MENTAL HEALTH SERVICES ACT ANNUAL PLAN UPDATE

DRAFT

FISCAL YEAR 2022-2023

MENTAL HEALTH SERVICES ACT (MHSA) DIVISION | ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES (ACBH) DEPARTMENT RELEASED FOR PUBLIC COMMENT: APRIL 1, 2022 – APRIL 30, 2022

MENTAL HEALTH BOARD MEETING MONDAY, MAY 16, 2022 | 3PM
PLEASE VISIT ACMHSA.ORG FOR UP TO DATE INFORMATION

alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES



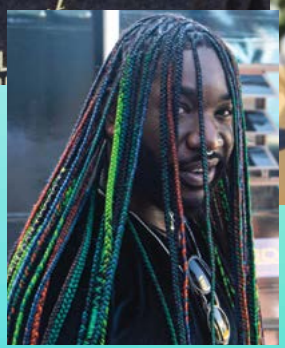










MENTAL HEALTH SERVICES ACT
FY22-23 ANNUAL PLAN UPDATE
Table of Contents

OESD 18 WELLNESS CENTERS: HEDCO

OESD 18 WELLNESS CENTERS: FREMONT

OESD 18 WELLNESS CENTERS: TOWNHOUSE

OESD 18 WELLNESS CENTERS: VALLEY

OESD 18 CONSULTANT SUPPORT, POCC SUPPORT & PEER SUPPORT (WRAP)

OESD 19 PATHWAYS TO WELLNESS, MEDICATION SUPPORT SERVICES

OESD 19 STEPS PROGRAM

OESD 20 INDIVIDUAL PLACEMENT SERVICES (IPS): BONITA HOUSE

OESD 20 INDIVIDUAL PLACEMENT SERVICES (IPS): CENTER FOR INDEPENDENT LIVING (CIL)

OESD 20 VOCATIONAL PROGRAM

OESD 22 AFRICAN AMERICAN WELLNESS HUB COMPLEX PLANNING PHASE

OESD 23 CRISIS RESIDENTIAL SERVICES

OESD 24 SCHREIBER CENTER

OESD 25 BEHAVIORAL HEALTH - PRIMARY CARE INTEGRATION PROJECT (FREMONT PATH)

OESD 25 BEHAVIORAL HEALTH - PRIMARY CARE INTEGRATION PROJECT (SILVA CLINIC)

OESD 25 BEHAVIORAL HEALTH - PRIMARY CARE INTEGRATION PROJECT (OAKLAND PATH)

OESD 25 BEHAVIORAL HEALTH - PRIMARY CARE INTEGRATION PROJECT (LIFELONG)

OESD 25 BEHAVIORAL HEALTH - PRIMARY CARE INTEGRATION PROJECT (AXIS)

OESD 25 TRUST CLINIC HEALTH CENTER

OESD 25 PEDIATRIC CARE COORDINATION PILOT

OESD 26A TRAINING & TA ON ACCURATE/APPROPRIATE PRACTICES FOR AFRICAN-AMERICANS

OESD 26B AFIYACARE

OESD 26C MH WELLNESS SUPPORTS AT MHSA HOUSING SITES

OESD 27 ADULT RECOVERY, OUTREACH AND CONNECTION (ADROC)

OESD 27 IN-HOME OUTREACH TEAM (IHOT): ABODE SERVICES

OESD 27 IN-HOME OUTREACH TEAM (IHOT): BONITA HOUSE

OESD 27 IN-HOME OUTREACH TEAM (IHOT): LA FAMILIA

OESD 27 IN-HOME OUTREACH TEAM (IHOT): STARS

OESD 27 TRANSITION AGE YOUTH (TAY) ROC PROGRAM

OESD 28 SUCCESS AT GENERATING EMPOWERMENT (SAGE)

OESD 29 OLDER ADULT SERVICE TEAM

OESD 29 SERVICE TEAMS

OESD 30 PEER RESPITE, SALLY'S PLACE

OESD 31 1ST ONSET: FELTON EARLY PSYCHOSIS PROGRAMS: (RE)MIND AND BEAM

OESD 32 SUICIDE PREVENTION CRISIS LINE

OESD 32 ZERO SUICIDE

OESD 33 DEAF COMMUNITY COUNSELING SERVICES

OESD 33 TA AND CAPACITY BUILDING (ACNMHC)

OESD 34 SCHOOL-BASED BEHAVIORAL HEALTH: ALAMEDA FAMILY SERVICES

OESD 34 SCHOOL-BASED EXPANSION: CASTLEMONT/ROOSEVELT CE CLASSROOM

OESD 34 SCHOOL-BASED BEHAVIORAL HEALTH: FRED FINCH YOUTH CENTER

OESD 34 SCHOOL-BASED EXPANSION: LINCOLN CHILD CENTER

Love Takes Root & Grows

By Eric Fahey

I learned about equal rights, justice and kindness, compassion which I hope grows and dominates across the globe. Lets express ourselves with love.

Age Group | Older Adult

Message From the Director

Welcome to Alameda County Behavioral Health Care Services (ACBH) Department's Fiscal Year (FY) 2022-2023 Mental Health Services Act (MHSA) Program and Expenditure Plan Update.

Fiscal Year 2022-2023 marks the third and final year of our current MHSA Three-Year Plan (FY 20/21-22/23). This Plan Update captures our efforts and outcomes from the previous full fiscal year, FY 20/21 and looks forward towards FY 22/23 in terms of budging and programmatic changes.

This past year has seen numerous memorable events which have shaped our collective experience. It is with hope and purpose that I know our communities will weather any upcoming difficulties and remain strong in service to the many diverse and culturally enriched communities here in Alameda County.

As the Director of Alameda County's Behavioral Health department, I invite you to explore our new Plan Update and provide public comment through our various forums. Our client experiences, data from many sources, and our own local community voices affirm that there is an ever-increasing need for mental health services. To that end, ACBH believes that joint efforts with our system providers continue to offer critical services to Alameda County's residence and we will continue to pursue the expansion of services to meet this growing need. I am pleased with the continued success of many of our programs and encouraged by the plans further expand our system and outreach methods in new and exciting ways that elevate the ideals of health equity and cultural humility.

Some of the areas that we are especially honored to support include:

1) Our increased efforts to expand services for the new Afghan arrival community. With the fall of Kabul in August 2021 and the influx of Afghan refugees, ACBH increased its capacity to provide mental health services and supports to this severely traumatized community.

2) Secondly, I'd like to highlight our new MHSA Innovation proposals to serve adults with Severe Mental Illness (SMI) who have been involved with the criminal justice system. It is our goal to support this community through a continuum of peer and clinical services for individuals and their families with the goal of diverting individuals away from the criminal justice system and preventing recidivation. As one community member stated in our listening sessions, "*When I was doing time, my whole family was also doing time*".

3) And finally, we invite you to explore some of our continued efforts to expand upon services to our diverse populations including services to African American, Youth and Transitional Age Youth, and unhoused individuals. Please see the Changes section of this Plan for more details.

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. We continue to invite your feedback and look forward to ongoing ways to promote partnership and community engagement.

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

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 Care Services (ACBH) is pleased to present the Mental Health Services Act (MHSA) Annual Plan Update for fiscal year 2022-23. The Annual Plan is based on data from fiscal years 2020-21 and 2021-22. This report is the final fiscal year report of the MHSA Three-Year Program and Expenditure Plan (Three-Year Plan) covering fiscal years 2020-23. The Three-Year Plan began July 1, 2020, and has been updated annually for fiscal years 2021-22 and 2022-23.

The Three-Year Plan and Annual Plan Update describe 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 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

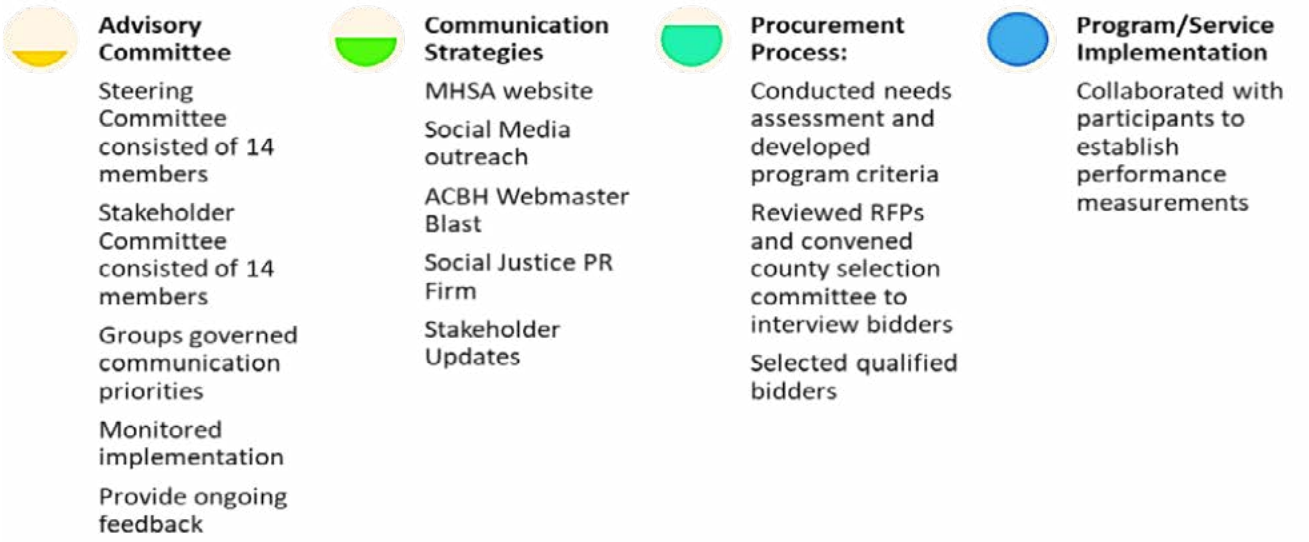
The importance of MHSA support is well known to our department, as it's currently 24% of the overall ACBH budget. For State Fiscal Year (FY) 22/23, ACBH set aside up to $150.6 million in budget authority, which is an increase of 7% over the previous fiscal year of 2021-22. ACBH has been able to increase this budget level due to increased allocation amounts from the State and unintended carryover from the previous year's budget where not all of the budget was spent due to multiple factors including workforce shortages and staff vacancies, slow project start-up, and continued service/engagement issues due to the Novel Coronavirus (COVID-19).

Within the past few years all counties in California have experienced increased MHSA allocations due to the success of the California economy. However, it should be noted that the MHSA funding stream is highly volatile with a two- year lag of final allocation amounts; so, while counties are currently receiving stable or increased allocations year over year it's important for ACBH to monitor the allocation estimates closely and adjust funding as needed so that as much funding as possible can be used in the communities of Alameda County. At this time, it is projected that the FY 22/23 MHSA allocation will closely mirror the allocation from FY 21/22, however there are additional increases being estimated for FY 23/24 and FY 24/25. These increases will be reviewed during next year's Community Program Planning Process as ACBH develops the next MHSA Three Year Plan. ACBH strives to balance community need in collaboration with fiscal responsibility so that there is not a fiscal "cliff" where dramatic reductions will be needed and vice versa as much funding as prudently possible is allocated to mental health services within Alameda County. As an example of this accountability, ACBH has developed two budget workgroups (one for county staff and one for contracted provider/peers/family members). Within these workgroups MHSA spending strategies/guidelines will be discussed and recommendations will be made to ACBH Leadership. This will take place in Spring 2022.

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 MHSA Stakeholder Group (MHSA-SG) and other representatives to participate in the development of our Plans. During fiscal year 2019-20 and 2020-21, MHSA increased the membership of the MHSA-SG by 27% and its underserved/unserved demographics (including Transitional Aged Youth representation) by 250%.

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



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. The CPPP for the Annual Plan Update is informed by activities conducted during the Three-Year Plan CPPP. The Three-Year Plan 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.

In addition to a combined 17 focus groups facilitated during the CPPP for FY20/23 Three-Year Plan (198 group participants) and FY21/22 Annual Plan Update (45 participants), MHSA coordinated a larger CPPP between October 2021- January 2022, facilitating TAY forums for young men of color, a "How to Read the MHSA Plan" webinar, and 18 listening sessions with 307 total participants. Each listening session represented an important cross section of Alameda County populations in accordance with data from the Three-Year Plan CPPP (See Appendix B-4 for CPPP findings). Some reoccurring themes include:

- Isolation and lack of community; workforce need
- Address the response time in systems such as ACCESS
- More services for the African American community across the lifespan
- Supports and activities for the LGBTQ community, particularly the transgender

community of color and sex workers
- Need for increased language capacity, especially for Asian communities
- More peer support services
- Address insecure housing utilizing Full-Service Partnerships (FSPs)
- Support the reentry community with services to divert people from John George and Jail

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*: Even though Alameda County is growing, the number of children is decreasing and overall the county is aging. Women comprise 51% of the county population, and is home to the second-highest number of veterans among Bay Area Counties. 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 unemployment, housing and homelessness, and environmental data over time suggest that MHSA funded providers are called upon to serve more people in need, especially as the pandemic health emergency continues.

Program Update and Changes

Significant changes from the FY 2020-23 Three-Year Plan that are incorporated into the FY 2022-23 Annual Plan Update are in response to the CPPP and operationalized through a three-pronged departmental lens: that of Alignment, Communication, and Organizational Structure. Specifically, we have determined it to be critical for the success of our MHSA strategies and programs to both be reflective of our community needs and supported through departmentwide organizational improvement strategies. Our CPPP and implementation of our new Three-Year Plan will primarily focus on our ***Alignment*** with county, agency and departmental mission, vision, values; improving ***Communication*** (internal/external stakeholders); and improving our ***Organizational Structure*** and service delivery. In February of 2021, our focus on enhancing our care delivery system was also expanded to help chart our departmental course is it relates to the direction, guidance, and set of principles that will shape our transformational efforts towards quality improvement. We believe these metrics to be in line with the fundamental values of the MHSA, and now represent five key areas: ***Quality, Investment in Excellence, Accountability, Financial Sustainability, & Outcome-Driven Goals***. We are pleased that this focus and our dynamic efforts relative to system improvement will continue to support the work and critical areas supported through our MHSA planning efforts.

Several critical areas were identified and prioritized through the planning process and focused on a spectrum of behavioral health services and support needs. A variety of key cultural and community-centered strategies, supportive housing and crisis stabilization programming, and engagement and support strategies which target persons most challenged by serious mental illness were prioritized. Including, but not limited to:

- Transform community-based Service Team and Case Management programs to Full-Service Partnership (FSP) model
- Assigning additional resources to multiple PEU programs that have been historically underfunded, transitioning from the Innovation (INN) plan element to Prevention & Early Intervention (PEI), address health equity, and/or address themes identified in recent CPPP
- Increased funding for INN Community Assessment & treatment Team (CATT) and three new INN proposals
- Expansion of the Alameda County Loan Repayment Program (ACLRP) and transition to the state-funded Regional Workforce Education and Training Partnership Program (RP)
- Workforce Education and Training staffing expansions in accordance with data from recent CPPP
- Increased funding to support a new Medical Respite bed expansion project
- Augmenting the African American Wellness Hub Complex with and additional $8/8M in non-MHSA funds.
- Funding to support the development of a new billing system, which will be linked with ACBH's future electronic health record

General System Improvement Efforts

Performance indicators for MHSA, including the FSP Programs and Prevention and Early Intervention component have been updated for FY20/21, and include performance measurements and outcomes. The MHSA plan and plan element evaluation reports are included in Appendices C and D. In addition, a new Performance Management section contains a summary of quality assurance and improvement strategies.

Additional funding has been identified for the replacement of the current billing system, improvements to the ACBH web-based data and outcome reporting system called *YellowFin,* and newly created reporting dashboard on Full Service Partnership (FSP) clients that covers hospitalizations, housing, incarcerations, primary care linkage, employment, education, cost, and data quality.

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 Annual Plan for fiscal year 2021-22 is 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 (FY21/22)

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), Workforce Education & Training (WET) Capital Facilities and Technology (CFTN) and Innovative Programs (INN), which account for the full MHSA funding received by Alameda County[1].

I. COMMUNITY SERVICES AND SUPPORTS

a. Transition of Service Team Case Management Model to Full Service Partnership Model

II. PREVENTION AND EARLY INTERVENTION (PEI)

a. Contract Changes: Multiple PEI Programs

III. INNOVATIONS (INN)

a. New INN Programs under Development

IV. WORKFORCE, EDUCATION, AND TRAINING (WET)

a. Alameda County Loan Assumption (Repayment) Program Expansion
b. WET Staffing Expansion
c. Graduate Intern Stipend Program Expansion

V. CAPITAL FACILITIES AND TECHNOLOGICAL (CFTN) NEEDS

a. African American Wellness Hub Update
b. Medical Respite Program
c. Electronic Health Record System Update

[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.

I. COMMUNITY SERVICES AND SUPPORTS

Transition of Service Team Case Management Model to a Full-Service Partnership Model

In FY 22/23 ACBH will be initiating the change process to transform the community-based Service Teams and Case Management programs into the Full-Service Partnership (FSP) model in order to increase system capacity and team centered quality of care for our clients who have a severe and persistent mental illness (SPMI).

The FSP model is a comprehensive and intensive mental health program for adults with severe and persistent mental illness. FSP utilizes a "whatever it takes" field-based approach using innovative interventions to help people reach their recovery goals.

Clients must be approved by ACBH Acute Crisis Care and Evaluation for Systemwide Services (ACCESS) for services. Referrals to ACCESS can come from sources including but not limited to family members, behavioral health care providers, primary care providers, and psychiatric hospitals. Clients 18+ may also self-refer to ACCESS. All Client are 18+ years old. The ACCESS line can be reached by dialing: 1-800-491-9099.

II. PREVENTION AND EARLY INTERVENTION (PEI)

a. Contract Changes to Multiple PEI Programs

In FY 22/23 ACBH will support contract augmentations to several PEI programs for the following reasons:

- Historically underfunded,
- Are moving from INN to PEI and/or
- Will address themes identified in the recent Community Program Planning Process (CPPP).

These augmentations align with the department's priority of increasing community health equity. The activities include additional resources for Transition Age Youth (TAY), outreach and support for African American family members, new community healing circles to reduce isolation, support for the African American focused Speaker's Bureau, expansion of the African American Women's Health and Wellness project, supports for individuals who hear voices/special messages, mental health apps for multiple community groups, expansion of the Health through Art program and mental health supports for the Afghan and Middle Eastern communities.

ACBH identified this funding through fiscal analysis where it was determined that the PEI budget could expand due to increases in the current PEI revenue (state allocation) as compared to the FY 21/22 budget.

III. INNOVATIONS (INN)

a. Augmentation of Approved INN Program in FY 21/22

The Community Assessment & Treatment Team (CATT) was approved by the MHSOAC on October 25, 2018 and after an in-depth planning process CATT had a soft launch on July 21, 2020 with a team in Oakland, San Leandro and Hayward, respectively. (An additional team will be launched in Fremont at a

later date). Limited coverage was begun in order to focus on identifying challenges and seeking solutions to address these issues quickly before broadening team coverage.

The original budget did not anticipate the challenges surrounding hiring clinicians, nor was it foreseeable that the ambulance operator provider who employs the project's needed EMTs, would change. Due to these issues, ACBH has requested approval of the use of additional INN funding, $4,759,312 from the Mental Health Services Oversight and Accountability Commission (MHSOAC). This request was approved on 11/19/21 This funding will be used for EMS, EMTs, and EMS' project administrator. Funding for the extra costs of clinicians has been covered through other county funds.

More information can be found on the CATT project in the Innovation section of this Plan Update.

b. New INN Programs under Development

ACBH has developed three new INN proposals based on the FY 20/21 and FY 21/22 Community Program Planning Process (CPPP) and ACBH's priorities/foci. Below are brief summaries of each of these proposals. For the full proposals, please see *Appendix B-5*

Proposal 1: Online Dialectical Behavioral Therapy (DBT) Training Program for Peers

ACBH has a long history of supporting peer organizations, providing peer support services and offering peer support specialist training.

One of the ways ACBH has identified to uplift peers as being a provider type and becoming certified (through the California's Peer Support Specialist Certification Program Act of 2020) is to further build trainings to enhance peer skills increasing their hire ability. ACBH feels that the development of an *online Dialectical Behavioral Therapy (DBT) training program to train peers with the essential skills of DBT* is an innovative idea that will not only increase skill building but will allow for the learning and study of using peers in a field that is most typically held by clinicians.

DBT is primarily a cognitive-behavioral treatment, with roots in Eastern and Zen mindfulness practices. DBT generally treats severe emotional dysregulation, suicidality, and non-suicidal self-injury in clients.[2] However, its principles are being expanded to many other populations. DBT's core philosophy includes its basis in mindfulness, clear prioritizing of treatment targets, and a dialectical balance between acceptance and change strategies.

It is well documented that peer supported services provide a unique and beneficial aspect to mental health treatments. With the pandemic unintentionally showing that online meetings, trainings, and learning are feasible, ACBH seeks to develop a DBT online training for peers to improve/add to their skills, avoiding high costs and low accessibility associated with standard DBT training; support the emerging certification process for peer support specialists empowering peers in their supportive roles; and decrease mental health stigma.

[2] Koerner K. What must you know and do to get good outcomes with DBT? Behav Ther. 2013 Dec;44(4):568-79. doi: 10.1016/j.beth.2013.03.005. Epub 2013 Apr 6. PMID: 24094782.

Proposal 2: Peer Led Continuum of Forensic Mental Health Services

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

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

Proposal 3: Alternatives to Incarceration Project

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

- Forensic Crisis Residential Treatment (CRT)
- Arrest Diversion/Triage Center
- Reducing Probation/Parole Violations (RP/PV)

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 through the transfer of funds from CSS as well as other strategies like the Regional Partnership listed below.

a. **Alameda County Loan Assumption (Repayment) Program Expansion**

The Alameda County Workforce Education and Training (WET) local Loan Repayment Program (ACLRP) is in the process of transitioning into the State-funded Regional Workforce Education and Training (WET) Partnership Program (RP).

In September 2021, Alameda County opted to participate in the WET RP, funded by the State Health Care Access and Information (HCAI), formerly called the Office of Statewide Health Planning and

Development (OSHPD). OSHPD's five-year WET county funding allocation is effective from July 1, 2020 through June 30, 2025.

The total OSHPD grant allocation for Alameda County is $2,102,701 from July 1, 2020 through June 30, 2025. This funding will increase the number of loan repayment recipients Alameda County will be able to support as well as allow for additional local WET activities. Please see the WET section in the Plan Update for additional details.

b. WET Staffing Expansion

During the recent Community Program Planning Process (CPPP) workforce issues and concerns were highlighted in every session. In order to begin to address these concerns and identify solutions, the WET unit will be expanding by three new staff positions. This will help to increase infrastructure and provide department wide training support and other workforce development functions to ACBH staff and contracted CBO providers. The WET unit intends to begin the hiring process starting from July 1, 2022.

c. Graduate Stipend Intern Program Expansion

ACBH currently offers up to 20 stipends for graduate level interns as a workforce recruitment and retention strategy, and to increase workforce diversity. The stipends are awarded to graduate interns placed in ACBH and contracted community-based organizations, and who are linguistically and or culturally able to serve the underserved and unserved populations of the County. In FY 22/23 ACBH will add 15 additional intern awards, for a total of 35 possible awards. More information on this program can be seen in the WET section of this Plan Update.

Additional workforce projects are also in development as the topic of workforce, financial incentives, peer support services and training were top issues highlighted during the most recent CPPP Listening Sessions. More information will be available in the next MHSA Three Year Plan FY 23/24-25/26.

V. CAPITAL FACILITIES AND TECHNOLOGICAL NEEDS (CFTN)

a. African American Wellness Hub Complex Update (CF5)

ACBH, in partnership with the Alameda County General Services Agency (GSA) department, continues to work on the development of the African American Wellness Hub Complex (HUB). In FY 21/22 ACBH Leadership identified an additional $8.8M (non-MHSA funds) to enhance the current $6M (MHSA CFTN funds) budget for a total development budget of $14.8M.

The ACBH Office of Ethnic Services, in partnership with the ACBH Building Facility Manager and GSA identified an outside architecutural team who completed their final Space Needs Assessment report for the African American Wellness HUB. The report presented three viable options and limitations for the procurement of the HUB. The partnership continues by explorating and examining the inventory of County owned facilites for the HUB and other potential suitable sites.

In addition to the ongoing exploration of space and facilities, ACBH is also creating a video to chronicle the years long effort to build a wellness center that focuses on the mental and behavioral health needs of the African American community.

First articulated in the African American Utilization report commissioned by the department in 2011, the African American Wellness Hub concept came about as a direct result of community feedback and collaboration with ACBH staff. This 5-minute video aims to briefly tell the story of the origins of the project through the reflections of some of its early architects, current contributors and community leaders who will speak to the benefits and long term impacts the facility will have on the African American population it seeks to serve.

More information will be available on the progress of the video and either a land purchase or building purchase/renovation as it becomes available and will be posted on the MHSA website and in the next MHSA Three Year Plan (FY 23/24-25/26)

b. New Medical Respite Project (CF2)

In FY 19/20 ACBH allocated $3M in MHSA CFTN funding for Medical Respite bed expansion projects in Alameda County. The Health Care for the Homeless (HCH) unit under the Alameda County Health Care Services Agency (HCSA) is developing a new medical respite project called Oak Days utilizing these funds.

Oak Days is currently running as a non-congregate emergency shelter with 40 beds set aside for very medically fragile clients who have complex physical and mental health care needs.

