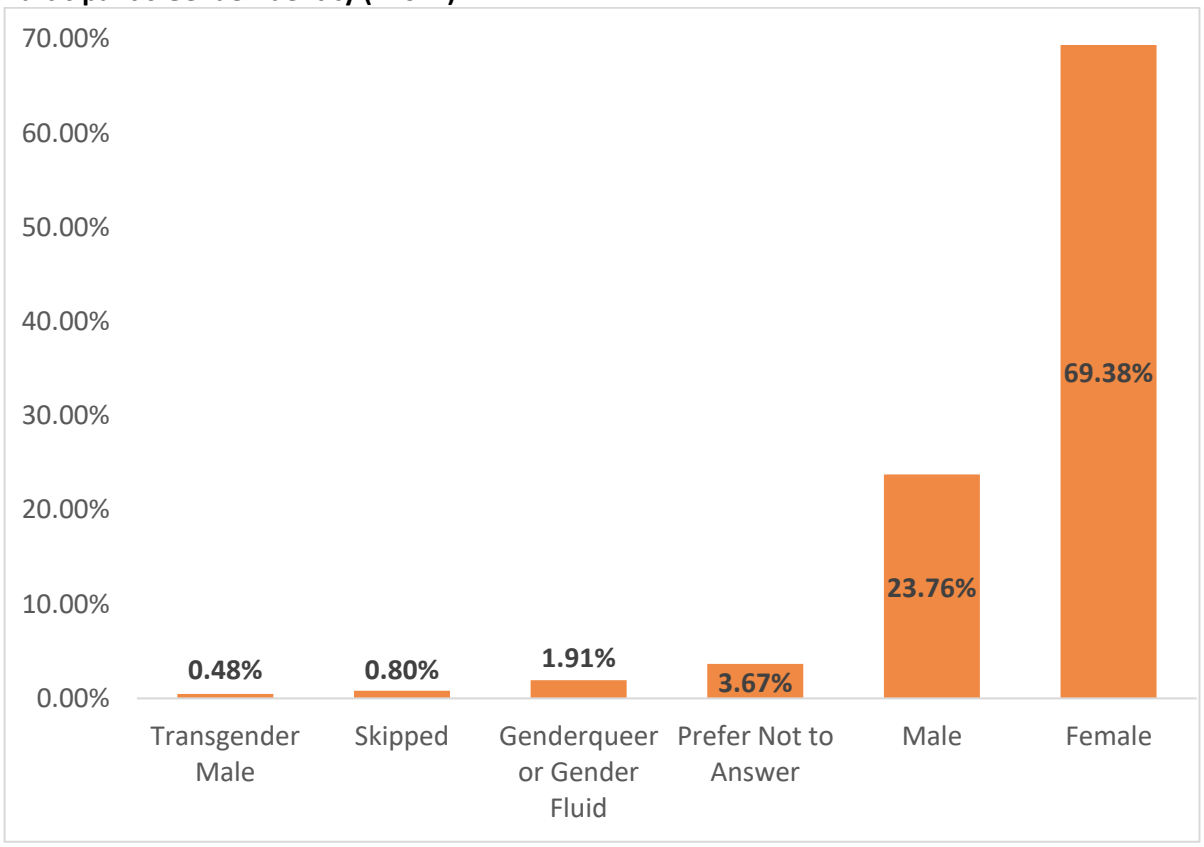

*Q11. In which part of Alameda County do you LIVE?*

**Participant's City of Residence (n=607)**



*Q12. What is your GENDER IDENTITY?*

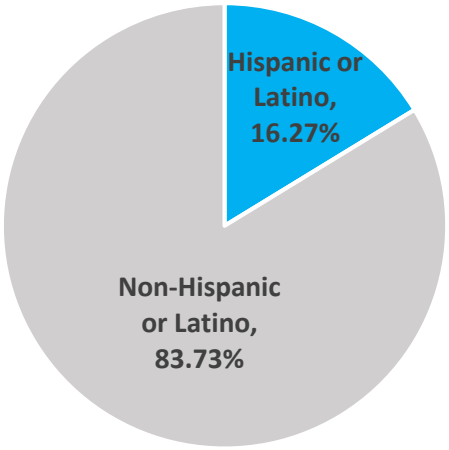
**Participant's Gender Identity (n=627)**




*No Transgender Female participants.

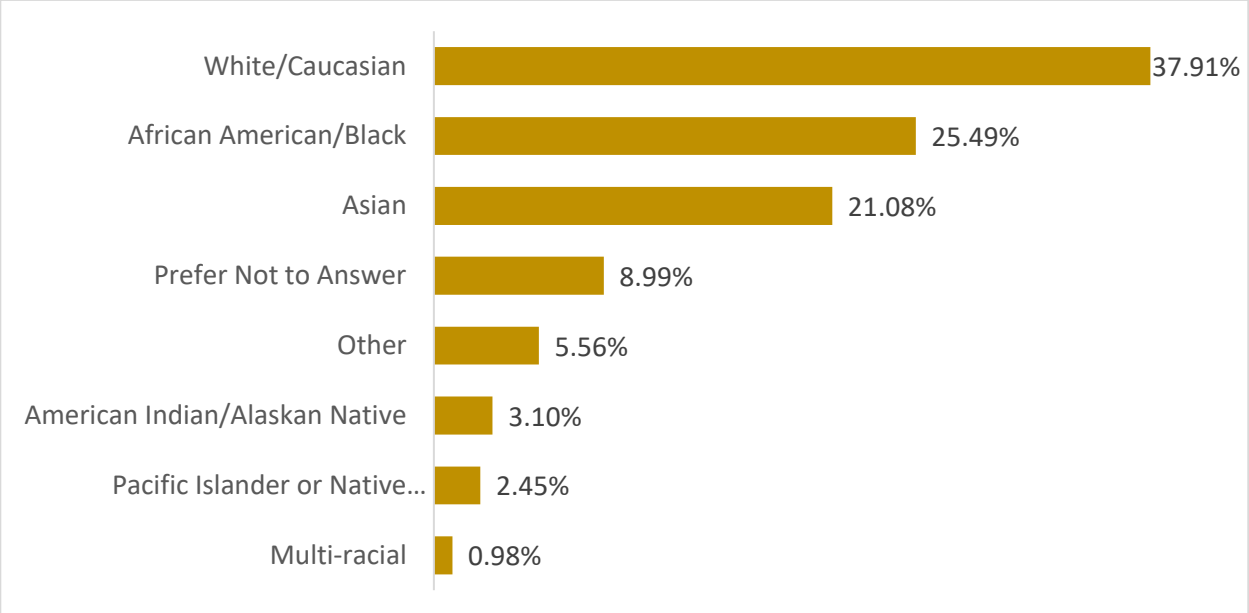
*Q13. What is your ETHNICITY?*

**Participant's Ethnicity (n= 553)**



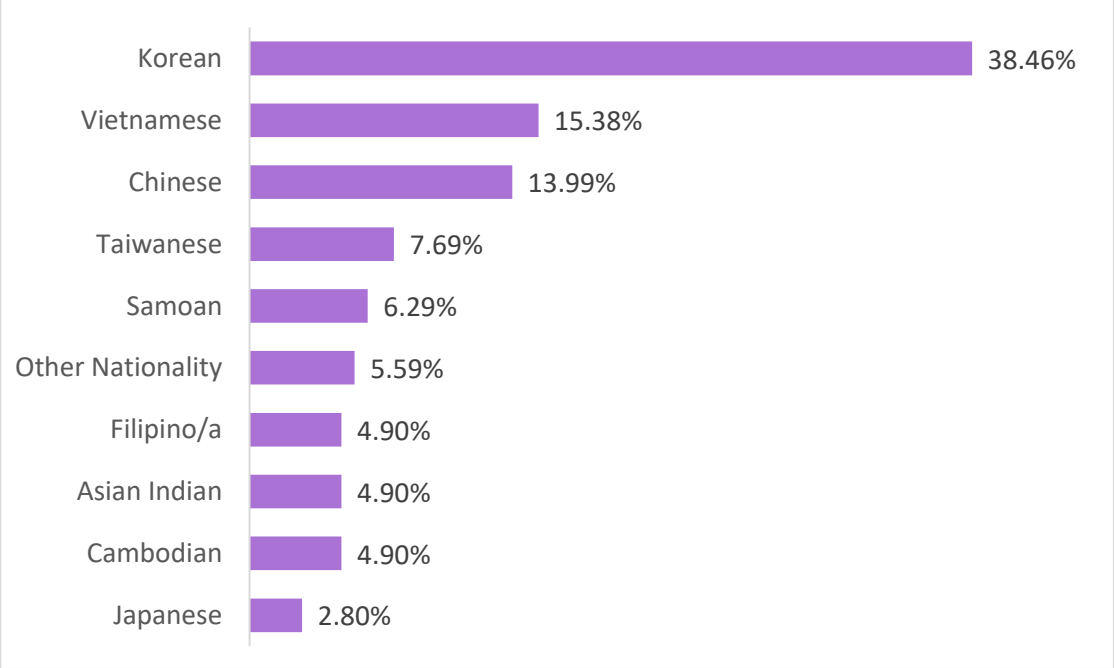
*Q14. What is your RACE? (Please select all that apply)*