To be eligible for one of the 40 beds at Oak Days clients must meet ALL THREE of the following criteria:

1. Functionally compromised (which includes both physical and mental health issues)
2. Complex chronic condition (including mental health)
3. 8 or more ED visits, or 2 or more inpatient in last year (psych ED visits and inpatient psych admissions are included in the count)

These beds were created to meet a need that doesn't exist. The majority of start-up costs have been provided through Alameda County's Whole Person Care Program, but there is currently a need for the provider to purchase a Home Health Agency License. This is a one-time expense that will allow the agency to pay for caregivers with Medicaid funding and will open up other medical respite opportunities for Alameda County.

c. MHSA Technology Project (TN1)

ACBH has utilized CFTN funds to support the following Technological Needs (TN) Projects:

Development of new billing system: ACBH is now partnering with the vendor Streamline Healthcare Solutions, LLC, to formally initiate the effort to provide a fully integrated billing system on the SmartCare Platform to replace *INSYST* (our department's current registration and billing platform).

Streamline and the integrated SmartCare Platform will incorporate all of the functionality necessary to ensure staff and contracted providers work together within and across organizational boundaries. This platform will help to advance the effective delivery of behavioral health care for our clients and the communities we serve. SmartCare will also provide our system with options to resolve system challenges and facilitate enhanced flexibility for data sharing.

The Implementation planning phase began in July 2021 and will continue through FY 21/22. More information will be available on the progress of this project as it becomes available and will be posted in the next MHSA Three Year Plan (FY 23/24-25/26)

Additional TN projects are also being considered as the issues related to CalAIM, provider readiness and implementation of the county and CBO EHR systems were topics highlighted during the most recent CPPP Listening Sessions.

MHSA Funding Summaries

FY 2022/23 Mental Health Services Act Annual Update
Funding Summary

County: Alameda Date: Date: 3/23/22

	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 2022/23 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	68,200,047	3,407,176	14,209,262	275,819	3,519,226	
2. Estimated New FY 2022/23 Funding	84,964,960	21,241,240	5,589,800			
3. Transfer in FY 2022/23[a/]	(12,000,000)			4,500,000	7,500,000	
4. Access Local Prudent Reserve in FY 2022/23						
5. Estimated Available Funding for FY 2022/23	141,165,007	24,648,416	19,799,062	4,775,819	11,019,226	
B. Estimated FY 2022/23 MHSA Expenditures	105,357,034	18,675,518	11,242,069	4,607,925	10,761,713	
G. Estimated FY 2022/23 Unspent Fund Balance	35,807,973	5,972,898	8,556,993	167,894	257,513	

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2022	14,593,038
2. Contributions to the Local Prudent Reserve in FY 2022/23	0
3. Distributions from the Local Prudent Reserve in FY 2022/23	0
4. 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.

FY 2022/23 Mental Health Services Act Annual Update
Community Services and Supports (CSS) Funding

County: Alameda Date: 3/23/22

		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	3,054,637	2,287,607	767,030			
FSP 4	Greater Hope Project	4,525,459	3,774,993	750,466			
FSP 10	Housing Services	15,728,553	15,273,908	454,645			
FSP 11	Community Conservatorship	671,309	671,309	0			
FSP 12	Assisted Outpatient Treatment	727,252	727,252	0			
FSP 13	CHANGES	4,593,363	2,939,172	1,654,191			
FSP 14	STRIDES	3,059,820	1,929,401	1,130,419			
FSP 16	Alameda Connections 0-8	755,297	407,860	347,437			
FSP 17	East Bay Wrap 8-18	756,302	438,655	317,647			
FSP 18	Homeless Engagement	4,525,460	3,846,641	678,819			
FSP 19	North County Senior Homeless	2,988,650	2,271,374	717,276			
FSP 20	Lasting Independence Forensic Team	3,054,636	2,229,884	824,752			
FSP 21	Prevention, Advocacy, Innovation, Growth, and Empowe	1,527,316	717,839	809,477			
FSP 22	Justice and Mental Health Recovery	4,282,635	2,955,908	1,326,727			
FSP 23	Older Adult Service Team	6,449,646	3,643,866	2,549,848			255,932
Non-FSP Programs							
OESD 4A	Mobile Integrated Assess Team for Seniors	688,550	467,479	221,071			
OESD 5A	Crisis Response Program	3,067,530	2,208,622	858,908			
OESD 7	Mental Health Court Specialist Program	621,565	490,449	131,116			
OESD 8	Juvenile Justice Transformation of Guidance Clinic	174,792	125,850	48,942			
OESD 9	Multisystemic Therapy	934,607	901,941	0			32,666
OESD 11	Crisis Stabilization Service	11,534,719	6,970,513	4,564,206			
OESD 14	Staffing to Asian Population	4,342,296	2,165,420	2,176,876			
OESD 15	Staffing to Latino Population	880,851	880,851	0			
OESD 17	Residential Treatment for Co-occurring Disorders	584,000	584,000	0			
OESD 18	Wellness Center	7,716,985	7,028,422	615,995			72,569
OESD 19	Medication Support Services	3,953,636	3,149,418	799,856			4,362
OESD 20	Individual Placement Services	6,438,145	4,754,476	1,683,669			
OESD 23	Crisis Residential Services	1,740,660	1,268,934	471,726			
OESD 24	Schreiber Center	382,931	275,710	107,221			
OESD 25	Behavioral Health - Primary Care Integration Project	6,655,322	5,915,274	691,417			48,632
OESD 26AB	Culturally-Responsive Treatment Programs for African-A	742,693	738,712	3,981			
OESD 27	In Home Outreach Team	2,980,338	2,037,389	942,949			
OESD 28	SAGE Case & Care Management	2,569,040	2,045,290	513,808			9,942
OESD 30	Peer Respite	1,088,043	1,088,043	0			
OESD 31	1st Onset	1,380,201	731,507	648,694			
OESD 32	Suicide Prevention/Crisis Line	275,165	275,165	0			
OESD 33	Deaf Community Counseling Services	306,685	290,399	10,629			5,657
OESD 34	School-Based Behavioral Health	1,272,959	1,272,959	0			
OESD 35	Community-Based Mental Health Outreach & Consultati	1,974,639	1,974,639	0			
OESD 36	Presumptive Transfer Project	762,973	762,973	0			
OESD 37	Re-entry Treatment Teams	1,064,858	556,195	508,663			
OESD 38	SSI Advocacy & Support Services	1,818,653	1,040,783	143,070			634,800
CSS Administration		15,336,179	11,114,370	4,221,809			
CSS MHSA Housing Program Assigned Funds		125,586	125,586	0			
Total CSS Program Estimated Expenditures		138,114,934	105,357,034	31,693,341	0	0	1,064,560

FY 2022/23 Mental Health Services Act Annual Update
Community Services and Supports (CSS) Funding

County: Alameda Date: 3/23/22

FSP Programs as Percent of Total	53.82%

FY 2022/23 Mental Health Services Act Annual Update
Prevention and Early Intervention (PEI) Funding

County: Alameda Date: 3/23/22

		Fiscal Year 2022/23					
		A	B	C	D	E	F
		Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention							
PEI 1A	School-Based Mental Health Consultation in Preschools	961,212	863,329	97,884			
PEI 1B	School-Based Mental Health Access & Linkage in Elementary, Middle, & High Schools	1,007,655	1,007,655	0			
PEI 1C	Early Childhood Mental Health Outreach & Consultation	303,063	300,000	0			3,063
PEI 1D	Unaccompanied Immigrant Youth Outreach	335,228	335,228	0			
PEI 4	Stigma & Discrimination Reduction Campaign	1,680,896	1,680,896	0			
PEI 5	Outreach, Education & Consultation for Latino Community	1,405,870	859,901	545,969			
PEI 6	Outreach, Education & Consultation for Asian Pacific Islander Community	2,007,619	1,665,223	331,591			10,805
PEI 7	Outreach, Education & Consultation for South Asian/Afghan Community	1,982,990	1,810,373	172,617			
PEI 8	Outreach, Education & Consultation for Native American Community	319,202	277,055	23,553			18,594
PEI 9	Outreach, Education & Consultation for Middle Eastern Community	702,723	702,723	0			
PEI 10	Outreach, Education & Consultation for African Community	319,094	319,094	0			
PEI 12	Suicide Prevention and Trama-Informed Care	1,755,165	1,755,165	0			
PEI 17AB	TAY Resource Centers	939,714	939,714	0			
PEI 19	Older Adult Peer Support	307,892	307,892	0			
PEI 20A-E	Culturally Responsive PEI programs for the African American Community	1,387,568	1,385,854	0			1,714
PEI 22	LGBT Support Services	349,862	349,862	0			
PEI 24	Sobrante Park Comm Proj	350,000	350,000	0			
PEI 25	Trauma Informed Servcies	115,537	115,537	0			
PEI 26	Mental Health Applications	250,000	250,000	0			
PEI 27	Hearing Voices Groups	24,500	24,500	0			
PEI 28	Restorative Justic Program	532,094	532,094	0			
PEI Programs - Early Intervention							
PEI 3	Mental Health for Older Adults, Geriatric Assessment & Response Team	1,036,351	746,173	290,178			
PEI Administration		2,504,045	2,097,251	406,794			
PEI Assigned Funds		0					
Total PEI Program Estimated Expenditures		20,578,281	18,675,518	1,868,586	0	0	34,176

FY 2022/23 Mental Health Services Act Annual Update
Innovations (INN) Funding

County: Alameda Date: 3/23/22

		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	5,247,726	5,109,708	138,018			
INN 4	Land Trust	175,000	175,000	0			
INN 7	Forensic Alternatives: Clinical Focused	3,209,580	3,209,580	0			
INN 8	Forensic Alternatives: Peer Focused	2,149,584	2,149,584	0			
INN 9	Online Peer Training Project	315,990	315,990	0			
		0					
		0					
		0					
		0					
		0					
		0					
		0					
		0					
		0					
		0					
		0					
		0					
		0					
		0					
		0					
INN Administration		333,621	282,207	51,414			
Total INN Program Estimated Expenditures		11,431,501	11,242,069	189,432	0	0	0

FY 2022/23 Mental Health Services Act Annual Update
Workforce, Education and Training (WET) Component Worksheet

County: Alameda Date: 3/23/22

		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	1,250,509	900,367	350,143			
Action 2	Training/Technical Assistance	2,514,296	2,514,296	0			
Action 3	Mental Health Career Pathways	778,262	778,262	0			
Action 4	Residency/Internship	200,000	200,000	0			
Action 5	Financial Incentive	215,000	215,000	0			
WET Administration							
Total WET Program Estimated Expenditures		4,958,067	4,607,925	350,143	0	0	0

FY 2022/23 Mental Health Services Act Annual Update
Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: Alameda Date: 3/23/22

		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 Program - Capital Facilities Projects							
CF2	Respite Bed Expansion	500,000	500,000				
CF3	County Facility Renovation	1,000,000	1,000,000				
CF4	APC Medical Respite Project	1,500,000	1,500,000				
CF5	AA Wellness Hub	2,000,000	2,000,000				
CF6	A Street Shelter Project	900,000	900,000				
		0					
		0					
		0					
		0					
		0					
CFTN Program - Technological Needs Projects							
TN1	Behavioral Health Management System	2,063,718	2,063,718				
TN3	County Equipment & Software Update	1,000,000	1,000,000				
TN4	Consulting Services	848,966	848,966				
		0					
		0					
		0					
		0					
		0					
		0					
CFTN Administration		1,318,096	949,029	369,067			
Total CFTN Program Estimated Expenditures		11,130,780	10,761,713	369,067	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 estimated numeric increase in population from 2017 to 2019 with over 4,500 people and the third highest percent of foreign-born residents (33%). Since the 2010 Census, the population has increased 11%, the highest of any Bay Area County (**Table 1**).

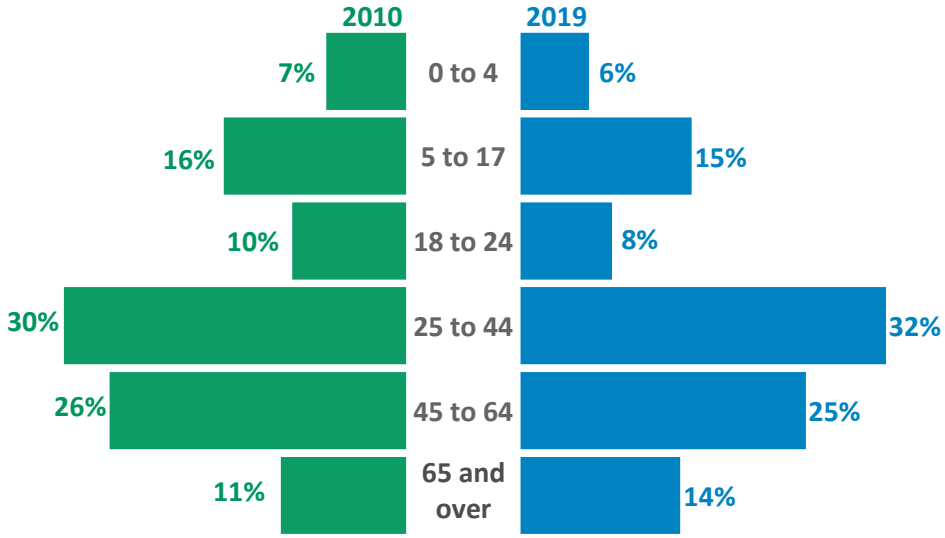
Table 1: Alameda and Select Bay Ares Counties Population Characteristics

Description	Alameda	Contra Costa	Marin	San Francisco	Santa Clara
Census, April 1, 2020	1,510,271	1,165,927	262,321	873,965	1,936,259
Estimates base, April 1, 2010, (V2019)	1,510,258	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)	11%	10%	3%	10%	8%
Total change estimates, July 1, 2017 to July 1, 2019	4,573	3,007	-836	853	-4,485
Foreign-born residents, percent 2015-2019	33%	25%	18%	34%	39%

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: 3/2020, Retrieved: 1/12/2021

Even though Alameda County is growing, 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 37.9 years in 2019. Between 2010 and 2019 Alameda County was home to fewer children 0 to 4 years old (7% to 6%), youth 5 to 17 (16% to 15%), young adults 18 to 24 (10% to 8%), and adults 45 to 64 (26% to 25%). The two age groups that increased between 2010 and 2019 were adults 25 to 44 (30% to 32%) and adults 65 and older (11% to 14%) (**Figure 1**). Women are 51% of the county population and is home to 48,602 Veterans (2015-2019), which is the second-highest number among Bay Area Counties with Santa Clara having the most and Marin having the least.

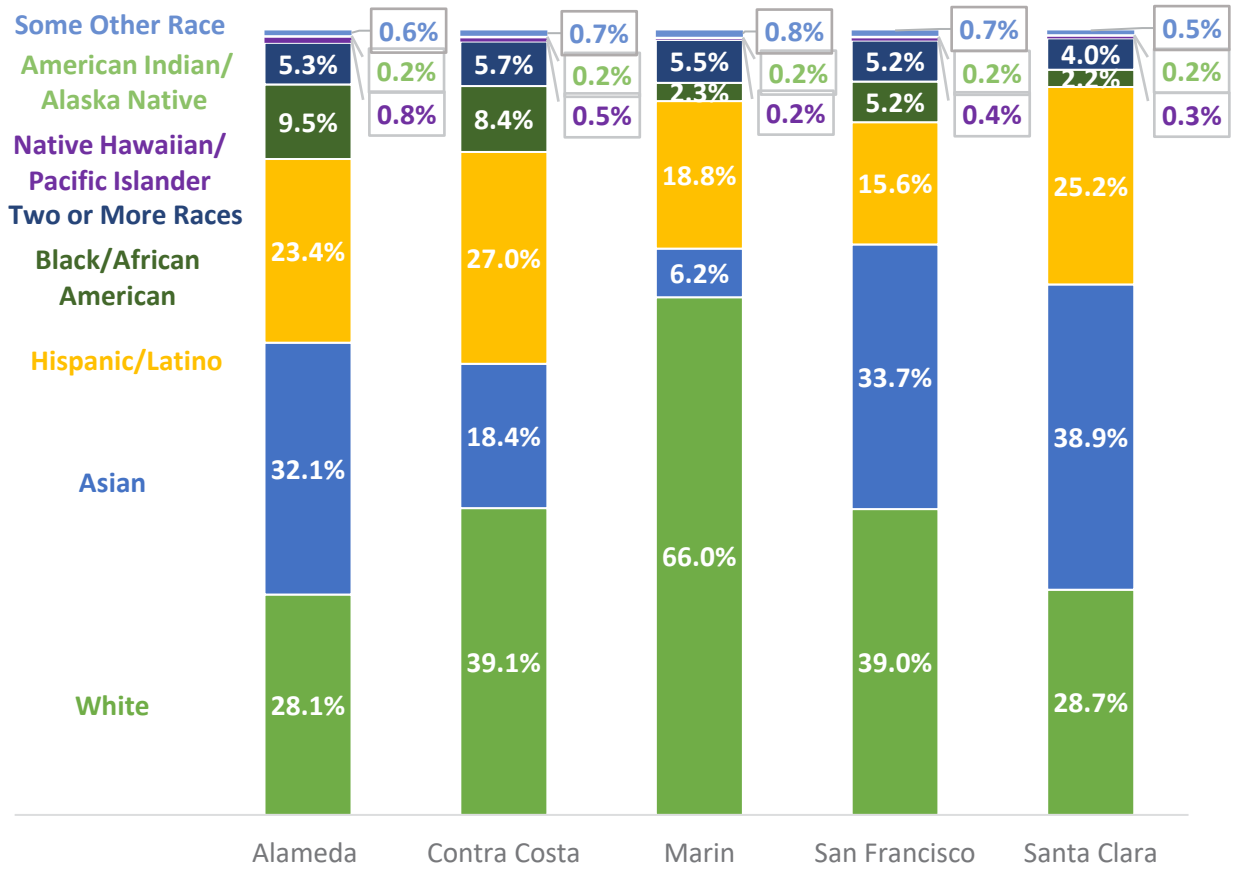
Figure 1: Alameda County Age Group as a Percentage of Total Population, 2010 v. 2019



Source: Annual County and Resident Population Estimates by Selected Age Groups and Sex: April 1, 2010 to July 1, 2019

Alameda County ranks as one of the most diverse counties, consisting of 28% White, 32% Asian, 23% Hispanic/Latino, 10% Black or African American, 5% Two or more races, and less than 1% each of Native Hawaiian or Pacific Islander, American Indian or Alaska Native, and Some Other Race (**Figure 2**). The percent of Asian residents in Alameda County is double the State of California's (15%).

Figure 2: Bay Area Counties Percent Race and Ethnicity 2020



Source: 2020 Census Redistricting Data (Public Law 94-171) Summary File, Retrieval Date: December 10, 2021

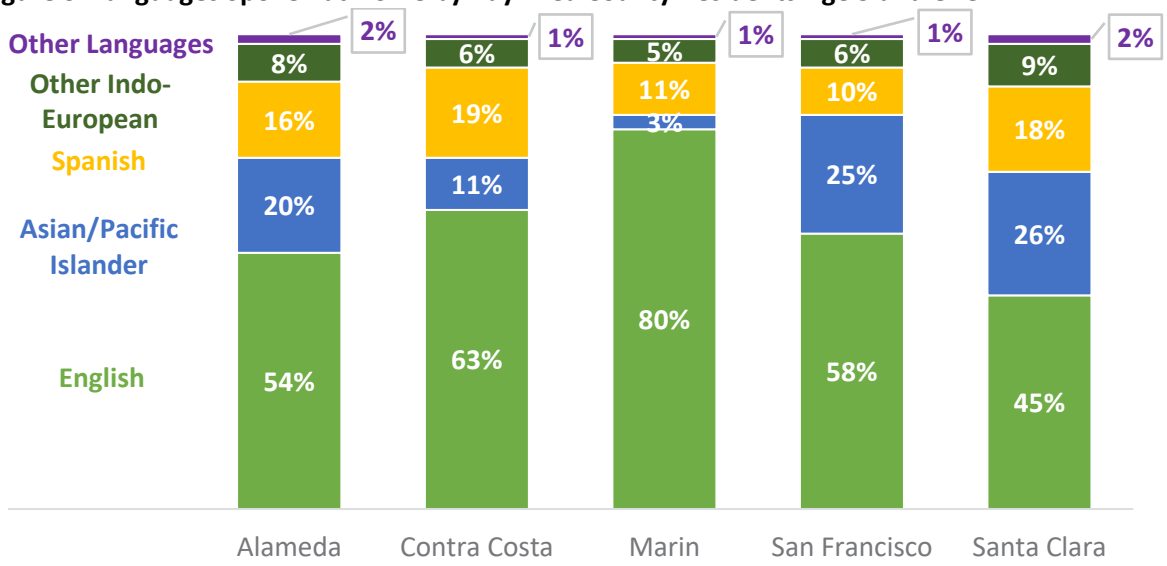
At home, Alameda County residents speak a variety of languages. Among the neighboring Bay Area Counties, Alameda has the second highest percent of residents who speak non-English languages at home. While over half of residents speak English at home (54.3%), 20.0% of residents speak Asian/Pacific Island languages, 16% speak Spanish, 8% speak Other Indo-European languages, and 2% speak Other Languages (**Figure 3**).

Due to this diversity of languages, Alameda County has seven threshold languages:

- English
- Spanish
- Vietnamese
- Arabic
- Tagalog
- If written, Traditional and Simplified Chinese
- If spoken Cantonese and Mandarin

Threshold languages are defined as those where at least 3,000 residents or 5% of the Medi-Cal beneficiary population, whichever is lower, identify that language as their primary one. Farsi is no longer a threshold language, but Alameda County is committed to providing materials in this language because of how close it is to becoming a threshold language. 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: Languages Spoken at Home by Bay Area County Residents Age 5 and Over



Source: 2019 ACS 1-Year Estimates Subject Tables, Retrieved: 1/26/2021

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 higher rental rate compared to Contra Costa, Marin, and Santa Clara counties, meaning a higher percentage of residents do not own a home. Additionally, 50% of red 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. Alameda County has the second highest percent of households that receive SNAP and many ACBH providers report that they connect their clients to food resources[1].

Table 2: Poverty Indicators for Bay Area Counties

Indicator	Alameda	Contra Costa	Marin	San Francisco	Santa Clara
Median household income±, 2015-2019	**$99,406**	$99,716	$115,246	$112,449	$124,055
Per capita income, past 12 months±, 2015-2019	**$47,314**	$48,178	$72,466	$68,883	$56,248
Median gross rent, 2015-2019	**$1,797**	$1,819	$2,069	$1,895	$2,268
Rental Rate	**47.0%**	34.6%	38.0%	62.9%	45.1%
Households whose rent is 30% or more of their income	**49.7%**	51.5%	54.8%	32.5%	44.8%
Poverty percent, all ages	**8.9%**	7.9%	6.7%	9.5%	6.1%
Poverty percent, under 18	**9.7%**	10.4%	7.5%	7.3%	5.1%
Households with SNAP, percent	**5.4%**	5.2%	2.6%	5.5%	3.7%

±In 2019 dollars; Source: 2020 Census Quickfacts; Annual Estimates of the Resident Population for Counties in California: April 1, 2010 to July 1, 2019; and 2019 ACS 1-Year Estimates Subject Tables; Retrieved: 1/26/2021

[1] Mental Health Services Act FY 2020-2023 Plan

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. Due to the COVID-19 Pandemic the 2021 count was postponed. 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):

33% Rent Assistance

30% Benefits/ Income

23% Employment Assistance

21% Mental Health Services

17% Alcohol/Drug Counseling

Survey respondents reported the following health conditions:

30% Post-traumatic Stress Disorder

13% Traumatic Brain Injury

39% Psychiatric/Emotional Conditions

30% Alcohol/Drug Counseling

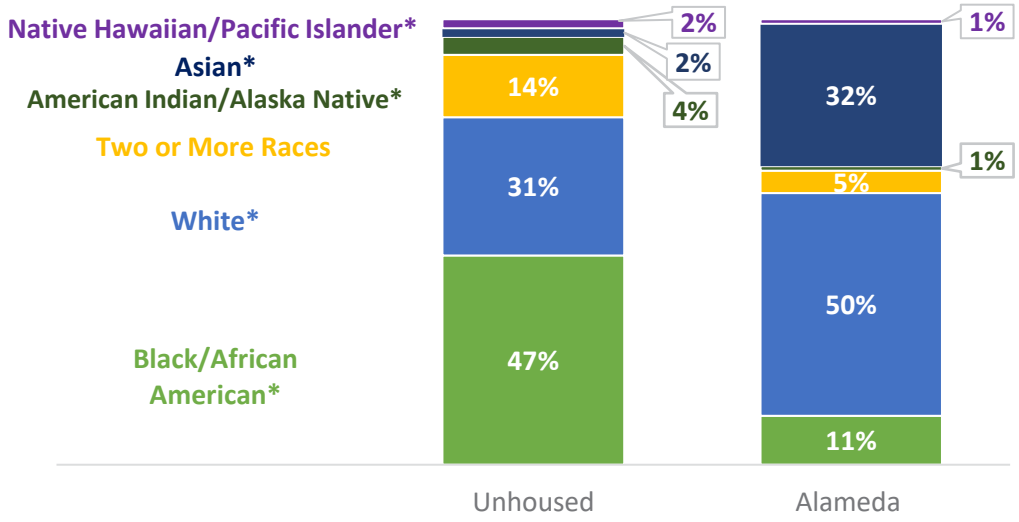
Only three percent of respondents were not interested in independent, affordable rental housing, or housing with supportive services. The lack of affordable housing has impacted Alameda County residents, the workforce, and consumers and family members in MHSA programs. During the MHSA Community Program Planning Process, the top concern that survey respondents named for all age groups was housing and homelessness and persons experiencing homelessness were one of top three groups that respondents felt were not adequately served by the ACBH system[2].