**Participant's Race (n= 612)**



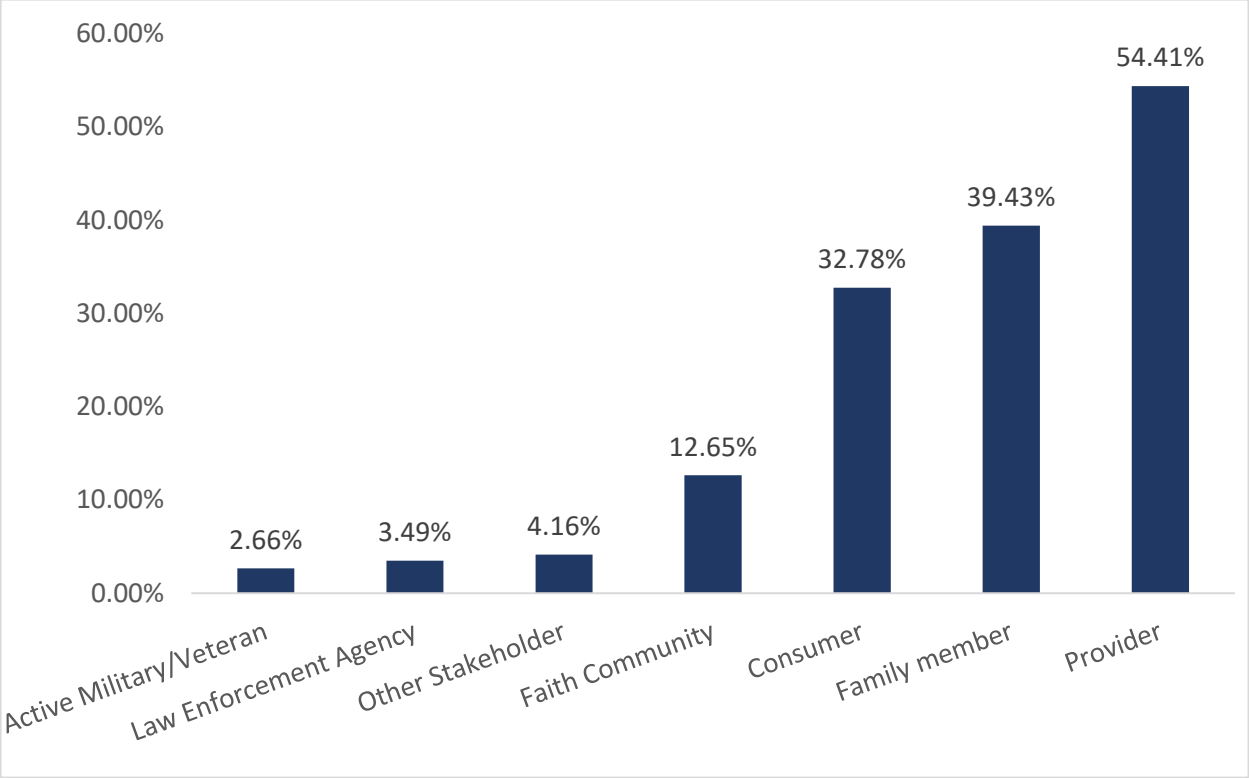

*Q15. If you marked "ASIAN OR PACIFIC ISLANDER" under question 14, please tell us about your nationality or country of origin? (Please select all that apply)*

**Participant's Nationality or Country of Origin (N= 144)**



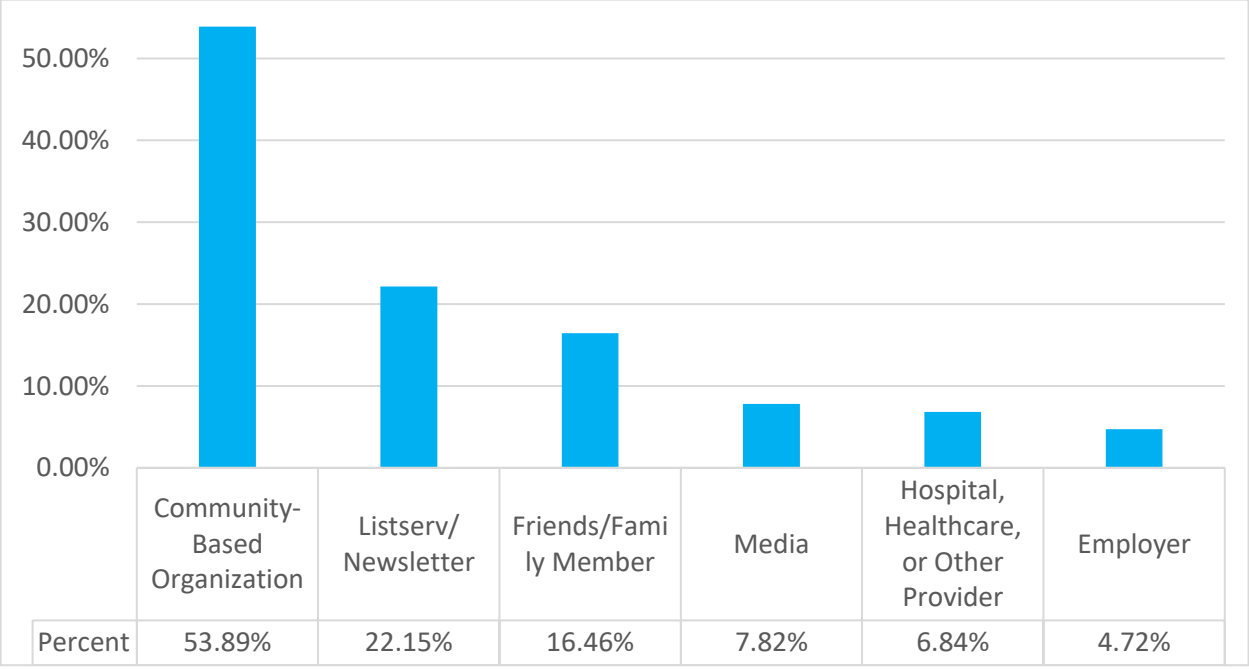
*Q16. Which of the following stakeholder group(s) do you primarily represent (Please select all that apply).*

**Participant's Stakeholder Group (n= 601)**




*Q17. How did you learn about the MHSA Community Participation & Feedback Survey? (Please select all that apply).*

**Learn about Community Participation and Feedback Survey (n=614)**




| | Community-Based Organization | Listserv/ Newsletter | Friends/Family Member | Media | Hospital, Healthcare, or Other Provider | Employer |
|---|---|---|---|---|---|---|
| Percent | 53.89% | 22.15% | 16.46% | 7.82% | 6.84% | 4.72% |

*Q18. What services are you receiving at this time? (Please select all that apply)*

**Services Received by Participants (n= 160)**

| Service | Number | Percent |
|---|---|---|
| Mental Health Services | 125 | 78.13% |
| Community Group | 51 | 31.88% |
| Vocational Rehabilitation | 14 | 8.75% |
| Homeless Services | 8 | 5.00% |
| Alcohol & Other Drug Services | 5 | 3.13% |

*Q19. COMMUNITY INPUT MEETING EVALUATION SECTION: Please tell us about your recent experience (If you did not attend a recent forum, please skip questions 19-22). What is your overall satisfaction with the MHSA Community Input Meeting today?*

**Participant's Satisfaction with the Meeting (n= 148)**


*Q20. Please share any comments about strengths of today's MHSA Community Input Meeting.*

Of the 58 participants that wrote strengths of the meeting the top three were:

1) Appreciate being asked (n= 19)
2) Informative (n= 8)
3) Survey was good (n= 7)

*Q21. Please share any comments about areas for improving today's MHSA Community Input Meeting.*

Of the 51 participants that suggested areas of improvement the top three were:

1) Survey improvements (n= 9)
2) More advertising of the meetings (n= 8)
3) Hope that the meetings lead to change (n= 5)

*Q22. For those who attended a recent Community Input Meeting, was it easy for you to understand the purpose of the forum?*

**Participant's Understanding Purpose of the Meeting (n= 69)**

| Response | Number | Percent |
|---|---|---|
| **Mostly Yes** | 65 | 94.20% |
| **Mostly No** | 4 | 5.80% |

*Q23. Thank you again for taking the time to provide your input on the County of Alameda's MHSA future plans. We appreciate you! To learn about more ways to get involved, please visit our website at https://acmhsa.org/ This area is for any additional comment you would like to give us.*

Of the 126 participants that wrote additional comments the top three subject areas were:

1) Suggested system changes (n = 57)
2) Appreciation for being asked to participate (n= 32)
3) Thankful for MHSA work and programs (n=16)

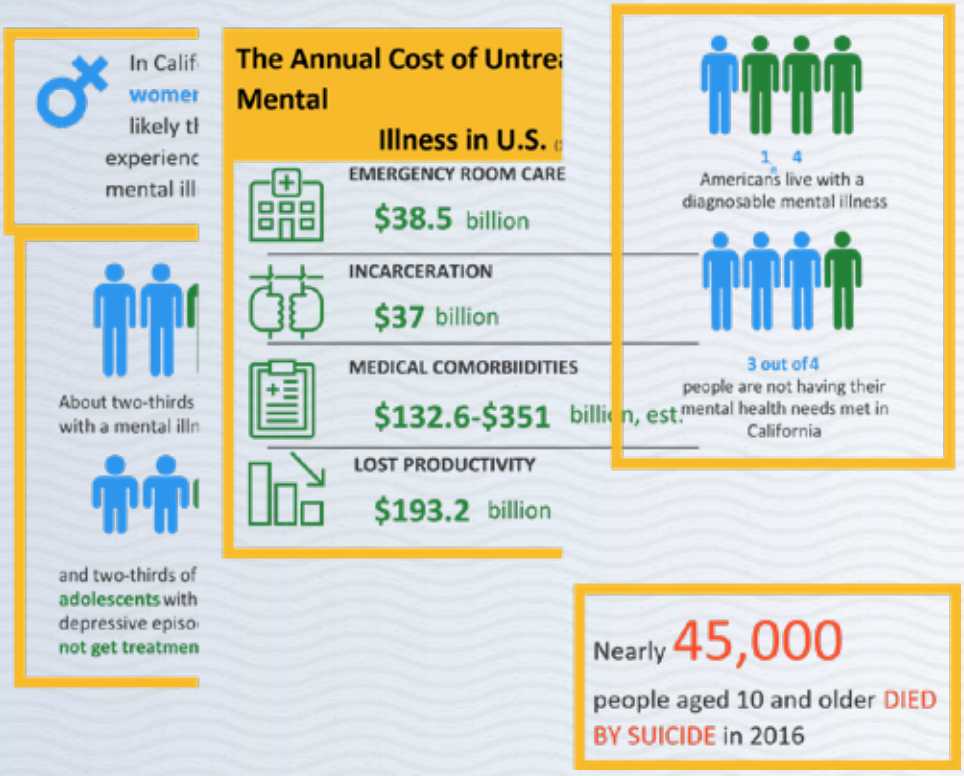
# Alameda County Prevention Services Make a Difference

## THE PROBLEM

More than two million Californians are affected by potentially disabling mental illnesses every year.

Research has shown that mental illness can lower or negatively impact a person's life expectancy. Adults in the U.S. living with serious mental illness (SMI) die at least 25 years earlier than the general population. This is largely due to treatable medical conditions.

In 2003, a report by the California Mental Health Planning Council estimated that as many as 1.7 million Californians were not receiving the mental health services they needed. As many as 80% of children with mental health needs were undiagnosed or unserved. The consequences of untreated mental illness were seen throughout health systems, schools, and the criminal justice system. To address these challenges, California voters passed Proposition 63, known as the Mental Health Services Act (MHSA), in 2004. It places a one percent tax on personal income above $1 million. MHSA was designed to expand and transform the mental health system while improving the quality of life for people living with mental health challenges. MHSA's core values include: community collaboration; cultural competence; consumer and family-driven services; focus on wellness, recover, resiliency; and integrated services for clients and families.