Multiple populations were overrepresented in the homeless populations, veterans (9% versus 5%) compared to the overall Alameda County population and adults with serious mental illness when compared to the United States population (32% versus 5%). Compared to the general Alameda County population the unhoused population has a higher percentage of Black/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%

[2] Mental Health Services Act FY 2020-2023 Plan

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 83.1 years compared to the neighboring counties (range 82.5 - 85.9). Alameda and San Francisco Counties have much higher rates of violent crime than the other neighboring counties. Alameda County has the lowest percent of those without health insurance under the age of 65 (range 5.1% - 6.5%). However, rates are similar 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 5.6% in Alameda County (**Table 3**).

Table 3: Health Indicators for Bay Area Counties

Indicator	Alameda	Contra Costa	Marin	San Francisco	Santa Clara
Life expectancy, years	**83.1**	82.5	85.4	84.0	84.9
Violent crime rate (per 100,00 people)	**629**	336	178	760	264
Persons without health insurance, under age 65 years	**5.1%**	6.5%	5.3%	5.2%	5.5%
With a disability, under age 65 years, 2015-2019	**5.6%**	7.5%	5.1%	5.7%	4.6%

Source: 2020 and 2021 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 and July 2021, Retrieved: 1/12/2021 and 12/10/2021 and County Health Rankings 2020

In contrast to life expectancy, Alameda County has the second lowest age-adjusted[3] death rates due to drugs (11.7 per 100,000), which is higher than the Healthy People 2020 goal. However, the age-adjusted suicide rate is 9.0 per 100,000, which is lower than Health People 2020 goal, but higher than two other neighboring counties (**Table 4**). 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. Additionally, suicide rates increased by 5% from 2019-2020 for those between the ages of 25 to 34 and increased from 6.8 in 2007 to 10.6 per 100,000 in 2017.

[3] Rates are age-adjusted to correct for the influence of age on health outcomes, allowing counties with different age profiles to be compared.

Table 4: Selected Causes of Death, 2017-2019

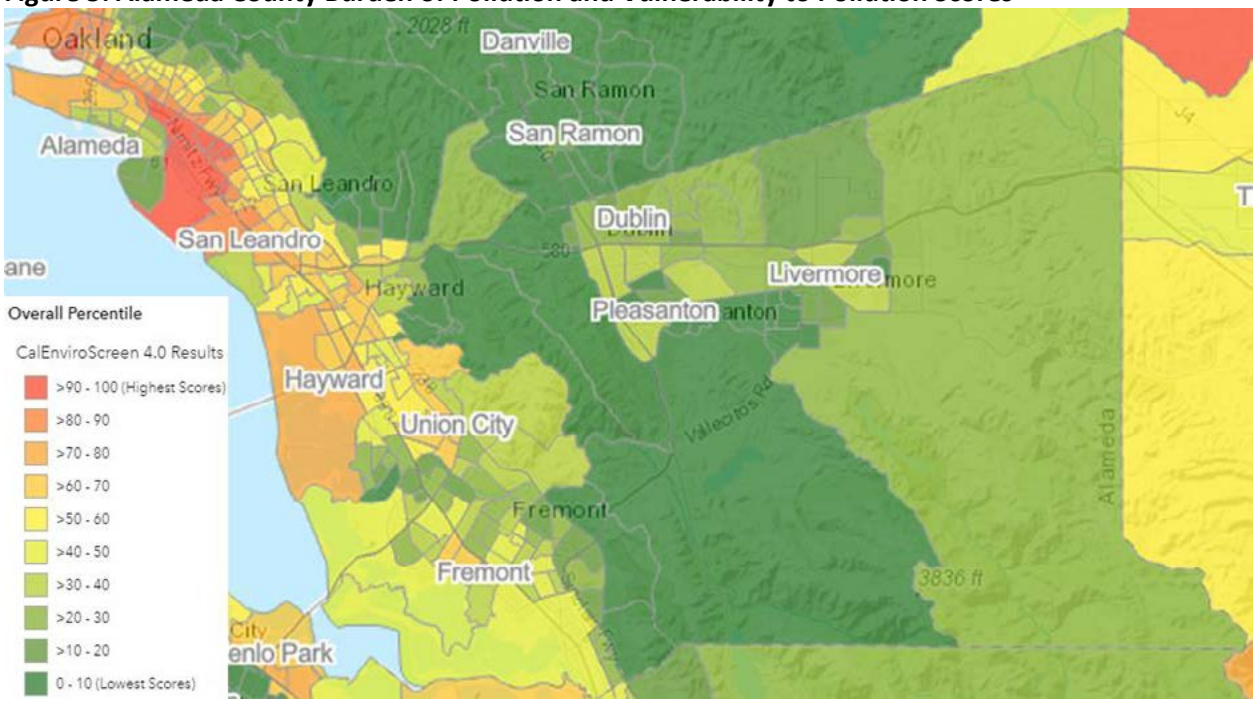
County	Drugs		Suicide	
	Deaths (Average)	Age-Adjusted Death Rate	Deaths (Average)	Age-Adjusted Death Rate
Alameda	207.7	11.7	157.3	9.0
Contra Costa	161.7	13.4	112.7	9.5
Marin	37.7	14.0	43	15.2
San Francisco	281.3	27.0	90	8.8
Santa Clara	191.0	9.0	157	7.7
Healthy People 2020 Objective	-	11.3	-	10.2

Source: California Department of Public Health, California Comprehensive Master Death Files, [2017-2019] Retrieved, January 2022.

Environmental Health

California's Office of Environmental Health Hazard Assessment has created the CalEnviroScreen 3.0 model[4] 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 2021 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 Hayward have the highest burden of pollution and vulnerability to pollution.

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



[4] A detailed explanation of the model can be found here: https://oehha.ca.gov/calenviroscreen/scoring-model.

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. Of the Bay Area Counties, San Francisco (15%) has the highest percentage of their population that reported to have "likely had psychological distress during the last year" and the rest have 12% (**Table 5**). Alameda County has the third highest percentage of moderate or severe "social life impairment" during the past year (18%), and "ever seriously thought about committing suicide" (11%) compared to other Bay Area counties. Additionally, 22% of Alameda County respondents, the second highest among Bay Area Counties, reported that they "needed help for emotional/mental health problems or use of alcohol/drugs." Of those Alameda County respondents, 71% of them reported receiving treatment, which is the lowest percent. The ratio of mental health providers to residents is 150:1 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	**12%**	12%	12%	15%	12%
Moderate or severe social life impairment in the past year	**18%**	15%	15%	24%	20%
Ever thought about committing suicide	**11%**	12%	11%	15%	13%
Needed help for emotional/mental health problems or use of alcohol/drugs	**22%**	20%	19%	30%	21%
Of those that needed help, received treatment for mental/emotional and/or alcohol/drug issues	**71%**	75%	74%	83%	73%
Mental health providers	**150:1**	300:1	130:1	110:1	290:1

Source: 2019 and 2020 California Health Interview Survey and County Health Rankings 2020

In Alameda County 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" (39%). Among those that needed help for emotional/mental health problems African Americans were the least likely to receive help (64%). 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

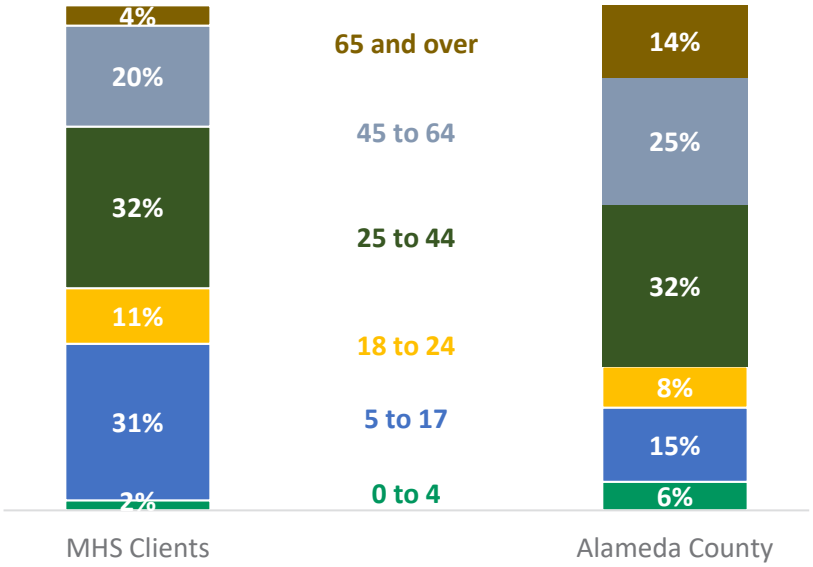
Indicator	Hispanic/ Latino	White	African American	Asian	Two or More Races
Likely has had serious psychological distress in the past year	9%	12%	10%	9%	*
Moderate or severe social life impairment in the past year	14%	19%	14%	*	*
Ever thought about committing suicide	7%	13%	11%	*	*
Needed help for emotional/mental health or alcohol/drugs	15%	27%	20%	15%	39%
Of those that needed help, received treatment for mental/emotional and/or alcohol/drug issues	*	78%	64%	68%	*

* = suppressed because statistically unstable; Note: American Indian or Alaska Native and Native Hawaiian or Pacific Islander suppressed due to statistically unstable or sample size.
Source: 2015, 2016, 2017, 2018, 2019, and 2020 California Health Interview Survey

Alameda County Behavioral Health Care Services Utilization

During FY 2020/2021, ACBH provided behavioral health services to 25,541 clients. Adults 25 and over make up more than half of the consumer population (56%), which is less than the County's population (71%). Children and Youth 0 to 17 are 33% and Young Adults 18 to 24 are 11% of clients both of which are higher than the Alameda County population. ACBH serves more males (54%) than females (46%). Nationally adult women have higher rates of any mental illness (26% versus 16%), serious mental illness (7% versus 4%), and treatment for serious mental illness (70% versus 55%)[5] than men.

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



Source: Annual County and Resident Population Estimates by Selected Age Groups and Sex: April 1, 2010 to July 1, 2019 (CC-EST2019-AGESEX) and MHSA Demographic Yellowfin Data Retrieved: 1/25/2022

The mental health services penetration rate is the percentage of eligible Medi-Cal insured individuals who are utilizing mental health services. **Table 7** shows the mental health services penetration rate by race and ethnicity. Asians or Pacific Islanders have the lowest penetration rate at 2% and Black or African Americans have the highest penetration rate (8%).

Table 7: Fiscal Year 20/21 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
Asian or Pacific Islander	97,377	1,553	2%	1,425	1%	838	2,391
Alaska Native or American Indian	1,063	66	6%	58	5%	32	98
White	47,995	2,761	6%	2,336	5%	1,378	4,139
Black or African American	73,657	5,572	8%	4,541	6%	1,589	7,161
Other/Unknown	115,896	4,985	4%	4,105	3%	1,645	6,630
Hispanic or Latino	113,485	4,984	4%	4,548	4%	138	5,122
Total	**449,473**	**19,921**	-	**17,728**	-	**5,620**	**25,541**

[5] Substance Abuse and Mental Health Services Administration's National Survey of Drug Use and Health, 2020

Exploring the Medi-Cal penetration rate by language shows that the lowest penetration rates are among Chinese, Tagalog, and Vietnamese speaking individuals (**Table 8**). English speakers are the largest group of beneficiaries and are tied for have the highest penetration rate (5%) with Farsi speakers. Overall, 4% of beneficiaries are accessing mental health services in the ACBH system. Results from the Substance Abuse and Mental Health Services Administration's National Survey of Drug Use and Health (2020), showed that rates of serious mental illness are 6% of adults and 30% of residents are receive health insurance through Medicaid/CHIP[6].

Table 8: Fiscal Year 20/21 Alameda County Mental Health Services Medi-Cal Penetration Rate by Language

Language Group	Number of Recipients	Served with Medi-Cal	Penetration Rate	Served in Less Restrictive Care	Outpatient Penetration Rate	Served without Medi-Cal	Total Served
Farsi	2,507	118	5%	114	5%	30	148
Arabic	3,070	53	2%	50	2%	14	67
Tagalog	3,240	40	1%	37	1%	0	40
Vietnamese	11,054	144	1%	135	1%	9	153
Other	15,952	525	3%	492	3%	469	994
Chinese	37,101	338	1%	324	1%	52	390
Spanish	81,898	3,051	4%	2,910	4%	695	3,746
English	294,651	15,652	5%	12,951	4%	4,351	20,003
Total	**449,473**	**19,921**	-	**17,013**	-	**5,620**	**25,541**

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 January 25, 2022, Alameda County has the second highest number of cases of the Bay Area counties with 227,260 cases and 1,581 deaths. Alameda's case rate is 13,826 per 100,000, which is the third highest rate in the Bay Area, and the death rate is 96.2 per 100,000, which is the fourth highest (**Table 9**). These are all large increases compared to last year when this data was retrieved. Alameda County has fully-vaccinated 81% of their residents.

Table 9: Bay Area County's COVID-19 Cases and Deaths Cumulative and Rates

Indicator	Alameda	Contra Costa	Marin	San Francisco	Santa Clara
Number of Cases	**227,260**	170,857	31,893	115,000	274,130
Case Rate (per 100,000)	**13,826**	15,076	12,252	13,222	14,261
Number of Deaths	**1,581**	1,092	253	703	2,006
Death Rate (per 100,000)	**96.2**	96.4	97.2	80.8	104.4

Source: San Francisco Chronicle Coronavirus Tracker, https://www.sfchronicle.com/projects/coronavirus-map/#about-data; Retrieved: 1/25/2021

Residents of Alameda County are disproportionately affected by the virus. **Table 10** shows the cases and death rates per 100,000 people by **known** race and ethnicity. The groups with case and/or death rates higher than the overall case and death rates are highlighted in red below. African

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

American/Black, Hispanic/Latino, Pacific Islander, and Native American have case rates higher than the overall case rate of 9,568/100,000. The groups with the highest death rate were among those of Two or More Races, African American/Black, Hispanic/Latino, and Pacific Islander race/ethnicity. **Figure 7** 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.

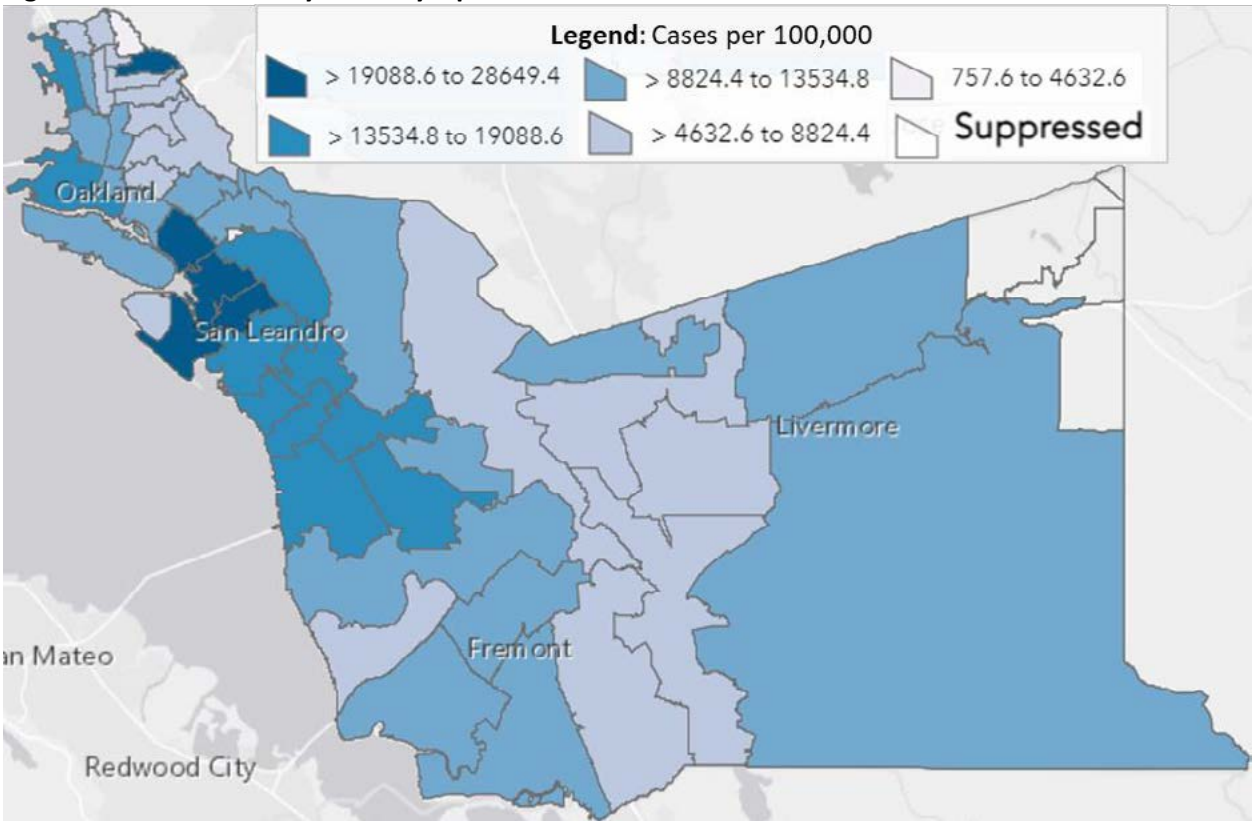
Table 10: Alameda County's COVID-19 Cases and Deaths Rates by Race/Ethnicity

Race Ethnicity	Case Rates	Death Rates
Two or More Races	6,509	137
African American/Black	12,108	180
Asian	5,983	60
White	6,427	81
Hispanic/Latino	17,595	95
Pacific Islander	17,048	152
Native American	14,275	*
Overall	9,568	88

*Suppressed on dashboard

Source: Alameda County Department of Public Health's COVID-19 website; https://covid-19.acgov.org/data; Retrieved: 1/26/2022

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 importance of meaningful stakeholder involvement.

The MHSA (MHSA) Community Program Planning Process (CPPP) engages 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 the FY20/23 Three Year Plan CPPP, 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 10: MHSA Three-Year Plan 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
Talia Bennett	Executive Director	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 the MHSA-SG Meeting Calendar).

During FY19/20 and FY20/21, the MHSA-SG exprienced a 27% increase in membership, growing from 11 participants to 15 participants (see Table 11). 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 including TAY representatives by 250% percent.

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

Table 11: MHSA-SG Demographics, FY20/21

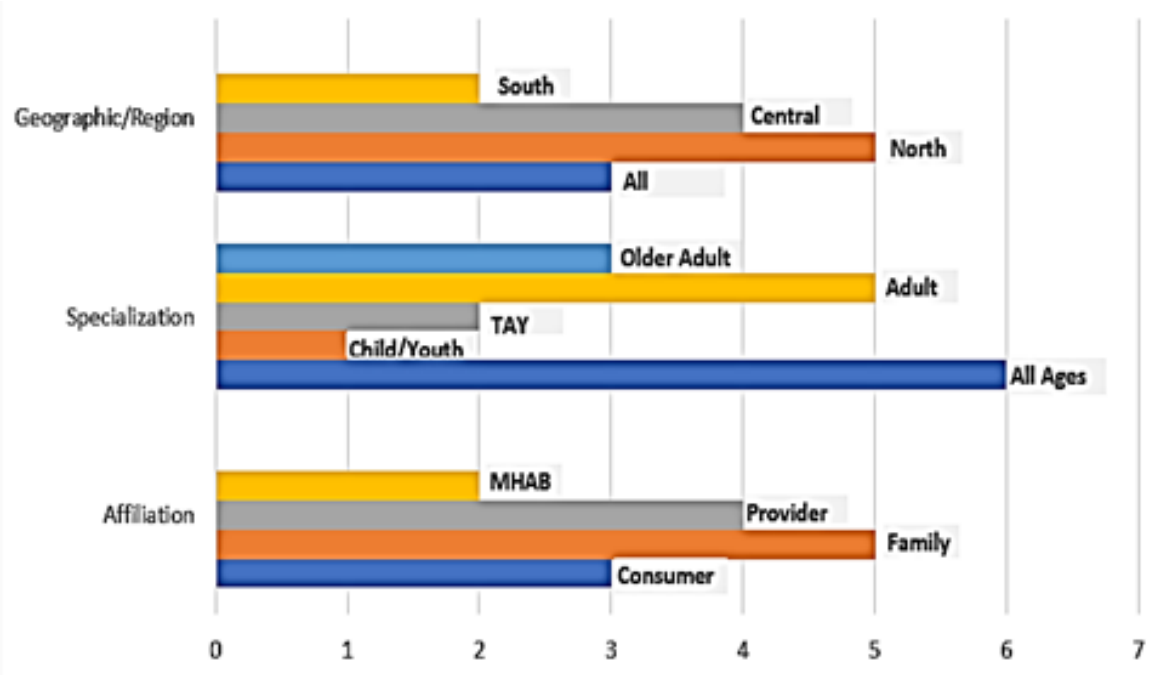


Table 12: Current MHSA Stakeholder Group Membership and Participating ACBH Leadership

Full Name	Seat/Role	Title/Affiliation
Annie Bailey	Provider	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
Margot Dashiell	Family Member	Alameda County Family Coalition, African American Family Support Group
Lee Davis	Mental Health Advisory Board (MHAB)	Chair, MHAB
Tracy Hazelton	ACBH - Agency Leadership	MHSA Division Director
Katherine Jones	ACBH - Agency Leadership	Adult System of Care Director
Terri Kennedy	ACBH	MHSA Administrative Assistant

Yuan Yuan "Yona" Lo	Provider-TAY Student	Ohlone College Student- Mental Health Ambassador
L.D. Louis	MHAB	Vice-Chair, MHAB/ Assistant District Attorney
Sarah Marxer	Family Member	Evaluation and Policy Specialist II, Peers Envisioning and Engaging Recovery Service (PEERS)
Imo Momoh	ACBH - Agency Leadership	Deputy Behavioral Health Director/ Plan Administrator
Elaine Peng 彭一玲	Consumer/ Family Member	Mental Health Association for Chinese Communities (MHACC)
Katy Polony	Provider	Family Advocate, Abode Services
Mariana Real	ACBH	MHSA Senior Planner/TIS Coordinator
Liz Rebensdorf	Family Member	President, National Alliance on Mental Illness (NAMI)- East Bay
Carissa Samuels	Provider-TAY Student	Ohlone College Mental Health Ambassador
Karyn Tribble	ACBH - Agency Leadership	Behavioral Health Director
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

COVID-19 Impact on All 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 has identified the following three key implementation challenges: **Administrative barriers, Resource Disparities**, and **Community Stressors.**

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 and MHSA-SG**: 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.

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 19 ACBH and community members who facilitated 16 remote focus groups between FY2019-20 and FY2020-21. 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). (See **Appendix B-1** for MHSA CPPP Outreach & Marketing Plan)

Community Input Process Summary: FY20/23 Three-Year Plan and FY21/22 Annual Plan Update

The MHSA community input process for the Three-Year Plan was conducted from April 27, 2020 – May 31, 2020. During the the Three-Year Plan CPPP, 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. 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.

The MHSA Steering Committee and MHSA-SG coordinated a smaller CPPP for FY21/22 Annual Plan Update conducted October 1, 2021 – January 31, 2022. Community members participated in 5 focus groups shedding light on mental health needs and services, system gaps and barriers, and innovative

ideas. A total of 45 participants attended the focus groups and represented important cross sections of Alameda County populations in accordance with data from the Three-Year Plan CPPP. Some reoccurring themes from focus groups included:

- requests for housing and homelessness programs
- school-based wellness programs
- conservatorship for the severely mentally ill
- long-term mental health care and substance abuse treatment programs to combat depression and suicide, cultural recognition in clinical programs
- digital kinship villages
- subacute and acute beds
- increased license board and care facilities
- Requests to target services for underserved and unserved communities- specifically African-Americans, veterans, transition age youth (TAY), persons experiencing homelessness and immigrants & refugees.

MHSA plans to collaborate with HHREC to produce a mental health podcast series featuring key informant interviews from local community members. The podcast series topics would explore the rise of telehealth and its impact on vulnerable populations, a spotlight on local MHSA programs and services, and the impact COVID-19 has on the African-American community. The podcast is tentatively scheduled to launch during the Annual Plan Update Public Comment Period beginning April 2022 - May 2021. MHSA will also develop a "How to Read the Plan" webinar to help inform the community on the plan contents and how to navigate the document to identify resources and services (see **Appendix B-2: CPPP Flyer**)

FY22/23 MHSA Annual Plan Update Community Input Process

Current CPPP outreach activities launched October 1, 2021 and ended January 31, 2022 (see *Figure 9*). MHSA employed a variety of tactics to engage the public such as hosting community forums for TAY, recording educational podcasts with community partners and mental health leaders, and coordinating 16 listening sessions with diverse stakeholders.

MHSA Community Forums for Young Men of Color:

MHSA and media partner HHREC coordinated a series of TAY health forums which focused on navigating stressful environments, and dealing with the ramifications of the pandemic's impact on TAY mental health. Each forum was coordinated on Zoom and live recordings are publicly posted on YouTube. The forum themes focused on handling stressful environments as a young person of color. Events occurred on 8/18/21. Subsequent forums focused on COVID pandemic and how It affects TAY mental health. TAY forums are publicly posted to the HHREC Youtube page at https://www.youtube.com/channel/UCXL5FVNzGgHSl7YEy4Rc63g/videos

Figure 9: MHSA Community Input Website (at https://acmhsa.org/community-input**):** CPPP & 30-Day Public Comment Outreach Period: October 1, 2021 – April 30, 2022

Mental Health Services Act (MHSA)
Alameda County Behavioral Health

WELLNESS • RECOVERY • RESILIENCE

WE WANT TO HEAR FROM YOU!

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

Help Spread the Word!