# Alameda County Prevention Services Make a Difference

alameda county behavioral health

One in 13 chil had a serious disturbance th with home, sc functioning.

In California, the rate of **suicide** was 10.9 suicides per 100,000 population in 2016; this represents a **14.8% increase** from the rate in 1999

Sources: MHSA 2017 Infographic; National Alliance on Mental Illness; Community Education Year End Report FY 17/18; California Health Care Almanac March 2018; National Association of State Mental Health Program Directors, Medical Directors Council, author, Morbidity and Mortality in People with Serious Mental Illness, 2006.

www.nasmhpd.org; CDC, 2019; (1) The Cost of Untreated Mental Illness January 2017 https://www.tccsc.org/single-post/2017/01/26/The-Cost-of-Untreated-Mental-Illness 1

## PREVENTION SOLUTIONS

Prevention programs address stigma reduction, increase protective factors and reduce risk factors, increasing resiliency, interpersonal connections and health and wellness for individuals, families and communities. Prevention programs engage individuals before the development of mental illness and prevent mental illness from becoming severe and disabling. These services are designed for residents who are unserved, underserved, and inappropriately served. Prevention programs emphasize strategies to reduce the following negative outcomes:

- Suicide,Unemployment,Homelessness, and Incarcerations,Prolonged suffering,
- Removal of children from their homes
- School failure or dropout,

**Prevention activities include:**

- Build protective factors and reduce risk factors for developing a serious mental illness. focus on or intended outcomes for at-risk individuals.
- Improve mental health for individuals/groups whose risk of developing a potentially serious mental illness is
- Strategies such as information campaigns, survivor informed models, training, and education.
- Relapse prevention for individuals recovering from a serious mental illness.

**Suicide Prevention activities include:**

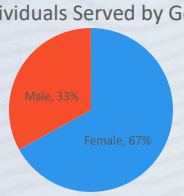
- Preventing suicide as a consequence of mental illness without a potentially
- Prevention or early intervention programs.
- screening greater than average.

## Alameda County Prevention Services in FY 17/18

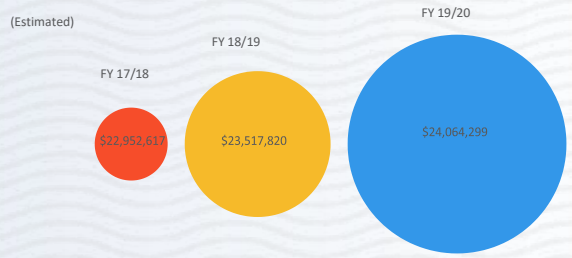
20 Ongoing Prevention Programs

1 Suicide Prevention Program

Individuals Served by Gender




Total Prevention Mental Health Expenditures



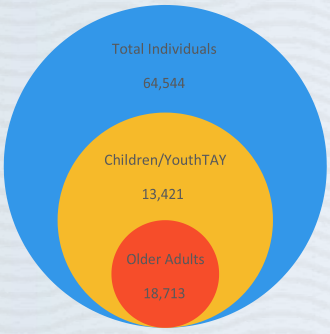
# Alameda County Prevention Services Make a Difference

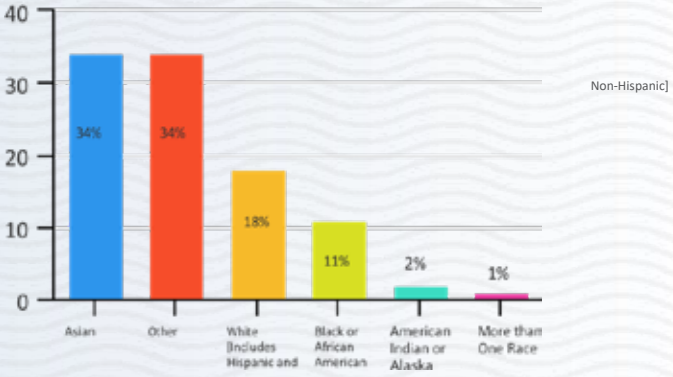
alameda county behavioral health

Conducted Prevention Outreach to **20,956** potential responders

Individuals Served by Race/Ethnicity

Number of Individuals Served Through Prevention Services




Native

Non-Hispanic]

Sources: MHSA 2017 Infographic; MHSA Annual Plan Update FY 18-19; MHSA 3-Year Plan FY 18-20; (PEI Trends Report); MHSOAC Prevention and Early Intervention Trends Report 2011

2

# Alameda County Prevention Services Make a Difference

## PREVENTION IN ACTION

**Underserved Ethnic Language Population (UELP)**

Each UELP program is built on a framework of three core strategies: 1) Outreach & Engagement, 2) Mental Health Consultation, and 3) Early Intervention services. These strategies are implemented through a variety of services, including one-on-one outreach events; psycho-educational workshops/classes; mental health consultation sessions with a variety of stakeholders (e.g., families, teachers, faith community, and community leaders); support groups; traditional healing workshops; radio/television/blogging activities; and short-term, low-intensity early intervention counseling sessions for individuals and families who are experiencing early signs and symptoms of a mental health concern.

Several years of data had demonstrated that the UELP programming is the optimal design for improving the health and wellness of these often marginalized populations, by meeting their cultural, language, mental, and emotional needs. In FY 17/18, Alameda County was awarded a National Association of Counties (NACo) Achievement Award for the work with UELP and serves as a national model for local governments.

UELP is continuing to transform the way mental health services are provided to underserved and unserved populations in Alameda County.

- Successes/Outcomes from FY 18/19:

7,895 Prevention events, which is a 37% increase from last year;
56,848 people were served at these Prevention events (duplicated count)

Survey respondents reported improved quality of life because of their programs. The data has shown improvements in the areas of mental health, emotional health, stress, and family.

Emotional Support60 %Mental Health 58% Stress52 % Family40 %

- *"Helpful always, good people making me better."*
-
-

*-Prevention Participant*

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

Wellness Centers provide a welcoming entry point for outpatient services for individuals who are unserved or underserved by the mental health system, including a step-down service for individuals transitioning from BHCS specialty mental health services. Wellness Centers provide services in an environment of inclusion and, more often than not, are managed and staffed by consumers who provide peer support, wellness, and recovery-oriented education.

# Alameda County Prevention Services Make a Difference

Successes/Outcomes from FY 17/18:

All of BACS wellness centers (WC) have increased efforts to connect participants with other resources. In total, nearly 800 referrals were made to ACCESS, housing support, and psychiatric services. Of these, nearly 600 referrals were for housing.
Reached 2,884 unduplicated individuals
More than 17,000 hours of peer counselor/site supervisor direct support to WC participants.

**Crisis Support Services of Alameda County (CSS)** SUICIDE PREVENTION

Crisis Support Services of Alameda County (CSS) is a nonprofit, volunteer-based crisis intervention and suicide prevention agency. Services include crisis hotline, school-based suicide prevention training, community gatekeeper trainings and consultation, Mental Health First Aid, teen text line, Trauma Informed Care (TIC) trainings, grief counseling for all ages and crisis event counseling.

Successes/Outcomes from FY 17/18:

**Crisis Line:**

Total Call Volume 57,551 calls

Call from Transitional-Age Youth 3,342 calls

Only 39% of high-risk calls resulted in police intervention and hospitalization. Utilizing collaborative problem solving and safety planning, the crisis line counselors deescalated suicidal crisis over the phone, evaluating and connecting the callers with suicidal desire and intent to their coping

**Text Line:**

Served 361 individuals, the highest number of unduplicated texters in a fiscal year since the start of the program.

**Community Education:**

887 completed sessions this year, more than doubled the number of completed sessions compared to last year at 434 sessions.

Teens for Life program reached 8,491 youth in 12 middle and high school-aged completed problem solving and safety planning, school districts.

Community Gatekeeper 1,264 adults

*"I think that receiving education on suicide is helpful, because it shows that you are not alone - 6th Grade Student*

*"You guys helped me wanna live." – Texter*

skills and their support network. Not only is this cost-saving to the county Behavioral Health Care system, it also reduces further traumatization that may occur when interacting with law enforcement agencies or mental health institutions.

*on this and other people will try and help you."*

Sources: Alameda County Behavioral Health UELP FY 18_19 Evaluation Report.pdf; MHSA Annual Plan Update FY 18-19; Text Line Program Year End FY 17/18; Crisis Line Program Year End Report FY 17/18; Community Education Year End Report FY 17/18

3

## Prevention and Early Intervention (PEI) FY 19/20 Program Allocations and Age Groups

| PEI # | Program | Age Group (s) | Allocation | | |
|---|---|---|---|---|---|
| | **Prevention** | | **FFP** | **MHSA Portion** | **Total Budget** |
| **1A** | School-Based MH Consultation in Preschools-Blue Skies | 0-5 | $109,378 | $844,507 | $953,885 |
| **5** | Outreach, Education & Consultation, (Latino Community) – La Clinica | All ages | NA | $1,035,907 | $1,277,254 |
| **6** | Outreach, Education & Consultation (API Comm.) – Asian Health Services | All ages | NA | $590,035 | $590,035 |
| **6** | Outreach, Education & Consultation (API Comm.) - CERI | All ages | NA | $433,269 | $553,552 |
| **6** | Outreach, Education & Consultation (API Comm.) - CHAA | All ages | NA | $504,190 | $609,956 |
| **6** | Outreach, Education & Consultation (API Comm.) - KCCEB | All ages | NA | $241,667 | $241,667 |
| **6** | Outreach, Education & Consultation (API Comm.) - RAMS | All ages | NA | $290,000 | $290,000 |
| **6** | Outreach, Education & Consultation (API Comm.) - Tri City Health Center | All ages | NA | $290,000 | $290,000 |
| **7** | Outreach, Education & Consultation (So. Asian/Afghan Comm.) Afghan Wellness | All ages | NA | $260,960 | $280,000 |
| **7** | Outreach, Education & Consultation (So. Asian/Afghan Comm.) – Filipino Wellness | All ages | NA | $290,000 | $290,000 |
| **7** | Outreach, Education & Consultation (So. Asian/Afghan Comm.) - IRC | All ages | NA | $280,000 | $280,000 |
| **7** | Outreach, Education & Consultation (So. Asian/Afghan Comm.) – Hume Center | All ages | NA | $532,504 | $580,000 |

| PEI # | Program | Age Group (s) | Allocation | | |
|---|---|---|---|---|---|
| | **Prevention** | | **FFP** | **MHSA Portion** | **Total Budget** |
| **8** | Outreach, Education & Consultation – (Native American Community) – Native American Health Center | All ages | NA | $238,669 | $294,888 |
| **10** | Outreach, Education & Consultation (African Comm.) PTR | All ages | NA | $233,901 | $289,901 |
| **14** | Family Education & Resource Center (FERC) *(Program moved to CSS Component)* | TAY, Adult. Older Adult | NA | $1,684,982 | $1,718,538 |
| **20A** | Culturally Responsive Programs for African Americans-Beats, Rhymes & Life | TAY | NA | $279,450 | $279,450 |
| **20D** | Culturally Responsive Programs for African Americans-Restorative Justice for Oakland Youth (RJOY) | All ages | NA | $415,227 | $415,227 |
| **20E** | Culturally Responsive Programs for African Americans-PEERS | TAY, Adult. Older Adult | NA | $208,658 | $208,658 |
| **23** | Mentors on Discharge-Post Crisis Peer Mentoring | TAY, Adult, Older Adult | NA | $330,526 | $330,526 |
| **24** | Sobrante Park Community Project-Roots Community Health Center | Youth, TAY, Adult | | | |
| | **Early Intervention** | | | | |
| **2** | Early Intervention for the Onset of First Psychosis & SMI Among TAY | TAY | $445,818 | $820,958 | $1,266,776 |
| **3** | Mental Health for Older Adults, Geriatric Assessment & Response Team (GART) | Older Adults | $256,110 | $597,589 | $853,699 |
| **17A** | TAY Resource Centers-Youth Uprising | Youth, TAY | NA | $368,977 | $368,977 |
| **17B** | TAY Resource Centers-REACH Ashland | Child/Youth, TAY | $152,400 | $355,601 | $508,001 |

| PEI # | Program | Age Group (s) | Allocation | | |
|---|---|---|---|---|---|
| | **Outreach** | | **FFP** | **MHSA Portion** | **Total Budget** |
| **1C** | Early Childhood Mental Health Outreach & Consultation | 0-8 | NA | $300,000 | $300,000 |
| **1D** | Unaccompanied Immigrant Youth Outreach (UIY) | Youth, TAY | NA | $724,542 | $724,542 |
| **1E** | School-Based Mental Health Outreach | Child/Youth, TAY | NA | $157,626 | $157,626 |
| **1F** | Community-Based Mental Health Outreach & Consultation | Child/Youth, TAY, Adult | NA | $161,568 | $161,568 |
| **13** | Wellness, Recovery and Resiliency Services *(Program moved to CSS Component, OESD 18)* | NA | NA | NA | NA |
| **13** | Wellness, Recovery and Resiliency Services WRAP-PEERS | Youth, TAY, Adult, Older Adult | NA | $185,507 | $185,507 |
| **19** | Older Adult Peer Support-City of Fremont | Older Adult | NA | $60,390 | $60,390 |
| **20B** | Culturally Responsive Programs for African Americans-Black Men Speak | Adult, Older Adult | NA | $70,000 | $70,000 |
| **20C** | Culturally Responsive Programs for African Americans-Family Support | TAY, Adult, Older Adult | NA | $38,036 | $38,036 |
| **22** | Pacific Center LGBT Support Services | TAY, Adult, Older Adult | NA | $110,594 | $110,594 |
| **22** | Pacific Center Technical Assistance | TAY, Adult, Older Adult | NA | $217,350 | $217,350 |
| | **Access and Linkage** | | | | |
| **1B** | School-Based MH Access & Linkage in Elementary, Middle & High School | Children, Youth, TAY | NA | $1,696,509 | $1,696,509 |
| **15** | Acute Crisis Care and Evaluation for System-Wide Services (ACCESS) Staffing for Asian Population *(Program moved to CSS Component, OESD, 14)* | NA | NA | NA | NA |

| PEI # | Program | Age Group (s) | Allocation | | |
|---|---|---|---|---|---|
| | **Access and Linkage** | | **FFP** | **MHSA Portion** | **Total Budget** |
| **16** | Acute Crisis Care and Evaluation for System-Wide Services (ACCESS) Staffing for Latino Population *(Program moved to CSS Component, OESD, 15)* | NA | NA | NA | NA |
| | **Stigma and Discrimination Reduction Programs** | | | | |
| **4** | Stigma & Discrimination Reduction Campaign - "Everyone Counts" | TAY, Adult. Older Adult | $31,361 | $1,364,515 | $1,395,876 |
| | **Suicide Prevention** | | | | |
| **12** | Crisis Support Services Suicide Prevention Text Line | Youth, TAY, Adults | NA | $1,837,346 | $1,918,260 |

**Subject #:** _____ **Site:** _____

**Interviewer #:** _____ **Date:** _____

**Interviewer:** _____

**Interview: Pre** _____ **Post**_____

# Stigma Reduction

# Resisting Internalized Stigma Groups

## Pre-Post Assessment

## **SECTION A:** Background

*I. Demographics*

**A1. What is your current marital status (circle *only* one)?**

| | | | |
|---|---|---|---|
| 1 | Married | 4 | Separated |
| 2 | Widowed | 5 | Never Married |
| 3 | Divorced | 6 | Cohabitating |

**A2. Are you employed?**

1= yes, full-time
2= yes, part-time
3= retired
4= unemployed
5= student
888=refused

**A3. What is/was your occupation? (Last full-time job)** (specify and code)

| | |
|---|---|
| 1 | Executive and Proprietors of Large Concerns and Major Professionals (MD's, lawyers, and professors) |
| 2 | Managers and Proprietors of Medium Concerns and Minor Professionals (elementary and high school teachers and RNs) |
| 3 | Administrative Personnel of Large Concerns, Owners of Small, Independent Businesses and Semi-professionals (artists, actors, computer programmers) |
| 4 | Owners of Little Businesses, Clerical and Sales Workers and Technicians |
| 5 | Skilled Workers (Tailors, carpenters, policemen, firemen) |
| 6 | Semi-skilled workers (nurses' aides, machine operators) |
| 7 | Unskilled workers (waiter, assembly-line worker) |
| 8 | Housewife |
| 9 | Unknown |
| 10 | Student |

**A4. How far did you go in school?** (Record years using code below).

222 = no schooling
8 = completed 8th grade
12 = completed 12th grade
16 = completed college, and so forth Code: _____ 999

**A5. How old are you?** _____

**A6. Ethnic/ Racial group:** ***(code; if unclear, ask, "Do you consider yourself to be a member of a particular race or ethnic group? What is it?")***

| | | | |
|---|---|---|---|
| 1 | Asian | 4 | White |
| 2 | Black | 5 | Other (Specify) |
| 3 | Hispanic | | |

**A7. Sex:**

1 = Male 2= Female

## **SECTION B**: Primary (Stigma) Outcome Measures

There are many attitudes about mental illness. We would like to know what you think most of the public as a whole (or most people) believe about these attitudes. Please answer the following items using the 9-point scale below.

| I strongly Disagree | | | neither agree nor disagree | | | | | I strongly agree |
|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |

Section 1:

# I think the public believes…

1. _____ most persons with mental illness cannot be trusted.
2. _____ most persons with mental illness are disgusting.
3. _____ most persons with mental illness are unable to get or keep a regular job.
4. _____ most persons with mental illness are dirty and unkempt.
5. _____ most persons with mental illness are to blame for their problems.
6. _____ most persons with mental illness are below average in intelligence.
7. _____ most persons with mental illness are unpredictable.
8. _____ most persons with mental illness will not recover or get better.
9. _____ most persons with mental illness are dangerous.
10. _____ most persons with mental illness are unable to take care of themselves.

Section 2:
Now answer the next 10 items using the agreement scale.

| I strongly Disagree | | | neither agree nor disagree | | | | | I strongly agree |
|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |

# I think…

1. _____ most persons with mental illness are to blame for their problems.

2. _____ most persons with mental illness are unpredictable.

3. _____ most persons with mental illness will not recover or get better.

4. _____ most persons with mental illness are unable to get or keep a regular job.

5. _____ most persons with mental illness are dirty and unkempt.

6. _____ most persons with mental illness are dangerous.

7. _____ most persons with mental illness cannot be trusted.

8. _____ most persons with mental illness are below average in intelligence.

9. _____ most persons with mental illness are unable to take care of themselves.

10. _____ most persons with mental illness are disgusting.

Section 3

Finally, answer the next 10 items using the agreement scale.

| I strongly Disagree | | | neither agree nor disagree | | | | | I strongly agree |
|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |

# I currently respect myself less…

1. _____ because I am unable to take care of myself.

2. _____ because I am unable to get or keep a regular job.

3. _____ because I am dangerous.

4. _____ because I cannot be trusted.

5. _____ because I am to blame for my problems.

6._____ because I will not recover or get better.

7. _____ because I am disgusting.

8. _____ because I am unpredictable.

9. _____ because I am dirty and unkempt.

10. _____ because I am below average in intelligence.

**Corringan, Validation of Self-Stigma of Mental Illness Scale**

Corrigan, P.W., Watson, A.C., & Barr, L. (2006). The self-stigma of mental illness: Implications for self-esteem and self-efficacy. Journal of Social and Clinical Psychology, 25 (8), 875-884.

Fung, K. M. T., Tsang, H. W. H., Corrigan, P. W., & Lam, C. S. (2007). Measuring self-stigma of mental illness in China and its implications for recovery. International Journal of Social Psychiatry, 53, 408-418.

## *III. Self Protective Withdrawal:*

**Modified Theory Labeling Approach (Link et al. 1989)**

**Directions:** On a scale from 1-6, where 1 means you strongly agree and 6 means you strongly disagree, please respond to the following statements.