Outreach & Media Toolkit

- MHSA Community Input FLYER
- Share your Innovative Ideas HERE!
- Press Release
- Sample Public Service Announcements (PSAs)
- Sample Social Media Messages

MHSA Overview

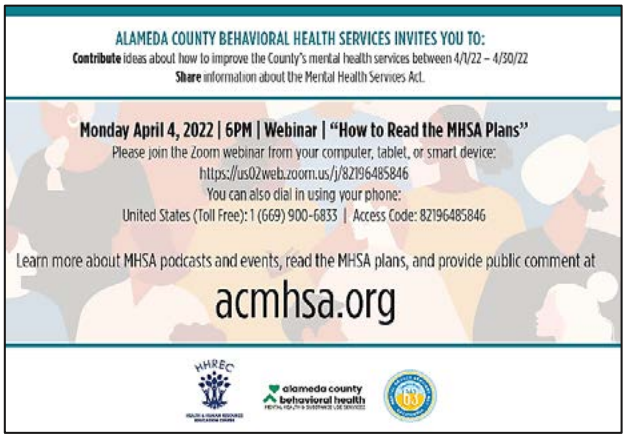
- MHSA 101 PowerPoint (PDF)
- MHSA 101: Fact Sheet
- Profile Sheet: MHSA Community Services & Supports
- Profile Sheet: MHSA Prevention & Early Intervention
- Profile Sheet: MHSA Innovation (coming soon)
- Profile Sheet: MHSA Workforce, Education, & Training (coming soon)
- Profile Sheet: MHSA Capital Facilities & Technological Needs (coming soon)

MHSA Focus Group Workbook
MHSA Focus Group Consent

Click here to preview all Community Participation & Feedback Surveys (PDF)

Want to know more about MHSA?
Watch this video.

Figure 10: MHSA Community Input & 30-Day Public Comment E-Flyers/Palm Cards (see **Appendix B-2)**



MHSA Podcast Series

MHSA and media partner HHREC designed a series of mental health focused podcasts featuring interviews with local leaders in the field. The first podcast for the FY22/23 CPPP featured an interview from Dr. Karyn Tribble, ACBH Director, on prioritizing mental health. Additional podcasts will focus on the following: Veterans, Korean Community, Telehealth, Racism during COVID-19, vaccine hesitancy in the African American community and TAY community service specialists. MHSA podcasts are featured on the HHREC Youtube page at https://www.youtube.com/channel/UCXL5FVNzGgHSl7YEy4Rc63g/videos

"How to Read the Plan" webinar

MHSA will facilitate a "How to Read the MHSA Plan webinar during 30-Day Public Comment on May 4, 2022. The overarching goal is to broaden the population's ability to understand, synthesize, and apply information that's provided in the MHSA Plans.

CPPP Listening Sessions

Eighteen focus groups were coordinated and hosted by ACBH, the MHSA CPPP-SM, and community-based organizations in which stakeholders provided input on mental health needs, priority underserved populations and mental health services (see **Table 13**).

Reoccurring themes were identified across listening sessions such as:

- Isolation (across the life span)
- Lack of community, fun things to do to help with mental wellness
- Workforce needs (clinicians/peers) that look like our clients and are bi-lingual
- More assistance with how to navigate our different systems
- Address the response time in systems such as ACCESS
- Youth suicides

- More services for the African American community across the lifespan
- Establish capacity building grant for African American CBOs
- Supports in the evenings and weekends
- Supports and activities for the LGBTQ community, particularly the transgender community of color and sex workers
- Need for increased language capacity, especially for Asian communities
- Increased culturally responsive training
- More peer support services
- Stigma all around, but particularly in the Asian communities
- Address insecure housing utilizing FSPs
- Support the reentry community with services to divert people from John George and Jail

The MHSA Division developed a revised listening session toolkit consisting of MHSA 101 Fact Sheets, MHSA PowerPoint presentation, Consent Form, and 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 at https://acmhsa.org/community-input . Sixteen ACBH staff and community volunteers participated in remote listening session trainings and facilitated 18 events.

During the listening sessions, MHSA Senior Planner, MHSA Division Director and co-presenters presented information regarding MHSA components and funded services. Participants provided input on five questions to help identify mental health challenges, prioritize existing services, identify unserved/underserved populations, and recommend future innovative programs and services. Approximately 307 community stakeholders participated in the FY22/23 MHSA CPPP. Interpreter services were available if requested.

Table 13: MHSA Community Input Listening Sessions (Please see **Appendix B-4** for complete list of listening session recommendations)

MHSA Listening Session	Description / # Participants	Recommendations
TAY Forums for Young Men of Color	Themes touched on how to handle a stressful environment as a young person of color. Events occurred on 8/18/21. Subsequent forums focused on COVID pandemic and how It affects TAY mental health.	All data and videos located ON HHREC YouTube site here
Veterans Community Collaborative Courts	Collaborative courts involve a partnership with the District Attorney's Office, judges, defense attorney, Probation,	ISSUES: 12 RECOMMENDATIONS: 12

	social services, and other allied professionals. The court programs are 12-24 months and provide guided oversight and accountability with offenders. Target audience were veterans held on 10/29/21, 9 participants	
ACBH contracted CBOs	This session was held on 11/3/21, 23 participants	ISSUES: 13 RECOMMENDATIONS: 18
Reentry Collaborative Court	Collaborative courts involve a partnership with the District Attorney's Office, judges, defense attorney, Probation, social services, and other allied professionals. The court programs are 12-24 months and provide guided oversight and accountability with offenders. This session was held on 11/16/21, 6 participants	ISSUES: 16 RECOMMENDATIONS: 9
PEERS Lift Every Voice and Speak (LEVS)- Speakers Bureau	PEERS LEVS is a speakers bureau providing a forum for members to live, grow, educate, and heal through story telling. held on 11/17/21 with 19 participants.	ISSUES: 50 RECOMMENDATIONS: 31
Prevention & Early Intervention (PEI) Providers	PEI is one of five MHSA components and contracted providers focus on engaging individuals before the development of a mental illness, and/or prove services to intervene early on. This session was held on 11/18/21, 28 participants	ISSUES: 51 RECOMMENDATIONS: 14
Mental Health Services Act Stakeholder Group (MHSA-SG)	15-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 11/19/21, 11 participants	ISSUES: 39 RECOMMENDATIONS: 10
City of Fremont Mobile Evaluation Team (MET)	Law enforcement mental health units and/or embedded emergency response programs including crisis intervention	ISSUES: 42 RECOMMENDATIONS: 10

	teams (CIT), mobile evaluation team (MET), MHSA Community assessment treatment team (CATT). Held on 12/2/21, 8 participants	
NAMI East Bay	Held on 12/8/21, with 20 participants	ISSUES: 35 RECOMMENDATIONS: 15
Veterans - Swords to Plowshares	Held on 12/10/21 with 7 attendees.	ISSUES: 18 RECOMMENDATIONS: 17
Peers Organizing Community Change (POCC) #1	1/5/22, 29 participants 1/6/22, 32 participants	ISSUES: 25 RECOMMENDATIONS: 19
PRIDE Coalition	1/5/22, 16 participants	ISSUES: 22 RECOMMENDATIONS: 14
Cultural Responsiveness Committee	Co-hosted in partnership with the Office of Ethnic Services 1/12/22, 25 participants	ISSUES: 73 RECOMMENDATIONS: 41
African American Communities	Co-hosted in partnership with the Office of Ethnic Services African American Steering Committee, 1/13/22, 29 participants	ISSUES: 44 RECOMMENDATIONS: 11
City of Fremont- Older Adult	1/18/22, 8 participants	ISSUES: 28 RECOMMENDATIONS: 14
Family Members	Office of Family Empowerment, 1/19/22, 9 participants	ISSUES: 30 RECOMMENDATIONS: 19
NAMI Chinese	Coordinated 1/14/22, 22 participants	ISSUES: 25 RECOMMENDATIONS: 10
Transition Aged Youth (TAY) Forum	Target membership reflects transitional aged youth (TAY) ages 18-24. Held on 2/8/22 with 6 participants.	ISSUES: 31 RECOMMENDATIONS: 17
18 completed listening session	**Total number participants: 307**	

Local Review Process

Current information for this section will be provided in the final FY22/23 Plan Update.

COMMUNITY SERVICES AND SUPPORTS

Community Services & Supports (CSS) Program Summaries
"Extending Our Hand"

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 21/22, CSS component funds 12 Full Service Partnerships (FSP) programs (990 slots) and 27 Outreach Engagement/System Development (OESD) *workplans.* 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 20/21 AGGREGATED FSP DEMOGRAPHICS & PERFORMANCE INDICATORS[1]

FY 20/21 FSP Demographic Data

During FY 20/21 1,179 individuals were served in one of ACBH's FSP programs (10% increase over FY 19/20). Below is demographic information on these partners.

RACE/ETHNICITY

Fiscal Year	Ethnic Group	Clients	% of Clients
FY 2020-2021	Alaska Native or American Indian	8	1%
	Asian	81	7%
	Black or African American	569	48%
	Hispanic or Latino	108	9%
	Other	57	5%
	Pacific Islander	7	1%
	Unknown	13	1%
	White	336	28%
		1,179	100%

LANGUAGE

Fiscal Year	Language Group	Clients	% of Clients
FY 2020-2021	Arabic	1	0%
	Chinese	5	0%
	English	1,104	94%
	Other	35	3%
	Spanish	30	3%
	Tagalog	2	0%
	Vietnamese	2	0%
		1,179	100%

GENDER IDENTITY

Fiscal Year	Gender Identity	Clients	% of Clients
FY 2020-2021	Male	471	40%
	Missing	441	37%
	Female	246	21%
	Multiple Gender Identities	8	1%
	Male to Female	3	0%
	Intersex	2	0%
	Non-Conforming	2	0%
	Other	2	0%
	Queer	2	0%
	Female to Male	1	0%
	Prefer Not to Answer	1	0%
		1,179	100%

AGE

Age	Clients	% of Clients
0-8 yrs.	21	2%
9-17 yrs.	53	5%
18-24 yrs.	144	12%
25-59 yrs.	730	61%
59+ yrs.	231	20%
	1,179	**100%**

COUNTY REGION OF RESIDENCE

Fiscal Year	Region	Clients	% of Clients
FY 2020-2021	1. North	629	53%
	2. Central	407	35%
	3. South	67	6%
	4. East	30	3%
	5. Out of County	46	4%
		1,179	100%

[1] All data is derived from the ACBH billing and tracking system called INSYST unless otherwise noted.

FY 20/21 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. Below are a number of indicators ACBH is tracking for the FSP partners. This is data from FY 20/21.

1. **Reductions in Hospital Admissions:** Do hospital admits decrease in the years that a partner was active in an FSP, when compared to the year prior to program admission?

All FSP Episodes*	Pre Year: FSP Episodes with At Least 1 Hospital Admit	Year 1: Eligible Episodes**	Year 1: Episodes with Decrease in Hospital Admits	Year 1: Percent with Decrease	Year 2: Eligible Episodes	Year 2: Episodes with Decrease in Hospital Admits	Year 2: Percent with Decrease	Year 3+: Eligible Episodes***	Year 3+: Episodes with Decrease in Hospital Admits	Year 3+: Percent with Decrease
919	454	314	225	72%	214	163	76%	74	56	76%

*Total number of FSP episodes considered for the metric

**Eligible Episodes - FSP episodes who had at least one hospital admit 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+ provides data for the most recent 12 month period that a partner was active in an FSP, for partners with a length of stay/time in service of at least 3 years.

2. Reductions in Hospital Days: Do hospital days decrease in the years that a partner was active in an FSP, when compared to the year prior to program admission?

All FSP Episodes*	Pre Year: FSP Episodes with At Least 1 Hospital Day	Year 1: Eligible Episodes**	Year 1: Episodes with Decrease in Hospital Days	Year 1: % with Decrease	Year 2: Eligible Episodes	Year 2: Episodes with Decrease in Hospital Days	Year 2: % with Decrease	Year 3+: Eligible Episodes***	Year 3+: Episodes with Decrease in Hospital Days	Year 3+: % with Decrease
919	459	318	244	77%	216	182	84%	76	64	84%

*Total number of FSP episodes considered for the metric

**Eligible Episodes - FSP episodes who had at least one hospital day 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+ provides data for the most recent 12 month period that a partner was active in an FSP, for partners with a length of stay/time in service of at least 3 years.

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
730	446	61%

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. The lower end benchmark is 70% and the high end benchmark is 90%.

Hospital/Crisis Episodes	Follow-Up in 5 Days	Success Rate
1,653	1,152	70%

*Phone contact with partner considered equivalent to face-to-face contact during covid-19 shelter-in-place (beginning 3/16/20).

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. The lower end benchmark is 70% and the high end benchmark is 90%.

Clients with Episode(s)	Clients with Average of 4+ Visits Per Month	Success Rate (%)
951	662	70%

*Phone contact with partner considered equivalent to face-to-face contact during covid-19 shelter-in-place (beginning 3/16/20).

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
42	39	93%

6. Incarceration[2]: 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*	Pre Year: FSP Episodes with At Least 1 Incarceration	Year 1: Eligible Episodes**	Year 1: Episodes with Decrease in Incarcerations	Year 1: % of Episodes with Decrease	Year 2: Eligible Episodes	Year 2: Episodes with Decrease in Incarcerations	Year 2: % of Episodes with Decrease	Year 3+: Eligible Episodes***	Year 3+: Episodes with Decrease in Incarcerations	Year 3+: % of Episodes with Decrease
637	247	204	136	67%	128	97	76%	20	15	75%

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

**Eligible Episodes - FSP episodes who had at least incarceration in the 12 months prior to their FSP provider admission, and remained in the FSP provider 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 a FSP episode, for FSP episodes that have lasted at least three full years.

7. Housing[3]: Do community living housing days increase in the years that a partner was active in an FSP, when compared to the year prior to program admission?

All FSP Episodes*	Pre Year: FSP Episodes with At Least 1 Homeless or Institutional Setting Day	Year 1: Eligible Episodes**	Year 1: Episodes with Increase in Community Living Days	Year 1: % with Increase	Year 2: Eligible Episodes	Year 2: Episodes with Increase in Community Living Days	Year 2: % with Increase	Year 3+: Eligible Episodes***	Year 3+: Episodes with Increase in Community Living Days	Year 3+: % with Increase
679	354	345	137	40%	281	112	40%	90	32	36%

*Total number of FSP episodes considered for the metric

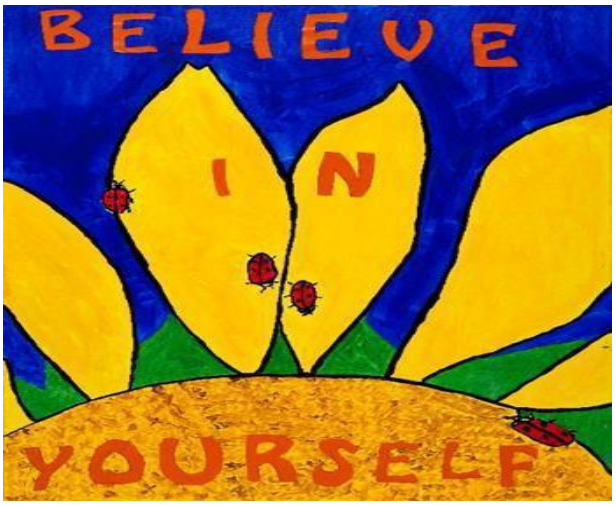
**Eligible Episodes - FSP episodes who had at least one homeless or institutional day in the 12 months prior to their FSP admission, and remained in the FSP for at least the number of years indicated (1, 2, or 3)

***Year 3+ provides data for the most recent 12 month period that a partner was active in an FSP, for partners with a length of stay/time in service of at least 3 years.

Housing Types Considered "Community Living":

- In an apartment or house
- With one or both biological parents
- With adult family member
- Assisted Living Facility
- Unlicensed but supervised individual placement
- Unlicensed but supervised congregate housing
- Unlicensed but supervised congregate placement
- Licensed Community Care Facility
- Group home
- Treatment Facility
- Foster Home
- Single Room Occupancy (must hold leas

[2] Data Source: Alameda County Sherriff's Department/Information technology Department (ITD)
[3] Data Source: MHSA Required Partnership Assessment Form (PAF) and Key Event Tracking Form (KET)



The Circa 60 Full Service Partnership (FSP) is run by the Telecare Corporation. This is two of their success stories of Circa 60 FSP partners (clients).

An 82-year-old partner who struggles with intimate partner violence, with a high level of hospitalizations. We were able to offer her partner support and housing while she participated in intimate partner violence treatment. She was able to return home successful and limit the harm she was causing her partner. This client got diagnosed with COVID-19 and utilized the safer ground spaces in order to self-isolate. She was able to use the resources offered by the county, and made a full recovery. This speaks to the importance on treating the *whole system*, and highlighting the importance of natural supports.

Circa 60 also continued providing services in the community throughout the pandemic educating all partners, providing masks, hand-sanitizer and making sure they have the ability to socially distance. A 71-year-old client has a daughter in a different FSP. The two FSPs combined to host a family dinner with both participants and other family members. This provides a safe meeting space with the FSP staff offering containment.

CHILDREN & YOUTH FSPs

FULL SERVICE PARTNERSHIP (FSP) REPORT FORM
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 facilitate positive, healthy parent/child interactions and relationships; strengthen families by enhancing natural supports and providing help with navigating service systems; provide developmental guidance and behavioral coaching to families to promote healthy development and emotional regulation; connect families to resources in their communities; and 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.

How Much Did We Do?
I. FY 20/21

a. **Number of clients served:** 22

How Well Did We Do?
II. Language Capacity for this program and number of people served in each language: English (20) and Spanish (2)

III. FY 20/21 Challenges: Obviously the COVID 19 pandemic continued into this past fiscal year which had a significant impact on our service delivery model as well as direct referrals from providers in the community. Referrals were slow to come in, primarily because most pre school aged children were not enrolled in preschool programming through the pandemic. The therapeutic nursery schools, primary referral sources, closed or had very low enrollment. Half way through the fiscal year we began to serve more families and youth in person in the community. Telehealth was a valuable tool for many families and treatment team members but, it wasn't nearly as efficient or effective as in person, face to face work. Our families and kids needed to be seen regularly, in person so, we were able to adapt our treatment delivery model to safely see families in their homes (or backyards, porches, etc.). The strain of the pandemic also exacerbated the mental health challenges of the parents we serve. Many of our families were just struggling in so many ways. Stable housing, which is always challenging, became much more of a focus of our treatment as many of our families face housing insecurity.

Is Anyone Better Off?
IV. FY 20/21 Client Impact: Here are a few stories submitted by our Care Coordinators that highlight some of the interventions provided by Connections and the successes the youth and family were able to achieve during the course of treatment. **(Clients' names have been changed to protect identity.)**

"Roger" was referred to Wraparound due to aggressive and disruptive behaviors that put him at risk of losing his placement in preschool and in daycare. Roger also struggled in the community as he would present with impulsivity and intense temper tantrums. Roger was under his grandmother's care and was experiencing repetitive grief and separation from his biological mother who suffers from addiction. With high behavioral needs and a lack of natural support, Roger's grandmother was no longer able to continue with her full-time job.

Roger was receiving individual/dyadic therapy from another nonprofit agency. The Wraparound Care Coordinator was able to immediately collaborate with Roger's individual therapist and coordinate Family Team Meetings to address Roger's biggest challenges. Roger's grandmother was a strong advocate for Roger and promoted his strengths, but she felt unsuccessful in supporting him when he was triggered. The Wraparound Care Coordinator worked closely with Roger's grandmother to better understand Roger's behaviors, reduce caregiver stress, and practice co-regulatory strategies. Additionally, they worked together to develop plans around visits from Roger's biological mother. The Wraparound Care Coordinator also collaborated with Roger's grandmother and his school team during the development of Roger's 504 plan.

Although Roger was bright, easy to engage, imaginative, and coordinated, he struggled to be safe with his body, follow directions, and accept support when feeling distressed. The Wraparound Support Counselor met with Roger consistently for a year and a half (virtually and in-person through COVID-19) to build rapport and practice pro-social, communication, and self-regulation skills outside of the home and in community settings. The Wraparound Support Counselor supported Roger through enormous feelings following his mother's visits as well as the grievance of his father's death from an unexpected event. The Wraparound Support Counselor also assisted Roger to positively engage and develop a friendship with a peer at a park.

With the help of Team Roger (Roger's grandmother, therapist, support counselor, care coordinator), Roger has developed the superpower of reflecting on his behaviors and pausing to think before acting! Roger and his grandmother enjoy the daily practice of reflecting on the highlights of his day as well as what he could do differently. Roger's grandmother reported that he has independently shared with her, "grandma, I was mad and was going to (unsafe behavior), but I made a better choice." He is also earning rewards in school for listening and follow instructions. Roger's grandmother is proud of his growth and feels ready to return to her full-time job. She thanks wraparound for "being so effective in helping him, and me, understand himself, his world, his life and experiences, and how it affects his behavior." Roger and his grandmother can now enjoy many activities together—going shopping, playing at the park, fixing things in the home, making plans for the day/week, etc. He is also spending time with extended family members who describe him as a "cool kid!".

Our Wraparound team has been working with a four-year-old boy, "Aaron," and his family since August of 2020. Aaron, his younger brother, and his mother had been living in a transitional housing program for several months, which combined with the pandemic, had caused Aaron's challenges to increase. After having witnessed domestic violence between his parents, Aaron struggled with symptoms of post-traumatic stress as well as a diagnosis of autism spectrum disorder. Attempting to attend virtual preschool and obtain therapeutic services virtually while living in a co-housing situation greatly increased Aaron and his family's stress. Aaron's mother's application to receive SSI benefits had been denied and she was behind on the portion of rent she was required to pay for her housing program. She was caring full-time for both of her children and unable to work. Aaron's mother is an immigrant who struggles to navigate systems and the stress of COVID had taken a toll on her mental health.

Our Care Coordinator quickly began to collaborate with Aaron's mother to determine how we could best support Aaron's needs. She offered in-person (with PPE & outside) to support both mom and Aaron. Our support counselor worked with Aaron during individual rehabilitation sessions on identifying and expressing his feelings, social skills, and developing regulation skills. We worked to support getting ABA services for Aaron in the home as well. Our Care Coordinator consulted with Bay Area Legal Aid to understand how to appeal Aaron's SSI denial. She collaborated with multiple providers to obtain letters and documentation of Aaron's disability and helped to draft the appeal. Our Care Coordinator helped Aaron's mom apply to be paid as an In-Home Support Services provider to Aaron. She also worked with mom to apply for a COVID housing relief program to cover all back-pay that she owed to her housing program. Most importantly, our Care Coordinator provided invaluable emotional support to mom during this time, helping her to develop her own coping skills and self-care strategies. During our monthly Family Team Meetings, we spent ample time allowing team members to share the strengths they had witnessed in Aaron and his mother which seems to fortify Aaron's mother to keep moving forward.

Over the course of the past 10 months, Aaron's mother won her SSI appeal (which included receiving retroactive payments), is now being paid as an IHSS provider for her son, and she is up-to-date with her rent. Although they are still living in their transitional program, the team is confident that mom will be able to transition to long-term housing within the next few months due to her more robust income level and the numerous low-income housing applications we've helped her to submit. Aaron has been able to receive regular support from our program as well as in-home ABA service. All team members report improvement in Aaron's behaviors, including increased ability to transition, accept limits, follow directions, and engage pro-socially with others. Our team hopes to be able to continue supporting Aaron and his family for the next few months to be able to return to in-person school, as well as to settle into more permanent housing.

V. FY 20/21 Additional Information: N/A

VI. FY 21/22 Projections of Clients to be Served: 20

VII. FY 21/22 Program or Service Changes: For FY 21/22 we made some changes to our program structure. We will begin to open our referral base to 9 and 10-year-old youth in efforts to broaden our referral base and keep our program at or near capacity. In addition, we have worked with ACBH to make some changes to our referral criteria to hopefully broaden our eligibility pool. We have added "recent psychiatric hospitalizations, risk of homelessness and failure to meet developmental milestones" to our criteria.

Metrics	% of FY 20/21 FSP clients that achieved the metric
Primary Care visit within the previous year	100%
Clients with no gap in services over 30 days	94%
Average of four or more visits per month per client	90%

*The metrics above measuring “reductions” are looking at FSP clients served in FY 20/21 who experienced one of these negative events (crisis, hospital admission, and incarceration) prior to enrollment in an FSP compared to the first year of FSP enrollment.
This methodology is the same for the housing stability metric, instead of a reduction it is looking for an increase in the number of days someone was stably housed before FSP enrollment compared to their first year of FSP enrollment.

FULL SERVICE PARTNERSHIP (FSP) REPORT FORM
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, receive Alameda County Medi-Cal, and have met the entry criteria for services.

Target Population: East Bay Wrap-FSP serves youth aged 8-18. The 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).

How Much Did We Do?
I. FY 20/21

a. **Number of clients served:** 33

How Well Did We Do?
II. Language Capacity for this program and number of people served in each language: We have 2 staff (Parent Partner and Youth Partner) who speak Spanish. We had 5 youth/families where Spanish is spoken in the home, exclusively by the parent (usually the youth spoke and/or understood English).

III. FY 20/21 Challenges: The three main areas of challenge are for our program are: staffing, impact of COVID and the general impact of excessive paperwork demands. These main issues are inter-related in many ways. Three clinicians left their position during this fiscal year, two of whom left shortly after they became licensed and one left before their year hire anniversary. COVID seems to be causing an overall work force shortage, making it harder to fill open positions. We were fortuante to recently hire a new clinician so that we are at full capacity with 2.5 FTE clinicians but staff turnover is negatively impactful to our youth and families who are weary to trust social service providers.

COVID-19 continues to challenge how we prefer to conduct business. Staff and families have been very understanding and we have been doing in-person visits on porches or backyards and taking walks to do the visits in safer ways. We know that the transition back to in-person schooling will be very difficult for many families. Youth have been able to set their own schedules and families have a hard time setting these important structures in the home.

The excessive paperwork demands is also a continued issue for providers. Staff indicate that they spend about 30-40% of their work time doing tasks to satisfy the demands of paperwork (including Medi-Cal and MHSA requirements) and it has lead to clinicians leaving their position. Some indicated that they were reconsidering their career choice in this field. While staff complete the required MHSA forms (3M, KET), we do not get the aggregated data back after submitting the information and the questions are more geared to adult/TAY needs.

Is Anyone Better Off?

IV. FY 20/21 Client Impact: From the incentive measurements, we fully reached 2 out of the 3 areas. We averaged meeting 4 visits per month with each youth at 86% (full goal was 80%) and we had no service gaps in 92% of our youth (full goal was 90%). We missed the goal for follow up visits within 5 days after a discharge from an acute care. We were at 79% and the partial goal was 80%. Several visits took place at day 6 or had some attempts to reach out to the youth/family that was an informational note. Additionally, we do not get notification regularly when a youth is admitted to acute care. In these instances, a lack of engagement issue is the primary work that we are attempting to strengthen.

We had 1 family that was very reluctant to use our services. The youth has psychotic symptoms and the parent is trying to understand how to help their child manage safely when these symptoms are present. When they entered our service, they were unhoused. The youth's symptoms made it hard to stay with friends and family for any length of time. They also had difficulty staying at homeless facilities due to our client's behaviors. The family ended up sleeping in their car. Using Flex Funds, we were able to house them in a safe neighborhood by paying for the deposit and first month's rent. The parent is employed and able to pay the rent ongoing. Flex funds were also used to help the parent purchase a used car to get to and from work. She is working with the wrap team on better understanding and meeting her son's mental health needs.

V. FY 20/21 Additional Information: We are very concerned about the longterm impact from COVID-19 protocals, especially the impact on educational and social skill gaps. Most of the youth in our program have struggled acaedmically and likely lost a significant amount of gains during the remote learning period. We are concerned about our youth and family's well-being and attempt to encourage those who are eligible to get vaccinated.

Fred Finch has been taking serious steps in addressing racial equity in our operations. We currently have staff participate in Affinity Groups to learn more about the impact of privlidge for white identified staff and to help provide a voice for staff who identify as BIPOC. The EBW program attempts to use individual, group and staff meetings as well as monthly trainings to give space to this important topic.

VI. FY 21/22 Projections of Clients to be Served: We are contracted to serve 20 youth at a time. We hope that our current staffing allows us to maintain this level throughout the full fiscal year.

VII. FY 21/22 Program or Service Changes: N/A

Metrics	% of FY 20/21 FSP clients that achieved the metric
Reduction in Hospital Admits*	100%
Reduction in Hospital Days*	100%
Reduction in Incarceration Days*	100%
Increase in the number of days Stably Housed*	100%
Primary Care visit within the previous year	77%
Received a follow up visit within five days after a mental health hospitalization or crisis	80%
Average of four or more visits per month per client	86%

*The metrics above measuring "reductions" are looking at FSP clients served in FY 20/21 who experienced one of these negative events (crisis, hospital admission, and incarceration) prior to enrollment in an FSP compared to the first year of FSP enrollment.

This methodology is the same for the housing stability metric, instead of a reduction it is looking for an increase in the number of days someone was stably housed before FSP enrollment compared to their first year of FSP enrollment.

TRANSITION AGE YOUTH FSPs

FULL SERVICE PARTNERSHIP (FSP) REPORT FORM
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.

How Much Did We Do?
I. FY 20/21

b. Number of clients served: 67

How Well Did We Do?
II. Language Capacity for this program and number of people served in each language:

- Participants' language needs were as follows for FY 20-21: 1 participant is monolingual Spanish-Speaking; 5 are bilingual English and Spanish-Speaking, 1 participant is bilingual English and Vietnamese, and 1 participant is bilingual English and another undisclosed language.
- Participants' families were primarily English-speaking with one participant's family monolingual Spanish-Speaking and one participants' family bilingual English-Speaking
- One bilingual English/Spanish-speaking Peer Mentor remained on staff for the duration of FY20-21 and the bilingual English/Spanish-speaking Clinical Supervisor started in June 2021. One bilingual English/Spanish-speaking clinician worked temporarily in December 2020. One part-time bilingual English/Farsi-speaking clinician worked temporarily October 2020-January 2021.
- When in collaboration with participants and families, services are offered in their preferred language in person or by language link interpreter.

III. FY 20/21 Challenges:
COVID-19: Overall, the primary barrier to program implementation was COVID-19. For about 2 months of FY 20-21, Alameda County was in a Shelter in Place order. Although the program continued to provide in-person services, participants were often not open to this due to concerns of health needs. Also, there was a clear impact on the implementation of housing and employment/education services due to COVID-19 in that employers, educators, and housing agencies moved to primarily digital platforms, causing a barrier to participants' engagement in these services.

Hiring shortages: The STAY team has been understaffed for all of FY20-21. For most of the year, the team had 4 of 7 clinicians positions filled, 1 of 2 peer mentors, and 0.4 family partner. An RN was hired in Spring of 2021 at 0.4 FTE. Overall, there have been more non-clinician applicants than clinicians, which impacts the programs' ability to increase program caseload size.

Housing shortages and disruptions in services: At the start of COVID-19, shelters decreased their census size in order to ensure health and safety of occupants. Also, collaborating agencies experienced difficulties in obtaining timely construction permits, and the explanation for these delays are impact COVID-19 had on governing agency's ability to do inspections in a timely manner and complete repairs on time. One participant was displaced for the majority of FY 20-21 due to a fire at their apartment for these reasons.

Coordinated entry: Changes occurred in FY 20-21 with regard to how Coordinated Entry was managed through partnering agencies. This presented a challenge to staff in the FSP as well as participants. Phone calls were made to coordinated entry through 211 and attempts were made to connect to Coordinated Entry list through the partnering agency center, and many times, staff and participants were asked to try again, call a different number, or come another time. At least 2 STAY participants were unable to connect to Coordinated Entry when the attempts were made, despite several attempts, due to residing in a treatment facility past the 90 days allowable by HUD requirements.

Coordination of Care: Coordination with psychiatric hospitals has improved due to county alerts indicating when a participant has presented to psychiatric emergency. Also, coordination directly with the social work supervisor has increased collaboration with social workers at the hospital. At the same time, social workers on the units continue to have a difficult time returning calls and coordinating. Also, subacute placements have a difficult time responding to inquiries, impacting response time and ability to coordinate strong discharge plans. Lastly, COVID-19 restrictions impacted visits to these facilities when a unit experienced an outbreak, which further impacted collaboration and contact.

Is Anyone Better Off?

IV. FY 20/21 Client Impact: "Improve the ability of clients to secure and maintain stable permanent housing in the least restrictive and most integrated living situation appropriate to meet their needs and preferences". At the end of FY 20-21, 28 participants were residing in stable living environments that matched their current level of needs and preferences; these included board and cares, independent living homes, family or friends' homes, or their own permanent housing in which they have a lease. These individuals resided in the same place for at least 90 days. 9 of these participants were in their own subsidized permanent housing. Of these 9 participants, 4 receive Housing Choice Vouchers through a special program for former foster youth, 2 reside in Berkeley at a Project-based site, and 3 reside in their own units in collaboration with a third-party housing services agency, such as Abode Services or Building Opportunities for Self-Sufficiency.

"Reduce client hospitalizations and utilization of emergency health care services for mental health and physical health issues". One of STAY's goals is to reduce the inpatient hospital rate and recidivism rates for program participants. Of 26 hospital discharges that occurred in FY20-21, only 15% experienced recidivism in 7 days, and only 27% experienced recidivism in 30 days. The STAY team was able to follow up with discharging participants within 5 days of discharge 83% of the time by phone or in-person in order to ensure continuity of care. 80% of participants in the STAY program reduced the number of psychiatric emergencies, inpatient, crisis stabilization utilization.

"Connect clients with ongoing primary healthcare services and coordinate healthcare services with clients' primary care providers". One of STAY's goals is to address all aspects of wellness for the participant, including connection to healthcare and primary care. In FY 20-21, 87% of participants were connected to primary care, and 80% of participants had at least two visits in the years' time. All participants are screened for health and nutrition needs at intake, and all participants who do not have

an established primary care provider at that time are referred to Rising Harte Wellness Center/Native American Health Center.

Personal Client Story: One participant in the STAY program for several years has solidified permanent housing and stability of symptoms over the course of their involvement in the program. This participant has also expressed interested in gaining skills in baking, and due to the impact of symptoms and life pressures, has not been able to address this goal fully despite starting a program a few years ago. The STAY employment specialist who has been collaborating with this participant on work and education goals for several years was able to address her needs and goals, while also prioritizing her capacity and preferences - supporting her in going slow, taking breaks, and continuously persisting to address this goal over time. By continuing to show up and offer support, and through this participants' readiness and resiliency, the participant restarted the program and completed it this year! This participant is now serv-safe certified and has graduated the baking program, which is a huge success, two years in the making!

V. FY 20/21 Additional Information: The projection of clients for FY 21/22 is related to staff and hiring opportunities over the course of the next year. In order to increase program caseload size, the program will have to complete 2 intakes for every 1 discharge, and clinician hiring impacts the ability to complete intakes, assessments, and treatment plans across the program.

VI. FY 21/22 Projections of Clients to be Served: 75

VII. FY 21/22 Program or Service Changes: In the final month of FY 20/21, the STAY team implemented a rotating schedule of Outreach Person of the Day to better cover the immediate needs of participants and to outreach more readily to those who have struggled to engage or have been referred. FY 21/22 will be the first year to have this rotating schedule as a part of the program infrastructure.

Care Connect – the STAY team now has access to Alameda County Care Connect, the centralized portal for several social services agencies in Alameda County. This likely will have impact on STAY's ability to coordinate care with other providers in the participants' lives. Up until this point, coordinating with healthcare and housing have been impacted by participants' own recall and impact of symptoms on communication. Having access to this portal will likely have a positive impact on case management provision and engagement across the program because staff will be better able to actively engage around connection with these agencies and services.

Metrics	% of FY 20/21 FSP clients that achieved the metric
Reduction in Hospital Admits*	63%
Reduction in Hospital Days*	82%
Reduction in Psychiatric Emergency Services (PES)/Crisis Stabilization Days*	80%
Reduction in Incarceration Days*	58%, this increases to 86% after 2 yrs of service
Increase in the number of days Stably Housed*	35%
Primary Care visit within the previous year	71%
With a vocational goal who are employed	11%
Received a follow up visit within five days after a mental health hospitalization or crisis	84%
Average of four or more visits per month per client	75%

*The metrics above measuring "reductions" are looking at FSP clients served in FY 20/21 who experienced one of these negative events (crisis, hospital admission, and incarceration) prior to enrollment in an FSP compared to the first year of FSP enrollment.

This methodology is the same for the housing stability metric, instead of a reduction it is looking for an increase in the number of days someone was stably housed before FSP enrollment compared to their first year of FSP enrollment.

FULL SERVICE PARTNERSHIP (FSP) REPORT FORM
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 TAY 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.

How Much Did We Do?
I. FY 20/21

a. **Number of clients served:** 63

How Well Did We Do?

II. Language Capacity for this program and number of people served in each language: English and Spanish

III. FY 20/21 Challenges: As the pandemic continued this year, PAIGE team continued to go above and beyond to meet participants in the community, in office spaces, and via digital platforms to ensure their needs were being met. One of the biggest challenges continued to be accessing and outreaching in psychiatric care settings and jail. Historically locked settings are an opportunity for intensive engagement and trust building to prepare for reentry and support in the community. However, this year continued to have many barriers to outreach and engagement efforts; though PAIGE team was able to use unique and collaborative strategies to continue to meet our partners where they were at in their recovery and goals.

Another challenge was ability to engage families in TDMs due to COVID-19 protocols—we were able to host a few team meetings using in-person, internet, and outdoor settings, though families overall struggled with follow through. PAIGE team continues to encourage wraparound and TDMS as a significant part of the model and innovative techniques have helped pull in families that may have otherwise struggled with attendance. PAIGE team also experienced significant staff turnover (transferring internally, medical leave, and leaving the agency) which put a strain on the program as a whole. Though the team banded together and participant & programmatic needs continued to be met.

Is Anyone Better Off?
IV. FY 20/21 Client Impact: PAIGE team participants have overcome a lot in the past year. Entering into the year during the pandemic, participants identified PAIGE team as one of the few resources they could continue to rely on during the chaos. The pandemic created increased barriers in the system for participants to access resources that they could previously manage independently, such as social

services, DMV, social security. PAIGE team was able to minimize barriers and enroll/transfer Medi-Cal, SSI, and access to DMV services for participants, where they otherwise were unable to follow through. PAIGE team was able to support participants with employment with IPS throughout pandemic and had many success stories linking participants to jobs at Tesla, Good Eggs, Amazon and educational opportunities. Primary care and medication management were also great accomplishments of the PAIGE program this year—with many clinics closing to in-person services, PAIGE was able to offer advocacy, support, and our medication services to ensure participant needs were addressed.

Client Story: One incredible success story is about a participant who we began serving in 2019 who struggled with managing psychosis symptoms, substance use, and was in and out of John George frequently. He had lost his parent in his adolescence and while he was in custody his fiduciary was forced to sell his family home which caused him a great deal of distress and anger due to the loss. PAIGE team opened the participant following an episode where he was in locked settings for over 7 months (Villa, JGPP, Santa Rita). He had difficulty managing severe psychosis symptoms, agitation, assaultive behaviors which resulted in recidivism in these crisis and criminal justice settings for most of 2019. In 2020 he began increasing engagement with PAIGE team and would regularly come to Hedco for drop-in support, though was ambivalent about medication and continued substance use which resulted in homelessness and ongoing interactions with crisis services. Despite his struggles, he continued to meet with PAIGE, reach for support, and explore barriers to his engagement with recovery in a meaningful way. His trauma history led to challenges with attachment and testing PAIGE or BACS around abandonment as well. Between May 2020 and December 2020, he had more than 22 encounters with crisis services and 3 with criminal justice. This participant utilized Amber House as a support, while PAIGE program and Amber worked collaboratively to meet participant where he was at and continue to develop creative strategies to engage him—whatever it takes. It was this collaboration that led to this participant agreeing to and accessing an injectable to manage his psychosis symptoms. He was able to identify that his substance use was directly linked to trying to self-medicate the voices, and that he wanted to change his life. This participant has had *zero* interactions with emergency services in over 7 months. He has been able to successfully manage his psychosis symptoms and engage in therapy to explore his trauma and grief, in addition to developing and enhancing coping tools, independent living skills, and communication skills. He currently takes his monthly injectable, and sought additional prn to manage breakthrough symptoms. He is enrolled in an intensive online cyber security program that he attends independently 5 days a week. He researched this program and has been following through, and upon completion will lead to full-time employment. This partner has benefited from BACS collaboration through use of Amber House, PAIGE, and The Henry Robinson as his support system. He is currently at the top of the waitlist for BOSS Meekland permanent supportive housing where he will be able to continue to work on his independent living skills.

Overall the PAIGE team reduced the number of partners that were re-hospitalized, by providing wraparound services 7 days a week with a passionate and dedicated team. PAIGE team exemplifies what it means to provide collaborative wraparound care, coordinating with family, friends, landlords, hospitals, and clinics from the start of services with participants and timely in the event of crisis or support needs. The Wellness Centers have also been an asset to the team, working closing with HRC staff to link participants and their families to the support resources they are interested in. As COVID-19 regulations begin to lift, PAIGE team has supported participants in accessing vaccines, COVID tests, and has begun to offer groups for participants to engage. PAIGE recently had a field trip to an A's game where participants and their families were invited to attend in order to enhance the connection to community. PAIGE team continues to be looked to as a model program for reducing barriers and utilizing creative engagement strategies in order to support youth in accomplishing their goals.

V. FY 20/21 Additional Information: PAIGE team had some fluctuations in staff during this year, which they were able to take on with stride. PAIGE team was able to continue supporting 40+ participants with half of the staff deemed appropriate in the RFP. The team was able to onboard, train, and integrate new staff utilizing the opportunity to reengage participants that had been struggling to meet. PAIGE team has great comradery as a program and all members are passionate about serving TAY and embracing the "Whatever it Takes" approach. PAIGE team is collaborative and supportive of one another and the youth and has been able to successfully implement the daily schedule in ACT model, ensuring participants meet with 2-5 different staff monthly, and typically minimally 2 meetings a week. The team is not afraid to step in or step up when needed and the participant outcomes demonstrate this success.

VI. FY 21/22 Projections of Clients to be Served: 70

VII. FY 21/22 Program or Service Changes: The PAIGE team would like to increase primary care linkage and increase the number of live in-person stakeholder meetings each partner has each month which have been impacted due to the pandemic. We would like to get more natural supports involved and engaged in each partners treatment plan. PAIGE has exemplified response to emergency hospitalizations and will continue to build relationships and reduce barriers to collaborative discharge planning by working very closely with John George Psychiatric Pavilion, Villa Fairmont, Jay Mahler, Woodroe, Amber House, Refuge, Casa De La Vida, ILA homes, and HSP board and care to be involved in all steps of discharge planning and will continue to do so during this fiscal year. PAIGE team would like to move back towards a model where groups are planned and a calendar is produced monthly to encourage participant attendance and voice in groups. PAIGE will work this year to implement at least 2 groups per month and one social event to encourage community building, interdependence and support.

Metrics	% of FY 20/21 FSP clients that achieved the metric
Reduction in Hospital Admits*	91%
Reduction in Hospital Days*	97%
Reduction in Psychiatric Emergency Services (PES)*	78%
Reduction in Incarceration Days*	68%
Increase in the number of days Stably Housed*	47%
Primary Care visit within the previous year	70%
With a vocational goal who are employed	6%
Received a follow up visit within five days after a mental health hospitalization or crisis	84%
Average of four or more visits per month per client	83%

*The metrics above measuring "reductions" are looking at FSP clients served in FY 20/21 who experienced one of these negative events (crisis, hospital admission, and incarceration) prior to enrollment in an FSP compared to the first year of FSP enrollment.

This methodology is the same for the housing stability metric, instead of a reduction it is looking for an increase in the number of days someone was stably housed before FSP enrollment compared to their first year of FSP enrollment.

ADULT FSPs

FULL SERVICE PARTNERSHIP (FSP) REPORT
FSP # FS4

PROVIDER NAME: Abode Services

PROGRAM NAME: Greater HOPE FSP

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

Target Population: chronically homeless adults 18-59 years old

How Much Did We Do?
I. FY 20/21

a. **Number of clients served:** 122

How Well Did We Do?
II. Language Capacity for this program and number of people served in each language: Portuguese, American Sign Language, Khmer, Spanish and Cantonese.

III. FY 20/21 Challenges: Hiring has continued to be a signficant challenge during the past year. There has been a dramatic reduction in applicants for Management and Clinical positions in particular. The Greater HOPE Team also continued to navigate additional safety protocols around COVID, linking participants to vaccines and COVID testing as well as access to primary care while working to protect their safety. We also have had some participants and staff test positive for COVID as well as experience exposures and quarantine in the last year which has caused additional staff shortages throughout the year. Greater HOPE continues to offer in person services to all participants despite the pandemic.

Is Anyone Better Off?
IV. FY 20/21 Client Impact: The team continues to see an increase in graduating participants to lower levels of care. Four participants were stepped down in the last year, three of these participants had been with the program over 5 years. One participant who graduated was stably housed, driving herself to all of her appointments, reconnected with family and was able to step down from Subpayee to manage her own finances. Greater HOPE has also been able increase collaboration with John George and Santa Rita around discharge planning and achieved the partial incentive from Alameda County as a result. The Consumer Advisory Board has also assisted participants with an increase in engagement in services, their individual recovery plans, as well as staff participation as these groups are facilitated by Peers.

Reduce mental health stigma: Greater HOPE launched a Consumer Advisory Board (CAB) to gather feedback from long term participants on their experience in program. We have explored topics such as: outreach, engagement, psychiatry supports, our office environment, and

accessing FSP flex funds. Greater HOPE also continues to employ multiple staff across different levels of the team with lived experience with Mental Health needs to ensure the consumer perspective is discussed in all spaces.

Create a welcoming environment: During COVID we have had to close down the physical lobby space and create an outdoor waiting area. Participants are still welcomed with water and food at our office to ensure basic needs are met before engaging in treatment interventions. We also gathered feedback from our CAB regarding their experience coming to our offices and incorporated their feedback around what they liked (warm food, coffee, etc.) and what could be better (more clearly posted hours of operation, training new hires on how to quickly help them connect with their Case Manager and helping them more quickly access their mail).

V. FY 20/21 Additional Information: N/A

VI. FY 21/22 Projections of Clients to be Served: 150

VII. FY 21/22 Program or Service Changes: Greater HOPE opened a second office location in Oakland this past fiscal year. No additional program or service changes planned.

Metrics	% of FY 20/21 FSP clients that achieved the metric
Reduction in Hospital Admits*	76%
Reduction in Hospital Days*	82%
Reduction in Psychiatric Emergency Services (PES)*	83%
Reduction in Incarceration Days*	87%
Increase in the number of days Stably Housed*	36%, increases to 52% after 2 yrs of service
Primary Care visit within the previous year	54%
With a vocational goal who are employed	1%
Received a follow up visit within five days after a mental health hospitalization or crisis	44%
Average of four or more visits per month per client	51%

*The metrics above measuring "reductions" are looking at FSP clients served in FY 20/21 who experienced one of these negative events (crisis, hospital admission, and incarceration) prior to enrollment in an FSP compared to the first year of FSP enrollment.

This methodology is the same for the housing stability metric, instead of a reduction it is looking for an increase in the number of days someone was stably housed before FSP enrollment compared to their first year of FSP enrollment.

FULL SERVICE PARTNERSHIP (FSP) REPORT FORM
FSP # FS7

PROVIDER NAME: Alameda County Homeless Action Center (HAC)
PROGRAM NAME: Alameda County Supplemental Security Income Program (SSI) and Social Security Disability Insurance Program (SSDI) Advocacy Services Project
Program Description: HAC Provides SSI/SSDI advocacy to increase the number of Alameda County residents facing moderate to severe mental health issues who are approved for SSI/SSDI benefits.
Target Population: individuals with moderate to severe mental and individuals released from or about to be released from Santa Rita Jail, Glenn Dyer Detention Facility, or the State prison system.

How Much Did We Do?
I. Number of clients served: 392

How Well Did We Do?
II. Language Capacity for this program and number of people served in each language:
Languages spoken by Staff during FY 20-21 and Number of clients:

Arabic	4
Cambodian/Khmer	2
Cantonese	1
English	324
Farsi/Persian	1
French	0
Korean	2
Mandarin	2
Portuguese	0
Spanish	16
Vietnamese	0

Languages spoken by clients but no staff:

Pashto	2
Hindi	1
Farsi	1
Language not identified	36

III. FY 20/21 Challenges: Our full staff worked remotely for the entire FY, with the exception of a small team of in-office staff who showed up daily to sort and hand out mail, and our exceptional outreach Team who helped us connect with SSI/SSDI clients in encampments and other places when they couldn't come to us. We moved our drop-in legal services, intakes, and client referrals to phone, mail, and email. The subset of our clients or would-be clients whose disabilities and/or housing status make those methods of communication challenging are already the ones who face the largest hurdles in the Social Security disability application process. With the extra barrier of not being able to drop in and complete an intake or reach their attorney without a scheduled appointment, some of them fell off our radar entirely. 47 of our BHCS-funded cases were closed when the clients disappeared.

Visits to the jail were discontinued, so our strategy with those referrals changed as well, to the jail's short-session videoconference system. We made an effort to reach out to all jail clients referred to us, even if the circumstances normally wouldn't merit an SSI application, because they were so isolated at the jail during COVID It was in many ways easier to reach clients than when we had to physically travel to the jail, but because the paperwork had to travel separate from the interview, it was more difficult to get a claim started.

Social Security claims processing slowed considerably. Cases where there was not enough medical evidence for a favorable decision had been on hold for months as the fiscal year started, waiting for a remote hearing or remote exam to be scheduled, a process in which all but the most obviously disabled clients did not get a reasonable timeline or the same chances of convincing a decision maker of their need for benefits. Clients, like everyone, tended to avoid healthcare settings if not having COVID symptoms, so building a record of disability was more difficult. We worked with our evaluating psychologists to try to bridge this gap, but it took them a while to pivot to remote exams. Phone exams would allow only a fraction of the usual battery of exams to be given, and although by July we had two psychologists providing remote video exams via Teams, but it was initially only available to clients with their own phone or computer to participate. At this writing, phone and video exams and phone and video hearings are still the only options for our clients.

Is Anyone Better Off?

IV. FY 20/21 Client Impact: Our clients enjoyed over 80 favorable disability determinations in the fiscal year, despite the severe slowdown of decisions that resulted from SSA's operational changes in the pandemic. Another three cases had favorable outcomes without a disability determination: we helped a client obtain proof of birth to qualify for age related benefits, helped another stop an SSA overpayment from lowering his monthly benefits, and one client became employed to the extent she no longer needed or qualified for disability benefits.

Case Study: We appreciate most the stories where a client is initially suspicious or otherwise not comfortable with HAC or the services we provide. Because of the nature of disability claims – long and

quite personal — the relationships we have with clients often change over time. Mrs G. had a severe and longstanding personality disorder, diagnosed as early as grade school according to her records. Her 'maladaptive' patterns of interaction had remained stable over time, and like many with her diagnosis she had held a number of jobs, but none for long. She did not see her own part in the loss of jobs or relationships, but by the time she reached us she had seen so many relationships with employers, friends, family, and service providers end badly that she had no reason to think it would work out any differently with HAC. Her attorney's position was, "Yes, she is difficult to work with. And she's not going to like me, but I'm going to get her on disability anyway, because she deserves my help as much as anyone." And she did. Her attorney, R, gathered all her medical records as soon as their initial meeting was over and obtained a detailed letter of diagnosis from her treating provider. She submitted these and earned the ultimate success for the client, a win at the initial stage of the process. No disappointing denial, no length appeals. Mrs. G. knew that most people were denied at the initial stages of the process, and seemed almost pleased, but continued to have a distrustful and antagonistic relationship with her attorney even as they went to the Social Security office to finish the claim and start her benefits rolling. With her first check, Mrs. G, who had been living in her car, rented a hotel room for a week to shower and rest comfortably. However, her small dog that lived in the car with her was not allowed, and threatened to get her kicked out of the hotel. R. offered to look after the dog while Mrs. G stayed in the hotel. It was not part of her job, but she loved dogs and wanted to help Mrs. G. Mrs. G. distrustfully accepted. She came to the office each day to visit her dog, making sure the dog was cared for, and admonishing R for various things. On the last day of the stay, well-rested with her dog intact and seemingly happy, she presented R with a greeting card, containing a sincere thank you message written inside. It was completely out of character, and as such it was incredibly touching for all of us, especially R.