B1. In order to get a job, a former mentally ill patient will have to hide his or her history of hospitalization

| Strongly Agree | | | | | Strongly Disagree |
|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 |

B2. If a person was treated for a serious mental illness, the best thing for them to do is to keep it a secret

| Strongly Agree | | | | | Strongly Disagree |
|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 |

B3. If I was in psychiatric treatment, I would feel the need to hide it

| Strongly Agree | | | | | Strongly Disagree |
|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 |

B4. I've found that it's best to help the people close to me understand what psychiatric treatment is

| Strongly Agree | | | | | Strongly Disagree |
|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 |

B5. It is easier for me to be friendly with people who have been psychiatric patients

| Strongly Agree | | | | | Strongly Disagree |
|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 |

B6. If I believed that a person I knew thought less of me because I have been in psychiatric treatment, I would try to avoid him or her

| Strongly Agree | | | | | Strongly Disagree |
|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 |

B7. When I meet people for the first time, I make a special effort to keep the fact that I have been in psychiatric treatment to myself

| Strongly Agree | | | | | Strongly Disagree |
|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 |

## **SECTION C**: Secondary (Support, Distress, and Burden) Outcome Measures

### *I. Social Support:*

**Abbreviated Duke Social Support Scale (Koenig et al., 1993)**

Next are some questions relating to your social interaction and support system.

***Social Interaction Subscale***

**C1.** Number of family members within 1 hour's travel that you can depend on or feel close to _____

**C2.** Number of times past week spent time with someone not living with _____

**C3.** Number of times past week talked with friends/relatives on telephone _____

**C4.** Number of times past week attended meetings of clubs, religious groups, or other groups that you belong to (other than work) _____

***Subjective Support Subscale***

| | | |
|---|---|---|
| **C5.** | Do family and friends understand you? | Y or N |
| **C6.** | Do you feel useful to family and friends? | Y or N |
| **C7.** | Do you know what's happening with family and friends? | Y or N |
| **C8.** | Do you feel listened to by family and friends? | Y or N |
| **C9.** | Do you feel you have a definite role in family and among friends? | Y or N |
| **C10.** | Can you talk about your deepest problem? | Y or N |
| **C11.** | Are you satisfied with relationships with family and friends? | Y or N |

## *II. Depressive Symptoms:*

**Center for Epidemiological Studies of Depression Scale (CES-D, Radliff, 1977)**

**Directions:** I will read you some statements about how you might have felt during the past week. Please listen to each statement and tell me if you felt this way:

| | |
|---|---|
| **Rarely or none of the time (less than one day)** | **1** |
| **Some or a little of the time (one to two days)** | **2** |
| **Occasionally or a moderate amount of time (three to four days)** | **3** |
| **Most or all of the time (five to seven days)** | **4** |
| **Don't know** | **777** |
| **Refusal to answer** | **888** |
| **Not applicable** | **999** |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **C12. I was bothered by things that don't usually bother me.** | 1 | 2 | 3 | 4 | 777 | 888 | 999 |
| **C13. I had trouble keeping my mind on what I was doing.** | 1 | 2 | 3 | 4 | 777 | 888 | 999 |
| **C14. I felt depressed.** | 1 | 2 | 3 | 4 | 777 | 888 | 999 |
| **C15. I felt that everything I did was an effort.** | 1 | 2 | 3 | 4 | 777 | 888 | 999 |
| **C16. I felt hopeful about the future.** | 1 | 2 | 3 | 4 | 777 | 888 | 999 |
| **C17. I felt fearful.** | 1 | 2 | 3 | 4 | 777 | 888 | 999 |
| **C18. My sleep was restless.** | 1 | 2 | 3 | 4 | 777 | 888 | 999 |
| **C19. I was happy.** | 1 | 2 | 3 | 4 | 777 | 888 | 999 |
| **C20. I felt lonely.** | 1 | 2 | 3 | 4 | 777 | 888 | 999 |
| **C21. I could not get "going."** | 1 | 2 | 3 | 4 | 777 | 888 | 999 |

## *III. Mental Health History*

**A8. At what age were you first treated for symptoms of mental illness?**

**Age =** _____

**A9. Have you ever been hospitalized for mental illness?**

_____ Yes _____No

**A11. If yes, at what age were you first hospitalized?**

**Age =** _____ (999 = NA)

**A12. How many times in total have you been hospitalized for symptoms of schizophrenia mental illness?** ***(Encourage estimation, or get a range if that is easier and take the mean. Do not leave blank).***

# of times = _____

## Recovery Assessment Scale

Instructions: I am going to read a list of statement that described how people sometimes feel about themselves and their lives. Please listen carefully to each one and indicate the response that best describes the extent to which you agree or disagree with the statement. For each of the statement, please indicate whether you strongly disagree (1), disagree (2), not sure (3), agree (4), or strongly agree (5) with these statements.

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Strongly Disagree | Disagree | Not sure | Agree | Strongly Agree |

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. | I am hopeful about my future. | 1 | 2 | 3 | 4 | 5 |
| 2. | I continue to have new interests. | 1 | 2 | 3 | 4 | 5 |
| 3. | I ask for help when I need it. | 1 | 2 | 3 | 4 | 5 |
| 4. | I am willing to ask for help. | 1 | 2 | 3 | 4 | 5 |
| 5. | I have goals in life that I want to reach. | 1 | 2 | 3 | 4 | 5 |
| 6. | Even when I don't believe in myself, other people do. | 1 | 2 | 3 | 4 | 5 |
| 7. | I have people I can count on. | 1 | 2 | 3 | 4 | 5 |
| 8. | Even when I don't care about myself, other people do. | 1 | 2 | 3 | 4 | 5 |
| 9. | My symptoms interfere less and less with my life. | 1 | 2 | 3 | 4 | 5 |
| 10. | Coping with my mental illness is no longer the main focus of my life. | 1 | 2 | 3 | 4 | 5 |

## *III. Self Report Measure of Program and Participant Contact Post-intervention*

All caregivers will be given information about the NAMI Family-to-Family program, and family programs at the Institute of Living. At **PRE-ASSESSMENT ask question D1 only. At post, post- three and post- six month follow-up ask D2-D5**, caregivers will report on whether they have had any contact with other IOOV-FC attendees or have contacted or attended any family program.

**ASK in PRE-ASSESSMENT ONLY**

D1. Have you currently or in the past attended any ***ongoing*** programs or support groups for people with mental illness?

Yes or No

a. If yes, name of program_____.
b. If yes, Current or Past
c. If yes, number of times attended _____
d. If yes, last time attended (date) _____

OPEN- ENDED Question:

PRE-TEST

1) What do you hope to change in your life from participating in this group?

**(ASK in POST- -follow up):**

"SINCE YOU ATTENDED THE SESSION…

D2. Have you been in contact with any other attendees from the stigma intervention program outside of Asian Community Mental Health Services Center or the Chinese Community Methodist Church?

Yes or No

a. If yes, how many participants have you contacted?_____
b. If yes, how many participants have contacted you? _____

D3. Have you socialized with any participants outside of Asian Community Mental Health Services Center or the Chinese Community Methodist Church?

Yes or No

a. If Yes, on how many occasions?_____

D4. Have you contacted any support groups outside of Asian Community Mental Health Services Center or the Chinese Community Methodist Church?

Yes or No

a. If yes, how many support groups or family programs have you contacted?_____
b. If yes, which ones have you contacted?_____

D5. Have you attended any support groups outside of Asian Community Mental Health Services Center or the Chinese Community Methodist Church?

Yes or No

a. If yes, name of program_____.
b. If yes, number of times attended _____
c. If yes, last time attended (date) _____

OPEN- ENDED Question:

PRE-TEST

1) What do you hope to change in your life from participating in this group?

POST-TEST

1) What did you find most helpful about the intervention?

2) What would you change about the intervention to better address stigma?

alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES
Mental Health Services Act (MHSA)
Alameda County Behavioral Health

2000 Embarcadero Cove, Suite 400
Oakland, California 94606
(510) 567-8100 / TTY (510) 533-5018

**Alameda County Behavioral Health**
**Monitoring Tool Checklist for**
**Prevention and Early Intervention (PEI) Provider Virtual Site Visits**
Revised 06.09.20

| **Provider Program-Specific / ACBH Staff Information** | | | | |
|---|---|---|---|---|
| **Provider Name** | | | **Date of Virtual Site Visit (via GoToMeeting)** | |
| **Program Name(s)** | | | **Site Address** | |
| **Site Manager Name / Title** | | | **Completed by** | ☐Kelly Robinson, PEI Coordinator<br>☐Cheryl Narvaez, PEI Program Specialist |
| **Phone / Fax Number** | | | **Other Provider or ACBH Staff Present (Name/Title)** | |
| **Email Address** | | | | |

**Instructions:**

1. Please complete a thorough "self- check" using this Monitoring Tool in lieu of submitting all documents up front as evidence of compliance. In the column named "**Action/Task for Provider**," you will find suggestions on how and what to review in order to be able to confirm (and mark "yes") that your program/agency is in compliance. You may add brief comments/notes in this column as well.
2. For each item, please mark checkbox ☒for **Yes**, **No**, or **N/A**. Do not change or edit this column.
    a. For areas in which you indicate compliance (i.e. mark "Yes"), ACBH will request that a selection of those documents be emailed to us **one week after** the virtual site visit.
    b. In areas where "no" is marked, ACBH staff will provide technical assistance and discuss a timeline for submission of evidence **during** the virtual site visit.
3. Submit this completed checklist to ACBH staff **one week (5 working days) prior** to your virtual site visit. **No additional documents** need to be sent at this point.
4. During the virtual site visit, there will time to highlight your program's accomplishments and challenges.
5. Please feel free to reach out to Cheryl.Narvaez@acgov.org or Kelly.Robinson@acgov.org with any questions about this process.