V. FY 20/21 Additional Information: N/A

VI. FY 21/22 Projections of Clients to be Served: This depends on the rate at which Social Security decides cases and the portion of those decisions that are favorable. It's hard to project this because of continuing pandemic impacts, but based on the past two years we would expect to serve a minimum of 400 clients. That includes approximately 250 cases still pending from the past FY, and new cases up to our maximum capacity under this contract of 560 rolling.

VII. FY 21/22 Program or Service Changes: N/A

FULL SERVICE PARTNERSHIP (FSP) REPORT FORM
FSP # FS7

PROVIDER NAME: Bay Area Legal Aid (BayLegal)
PROGRAM NAME: Alameda County Supplemental Security Income Program (SSI) and Social Security Disability Insurance Program (SSDI) Advocacy Services Project
Program Description: BayLegal Provides SSI/SSDI advocacy to increase the number of Alameda County residents facing moderate to severe mental health issues who are approved for SSI/SSDI benefits.
Target Population: Individuals with moderate to severe mental and individuals released from or about to be released from Santa Rita Jail, Glenn Dyer Detention Facility, or the State prison system.

How Much Did We Do?

I. FY 20/21

a. **Number of clients served:** 328

How Well Did We Do?

II. Language Capacity for this program and number of people served in each language:
BayLegal served clients in English (307), Spanish (6), Arabic (2), Burmese (2), Cantonese (2), Mandarin (1), Farsi (3), Tagalog (2), Mon-Khmer (1), and Vietnamese (2).

III. FY 20/21 Challenges: The ongoing COVID-19 pandemic presented significant challenges to service delivery in FY 20/21, particularly in ways the pandemic affected communication with clients. For instance, clients often rely on public libraries or other public spaces—which were closed for months—to access their email. USPS delays in processing mail particularly affected homeless clients who use General Delivery and made obtaining necessary signatures more difficult. Clients sometimes do not have a stable address, move in and out of Santa Rita Jail or medical facilities, and experience periods of homelessness. All of these issues slowed services and delayed communications between staff and clients.

The closure of Social Security Administration (SSA) offices due to the pandemic also presented a unique set of challenges. BayLegal staff effectively transitioned to submitting most documents to SSA electronically. However, the SSA field offices are understaffed, the offices are generally closed to the public except for limited appointments, and hearings were held virtually. Clients have the right to an in-person hearing, so they had to consent to a virtual hearing to progress their case. BayLegal worked with clients to ensure they could attend virtual hearings and brought clients into the Oakland office as needed to attend hearings in special conference rooms retrofitted to comply with all safety protocols.

Despite these challenged, staff continued to obtain positive outcomes for clients, including initial approvals, successful virtual hearings, on the record decisions, Appeals Council and federal court remands, and effective policy advocacy with SSA and CDSS.

Is Anyone Better Off?

IV. FY 20/21 Client Impact: BayLegal served 328 clients with 356 cases in FY 20/21. BayLegal closed 169 cases: 7 cases assisted clients with advice and counsel, 19 cases assisted clients with brief services, and 143 cases assisted clients with extended services. Of extended service cases, 109 cases assisted clients with Administrative Agency Decisions, 9 cases assisted clients with court decisions, 15 cases assisted clients with extensive services not resulting in settlement or court or administrative action, 1 case assisted a client with a negotiated settlement with litigation, and 9 cases assisted clients with other

extensive services. Clients with closed extended representation cases received the following benefits: accessed client's rights to the justice system, including obtaining jurisdiction over a threshold issue, obtaining standing for a client, and preventing wrongful jurisdiction; obtained, preserved, or increased disability, age-related, and maintenance benefits; and obtained other access to justice such as a referral or other monetary benefit. Monetary benefits for clients from back awards and lump-sum settlements, reductions or eliminations of claimed amounts, cost savings, and benefits totaled $2,622,214.

BayLegal's ACBH contract, Section IV Contract Deliverables and Requirements sets the following goal: 15% or fewer cases will be closed without obtaining benefits for the following reasons: loss of contact, insufficient merit to proceed, change in eligibility status, or client withdrawal. BayLegal's rate for cases closed without obtaining benefits due to loss of contact, insufficient merit to proceed, change in eligibility status, or client withdrawal was 11%. BayLegal successfully accomplished this goal.

BayLegal's ACBH contract, Section IV Contract Deliverables and Requirements sets the following goal: achieve an SSI/SSDI allowance rate at least equal to that of the national average approval rate. In the *SSI Annual Statistical Report, 2019,* the national 2018 allowance rate was 43.5%.[4] BayLegal's FY 20/21 allowance rate for closed cases was 73%. BayLegal successfully accomplished this goal.

The client story below illustrates the work funded by this grant. *Client name changed to protect confidentiality:
Quondra D.* was living in temporary housing but was not in a supportive environment. After an incident, she was arrested and sent to Santa Rita Jail. BayLegal had previously helped Quondra obtain SSI benefits and her attorney once again stepped in to help her obtain benefits once she was released. Quondra's attorney worked with her social worker and the Public Defender's Office to determine her release date and set up housing and other social services. Quondra's attorney reviewed medical and eligibility documents and filed for SSI benefits. When Quondra was released, BayLegal and her social worker had already set up housing for her and connected her with Bay Area Community Services Homeless Engagement Action Team to provide further support. Quondra's SSI application was approved with nearly $5,000 in back payments covering the time from when she was released to when her application was approved. Quondra is now in a supportive environment, is stably housed, and is able to take care of herself.

V. FY 20/21 Additional Information: Cases with the Social Security Administration (SSA) and the California Department of Developmental Services (DDS) are generally moving more slowly due to the ongoing pandemic. SSA and DDS are both understaffed and SSA field offices are generally closed to the public. Cases with DDS are sometimes stalled awaiting a consultative examination that DDS staff has been unable to schedule due to the lack of in-person appointments, or client or clinician objections to an in-person appointment.

Despite these challenges, BayLegal continued to advocate for its clients. In part with BayLegal's advocacy, SSA established "vulnerable population liaisons" in field offices to help facilitate applications and address barriers to processing claims, appeals, appointment of representative, and other forms as part of SSA's COVID workgroup. In September, SSA plans to roll out a new online tool to make it easier to establish a protective filing date or application lead similar to California's GetCalFresh.org tool. BayLegal hopes that these changes will increase service access for its clients and result in more benefit

[4] This is the latest national allowance rate published directly by the Social Security Administration. https://www.ssa.gov/policy/docs/statcomps/ssi_asr/2019/ssi_asr19.pdf.

awards.

VI. FY 21/22 Projections of Clients to be Served: BayLegal estimates the number of clients to be served in FY 21-22 to be approximately 300. Clients will be represented at all stages of SSI/SSDI applications, and staff will advocate for clients with SSA and DDS.

VII. FY 21/22 Program or Service Changes: Due to the ongoing pandemic, in-person services have shifted to remote whenever possible. The Oakland office is open on a limited basis for walk-in clients. The SSI/SSDI advocacy project is supported by a remote attorney of the week who calls back clients looking for assistance. The attorney of the week screens for eligibility and merit, provides advice or brief service as needed, and adds clients to the referral list for representation.

FULL SERVICE PARTNERSHIP (FSP) REPORT
FSP # FS10

PROVIDER NAME: Alameda County Health Care Services Agency Office of Homeless Care and Coordination (OHCC), (formerly known as Behavioral Health Care Services (ACBH) Housing Services Office (HSO)) and multiple subcontractors.

PROGRAM NAME: Housing Solutions for Health

Program Description: The OHCC 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: MHSA funded programs under the OHCC 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. OHCC efforts focus primarily, but not exclusively, on helping individuals experiencing homelessness and those with prolonged stays in institutional settings.

Age Group: Adults 18-59 years old; and those over age 60 years old

I. Specific program categories that operate under the OHCC 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 residential facilities;
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 residential facilities and permanent support housing slots countywide;
8) Housing education and counseling sessions at ACBH-funded Wellness Centers and other community locations;
9) Landlord Liaison Program recruits and works with landlords and property managers in the private rental market settings to acquire safe, decent and affordable housing countywide and retain units securing long-term housing for clients who have previously had barriers to locating affordable housing or maintaining long term tenancy;
10) Staff involvement and financial support toward countywide efforts focused on addressing homelessness;
11) MHSA affordable housing project application preparation in partnership with nonprofit affordable housing developers.

Program Outcomes & Impact: FY20/21

PERFORMANCE INDICATORS: How Much Did We Do?
Number of Clients Served: MHSA-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 442 households received long-term housing financial assistance and supportive services to keep their housing, 60 households received short-term housing financial assistance, over 88 stayed in MHSA-funded temporary housing, and more than 600 received housing-related services including outreach, navigation, or permanent supportive housing services. Due to decompression relating to pandemic mitigation efforts, temporary housing sites operated at lower occupancy during fiscal year 20/21.

% Retention Rates: permanent housing programs supported by the OHCC have maintained housing retention rates of around 86%, temporary housing exits to permanent housing have remained around 43%.

Challenges:
The pandemic has proven to add challenges to those experiencing homelessness and serious mental illness and accompanying household members. Due to risk mitigation efforts, temporary shelters operated within decompressed capacity limits to support social distancing and health measures. Additional on-going challenges facing include 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; this was notably experiencing during the last fiscal year.

Coordinated Entry System:
The County's Coordinated Entry System (CES) for addressing homelessness, formalized in 2017, underwent planning and transitions to an updated system intended to improve provision of services and prioritize of need. These changes were a result of extensive stakeholder feedback, alignment with System Modeling efforts, and improved efforts to reduce racial inequity in homelessness. 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.

Permanent Supportive Housing – *Success Story*
ACBH has provided landlord services since 2013 at a permanent supportive housing site in Oakland. Following a series of challenges, including incidents of violence between residents, Housing Services staff joined with the onsite service provider, and property manager to organize a comprehensive response. Through collective action, the partners leveraged existing relationships to integrate county crisis services and law enforcement to engage in a proactive plan of action to intervene with the high risk behaviors and outreach to residents to offer connections to mental health services. The team also initiated design and building modifications to enhance the safety of the physical environment. Frequent check-ins to ensure supportive care at the site for residents and staff continue among the collaborative partners.

PERFORMANCE INDICATORS: Is Anyone Better Off?

FY 2020-21 Impact: One of SAMHSA's four key dimensions of recovery (health, home, purpose, and community) is "home." Stable, safe and supportive housing reduces emergency and crisis service utilization, increases access to quality outpatient services, and improves overall health outcomes.

The OHCC worked collaboratively with cities, other county departments, and affordable housing developers to secure $54 million from the statewide No Place Like Home (NPLH) Program (Round 2 funds) for creating more supportive housing for homeless individuals with a serious mental illness. This funding will help create and support 111 new housing units set aside for the target population in buildings with 256 total affordable units. This allocation is in addition to the $43 million allocation in the state in Round 1 of NPLH. These new opportunities will be available in the next 2-5 years.

During FY 19-20, ACBH completed an expansion of its subsidized residential care beds (locally referenced as the Housing Support Program - HSP), with the addition of three tier levels of care, developed based on acuity of need. Additional funding helped 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 addition to mental health needs. During FY 20-21, a total of 251 individuals were served within 16 licensed facilities.

Housing Support Program – *Success Story*
Through successful efforts and collaboration, an HSP provider was able to share an innovative approach to bed bug mitigation efforts. Following concerns of bed bugs at the facility, the operator coordinated with County vector control to address the vector concerns, while utilizing a cost-effective heat treatment response, which resulted in full eradication of the bed bugs. Through further collaboration efforts, the operator later lead a best practice training with fellow operators. To date, this resolved the vector issues at the property.

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 and currently reflects 25 ILA certified sites.

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 ages 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/. State funding of $15M was approved by the Governor, adding critical resources during a crucial time in addressing a medically vulnerable population experiencing homelessness.

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 120 new additional permanent supportive housing opportunities created through a combination of additional HUD, No Place Like Home, and ACBH MHSA housing resources.

The Landlord Liaison project has led to a growing number of Landlord participants. This has been an integral effort to secure monthly rent payments, security deposits, risk mitigation funds which may be used for damages in preparation for new tenants. Additionally, a dedicated landlord hotline supports landlords with housing expertise that may be utilized for crisis needs, property management needs and problem solving. Staff triage the calls and provide immediate problem solving based which may include immediate response to an emergency (e.g. property management or behavioral); next day scheduling of property management or other service; or scheduling of non-urgent follow-up.

FULL SERVICE PARTNERSHIP (FSP) REPORT FORM
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 support of a treatment team, conservator, and court supervision.

Target Population*: Adults (Age 18 +) 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.

How Much Did We Do?
I. FY 20/21

a. **Number of clients served:** 33

How Well Did We Do?
II. Language Capacity for this program and number of people served in each language: Community Conservatorship staff utilize a certified language line to provide services in languages other than English. They can, at times, access language capacity of other Telecare program staff in case of emergency. These languages include Spanish, Khmer, Urdu, Taiwanese, and Cantonese.

III. FY 20/21 Challenges: The most significant issue during this FY was the COVID virus and response coordination. The CC program had all partners living in congregate licensed homes. We supported our housing partner's with education for staff and residents about hand washing and COVID 19 health and safety info. We were able to quickly purchase and distribute items like hygiene supplies, games/activities, food, and emergency items to provide to individuals in an effort to support them sheltering in place. We were also able to support some of the homes in accessing PPE – face-shields, gloves, face masks. The overall response to the COVID crisis from the county, our community partners and Telecare were massive and protected our partners from the spread.

For partners to remain eligible for conservatorship in the community, there is a requirement of living in a licensed board and care setting. The limited number of affordable licensed homes in Alameda County or homes participating in the HSP program and their availability, impacts our partner's ability to participate in the program. This program would benefit from additional options and access to licensed board and care homes in Alameda County.

Is Anyone Better Off?

IV. FY 20/21 Client Impact: We saw a decrease in hospitalizations and days in hospital, improvements in areas of functioning in the community, increase in partners engaging in employment or education goals, 2 partners were reconnected with benefits, increased connection and attendance to primary care, and support was provided for partners and their families to improve relationships and support systems. The CC staff's continued work with partners around accessing resources and educating around COVID has allowed staff to support many partners in getting their vaccination to increase the safety of all members of our community.

Personal story: When "Jane" was initially referred to the CC program, she had been at Villa Fairmont Hospital for a year. Prior to that hospitalization, Jane had lost her housing, relapsed on alcohol, lost connection with her family due to problematic behaviors, and been victimized in the community. When she joined the CC team, she was interested in maintaining her sobriety, reconnecting and repairing relationships with her family, as well as exploring educational and employment opportunities. She engaged with the team and developed positive therapeutic relationships with all staff on the team. She has been able to maintain her housing over the last and build community supports with staff at the B&C home, increase her visits with her family and repair those relationships. She is participating in primary care appointments and maintaining her healthcare needs.

V. FY 20/21 Additional Information: The CC program has consistently maintained 23-24 partners over the last year nearing our census expectation of 25.

VI. FY 21/22 Projections of Clients to be Served: Over the next year, we will continue to work with the Public Guardian's office and our county partners to increase our census to 25 partners served.

VII. FY 21/22 Program or Service Changes: N/A

Metrics	% of FY 20/21 FSP clients that achieved the metric
Reduction in Hospital Admits*	90%
Reduction in Hospital Days*	100%
Reduction in Incarceration Days*	67%, with a 100% decrease after 2 yrs
Increase in the number of days Stably Housed*	60%, with 75% increase after 2 yrs
Primary Care visit within the previous year	63%

*The metrics above measuring "reductions" are looking at FSP clients served in FY 20/21 who experienced one of these negative events (crisis, hospital admission, and incarceration) prior to enrollment in an FSP compared to the first year of FSP enrollment.

FULL SERVICE PARTNERSHIP (FSP) REPORT FORM
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 (Age 18 +) who are diagnosed with a severe mental illness, considered to be resistant or reluctant to mental health treatment, who meet the Welfare and Institution Code Criteria as outlined by AB1421.

How Much Did We Do?
I. FY 20/21

a. **Number of clients served:** 53

How Well Did We Do?
II. Language Capacity for this program and number of people served in each language: Assisted Outpatient Treatment staff utilize a certified language line to provide services in languages other than English. They can, at times, access language capacity of other Telecare program staff in case of emergency. These languages include Spanish, Khmer, Urdu, Taiwanese, and Cantonese.

III. FY 20/21 Challenges: The most significant issue during this FY was the COVID virus and response coordination. The AOT program had several partners living homelessly in congregate camps which were believed to be particularly vulnerable to the spread of the virus. We mobilized quickly and were able to get 4 people into hotels within the first week of the shelter-in-place orders. We were able to quickly purchase and distribute items like pre-paid phones, hygiene supplies, games/activities, food, and emergency items to provide to individuals in an effort to support them sheltering in place. The overall response to the COVID crisis from the county, our community partners and Telecare were massive and saved lives.

Another significant challenge we face in the Bay area is access and availability of quality, affordable housing. It is a significant barrier for AOT partners who want independent housing but have limited or no income and are not able to afford housing. With limited shleter options and no clear or accessible flow from shelter to affordable housing, individuals struggle with maintaining housing.

Is Anyone Better Off?
IV. FY 20/21 Client Impact: We saw a decrease in homeless days, hospitalizations and days in hospital, improvements in areas of functioning in the community, 3 partners got jobs, partners were connected with benefits, primary care when needed, temporary or permanent housing as possible, and support was provided for partners and their families to improve relationships and support systems. The AOT staff's continued work with partners around accessing resources and educating around COVID has

allowed staff to support many partners in getting their vaccine to increase the safety of all members of our community.

Personal client study: When "John" was initially referred to AOT for evaluation, he was in acute crisis at John George. He had become physically aggressive with his family due to his unmanaged psychosis and paranoid thoughts. He was sleeping outside because the family was fearful of having him in the home. John initially had limited interest in engagement with the team but could identify some goals for himself – improving his relationship with his family and getting a job. The team worked to support him with these goals specifically and that allowed us to build a strong supportive relationship with John. He began to accept our support more readily, started and maintained medications, was allowed back in the home with the family, he developed stronger coping skills, and secured employment with a local store. John completed 3 terms with the AOT team, demonstrating his increased commitment to his mental health, and was able to step down to a lower level of care in the community when he graduated from the AOT program. He continues to work with his new team with the support of his family, as well as maintain his employment.

V. FY 20/21 Additional Information: AOT program continues to work with community law enforcement, acute hospital settings, and the courts to identify and assess eligible individuals for the AOT program. Working closely with our county partners, we have reached and maintained our census expectation over the last year.

VI. FY 21/22 Projections of Clients to be Served: AOT will continue to work with our county partners to maintain our 30-person census.

VII. FY 21/22 Program or Service Changes: The AOT program has no projected changes, however we continue to respond to changing community needs during this pandemic. We continue to work diligently around increasing the number of AOT partners who have received their vaccination and to reduce their risks in the community. There were some referral stream changes which have not yet manifested for the team, but may over the coming year, where we could see an increase in referrals from judges directly to the program for evaluation.

Metrics	% of FY 20/21 FSP clients that achieved the metric
Reduction in Hospital Admits*	75%
Reduction in Hospital Days*	63%
Reduction in Incarceration Days*	67%
Primary Care visit within the previous year	61%

*The metrics above measuring "reductions" are looking at FSP clients served in FY 20/21 who experienced one of these negative events (crisis, hospital admission, and incarceration) prior to enrollment in an FSP compared to the first year of FSP enrollment.

FULL SERVICE PARTNERSHIP (FSP) REPORT FORM
FSP # FS 13

PROVIDER NAME: Telecare Corporation

PROGRAM NAME: CHANGES

Program Description: Telecare CHANGES is an adult Full Service Partnership located in the Eastmont Town Center in Oakland, CA. The CHANGES FSP provides comprehensive evidence-based 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 psychiatric nurse practitioner, and a nurse. The CHANGES FSP provides the following services: 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's services are delivered in the community.

Target Population: The CHANGES FSP serves adult Alameda County residents, 18 years of age or older, 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. The CHANGES FSP has a strong reputation for working effectively with individuals with co-occurring mental health and substance use conditions.

How Much Did We Do?
I. FY 20/21

a. **Number of clients served:** 124

How Well Did We Do?
II. Language Capacity for this program and number of people served in each language: English (123 clients served) and Spanish (1 individual served). We also have the capacity to serve Hmong and Samoan speakers although we don't currently have any in among our members.

III. FY 20/21 Challenges: The two chief challenges our program faced in the past year were staffing retention and hiring, and adapting to a service delivery environment defined by Covid-19 restrictions, safety precautions, and outbreaks. The latter challenge impacted our access to our members in jails, hospitals, CRPs, and congregate housing sites. It complicated hospital discharge consultation and coordination, and created another obstacle to service delivery to clients living in the community. And it especially increased the difficulty of conducting effective outreach and engagement to difficult to engage members.

Is Anyone Better Off?

IV. FY 20/21 Client Impact: Nearly half of CHANGES members have a chronic medical condition and we have made a commitment to make sure they get the medical care they need and deserve. One of the program's major successes in the past year has been in the gains many of our medically vulnerable members made in keeping routine and follow-up medical appointments, and in getting specialized treatment, including surgery. For example, one member had had a large hernia for over five years. His chronic homelessness and active addiction were both obstacles to him getting corrective surgery. In the

last year the CHANGES team helped him get placed in a SNF, which was his first period of housing stability for over 4 years. This was achieved through close partnering with the SNF management and staff, including much advocacy on the client's behalf after numerous AWOLs. Living in the SNF, and with the support of the CHANGES staff, the client was able to achieve sobriety, which in turn allowed him to get the surgery he needed. The persistent support and strong advocacy of CHANGES nurses and case managers helped another client get much needed surgery. They helped the client move from pre-contemplation to action around treatment for her condition. They advocated with the medical provider when the client would miss an appointment. And the team's RN educated the client's B&C staff about their role in preparing the client for surgery by following pre-operative instructions.

V. FY 20/21 Additional Information: N/A

VI. FY 21/22 Projections of Clients to be Served: 132

VII. FY 21/22 Program or Service Changes: N/A

Metrics	% of FY 20/21 FSP clients that achieved the metric
Reduction in Hospital Admits*	62%
Reduction in Hospital Days*	68%, with a decrease of 81% after 2 yrs
Reduction in Psychiatric Emergency Services (PES)*	76%
Reduction in Incarceration Days*	82%
Increase in the number of days Stably Housed*	43%
Primary Care visit within the previous year	62%
th a vocational goal who are employed	2%
Received a follow up visit within five days after a mental health hospitalization or crisis	61%
Average of four or more visits per month per client	66%

*The metrics above measuring "reductions" are looking at FSP clients served in FY 20/21 who experienced one of these negative events (crisis, hospital admission, and incarceration) prior to enrollment in an FSP compared to the first year of FSP enrollment.

FULL SERVICE PARTNERSHIP (FSP) REPORT FORM
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 and are high utilizers of mental health services and who are considered to be at great risk for psychiatric hospitalization.

How Much Did We Do?

I. FY 20/21

a. **Number of clients served:** 115

How Well Did We Do?

II. Language Capacity for this program and number of people served in each language: This past fiscal year, STRIDES provided services to one partner in Spanish (all other partner services were provided in English). In addition to English, STRIDES staff are able to provide services in Spanish, Khmer, and Cantonese. We utilize a certified language line for all other languages.

III. FY 20/21 Challenges: Ongoing COVID-19 difficulties from FY19-20 brought on similar challenges this fiscal year. While our staff continued to maintain and provide COVID-19 focused services and outreach, including screening and educating partners on safety and sheltering in place, learning to provide service while wearing PPE, learning to provide service by telephone and telehealth, linking with new community services such as COVID Motels, engaing with partners through the use of art, poetry, music, journaling, book clubs, and Telecare's own Recovery Centered Clinical System workbooks, etc., many partners became increasingly more restless after spending an entire year primarily in their residences. As soon as community-based drop-in wellness centers opened (including BACS HedCo/Townhouse) and day treatment programs (Fairmont Day Treatment and Highland Day Treatment), partners were quickly provided resources to attend and/or get referred to these programs. Additionally, through a collaborative effort between several Telecare programs within our building, Case Manager – Substance Use Specialist staff began providing Seeking Safety groups in community congregate homes where many of our partners reside. Lastly, there were ongoing challenges with limited housing options, especially for partners who are traditionally not successful in congregate living and/or have been through many housing placements.

Is Anyone Better Off?

IV. FY 20/21 Client Impact: As mentioned above, in order to support our partners who became increasingly more restless during this pandemic, as soon as as community-based drop-in wellness centers and day treatment programs became available, our partners were quickly connected to these programs. Through a collaborative effort between several Telecare programs within our building, staff began providing Seeking Safety groups in community congregate homes where many of our partners reside. As soon as COVID vaccines became available for our partners (either in their respective congregate homes or through County/State resources), there was a robust, immediate effort to provide education to and support all partners to get vaccinated. This also includes hosting our own Telecare vaccination clinic in our downtown Oakland office to increase accessibility on March 30th. We have also

been working with our Corporate office to discuss how we can continue accessing COVID-19 vaccine doses in our offices to host smaller clinics – especially to target our drop-in, hard-to-reach, transient partners. To address ongoing housing challenges for partners who have struggled to maintain housing and/or live in congregate settings, we increased our collaboration with various local motels who would accept our partners on short notice and who may not require identification. Additionally, we started a working relationship with local board and care operator to master lease our own property to increase housing access, specifically for Telecare partners in one of our four community-based programs. Lastly, we began offering a monthly Family Support Group to provide a safe space for family members struggling to care for their loved ones and to create an opportunity to provide psychoeducation to family members of our partners, including topics such as medication management (attended by our prescriber), co-occurring disorders, self-care, etc.

Personal Client Story: Mikal was referred to STRIDES FSP Program from an Alameda County Service Team in Dec 2020. FSP services were requested for Mikal as he had been homeless in the community for the past year (since he moved back to CA from out of state) and had multiple episodes of serious suicide attempts, including most recently in November 2020 during which he poured lighter fluid on his body and set himself on fire. He struggled with severe depression symptoms and disparaging voices, persistent SI/self-harming behaviors, inconsistent adherence to psych meds regimen, poor engagement in treatment services, and ongoing AOD use. STRIDES team engaged with him while he was recovering in medical hospital, then supported him with transferring to crisis residential treatment, and from there, STRIDES supported him with accessing several substance use rehabilitation programs. As of August 2021, Mikal has been sober for over 8 months, has successfully maintained housing since his initial enrollment, has consistently engaged in treatment – both with case managers as well as medication adherence, and a week ago, he successfully found a part-time employment position.

V. FY 20/21 Additional Information: N/A

VI. FY 21/22 Projections of Clients to be Served: We project that we will be able to serve between 110 - 115 unique individuals this year, as there is a focus on assessing partners who are ready for transitions to step-down case management teams in order to open up more slots for new referrals.

VII. FY 21/22 Program or Service Changes: Ongoing flexibility with service provision during rapidly changing directives during COVID-19 pandemic. Instituting virtual / in-person (socially distanced) groups; such as art group, family support group, Seeking Safety, Co-occurring education group, etc. Increasing housing flexibility with the use of partner housing funds to ensure that partners can access housing at a variety of levels of care depending on their needs.

Metrics	% of FY 20/21 FSP clients that achieved the metric
Reduction in Hospital Admits*	78%
Reduction in Hospital Days*	94%
Reduction in Psychiatric Emergency Services (PES)*	79%
Reduction in Incarceration Days*	90%
Increase in the number of days Stably Housed*	66%
Primary Care visit within the previous year	46%
With an educational goal who are enrolled in school	50%
Received a follow up visit within five days after a mental health hospitalization or crisis	72%
Average of four or more visits per month per client	71%

*The metrics above measuring "reductions" are looking at FSP clients served in FY 20/21 who experienced one of these negative events (crisis, hospital admission, and incarceration) prior to enrollment in an FSP compared to the first year of FSP enrollment.

This methodology is the same for the housing stability metric, instead of a reduction it is looking for an increase in the number of days someone was stably housed before FSP enrollment compared to their first year of FSP enrollment.

FULL SERVICE PARTNERSHIP (FSP) REPORT FORM
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.

How Much Did We Do?
I. FY 20/21

a. **Number of clients served:** 160

How Well Did We Do?
II. Language Capacity for this program and number of people served in each language:
We have clinicians and staff who speak, English and Spanish.

III. FY20/21 Challenges: The biggest challenge faced by in FY 20 were HEAT this year were the intersections of three public health crisis', racism, homelesness and COVID-19, these challenges continued to be our biggest challenges in FY21. Racism and homelessness are ongoing public health issues that effect the lives of our clients, staff and programs everyday. COVID-19 created more challenges with seeing clients, keeping clients and staff healthy, and having new housing oppurtunties for clients.

In FY 21, we focused on getting folks vaccinated, and offering support as we ended COVID restrictions. There continue to be barriers of other nonprofits not doing face to face meetings with clients, having decreases census in their transitional housing oppurtuities, and a decrease in PSH matches.

Is Anyone Better Off?
IV. FY 20/21 Client Impact: P was hospitalized 10 times in the month before she came to HEAT. The level one team reported, P was spending all night outside walking and decompensating. She had been hospitalized 10 times in during the month of the referral. She felt alone. She had been in a relationship for 15 years where she felt isolated from healing spaces. She was self-harming, and leaving brutal scars on her arms. She didn't want to die, and she wanted her life to be different.
When she came to HEAT she was given a team of folks and a crisis number to call. We invited her to our community wellness gatherings on Fridays, where she began to find a sense of belonging. We set her up with DBT interventions by positively reinforcing her coping behaviors. She started using the crisis stabilization unit, and HEAT partnered closely with their team to offer stabilization. She began to come to town house every day, where she ate snacks and sat on the couch. She talked to everyone about her desire to self-harm, feelings of depression, and lack of natural supports. She felt she lacked community, positive supports, and a sense of belonging.

Every week she came to our community building wellness events, to our spirit of therapy in movement. She ate, she got to know people, we expected her to be there. When she walked in, the room erupted with “Hey P”. She had a space that was truly hers, designed for her and her own personal healing.

This last week she asked to bring a friend. I found P s at the table at town house, smiling, eating candy, and helping her friend through a hard time. This is what the beginning to healing looks like, it looks like the energy and space between friends.

V. FY 20/21 Additional Information: N/A

VI. FY 21/22 Projections of Clients to be Served: 150

VII. FY 21/22 Program or Service Changes: HEAT will work to hire more substance use specialists who have experience in working with folks who have co-occurring disorders. We are continuing to build up our staff teams, and piloting different organization structures of the team. We have a focus on education and employment, and using the IPS model to increase retention for clients. We want to increase retention on our staff team, and are piloting a new onboarding technique to folks feel grounded and held in their experiences.

Metrics	% of FY 20/21 FSP clients that achieved the metric
Reduction in Hospital Admits*	79%, with a decrease of 85% after 2 yrs
Reduction in Hospital Days*	82%, with a decrease of 92% after 2 yrs
Reduction in Psychiatric Emergency Services (PES)*	81%
Reduction in Incarceration Days*	77%, with a decrease of 95% after 2 yrs
Increase in the number of days Stably Housed*	23%
Primary Care visit within the previous year	65%
With a vocational goal who are employed	1%
Received a follow up visit within five days after a mental health hospitalization or crisis	69%
Average of four or more visits per month per client	55%

*The metrics above measuring “reductions” are looking at FSP clients served in FY 20/21 who experienced one of these negative events (crisis, hospital admission, and incarceration) prior to enrollment in an FSP compared to the first year of FSP enrollment.

FULL SERVICE PARTNERSHIP (FSP) REPORT
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.

How Much Did We Do?
I. FY 20/21

a. **Number of clients served:** 107

How Well Did We Do?
II. Language Capacity for this program and number of people served in each language: Provided services in English, Spanish, and Cantonese.

III. FY 20/21 Challenges: The continuation of the COVID-19 pandemic has created even more challenges for our resource deprived partners who are more isolated now than they already have been, which exacerbates their mental health symptoms. LIFT met the challenges of these external stressors by employing a combination of increased physical distancing protocol, continuing to provide PPE, and outdoor engagement. All of the BACS FSPs continued to deliver face-to-face services for its clients.

Another challenge continues to be finding appropriate shelter housing placements due to increased demand of resources 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.

Is Anyone Better Off?
IV. FY 20/21 Client Impact: LIFT has continued to make a positive impact in the lives of the partners we serve. LIFT has worked tirelessly to decrease reliance on emergency psychiatric services to promote independence, community, and self-esteem.

One of LIFT's most challenging partners with an extensive history of aggression, incarceration, homelessness, and violence, was able to maintain stable housing for 5 months. This is the longest he has maintained housing outside of an institution. He was initially reluctant to accept engagement and was standoffish with the team. He would often threaten staff and scream expletives refusing support. Although he continues to refuse medication he continues to engage with the team in a respectful manner.

LIFT partnered with the other BACS FSPs to host weekly wellness events, focused on building community and fostering creativity. These events also pull in the surrounding Oakland community to create an atmosphere of healing in connection with other people.

Reduce mental health stigma: We help the partners in mirroring the clients' strengths, foster individuality, increase self-esteem, increase confidence, and holding one-self in a positive regard. LIFT partnered with the other BACS FSPs to host weekly community wellness events. These structured social activities reduce isolation while building a sustainable self-supportive community. LIFT uses a wraparound model to foster natural supports to increase connection, resiliency, and community.

Create a welcoming environment: The LIFT Team creates a welcoming environment by providing an open, non-judgmental environment. LIFT has many team members with lived experience which allows the program to understand the unique challenges faced by people struggling with an extensive history of incarceration. LIFT continued to focus on providing services in the community, fostering natural supports, and leveraging its community connections to promote stability. LIFT personnel are trained in Harm-Reduction and Trauma-Informed Care principles to meet the participant where they are at in a whole-person manner. Cultural responsivity is a core axiom of the care provided by the team as the LIFT program was designed with Culturally and Linguistically Appropriate Services (CLAS) standards in mind.

V. FY 20/21 Additional Information: N/A

VI. FY 21/22 Projections of Clients to be Served: LIFT has a program goal and projects to serve 105-110 individuals.

VII. FY 21/22 Program or Service Changes: Changes for LIFT this fiscal year are revolving around prioritizing safety for both our partners and personnel in the midst of COVID-19. We anticipate no drop off in our services.

Metrics	% of FY 20/21 FSP clients that achieved the metric
Reduction in Hospital Admits*	70%
Reduction in Hospital Days*	73%, with a decrease of 81% after 2 yrs
Reduction in Psychiatric Emergency Services (PES)*	70%
Reduction in Incarceration Days*	82%, with a decrease of 90% after 2 yrs
Increase in the number of days Stably Housed*	24%, with an increase of 38% after 2 yrs
Primary Care visit within the previous year	72%
With an educational goal who are enrolled in school	50%
With a vocational goal who are employed	2%
Received a follow up visit within five days after a mental health hospitalization or crisis	76%
Average of four or more visits per month per client	78%

*The metrics above measuring “reductions” are looking at FSP clients served in FY 20/21 who experienced one of these negative events (crisis, hospital admission, and incarceration) prior to enrollment in an FSP compared to the first year of FSP enrollment.

This methodology is the same for the housing stability metric, instead of a reduction it is looking for an increase in the number of days someone was stably housed before FSP enrollment compared to their first year of FSP enrollment.

FULL SERVICE PARTNERSHIP (FSP) REPORT FORM
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.

How Much Did We Do?

I. FY 20/21

c. Number of clients served:

- 103 unique clients were served by JAMHR
- 14 partners received outreach services although they have not joined the program yet

How Well Did We Do?

II. Language Capacity for this program and number of people served in each language: JAMHR has language capacity in English, Spanish and Urdu. We regularly utilize certified language interpreters to communicate with partners and family members whose first language is not English. Four partners and three family members were served in Spanish. The rest were served in English.

III. FY 20/21 Challenges: FY20/21 was a time of great uncertainty due to the stressors of the global pandemic, civil unrest, housing insecurity, increased risk of substance use, increase of hate crimes directed at vulnerable populations. These factors impacted our partners as well as everyone else in society.

Is Anyone Better Off?

IV. FY 20/21 Client Impact: JAMHR staff continuously and safely provided in person services to our clients throughout COVID using fact-based/science-based education about the COVID-19 Virus, safety protocols, testing and vaccination. 37% of partners were vaccinated due to the direct support of JAMHR staff. Vaccine clinics were held at the JAMHR office. Fact-based education about COVID-19 risks and

best practices was shared with housing providers where our partners resided. PPE was provided as needed. We provided linkage to housing for partners who tested positive for COVID and needed a safe place to recover, and for partners who were at a high risk for contracting the virus.

Housing support and rent supplements were provided during a time of skyrocketing housing costs and diminishing options for partners. We provided access to an 11-bed independent living home dedicated exclusively to serving JAMHR partners and other partners of Telecare community-based programs.

48 unique partners received personalized 1:1 substance use counselling using a harm reduction model and linkage to day and residential substance use treatment. 66 unique partners received personalized vocational support services using the IPS Model (Individualized Placement and Support – a 'no exclusions' model of vocational support).

We provided access to 'Seeking Safety' groups and other smaller, outdoor, socially-distanced gatherings to celebrate holidays, birthdays, graduations and other milestones, to increase social skills, and decrease isolation and celebrate successes.

12 unique partners received support accessing Behavioral Health Court and other collaborative courts, where they could work in a non-judgmental court setting to strengthen their commitment to their recovery, reduce risk of recidivism and eventually have charges removed from their records

Family members continued to benefit from our Family Support Group moved to Zoom.

Client Story: 'Dan' is a 41-year-old male, diagnosed with Schizoaffective disorder, who joined JAMHR in August 2020, due to extensive history of justice involvement, psychiatric hospitalization and substance use. He was building encampments on rooftops, trespassing, bringing trash to his mother's home and reporting hearing trains through running through building walls. He slowly built a rapport with the JAMHR staff, and overtime agreed to a low oral dose of Risperdal. After further psychoeducation and increased trust, he agreed to a long-acting injectable starting in November 2020. This resulted in significant symptom reduction and improvement in functioning, including accepting housing, primary care, dental and eye care to address untreated underlying health conditions. Dan identified hopes and dreams including, continuing education and employment. He is working with the JAMHR Vocational Specialist and participating in job interviews. His mom received additional support through participation in the Family Support Group.

V. FY 20/21 Additional Information: JAMHR met partial or full achievement on performance metrics as required in our contract with Alameda County Behavioral Health.

VI. FY 21/22 Projections of Clients to be Served: JAMHR currently has 94 unique partners open to service and 12 referrals in outreach status. We project that we will be at full census of 100 partners by the end of the calendar year, and will be able to serve additional 5 partners due to new vacancies by end of FY 21/22.

VII. FY 21/22 Program or Service Changes: There will be ongoing evaluation and change in practices to follow the federal, state and local guidelines about COVID, as they develop.

In the short term, JAMHR is instituting a mandate that all staff be fully vaccinated by September 30, 2021, unless they present a legitimate exemption.

JAMHR is reinstituting the Co-occurring Education Group, which provides education and motivation for people diagnosed with SMI and who are in the pre-contemplation or contemplation stage of change in their recovery. This group was suspended due to COVID last year. JAMHR will also start a new session of 'Seeking Safety' Group at a new location to ensure access to more partners

Metrics	% of FY 20/21 FSP clients that achieved the metric
Reduction in Hospital Admits*	58%, with a decrease of 68% after 2 yrs
Reduction in Hospital Days*	68%, with a decrease of 79% after 2 yrs
Reduction in Psychiatric Emergency Services (PES)*	87%
Reduction in Incarceration Days*	86%
Increase in the number of days Stably Housed*	60%
Primary Care visit within the previous year	67%
Received a follow up visit within five days after a mental health hospitalization or crisis	81%
Average of four or more visits per month per client	77%

*The metrics above measuring "reductions" are looking at FSP clients served in FY 20/21 who experienced one of these negative events (crisis, hospital admission, and incarceration) prior to enrollment in an FSP compared to the first year of FSP enrollment.

This methodology is the same for the housing stability metric, instead of a reduction it is looking for an increase in the number of days someone was stably housed before FSP enrollment compared to their first year of FSP enrollment.

OLDER ADULT FSPs

FULL SERVICE PARTNERSHIP (FSP) REPORT
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 (age 60+) 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.

How Much Did We Do?
I. FY 20/21

a. **Number of clients served:** 109

How Well Did We Do?
II. Language Capacity for this program and number of people served in each language: Circa 60 has the capacity to provide treatment fluently in English and Spanish.

III. FY 20/21 Challenges: The main challenge confronting Circa 60 continues to be housing and COVID-19. Finding stable housing for the older adult population with severe mental illness is a challenging task. They have specific challenges which increase the difficulty physical health challenges which can make them ineligible for mental health facilities. The COVID-19 pandemic was especially dangerous for people over 60 with comorbidities and this is the Many of them live in assisted living and SNFs which were closed to members including case managers and family. These restricted visitation policies increased isolation and depression for many of our clients who are at the end of their lives.

Is Anyone Better Off?
IV. FY 20/21 Client Impact:
Reduce mental health stigma: Circa60 strives to decrease mental health stigma through building community with clients, staff, and neighbors. The Full-Service Partnerships have worked to integrate our care in order to decrease burnout among staff, and increase support of clients. With our integration, we are able to build multigenerational relationships within clients across programs. The FSPs have combined to create Wellness Celebration Fridays in order to increase community among partners and build community between the agency and Oakland's community. These wellness community events acknowledge that healing exists within relationships not in isolation. We work to de-colonize community mental health through creating relational interventions.

Create a welcoming environment: Team Circa 60 uses the wrap-around philosophy and this means the entire team outreaches and engages partners wrapping around them while pulling in significant community supports. We have an atmosphere of playfulness and welcoming in our office space. We

make sure that staff are connected to clients, and everyone is excited and joyful when folks come in to the office. We greet our clients with excitement about what they are doing with their lives, what their treatment goals are, and their plans for the week.

Client Story: A 82-year-old partner who struggles with intimate partner violence, with a high level of hospitalizations. We were able to offer her partner support and housing while she participated in intimate partner violence treatment. She was able to return home successful and limit the harm she was causing her partner. This client got diagnosed with COVID-19 and utilized the safer ground spaces in order to self-isolate. She was able to use the resources offered by the county, and made a full recovery. This speaks to the importance on treating the whole system, and highlighting the importance of natural supports. Circa 60 also continued providing services in the community throughout the pandemic educating all partners, providing masks, hand-sanitizer and making sure they have the ability to socially distance. A 71-year-old client has a daughter in a different FSP. The two FSPs combined to host a family dinner with both participants and other family members. This provides a safe meeting space with the FSP staff offering containment.

V. FY 20/21 Additional Information: Circa 60 played a lead role in educating partners about the hazards of COVID, provide PPE, connect partners to COVID testing, and vaccines.

VI. FY 21/22 Projections of Clients to be Served: 108

VII. FY 21/22 Program or Service Changes: The 20/21 fiscal year saw an exciting change in leadership. The program manager was promoted to an associate director position while both program supervisors were promoted to management positions. While the change in leadership was positive for the team, it required some adjustments and the core of the team was stable with no turnover. Circa 60 hired a new program supervisor who has a strong harm reduction background and years of experience working with high acuity partners. The core of the team had little to no turn over. The BACS FSPs have worked to integrate FSP leadership within BACS and leverage this knowledge to maintain continuity and support for all the teams.

Metrics	% of FY 20/21 FSP clients that achieved the metric
Reduction in Hospital Admits*	69%, with a decrease of 79% after 2 yrs
Reduction in Hospital Days*	74%, with a decrease of 80% after 2 yrs
Reduction in Psychiatric Emergency Services (PES)*	92%
Reduction in Incarceration Days*	86%, with a decrease of 100% after 2 yrs
Increase in the number of days Stably Housed*	49%
Primary Care visit within the previous year	35%
Received a follow up visit within five days after a mental health hospitalization or crisis	80%
Average of four or more visits per month per client	80%

*The metrics above measuring "reductions" are looking at FSP clients served in FY 20/21 who experienced one of these negative events (crisis, hospital admission, and incarceration) prior to enrollment in an FSP compared to the first year of FSP enrollment.

This methodology is the same for the housing stability metric, instead of a reduction it is looking for an increase in the number of days someone was stably housed before FSP enrollment compared to their first year of FSP enrollment.

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.

How Much Did We Do?

I. FY 20/21

a. **Number of clients served:** 68

How Well Did We Do?

II. Language Capacity for this program:

1. English – 39 clients
2. Farsi – 14 clients
3. Spanish – 2 clients
4. Cantonese— 1 client
5. Tagalog – 1 client

III. FY 20/21 Challenges: Barriers for program Implementation: Challenges experienced in the last year have been related to COVID 19 Pandemic. Pandemic made clients feel wary to having staff visit in person. Also, staff feel wary in visiting senior clients in fear of spreading the virus. Additional challenges as it relates to the pandemic have been client's severe mental health challenges as they often expressed paranoia and fear of using internet technology as a form of communication with their treatment team.

Clients have increased depressive and anxiety symptoms as it relates to feeling isolated and unable to participate in the activities they once enjoyed.

Medical/Mobility: This is an on-going challenge for our clients who have chronic medical ailments and resulting in limited and poor mobility. Due to their debilitating physical conditions limit their mobility and diminish their capacity to carry out their daily ADLs independently. Undoubtedly, this situation has contributed so some client's worsening symptoms of depression, anxiety an increased in isolative behavior.

In addition, one of the main obstacles the clients struggle with is accessing and using technology as part of their daily functioning. Devices such as smart phone and tablets have come ubiquitous today but some of our clients do have smart phones or tablets for a variety of reasons.

Due to Pandemic, the program shifted its service delivery structure via telehealth and video using their grand pads devices (IPAD for seniors). It was difficult at first to implement service delivery structure using high technology as our seniors lack the capacity to connect with high technology devices. The program continues to provide services to our clients during the pandemic year. As their symptoms increase or new symptoms occur, the program also increased frequency of telehealth services to clients normalizing their emotions and reactions to the pandemic. The program also addressed and provided increased emotional support to those who are grieving over the loss of their loved ones to Corona Virus. So far, our clients have adjusted to the service structure and accepted the fact that this will be the new normal until after COVID 19.

Is Anyone Better Off?

IV. FY 20/21 Client Impact: Case Study (Client EP): Client EP has been a client of the senior mobile mental health program since Feb 2020. Client was working with a case manager from another social service organization and the case manager encouraged the client to receive counseling services in conjunction with case management services. The client appeared apprehensive to clinicians; Client often challenged clinicians in their education and ability to provide therapy to her as she is an education woman. The client lives alone and has one adult daughter who is estranged. Clients focus of therapy was to build a relationship with her daughter or cope with the estranged relationship. Throughout the last year the client has made tremendous progress. The client opened herself to therapy and began to discuss her mental health challenges. The client contacted her daughter within the past year, and also has made improvement coping that her daughter is not ready to have a relationship with her. This Client that was often isolated and did not speak to others began to engage with coworkers at her job and build relationships. The Client offered herself up to senior neighbors who needed assistance and referred them to the city of Fremont aging family services department. The client offered to teach knitting and sewing classes at the city of Fremont senior center and online, and will provide the materials to the members in the class as a way to declutter her home. The client will begin teaching August 10th, 2021. This Client has come a long way within the past year; client reported to the clinician, “if it wasn’t for you, I don’t know where I’d be, I feel as if I have my life back.”

V. FY 20/21 Additional Information: We celebrate the positives our clients made during this difficult time. Most clients had no hesitation to receive their corona virus vaccine as soon as it became available for them.

VI. FY 21/22 Projections of Clients to be Served: The program will maintain and provide outpatient mental health services for 55 clients/year as stated in the county contract.

VII. FY 21/22 Program or Service Changes: The intent of the Mobile Integrated Assessment Team for Seniors (Senior Mobile Mental Health Program) is to increase service access for seniors with mental illness including those who are homebound. The program serves older adults age 60 years or older who are isolated, unable to access traditional mental health services and community resources, fearful of outside psychiatric interventions and maybe at risk of needing higher level of care such as psychiatric hospitalization. Most services are providing in the home of the seniors.

The program partners with seniors in promoting their ability to live healthy, productive lives as an active member of their community.

The program provides outpatient mental health services to homebound elders in their place of residence. The program serves Fremont, Newark, Union City and Hayward.

To address and respond to their on-going mental health needs, the program will provide the following services: These services include:

- In-home assessment for mental health needs
- Individual, group and family therapy
- Medication support and management
- Linkage to needed community resources
- Crisis Intervention as indicated

One of the major tasks of the program is to promote, coordinate and develop in conjunction with the community partners a menu of other mental health services which will allow a greater number of the senior population to remain in their homes and community if they are able and safe.

The program will establish a strong partnership and shared decision making between mental health service providers in the Tri-City areas and Hayward. This partnership and collaboration will ensure access to appropriate levels if services from crisis intervention to outpatient treatment and case management efforts.

The program will strengthen, solidify and maximize internal working relationship within the city structure, establishing formal service integration and collaboration between city programs. The program is currently and has been coordinating services with Targeted Case Management (TCM) Multi Senior Service Program (MSSP) Community Ambassador Program (CPAS) Life Elder Care, Senior Peer Counseling Program, Senior Centers Care Giver Support Program, Youth and Family Services, Family Resource Center, Para Transit program, Afghan Elderly Association, Afghan Coalition and the City Information and Assistance Line.

The program works very closely with the City's First Responders (Police and Fire Department and Code Enforcement). Further, the program will extend collaborative efforts with the Police and Fire Department and Code Enforcement in the cities of Union city, Newark and Hayward. The program will provide and has been providing outreach and education to the above departments in the forms of training on mental health issues, system of care values and wrap around planning efforts. This system of collaboration and care coordination will increase referrals to the program and increase service access and utilization of outpatient mental health services for our older adults' population.

The program also advocates for culturally appropriate service delivery models and outreach to underserved ethnic community through community partners and system capacity building.
Lastly, the program promotes hope, recovery and resiliency. Our program in partnership with local community provides and client's advocates should overcome boundaries between health care providers.

This is how we collaborate and integrate services with our First Responders: The city of Fremont's First Responders responds to different types of calls from the community daily. The cases they refer to Human Services Department, Aging and Family Services are mostly cases needing case management services, needing assistance for their health issues, cases of hoarding problems housing, eviction, transportation, family conflict and psychiatric issues such as depression, anxiety, panic attacks, feeling overwhelmed, suicidal and homicidal thoughts, paranoia/ delusion homelessness.

Intervention to Reduce First Responder's Calls from our prospective clientele: Making appropriate referrals for needed service is the first step in reducing first responders' calls. Referred clients are assessed for mental health needs and if they meet program criteria for medical necessity and if they accept our services, we will open their case with the program. By accepting our services and resolve issues including calling 911, will reduce first responder's call.