| A. Compliance with required postings and site safety | Yes | No | Action/Task for Provider (Add brief comments/notes below if needed) |
|---|---|---|---|
| 1. ACBH grievance posters prominently posted for clients | ☐ | ☐ | *If not posted, here is the copy/link to materials (http://www.acbhcs.org/providers/Forms/SUD/Grievance_Appeal_Poster.pdf).* |
| 2. No observable safety or accessibility issues with site | ☐ | ☐ | *Review site for any observable safety issues for clients and families (especially young children), i.e., trip hazards, excessive temperatures, exits clearly marked, etc. If there are any concerns, please document, request immediate resolution, and inform ACBH staff of status.* |
| 3. Access to services and reasonable accommodation for people with disabilities | ☐ | ☐ | *Conduct a visual inspection, in particular inspections around ADA access, and the status. If ADA issues are identified, provider must address and inform ACBH upon resolution.* |
| 4. Implementation of services and training of staff around culturally and linguistically appropriate services (CLAS) | ☐ | ☐ | *Review documents that confirm dates of CLAS Standards trainings that staff have attended as evidence. Also, may include additional evidence of CLAS implementation beyond training.* |

| B. Evidence of required data collection | Yes | No | N/A | Action/Task for Provider (Add brief comments/notes below if needed) |
|---|---|---|---|---|
| 1. Registration/sign-in kiosk, sign-in sheets, other data collection protocols in place/being used to document program activities and collect demographic data | ☐ | ☐ | | *Review copy of blank sign in or intake sheet with demographic information asked of participants as evidence.* |
| 2. **For UELP providers and other Early Intervention Programs only**: Procedures regarding Insyst, Clinicians Gateway, and other data collection requirements per contract | ☐ | ☐ | ☐ | *Review a copy of the mechanism or tool used to document and check the accuracy of service documentation prior to entry into the electronic data entry system (e.g. instructions to staff regarding data collection) as evidence.* |
| 3. System in place for monitoring and tracking attendance of the clients in your program to ensure non-duplication of clients | ☐ | ☐ | | *Review written instructions, protocols for program staff on how to separate PEI funded participants from other programs as evidence.* |

| | | | | |
|---|---|---|---|---|
| 4. Submission of Annual PEI Data Report for the prior year in a timely manner<br>*Note: For UELP Providers, this report is named "UELP Annual Report"* | ☐ | ☐ | | *Confirm that Annual PEI Data Report (or UELP Annual Report) was submitted and emailed by July 31 as evidence.* |
| 5. Submission of PEI Evaluation report for the prior year in a timely manner<br>*Note: This item does not apply for UELP Providers* | ☐ | ☐ | ☐ | *Confirm that Annual PEI Evaluation Report was submitted and emailed by July 31 as evidence..* |
| 6. **For UELP Providers only:** Submitting or entering the following data in a timely manner:<br>a. Entering Clinicians Gateway data<br>b. Completing and submitting MAA/ISLs<br>c. Closing/Opening Insyst episodes<br>d. Completing PEI Maintenance Screen in InSyst<br>e. Completing and Submitting Client Satisfaction Surveys<br>f. Completing and Submitting Pre/Post Health Assessment for Preventive Clients | ☐ | ☐ | ☐ | *Review internal agency protocols, instructions, etc. on timelines/deadlines regarding the submission and entering of the data listed as evidence.* |

| C. Compliance with staffing/personnel requirements | Yes | No | Action/Task for Provider (Add brief comments/notes below if needed) |
|---|---|---|---|
| 1. Written job descriptions | ☐ | ☐ | *Review job descriptions as evidence.* |
| 2. Written code of conduct | ☐ | ☐ | *Review code of conduct and/or personnel manual as evidence. Should include clauses re: use of alcohol/drugs; scope of services; confidentiality; cooperation w/investigations; conflict of interest; prohibition against discrimination, harassment & inappropriate sexual conduct.* |

| D. Compliance with confidentiality requirements | Yes | No | Action/Task for Provider (Add brief comments/notes below if needed) |
|---|---|---|---|
| 1. Double-locked client charts and records, and no loose client charts | ☐ | ☐ | *Conduct visual inspection as evidence.* |

| D. Compliance with confidentiality requirements | Yes | No | Action/Task for Provider (Add brief comments/notes below if needed) |
|---|---|---|---|
| 2. Locked computers in non-secure areas | ☐ | ☐ | *Conduct visual inspection as evidence.* |
| 3. Password changes every 90 days | ☐ | ☐ | *Review policy & procedure as evidence.* |
| 4. Secure/encrypted emails (that include a warning banner) | ☐ | ☐ | *Review a secure/encrypted email to ensure that warning banner is in place stating that: data is confidential, systems are logged, system use if for business purposes only by authorized users, and direction to users to log off the system if they do not agree with these requirements as evidence. (p. 26, Section J. of Privacy and Security Provisions).* |

| E. Documentation of program implementation (Note: For providers who have more than one PEI program, please provide evidence per each program) | Yes | No | N/A | Action/Task for Provider (Add brief comments/notes below if needed) |
|---|---|---|---|---|
| What PEI category is/are your program(s)? Mark all that apply. | | | | ☐Access and Linkage<br>☐Stigma and Discrimination Reduction<br>☐Outreach for Increasing Recognition<br>☐Prevention<br>☐Early Intervention<br>☐Suicide Prevention |
| 1. Evidence-based practice standard, promising practice standard, community and/or practice-based evidence standard being implemented | ☐ | ☐ | ☐ | *Review documentation of the standard that program is implementing (i.e. curriculum or other lesson/activity plan and supporting documentation) as evidence.* |
| 2. Program designed, implemented, and promoted in ways that:<br>• Create access and linkage to treatment?<br>• Improve timely access to mental health services for individuals, families, and/or underserved populations? | ☐ | ☐ | ☐ | *Review any program guidelines, policy, etc. as evidence.* |

| | | | | |
|---|---|---|---|---|
| • Use non-stigmatizing and non-discriminatory language and activities? | | | | |
| 3. Process of referring participants to mental health treatment for clients that need such services | ☐ | ☐ | ☐ | *Review any program guidelines, policy, etc. as evidence.* |

| **F. Compliance with additional requirements of program design** | **Yes** | **No** | **Action/Task for Provider (Add brief comments/notes below if needed)** |
|---|---|---|---|
| 1. Use of ACBH and Prop 63 logos on all promotions | ☐ | ☐ | *Review flyers, promotional materials, etc. as evidence.* |
| 2. Ongoing program evaluation and improvement activities | ☐ | ☐ | *Review program guidelines, practices, policies, etc. that provider monitors their program, and identifies problems, challenges, and / or opportunities for improvement as evidence. Examples include documentation of staff productivity reports and monitoring, satisfaction surveys, staff training.* |

| **Please use the space below to share any additional comments. If referring to an item on this check list, please indicate the number of the item (i.e. C.2. Or F.1.) along with your comment.** |
|---|
| |

| G. Other TA Resources and hyperlinks |
|---|
| ☐ Information Systems Requirements, including Required Language for Secure/Encrypted Warning Banner<br>☐ ACBH Grievance Poster, at http://www.acbhcs.org/providers/Forms/SUD/Grievance_Appeal_Poster.pdf<br>☐ ACBH Training Calendar, at http://www.acbhcs.org/Training/default.htm<br>☐ Alameda County Training Registration Site, at http://alameda.netkeepers.com/TPOnline/TPOnline.dll/Home<br>☐ PEI Resources and Documents Drive and UELP Provider Resources Drive |

**For ACBH staff use only.** Additional comments or required follow up (post-virtual visit) for provider:

List of documents requested for review:

List of documents received:

List of documents unavailable or in process to submit and deadline (by when):

| ACBH Trainings: FY18-19 | 96 trainings; 105 training days; 2,842 staff trained; 422.5 CEs; | | | | | |
|---|---|---|---|---|---|---|
| **Date** | **Training Title** | **ACBH Sponsor/ Coordinator** | **# Attended** | **CEs** | **Location** | **Audience** |
| 7/17/2018 | Clinical Documentation Training for Clinician's Gateway-Electronic Health Record (EHR) Users | QA | 28 | 5.0 | Oakland, 2000 Embarcadero, Joaquin M | Clinical staff |
| 7/27/2018 | Treatment & Beyond: Improving Retention and Treatment Outcomes for African Americans through Effective Case Management | Ethnic Services | 46 | 5.5 | Oakland, 2000 Embarcadero, Gail Steele | All staff |
| 8/1/2018 | Mental Health Providers (MHP) Network Providers Clinical Documentation Standards Training | QA | 25 | 5.0 | Oakland, 2000 Embarcadero, Joaquin M. | MH Plan Providers |
| 8/15/2018 | Supporting Children of Incarcerated Parents: Breaking the Silence, Making a Difference | HCSA-Center for Healthy Schools & Communities (CHSC)/ Tuere Anderson | 33 | 6.0 | San Leandro, REACH | HCSA-All CHSC staff |
| 8/17/2018 | Clinical Documentation Standards Training "Train the Trainer" for Master Contract Providers Training | QA | 26 | 5.0 | Oakland, 2000 Embarcadero, Joaquin M | Providers -Clinical staff |
| 8/23/2018 | Consent, Confidentiality, and Behavioral Health for Youth in Foster Care | Office of Medical Director | 26 | 2.0 | Oakland, 2000 Embarcadero, Gail Steele | Clinical staff |
| 8/24/2018 | ASAM-A | SUDSOC | 49 | 5.5 | Oakland, 1900 Embarcadero, Brooklyn B | SUD Providers |
| 9/14/2018 | Supporting Children of Incarcerated Parents… | HCSA-CHSC/Tuere Anderson | 25 | 3.0 | San Leandro, 1000 S.L.Blvd; | Youth & Family Orgs |
| 9/18/2018 | Supporting Children of Incarcerated Parents: Breaking the Silence, Making a Difference | HCSA-CHSC/Tuere Anderson | 33 | 3.0 | San Leandro, 500 Davis St | School-based Hlth Center Staff |
| 9/19/2018 | Supporting Children of Incarcerated Parents: Breaking the Silence, Making a Difference | HCSA-CHSC/Tuere Anderson | 9 | 3.0 | San Leandro, Barbara Lee Health Ctr., Bancroft Ave | School District Staff |
| 9/26/2018 | Suicide Assessment & Intervention | Training Unit/CSS | 48 | 3.0 | San Leandro, Creekside - Redwood Rm | All staff |
| 9/28/2018 | BHCS Supporting Children of Incarcerated Parents; Breaking the Silence, Making a Difference (3 Hrs) | HCSA-CHSC/Tuere Anderson | 12 | 3.0 | San Leandro, 500 Davis St | School-Based Behavioral Health Staff |
| 10/2/2018 | Adult MHFA | Training Unit/CSS | 25 | 0.0 | Oakland, 1900 Embarcadero, Brooklyn B | All staff |

| Date | Training Title | ACBH Sponsor/ Coordinator | # Attended | CEs | Location | Audience |
|---|---|---|---|---|---|---|
| 10/3/2018 | BHCS QA: Clinician Gateway-EHR Clinical Documentation Training | QA | 29 | 5.0 | Oakland, 2000 Embarcadero, Joaquin M | Clinical staff |
| 10/10/2018 | QA: Clinical Doc & Auth for SUD Tx; Organized Delivery System (ODS) Requirements | QA | 42 | 5.0 | Oakland, 2000 Embarcadero, Joaquin M | SUD Providers |
| 10/12/2018 | CFT Facilitation Training | CYASOC/Andrea Kiefer | 10 | 6.0 | Oakland, 1900 Embarcadero, Brooklyn B | ICC Coordinators |
| 10/12/2018 | Adult MHFA (for Housing) | Housing/Robert Ratner | 24 | 0.0 | Oakland, 2000 Embarcadero, Joaquin M | Housing staff |
| 10/15/2018 | Youth MHFA (10/15 & 10/16 - 1/2 day each) | CYASOC/Lisa Carlisle | 16 | 0.0 | Oakland, 1900 Embarcadero, Brooklyn B | Family Partners |
| 10/15/2018 | Brief Tobacco Cessation Intervention | ATOD/Patricia Lopez | 9 | 3.5 | Oakland, 2000 Embarcadero, Gail Steele | All staff |
| 10/16/2018 | BHCS QA: Mental Health Plan (MHP) Fee-for-Service Providers Clinical Documentation Standards | QA | 41 | 5.0 | Oakland, 2000 Embarcadero, Joaquin M | MH Plan Providers |
| 10/18/2018 | TCOM Training for Trainers (CANS/ANSA) | Jen Cardenas | 18 | 5.5 | Oakland, 2000 Embarcadero, Joaquin M | Certified CANS/ANSA Users |
| 10/23/2018 | Cultural & Clinical Factors Affecting Retention of AfAm in SUD Tx Programs | Ethnic Services | 53 | 4.5 | Oakland, 1900 Embarcadero, Brooklyn B | SUD Providers |
| 10/24/2018 | Eating D/O & D/O Eating: What to Do | CYASOC/Sun Lee | 14 | 3.0 | Oakland, Eastmont | Clinical staff |
| 11/7/2018 | Suicide Assessmt & Intrvtn (Santa Rita staff only) | AFBH/Yvonne Jones | 18 | 3.0 | Dublin, Santa Rita | Santa Rita staff |
| 11/7/2018 | Eating D/O & D/O Eating: What to Do | CYASOC/Sun Lee | 11 | 3.0 | Fremont, Fremont Family Resource Ctr. | Clinical staff |
| 11/8/2018 | Clinical Documentation Standards Training "Train the Trainer" for Master Contract Providers Training | QA | 24 | 5.0 | Oakland, 2000 Embarcadero, Joaquin M | Providers -Clinical staff |
| 11/9/2018 | Strong, Brown & Proud-Genesis of the Latinx Raza… | Ethnic Services | 46 | 4.5 | Oakland, 1900 Embarcadero, Brooklyn B | All staff |
| 11/9/2018 | Adult MHFA (for Housing only) | Housing/Robert Ratner | 14 | 0.0 | Oakland, 2000 Embarcadero, Joaquin M | Housing staff |
| 11/28/2018 | Law & Ethics - HIPAA, Minor Consent, & 42CFR Part II (ACBH & Public Health) | Training Unit | 96 | 6.0 | Oakland, Cal Endowment | ACBH & PH |
| 11/29/2018 | Benefit Engagement as a Continuous Quality Improvement Strategy for Improving Services to African Americans | Ethnic Services | 22 | 5.5 | Oakland, 2000 Embarcadero, Gail Steele | All staff |
| 11/29/2018 | Asian & Pacific Islander (API) Statewide Conference; 11/29 & 11/30 (500 attended day 1; 350 day 2; 3 CEs day 1, 1 CE day 2) | QI/Sophia Lai | 500 | 3.0 | Oakland, Hilton Oakland Airport | All staff |

| Date | Training Title | ACBH Sponsor/ Coordinator | # Attended | CEs | Location | Audience |
|---|---|---|---|---|---|---|
| 11/30/2018 | Asian & Pacific Islander (API) Statewide Conference; 11/29 & 11/30 (500 attended day 1; 350 day 2; 3 CEs day 1, 1 CE day 2) | QI/Sophia Lai | 350 | 1.0 | Oakland, Hilton Oakland Airport | All staff |
| 12/4/2018 | Dynamic Mindfulness (1-day only, No CEs) | CYASOC/Colleen Sanford | 18 | 0.0 | Oakland, 1900 Embarcadero, Brooklyn B | All staff |
| 12/5/2018 | Youth MHFA | Training Unit | 22 | 0.0 | Oakland, 1900 Embarcadero, Brooklyn B | All staff |
| 12/11/2018 | Listening to the Silence: Asian American Cultural Competency in Culture | Ethnic Services | 44 | 5.5 | Oakland, 1900 Embarcadero, Brooklyn B | All staff |
| 1/7/2019 | "From Color-Blindness to Cultural Humility and Cultural Competence: Understanding Whiteness and Its Implications for Health Equity Training" | Ethnic Services | 48 | 5.5 | Oakland, 2000 Embarcadero, Gail Steele | All staff |
| 1/9/2019 | Adult MHFA | Training Unit/CSS | 29 | 0.0 | San Leandro, Creekside - Redwood Rm | All staff |
| 1/22/2019 | HANDLE Approach to Neurodevelopment; Introductory Course, Levels I&II (2-day 1/22 & 1/23; 13 CEs for both days, no partial) | CYASOC/Catherine Franck | | | Oakland, 1900 Embarcadero, Brooklyn B | Clinical staff |
| 1/23/2019 | Dismantling Implicit Bias and Healing Racial Trauma | Ethnic Services | 119 | 4.5 | Oakland, AC Learng Ctr-Oaklnd Rm | All staff |
| 1/23/2019 | HANDLE Approach to Neurodevelopment; Introductory Course, Levels I&II (2-day 1/22 & 1/23; 13 CEs for both days, no partial) | CYASOC/Catherine Franck | 14 | 13.0 | Oakland, 1900 Embarcadero, Brooklyn B | Clinical staff |
| 1/26/2019 | CSUEB Infant & Early Childhood Mental Health Program (1st Sem) | Early Childhood/ Margie Padilla | 15 | 60.0 | Online; CalState East Bay | Clinical staff |
| 1/29/2019 | Motivational Interviewing (2-day; 1/29 & 1/30; 12 CEs) | Training Unit/ Seneca | | | Oakland, Holy Redeemer Center | All staff |
| 1/29/2019 | Adult MHFA (for Housing) | Housing/Robert Ratner | 13 | 0.0 | Oakland, 2000 Embarcadero, Joaquin M | Housing staff |
| 1/30/2019 | Motivational Interviewing (2-day; 1/29 & 1/30;12 CEs) | Training Unit/ Seneca | 20 | 12.0 | Oakland, Holy Redeemer Center | All staff |
| 2/1/2019 | Youth MHFA (in SPANISH) Pilot: 5-10 staff | CYASOC/Dulce Lopez | 9 | 0.0 | San Leandro, Creekside, 500 Davis St | All Spanish spkg |
| 2/6/2019 | BHCS QA: Clinical Documentation for SUD Tx; (ODS) OS/IOS/RES | QA | 44 | 5.0 | Oakland, 2000 Embarcadero, Joaquin M | SUD Providers |
| 2/8/2019 | Co-Occurring Disorders in Addiction, Part 1 of 3 (Dr. Rob Lee) | Training Unit & Rob Lee | 54 | 2.5 | Oakland, 2000 Embarcadero, Gail Steele | SUD Providers |
| 2/13/2019 | CANS/ANSA Training for Trainers | Jen Cardenas | 17 | 5.5 | San Leandro, Creekside, 500 Davis St | Certified CANS/ANSA Users |

| Date | Training Title | ACBH Sponsor/ Coordinator | # Attended | CEs | Location | Audience |
|---|---|---|---|---|---|---|
| 2/13/2019 | BHCS QA: Clinical Documentation Standards 'Train the Trainer' for Master Contract Providers | QA | 27 | 5.0 | Oakland, 2000 Embarcadero, Joaquin M | Providers -Clinical staff |
| 2/15/2019 | Caught in the Crossfire of Cultures-Part I | Ethnic Services | 11 | 4.0 | Fremont, Fremont Family Resource Ctr. | Providers-Afghan Immigrant Population |
| 2/21/2019 | Youth MHFA | Training Unit/CSS | 19 | 0.0 | San Leandro, Creekside - Redwood Rm | All staff |
| 2/22/2019 | Preventing, De-Escalating, and Managing Aggressive Behavior in Behavioral Health Settings | Training Unit/ Seneca | 35 | 5.5 | Santa Rita, Dublin | All staff |
| 2/25/2019 | Dynamic Mindfulness- 1 day ONLY (no CEs) | CYASOC/Colleen Sanford | 10 | 0.0 | San Leandro, Creekside - Redwood Rm | All staff |
| 2/26/2019 | Dynamic Mindfulness 2-day 2/25 & 2/26 (11.5 CEs) | CYASOC/Colleen Sanford | 26 | 11.5 | San Leandro, Creekside - Redwood Rm | Clinical staff |
| 2/27/2019 | Preventing, De-Escalating, and Managing Aggressive Behavior in Behavioral Health Settings | Training Unit/ Seneca | 48 | 5.5 | Oakland, Seneca 6925 Chabot Road, | All staff |
| 3/1/2019 | Caught in the Crossfire of Cultures-Part I (repeated) | Ethnic Services | 3 | 4.0 | Oakland, 2000 Embarcadero, Gail Steele | Providers-Afghan Immigrant Population |
| 3/5/2019 | Tobacco Treatment Specialist Core Training (4-day: 3/5,6,12, and 13; 22.5 CEs) | ATOD/Patricia Sanchez | | | Oakland, 1900 Embarcadero, Brooklyn B | All staff |
| 3/6/2019 | SOGI -Sexual Orientation and Gender Identity: Working with Transgender and Non-Binary Populations (4-part series) | MHSA/Kelly Robinson/ Pacific Ctr | 9 | 6.0 | Oakland, 2000 Embarcadero, Gail Steele | All staff |
| 3/6/2019 | Tobacco Treatment Specialist Core Training (4-day: 3/5,6,12, and 13) | ATOD/Patricia Sanchez | | | Oakland, 1900 Embarcadero, Brooklyn B | All staff |
| 3/8/2019 | BHCS QA: Clinician Gateway-EHR Clinical Documentation Training | QA | 16 | 5.0 | Oakland, 2000 Embarcadero, Joaquin M | Clinical staff |
| 3/8/2019 | Co-Occurring Disorders in Addiction, Part 2 of 3 (Dr. Rob Lee) | Training Unit & Rob Lee | 43 | 2.5 | Oakland, 2000 Embarcadero, Gail Steele | SUD Providers |
| 3/12/2019 | Tobacco Treatment Specialist Core Training (4-day: 3/5,6,12, and 13) | ATOD/Patricia Sanchez | | | Oakland, 1900 Embarcadero, Brooklyn B | All staff |
| 3/13/2019 | Tobacco Treatment Specialist Core Training (4-day: 3/5,6,12, and 13) | ATOD/Patricia Sanchez | 12 | 22.5 | Oakland, 1900 Embarcadero, Brooklyn B | All staff |

| Date | Training Title | ACBH Sponsor/ Coordinator | # Attended | CEs | Location | Audience |
|---|---|---|---|---|---|---|
| 3/18/2019 | Brief Tobacco Cessation Intervention Training | ATOD/Alex Hay | 10 | 3.5 | Oakland, 2000 Embarcadero, Gail Steele | All staff |
| 3/19/2019 | Beyond Labels: An Introduction to the HANDLE Approach (2-day) | CYASOC/Catherine Franck | | | San Leandro, Juniper St | Clinical staff |
| 3/19/2019 | Adult MHFA | Training Unit/CSS | 30 | 0.0 | Fremont, Family Family Resource Ctr | All staff |
| 3/20/2019 | Beyond Labels: An Introduction to the HANDLE Approach (2-day) | CYASOC/Catherine Franck | 17 | 13.0 | San Leandro, Juniper St | Clinical staff |
| 3/20/2019 | QA-Clinical Documentation Standards training for MH Plan Fee-for-Service Providers | QA | 16 | 5.0 | Oakland, 2000 Embarcadero, Joaquin M | MH Plan Providers |
| 3/22/2019 | Caught in the Crossfire of Cultures-Part II | Ethnic Services | 13 | 4.0 | Oakland, 1900 Embarcadero, Brooklyn B | Providers-Afghan Immigrant Population |
| 4/2/2019 | Youth MHFA | Training Unit/CSS | 11 | 0.0 | Fremont, Fremont Family Resource Ctr | All staff |
| 4/4/2019 | Clinical Supervision (2-day; 4/4 & 4/5/19) | Training Unit/ABW | | | Oakland, 1900 Embarcadero, Wildcat C. | Clinical staff |
| 4/5/2019 | Clinical Supervision (2-day; 4/4 & 4/5/19) | Training Unit/ABW | 13 | 15.0 | Oakland, 1900 Embarcadero, Wildcat C. | Clinical staff |
| 4/11/2019 | BEHAVIORAL HEALTH INTERPRETER TRAINING (2-day; 4/11 & 4/12/19) | Ethnic Services | | | Oakland, 1900 Embarcadero, Brooklyn B | All staff |
| 4/11/2019 | Conference: From Surviving to Thriving: Older Adults & Trauma Informed Care | AOASOC/Ofra Paz | 40 | 3.0 | Alameda, Alameda Alliance for Health | All staff |
| 4/12/2019 | BEHAVIORAL HEALTH INTERPRETER TRAINING (2-day; 4/11 & 4/12/19) | Ethnic Services | 11 | 0.0 | Oakland, 1900 Embarcadero, Brooklyn B | All staff |
| 4/12/2019 | Co-Occurring Disorders in Addiction, Part 3 of 3 (Dr Rob Lee) | Training Unit & Rob Lee | 41 | 2.5 | Oakland, 2000 Embarcadero, Gail Steele | SUD Providers |
| 4/15/2019 | Seeking Safety: an EBP for Trauma and/or SUD | Training Unit/ Seneca | 62 | 5.5 | San Leandro, Creekside - Redwood Rm | All staff |
| 4/17/2019 | 5150/5585 certification (for CRP only) | AODSOC/ Stephanie Lewis | 13 | 6.5 | Hayward, 409 Jackson St | CRP staff |
| 4/18/2019 | 19th Annual SIPP Forum (Senior Injury Prevention Program) | HCSA EMS/Carol Powers | 17 | 3.0 | Oakland, Lincoln Ave | HCSA Older Adult staff |
| 4/22/2019 | Preventing Vicarious Trauma: Beverly Kyer | Training Unit/ABW | 45 | 6.0 | San Leandro, Creekside - Redwood Rm | All staff |

| Date | Training Title | ACBH Sponsor/ Coordinator | # Attended | CEs | Location | Audience |
|---|---|---|---|---|---|---|
| 4/24/2019 | QA-Clinical Documentation for SUD Res Providers | QA | 23 | 5.0 | Oakland, 2000 Embarcadero, Joaquin M | SUD Providers |
| 4/26/2019 | Caught in the Crossfire of Cultures-Part III | Ethnic Services | 6 | 4.0 | Oakland, 2000 Embarcadero, Gail Steele | Providers-Afghan Immigrant Population |
| 4/29/2019 | HANDLE Approach to Neurodevelopment; Introductory Course, Levels I&II (2-day; 4/29 & 4/30/19) | CYASOC/Catherine Franck | | | Oakland, 2000 Embarcadero, Gail Steele | Clinical staff |
| 4/30/2019 | HANDLE Approach to Neurodevelopment; Introductory Course, Levels I&II (2-day; 4/29 & 4/30/19) | CYASOC/Catherine Franck | 29 | 14.0 | Oakland, 2000 Embarcadero, Gail Steele | Clinical staff |
| 5/3/2019 | Caught in the Crossfire of Cultures-Part IV | Ethnic Services | 5 | 4.0 | Oakland, 2000 Embarcadero, Gail Steele | Providers-Afghan Immigrant Population |
| 5/8/2019 | The Impact of Parental Incarceration on Children in the Child Welfare System | CYASOC/Damon Eaves | 77 | 5.5 | Oakland, Cal Endowment | All staff |
| 5/8/2019 | BHCS QA: Clinical Documentation Standards 'Train the Trainer' for Master Contract Providers | QA | 22 | 5.0 | Oakland, 2000 Embarcadero, Joaquin M | Providers -Clinical staff |
| 5/10/2019 | Child & Family Team (CFT) Facilitation (by Invitation ONLY) | CYASOC/Andrea Kiefer | 8 | 6.0 | Oakland, 1900 Embarcadero, Brooklyn B | ICC Coordinators |
| 5/15/2019 | BHCS QA: Clinician Gateway-EHR Clinical Documentation Training | QA | 12 | 5.0 | Oakland, 2000 Embarcadero, Joaquin M | Clinical staff |
| 5/16/2019 | QM/SUD: Clinically Meaningful SUD Treatment & Documentation; (2-day 5/16 & 6/7; see end date of 6/7 for # of attendees, CEs) | QA/Sharon Loveseth | | | Oakland, 2000 Embarcadero, Gail Steele | SUD Providers |
| 5/22/2019 | Positive Behavioral Interventions for Children and Youth | Training Unit/ Seneca | 20 | 3.5 | Oakland, 1900 Embarcadero, Brooklyn B | Clinical staff |
| 5/23/2019 | Trauma Informed Care- Beyond the Basics | Training Unit/ABW | 30 | 4.0 | Berkeley, Adeline at ABW | Clinical staff |
| 5/24/2019 | Caught in the Crossfire of Cultures-Part V | Ethnic Services | 7 | 4.0 | Oakland, 2000 Embarcadero, Gail Steele | Providers-Afghan Immigrant Population |
| 5/29/2019 | Law & Ethics (Daniel Taube J.D., Ph.D.) | Training Unit/ABW | 23 | 6.0 | Dublin, Santa Rita | Clinical staff |

| Date | Training Title | ACBH Sponsor/ Coordinator | # Attended | CEs | Location | Audience |
|---|---|---|---|---|---|---|
| 6/4/2019 | QA-Clinical Documentation Standards training for MH Plan Fee-for-Service Providers | QA | 10 | 5.0 | Oakland, 2000 Embarcadero, Joaquin M | MH Plan Providers |
| 6/5/2019 | CANS/ANSA Training for Trainers | CYASOC/ Christine Mukai | 5 | 5.5 | Oakland, 2000 Embarcadero, Gail Steele | Certified CANS/ANSA Users |
| 6/7/2019 | Caught in the Crossfire of Cultures-Part V | Ethnic Services | 9 | 4.0 | Fremont, Fremont Family Resource Ctr | Providers-Afghan Immigrant Population |
| 6/7/2019 | QM/SUD: Clinically Meaningful SUD Treatment & Documentation; (2-day 5/16 & 6/7; see end date of 6/7 for # of attendees, CEs) | QA/Sharon Loveseth | 38 | 12.0 | Oakland, 2000 Embarcadero, Gail Steele | SUD Providers |
| 6/11/2019 | Brief Tobacco Cessation Intervention Training | ATOD/Alex Hay | 9 | 3.5 | Oakland, 2000 Embarcadero, Gail Steele | All staff |
| 6/20/2019 | Behavioral Health & Criminal Justice (6/20/19 and 6/21/2019; 6 CEs for both days, 12-4pm) | QI/Sophia Lai | 45 | 3.0 | Oakland, 2000 Embarcadero, Brooklyn Basin & Joaquin Miller | All staff |
| 6/21/2019 | Behavioral Health & Criminal Justice (6/20/19 and 6/21/2019; 6 CEs for both days, 12-4pm) | QI/Sophia Lai | 33 | 3.0 | Oakland, Embarcadero, Brooklyn B & Joaquin M | All staff |
| 6/24/2019 | Vaping Nicotine: How safe is it for our communities? | ATOD/ Alex Hay | 31 | 4.0 | Oakland, Oakland Museum of CA | All staff |
| 6/26/2019 | Dreams-Clinical Utilization in a Correctional Setting (for AFBH Only) | AFBH/Yvonne Jones | 20 | 2.0 | Dublin, Santa Rita | AFBH staff |
| 6/26/2019 | Impacto del Trauma de la Inmigración en las Familias: Cómo se manifiesta y estrategias para apoyar a niños/as y familias Latinas (Traumatic Impact of Immigration on Children and Families) Training in SPANISH | CYASOC/Libby Higgins | 45 | 4.0 | San Leandro, Creekside, 500 Davis St | All Spanish spkg |
| 6/28/2019 | Introduction to SBIRT (Screening, Brief Intervention, and Referral for Treatment) with MI (Motivational Interviewing) Skill Building | Training Unit/ABW | 55 | 6.0 | Oakland, 2000 Embarcadero, Gail Steele | Clinical staff |
| | ***105 Training days; Actual trainings: 96 (eight 2-day & one 4-day)*** | ***TOTALS*** | ***2,842*** | ***422.5*** | | |

For questions or additional information regarding this report, please contact the report preparer:

Mariana D. Dailey, MPH, MCHES

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