We also collaborate services with the YANA program (You Are Not Alone) a volunteer program developed by the Police Department where Fremont Police volunteers will provide services to our isolated seniors with peace of mind and a sense of security that they are not alone. Police volunteers will call enrollees daily. If enrollees don't answer their phone after several attempts, then a wellness check will be made to ensure their safety and well-being.

We also coordinate our services with the client's primary care doctors. We are current collaborating services with the new developed South County Crisis Assessment team. We will continue to collaborate survives with different agencies and share resources in addressing mental health issues of our community's homeless population.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 5A

PROVIDER NAME: Alameda County Behavioral Health

PROGRAM NAME: Crisis Services: Expansion and Transition to Mobile Crisis Team (MCT), Mobile Evaluation Teams (MET), Community Assessment and Transport Team (CATT), and Outreach & Engagement Teams

Program Description: In 2019, Crisis Response Program (CRP) underwent an expansion that transitioned the program into a fully mobile crisis service that responds to 5150 calls, engages with consumers who are in crisis, and assesses consumer needs and conducts follow up post crisis situation. The expansion also added on a third mobile crisis team as well as three post crisis follow up teams. CRP effectively changed it's name to Crisis Services. Currently, all clinical staff work primarily out in the field, which increases community-based crisis prevention and early intervention services, thereby ensuring clients are referred to the appropriate type of mental health services. ACBH clinical staff work on the Mobile Crisis Teams (MCT) for North County and South County as well as on the Mobile Evaluation Team (MET), a partnership with Oakland Police Department. Bonita House clinicians staff the third mobile crisis team, the Community Assessment and Transport Team (CATT) along with Alameda County's Emergency Medical Services and Falck. Three post crisis follow up teams focus on telephonic follow up, field-based services for ACBH's high utilizers, and field-based services focused on the county's population that are not securely housed.

Prior to March 2019, CRP was also an out-patient clinic that provides brief mental health services including case management, targeted crisis therapy, and psychiatry. On average, participants remained in the program for 30-90 days. Once stabilized, participants were 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 were also evaluated and referred. However, given the recent expansion of the Mobile Crisis Teams, the out-patient clinic function of Crisis Services no longer exists.

Target Population: Crisis Services serves residents of Alameda County along the entire lifespan who are living with a serious and persistent mental illness and are in crisis.

The MCT, MET, and CATT Programs provide on-the-spot crisis intervention, psychiatric assessment and evaluation to all ages, and make referrals to other agencies and provides follow-up services. MCT Responds to calls from police, shelters, designated community agencies, and community members throughout Alameda County. The MET teams pair a police officer with an ACBH clinician to respond to calls from police dispatch. The CATT teams pair a Bonita House clinician and EMT to respond to calls from dispatch as well.

How Much Did We Do?

I. FY 20/21

a. **Number of clients served:** 1,201 unique clients

How Well Did We Do?

II. Please describe ways that the program strives to:

a. **Reduce mental health stigma:** The mobile crisis teams provide ongoing outreach, engagement, and psychoeducation to individuals living with mental health challenges, their loved ones, law enforcement, and the general community. Crisis Services Outreach and Engagement teams are also 80% staffed by peers with lived experience. Many Crisis Services staff have been involved with the Peers Organizing for Community Change, formerly known as the Pool of Consumer Champions (POCC) in the past and/or are currently involved with POCC at this time. Crisis Services has worked closely with ACBH's Office of Peer Support Services, formerly known as the Office of Consumer Empowerment, to incorporate consumer voices in the planning, delivery, and continuous quality improvement of our expansion and current services. Crisis Services also incorporates views, feedback, and assistance from the Office of Ethnic Services in the recruitment, staff retention, and diverse needs around training and community resources in order to provide services to all residents of Alameda County. In other efforts to reduce stigma, Crisis Services utilizes a fleet of vehicles that have "Crisis Services" written on the side. This communicates the presence of Crisis Services in the communities we serve.

b. **Create a welcoming environment:** In regards to service delivery, Crisis Services now provides crisis intervention to individuals across the lifespan experiencing a mental health crisis anywhere in Alameda County and we respond within a few minutes to a few hours of the request for service.

   Starting in February 2022, Crisis Services has made the following changes to its Mobile team hours: Starting Monday, February 7, 2022 the mobile teams will be available Monday - Friday 8 AM to 6 PM. Our Mobile Evaluation Team (MET) with the City of Oakland, Hayward (H-MET), the Community Assessment & Transport team (CATT) hours will remain unchanged.

   Team hours respectively:
   MET (Mobile Evaluation Team in Oakland) Monday - Thursday 8AM-3:30PM
   H-MET (Hayward Mobile Evaluation Team) Monday - Friday 8AM-4PM
   CATT Monday through Sunday 7:30AM-11PM in the cities of Oakland, San Leandro, Hayward, and Fremont *dispatching for CATT through local law enforcement*
   MCT Monday - Friday

   In regards to a working environment, Crisis Services has developed a comprehensive training on-boarding program including a manual and at least two weeks of shadowing and learning from current staff.

III. Language Capacity for this program: Crisis Services currently has staff who speak fluent English, Spanish, Cantonese, and Mandarin. We also have staff who speak conversational Japanese and American Sign Language.

The language line is utilized for all other languages when translation is needed or requested. Video translation will be added in the future as well. The Office of Ethnic Services has assisted with the translation of all Crisis Services brochures and Resource materials translated into all threshold languages of Alameda County. Crisis Services staff also utilize consent forms and informing materials packets in English and all threshold languages provided by the ACBH Quality Assurance when appropriate.

IV. 20/21 Challenges: Crisis Services on-going expansion and services are impacted by the continuing effects of COVID-19 as well as other current events that have affected staff and residents of Alameda County including (but not limited to) political unrest and the spotlight on racial disparities, California wildfires and subsequent poor air quality, ongoing isolation, etc. The global pandemic, concurrent with these additional environmental factors, have increased crisis calls and requests for wellness checks (frequently requesting that Crisis Services provided crisis intervention without the aid of law enforcement), and a decrease in staffing due to staff going on leave to take care of COVID related family needs.

Is Anyone Better Off?

V. FY 20/21 Client Impact: Here are some examples of the impacts of Crisis Services has on individuals, families, and the community at large (names have been changed and PHI has been removed):

- Joe was referred to Crisis Connect after a crisis encounter with the Mobile Crisis Team. Staff reached out to Joe to see if he needed to connected to any services. In response to Joe's stated needs, she provided him with resources to ACCESS, the Homeless Action, and peer support groups such as the Hearing Voices Network, PEERS, and Pool of Consumer Champions. Joe was also given parenting resources (at his request) for Dad Corps, First Five Alameda. Prior to closing Joe's case, staff followed up with Joe and confirmed that he had been connected to Bonita House as his on-going mental health provider.
- A mother repeatedly called MCT to request evaluations for her 19 year old son, Raymond, who was admitted to John George on multiple occasions. MCT clinicians were able to advocate for a higher level of care for Raymond, who was eventually assigned to a full service partnership and then assisted outpatient treatment as the ACBH system of care supports Raymond in his journey towards recovery.
- Anita used to receive services from La Familia but discontinued services for several months due to no active Medi-Cal. She stated that she medication support and therapy. After 3 phone calls, staff successfully linked Anita to Tri-City for urgent med and reconnected her to La Familia.

VI. FY 20/21 Additional Information: Crisis Services has received a fleet of new vehicles, which has increased client access to transportation by Crisis Services staff to various mental health or community resources in Alameda County, including programs that divert clients from involuntary hospitalizations if clients are willing to access voluntary mental health care.

VII. FY 21/22 Projections of Clients to be Served: As Crisis Services expands and grows staffing numbers, we expect to increase our ability to respond to additional crisis calls in Alameda County within the next year. We also project an increase in the number of clients served by Outreach and Engagement staff due to recent efforts with John George and AC3 staff to collect more accurate phone numbers for follow up and provide all patients discharged from John George with the number to post crisis follow up programs. In 2021, outreach and engagement staff will began a partnership in the field with Healthcare for the Homeless, which has also lead to increased access and more services provided to individuals who are not securely housed.

VIII. FY 21/22 Program or Service Changes: Crisis Services will continue its expansion and continue to add staff to the Mobile Crisis Teams and Outreach and Engagement Teams.

FY 2020-21
COMMUNITY SERVICES & SUPPORTS (CSS) UPDATE REPORT

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 7

PROVIDER NAME: Alameda County Behavioral Health

PROGRAM NAME: Court Advocacy Program (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. Individuals must be eligible for diversion or re-entry services to the community. Consumers include Transitional Age Youth, Adults and Older Adults.

Operational Budget:

How Much Did We Do?

I. FY 20/21

a. **Number of clients served: 28**

How Well Did We Do?

II. Please describe ways that the program strives to:

Reduce mental health stigma: CAP offers 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.

Create a welcoming environment: CAP believes its our responsibility as clinicians to create a safe and tolerant environment, whether seeing a client at the jail, or in the court. CAP strives to be

FY 2020-21
COMMUNITY SERVICES & SUPPORTS (CSS) UPDATE REPORT

free from prejudice, stigma, and discrimination, to be respectful, understanding, and trauma-informed. CAP focuses on the ethical practices of social work.

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.

III. Language Capacity for this program: 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.

IV. FY20/21 Challenges: The Court Advocacy Project has had a steady decline in enrollment since the Covid pandemic began. Like 80% of counties in California, Alameda County continues to use the COVID-19 Emergency Bail Schedule, allowing many individuals to leave jail quickly and making it difficult to locate and connect them to services later on. Additionally, others may have been cited and releasd, allowing them to access services directly in the community. Individuals who are incarcerated experience ongoing delays in connection to the courts and community services due to COVID related precautions such as isolation and quarantine periods, housing and other facility closures, and other resource strains. COVID has also resulting in fewer clients being transported to and from the court house, and the move of many criminal courts to an online platform.

V. FY20/21 Client Impact:
As a result of CAP services:

- Clients were offered an opportunity to connect with 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
- Families and community treatment providers were better able to navigate the court system and advocate for their loved ones/partners

VI. FY20/21 Additional Information: Due to COVID-19 and the emergency bail schedule, large numbers of clients were released from custody very quickly. During this time CAP staff joined several outpatient mental health treatment programs to go to Santa Rita Jail, assist with obtaining medications, offer transitional support, and link individuals being released to mental health and other services as needed. One CAP clinician remarked that this process for release and linkage on discharge was a dream come true.

VII. FY21/22 Projections of Clients to be Served: Depending on the volume of arrests and charges brought against clients with severe mental illness, CAP will continue serving as many individuals

Please email the completed template by August 31st to MHSA@acgov.org and your Program Contract Manager.

FY 2020-21
COMMUNITY SERVICES & SUPPORTS (CSS) UPDATE REPORT

as possible once Covid allows for engagement again in the courts. There is currently no limit on the number of clients CAP may serve. CAP staff continue to work with clients deemed incompetent to stand trial, provide support to Behavioral Health Court, and are also assisting with other Covid related programs such as at the Project RoomKey Hotels.

VIII. FY21/22 Program or Service Changes: In January 2021, Senate Bill 317 was implemented and dramatic changes were made to Penal Code 1370.01 which affects individuals who are considered incompetent to stand trial (Law section (ca.gov)). Clients who are affected by this revised law, may be eligible for mental health diversion, Assisted Outpatient Treatment, or Conservatorship. Covid, legal changes, increased pre-crisis services available throughout Alameda County, and shifting political and societal awareness all have the potential to impact our forensic behavioral health services and the Court Advocacy Project. As always CAP remains flexible to meet clients' needs and offer education and support to help navigate the ongoing changes to the many systems it touches.

Please email the completed template by August 31st to MHSA@acgov.org and your Program Contract Manager.

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.

I. FY 20/21 Outcomes

a. Number of unique consumers/clients served: Approximately 97 clients were served during FY 20/21 clients with approximately 24 individuals graduating during that same period.

   FY 20/21 Impact: 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.

II. Please describe ways that the program strives to:

a. Reduce mental health stigma:
   BHC reduces stigma by reminding clients and the community that hope and recovery are possible. By having regular engagement with treatment and ongoing court oversight, clients are able to maintain stability in the community and make progress toward recovery in discovering meaningful activities and holding meaningful roles, often returning to school or work and becoming leaders and role models for their peers newly enrolled in Behavioral Health Court.
b. Create a welcoming environment: BHC is a collaborative effort between the Alameda County Superior Court, District Attorney, Public Defender, Alameda County Behavioral Health, and community mental health treatment providers. The BHC Team consists of dedicated staff from each department who have special knowledge and sensitivity to mental health issues, in addition to representatives from forensic focused treatment teams. BHC is non-adversarial. BHC Team members realize the importance of recognizing

and rewarding individuals who do well. Participants are praised and rewarded in court for their progress.

III. Language Capacity for this program:

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.

IV. FY 2020/21 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 Clinicians, Peer Specialist, and Clinical Supervisor. Funds for other court staff are provided by their respective agencies.

V. FY 2020/21 Challenges:

The BHC Program had a steady decline in enrollment throughout 2020. Census challenges included: a pause on all new admissions due to the Covid pandemic, the COVID-19 emergency bail schedule that allows for the discharge of potential clients/inmates from jail before connecting to behavioral health services; the move to an online platform instead of inperson hearings; treatment team staffing shortages and other complications related to Covid illness and emergency deployements.

The early months of 2021 saw the beginnings of an increase in referrals. It was observed that while the Public Defender's Office has a dedicated staff person assigned to BHC, there are mentally ill clients who are given court appointed council, not with the Public Defender's Office, who are often unaware of collaborative courts such as BHC. The Honorable Judge Syren and Judge Smiley completed a "Collaborative Courts 2.0" training on May 26, 2021 to increase education and understanding of the qualifications and referral process. For new referrals only, BHC additionally resumed inperson hearings.

Hearings on progress reports for ongoing clients remain on a virtual online platform. While the online platform seems to benefit some individuals, it does not work for all clients and poses technology to be able to engage with the court process. Ongoing complications related to provider staffing shortages, limited services, and facilty closures continue to affect the engagement of consumers and their ability to participate. Our collaborative partners continue to make adjustments to improve the quality of the court experience for clients and those who support them.

VI. FY 2021/22 Projections of Clients to be Served:

The BHC program was initially founded in 2009 with a collaborative agreement between ACBH, The Superior Court, Alameda County Public Defender's Office and District Attorney's Office. Many changes have evolved with the program since that time including an expansion of the types of

charges permitted for participation. FY 2020/2021 saw a shift toward ensuring that all individuals admitted to BHC are eligible for and connected to intensive community services or full service partnerships. Individuals needing less intensive services are referred to Informal Court or other court programs.

For FY 2021/2022, depending on the volume of arrests and charges brought against clients with severe mental illness, BHC will continue to serve as many individuals as possible. To maintain the high quality of engagement with current staffing available for assessments and collection of court reports, BHC clinicians maintain a 1 to 30 staff to client ratio.

VII. FY 2021/22 Program or Service Changes:

In July 2021 the BHC Program moved from Adult and Older Adult System of Care to the newly established the Forensic, Diversion, and Re-entry Services System of Care (Forensic System of Care). The Forensic System of Care is specifically designed for justice involved individuals who require behavioral health services and coordinates all of ACBH's forensic services across the age spectrum into one line of service. It aligns both in-custody and forensic outpatient services to enable better care coordination.

As part of our "True North Metric", intentional attention to Quality, Investment in Excellence, Accountability in Leadership, and Outcome Driven Goals (and metrics), ACBH ensures the Forensic System of Care will:

- Enhance in-custody mental health services and develop therapeutic programming for individuals with intensive mental health needs
- Strengthen and align discharge planning and coordination of re-entry services
- Improve quality of care across Forensic services to reduce recidivism for individuals with intensive mental health needs

Additionally, there have been several new laws implemented in the recent years that affect our community and implementation of mental health services with the forensic population. As a result, the Forensic System of Care is actively in the process of working toward a Memorandum Of Understanding with our collaborative court partners, and adjusting the work flow procedures and related policies.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 8

PROVIDER NAME: Alameda County Behavioral Health

PROGRAM NAME: Juvenile Justice Transformation of the Guidance Clinic

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:

How Much Did We Do?

I. FY 20/21

a. **Number of clients served: 324**

How Well Did We Do?

II. Please describe ways that the program strives to:

a. **Reduce mental health stigma:**

The Guidance Clinic (GC) actively works to reduce mental health stigma for youth involved in the Juvenile Justice System. This fiscal year, the GC implemented a new process to have a GC clinician meet with every youth upon their detainment into Juvenile Hall. During this initial meeting with youth, clinicians describe the available mental health services and how mental health services can be helpful during incarceration. The clinicians also help youth understand their rights in accessing mental health services and conduct a brief initial mental health assessment on each youth. If youth are interested in mental health services, the clinician will create a plan to connect them to regular and ongoing services. If youth are not interested in services, the clinician will explain that mental health services are always available and show the youth how to request/self-refer to services at any time. This new outreach approach helps reduce stigma by further integrating mental health services as part of the standard programming for youth (i.e., it is part of the intake process for every youth), and by helping youth understand that mental health services can be beneficial during stressful and traumatic events.

Additionally, GC clinicians continue to maintain a regular presence on the detention units in the Juvenile Hall and Camp Wilmont Sweeney (the other detention facility on the Juvenile Justice Center campus). The clinicians are part of the milieu, actively checking-in with youth and engaging staff from the Probation Department who work on the unit. Clinicians are seen as part of the daily functioning of the units and youth know that they can always speak to a clinician whenever the clinician is not in a session. Maintaining a presence on the units reduces mental health stigma by allowing the clinician to build trusting relationships with youth and staff, while normalizing the services the clinicians provide.

b. Create a welcoming environment:

The GC continues to work with our Probation partners to make several changes in order to create a more welcoming environment for our youth.

First, the Probation Department redesigned the detention units by adding new colors/paint to the walls in order to move away from sterile colors and brighten-up the space. Additionally, Probation painted chalk-walls inside the cells where youth sleep. This was an idea GC staff advocated for and allows youth more opportunity to safely write on their walls to express themselves or decorate their cells. The clinical offices (where clinicians met with youth prior to COVID-19 restrictions) were also updated with new furniture in order to create a more comfortable space.

Changes were not limited to the physical environment, GC staff pushed for other changes to help Juvenile Hall and Camp Wilmont Sweeney feel more welcoming and supportive of youth. These changes included allowing youth to keep stress-balls in their rooms for youth to use as a coping tool or a distraction. GC staff also convinced Probation to provide youth with eye masks (upon request) in order to help them sleep better at night. GC staff also succeeded in influencing larger procedural changes to address feelings of isolation experienced by some youth. For example, youth triggered by sleeping in the confined space of their cell, can request to sleep with their door open.

While incarceration will never be a truly welcoming experience, the GC has worked closely with Probation partners to improve the physical environment and ensure youth feel supported by staff.

III. Language Capacity for this program:

During FY20/21, the GC staffed 1 clinician who spoke Cantonese, 1 clinician who spoke Spanish, and 1 clinician who spoke Vietnamese. The GC is looking to increase its capacity to serve Spanish-speaking clients.

IV. FY20/21 Challenges:

The biggest challenge this fiscal year continues to be the COVID-19 pandemic. In late fall of 2019, the GC, in collaboration with Probation, started planning to implement new programs and services to better serve youth and families. Specifically, there was a plan to increase mental health groups throughout the Juvenile Hall and initiate family therapy with interested clients. The GC also hired a re-entry clinician to better connect youth to mental health services in their home community after being released from Juvenile Hall. However, everyone's focus has continued to shift to COVID-19 begning in March 2020. Shortly thereafter, the Juvenile Hall and Camp Wilmont Sweeney implemented strict physical distancing restrictions, which prohibited any groups as well as family visitation.

One positive outcome from the pandemic is that the numbers of youth in detention decreased significantly, as polcie departments were arresting fewer youth and the Courts were less likeley to keep youth detained. While this has impacted the number of youth served by the GC, it should be seen as one of the very few positive impacts of the pandemic.

VII. FY 21/22 Projections of Clients to be Served:

Given the fact that the COVID-19 pandemic is still not under control, we anticipate fewer youth being detained for FY 21/22. We project 400 youth will be served in the next fiscal year.

VIII. FY 21/22 Program or Service Changes: None confirmed.

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.

How Much Did We Do?

I. FY 20/21

a. **Number of clients served:** 10

How Well Did We Do?

II. Language Capacity for this program: English (7) and Spanish (3)

III. FY 20/21 Challenges: The COVID 19 pandemic continued to plague our clients and families. Our team was creative and innovative. We found ways to continue to provide a high level of service to our clients, families and community partners.

Is Anyone Better Off?

IV. FY 20/21 Client Impact: Case story (All names have been changed to protect the identity of the client):

“Adam” had been referred to MST by his probation officer. Reasons for referral were related to runaway behaviors, supervision and monitoring, substance use, and challenges in Adam's academic domain.

Initially at intake and in the first few months of treatment Adam struggled with his participation, often missing meetings, and in his ability to follow his mother, Carolyn's, expectations. On the other hand, Carolyn experienced high levels of overwhelm and found it difficult to both hold Adam to expectations and follow through with parental responses (i.e. consequences). The initial struggle led to Adam's having been arrested and was at risk of being sent to placement. Through team work, interventions, and advocacy, Adam was given another chance in his home environment.

Throughout treatment, with Carolyn's support, as well as Adam's father Adrian's support, they were able to increase co-parenting strategies and create a structured environment for Adam. The consistency

eventually contributed to his management of behaviors, no longer leaving home without permission, or connecting with negative peers outside of the home. Despite this progress, a large part of treatment focused on Adam increasing his attendance and participation at school. Adam began to receive community support from a local case manager/mentor and with the coordination of all supports, Adam began to experience advance in his school attendance, increased pro-social and employment participation, while continuing to manage behaviors.

Due to the above successes, Adam was also dismissed from probation. Treatment focus following Adam's dismissal was focused on ensuring that Adam and Carolyn are connected to sustainable school and community supports. Due to these advances and sustainable supports, Adam graduated the MST program.

V. FY 20/21 Additional Information: N/A

VI. FY 21/22 Projections of Clients to be Served: 10

VII. FY 21/22 Program or Service Changes: N/A

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT
OESD # OESD 11

PROVIDER NAME: Bay Area Community Services (BACS)

PROGRAM NAME: Crisis Stabilization Unit (CSU) & Crisis Residential Treatment (CRT): Amber House

Program Description: Amber House is a dual voluntary crisis stabilization unit (CSU) and voluntary crisis residential treatment (CRT) program. Amber House CSU is a 12-bed voluntary-only CSU whose purpose is to assess individuals who are having a mental health crisis and are in need of assessment, stabilization, and brief treatment. The service is available to individuals for up to 24-hours. 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.

Target Population: Amber House will serve adults 18 years or older (18-59 years) experiencing a mental health crisis.

How Much Did We Do?

I. FY 20/21

a. **Number of clients served:**
   Amber House CRT- 271 unduplicated clients
   Amber House CSU- 995 unduplicated clients

How Well Did We Do?

II. Language Capacity for this program:
All staff primarily speak English, with some able to speak Spanish conversationally. When necessary staff utilize the interpretation line in order to meet the needs of clients whose primary language is not Spanish.

III. FY20/21 Challenges:
COVID-19 continues to pose a particular challenge to congregate living facilities around protecting residents from infections without disrupting a treatment model that relies on group care. Staff have put in thorough protocols in place to ensure the milieu as as safe and socially-distanced as possible, with symptom screening of staff and clients before entry. Additionally, previous methods of clients entering into the CSU (in particular, provider drop offs) have declined, providing an additional barrier to access. Clients have had difficulty adjusting to protocols which as them to limit their ability to leave the program to “run errands” resulting in several AWOLs.

Is Anyone Better Off?

IV. FY 19/20 Client Impact:
Amber House CRT clients discharged to lower level of care: **211 (77.8%)**
Amber House CSU clients discharged to lower level of care: **930 (93.4%)**
Amber House CRT clients discharged to higher level of care/5150: **3 (1.1%)**
Amber House CSU clients discharged to higher level of care/5150: **3 (.3%)**

Amber House CRT clients discharged as a result of AMA: **57 (21%)**
Amber House CSU clients discharged as a result of AMA: **62 (6.2%)**

V. FY 20/21 Additional Information: N/A

VI. FY 21/22 Projections of Clients to be Served:
CSU: Pre-COVID, the CSU averaged a growth rate of 25-50% each month, with a disruption from March-May where the unit rate held steady. June resumed similar growth, and projection for the upcoming year would be to double the FY19/20 units.

CRT: Census average has risen to 12/day from 8/day, though COVID has temporarily increased client AMA discharges due to the stricter regulations around leaving the site. Projection for FY 20/21 is to maintain census average of 375 units per month.

VII. FY 21/22 Program or Service Changes: N/A

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.

How Much Did We Do?

I. FY 20/21

a. **Number of clients served:**
Unique Clients Served: 532
Program Enrollments: 702

How Well Did We Do?

II. Language Capacity for this program:
Twenty-seven percent of CSU staff speak a language other than English; languages represented include Hindi, Italian, Spanish, Tagalog, Tamil, and Vietnamese. All client and caregiver documents have been translated into Spanish, Simplified Chinese, and Vietnamese. Seneca does not track data on the number of clients served in each language.

III. FY 20/21 Challenges:
Through Seneca's experience as the Alameda County CSU provider for 13 years, the agency has identified the following systemic barriers that impact program implementation and delay or prevent access to crisis stabilization:

- ***Identifying transportation alternatives*** to mitigate frequent delays experienced by youth waiting to be transported from the CSU to an off-site location other than the PHF. Identifying alternatives, including allowing CSU staff to provide transportation for a young person to the next setting when census allows, would address these delays.
- ***Creating additional placement options*** for youth who no longer meet medical necessity, are prepared to discharge from the CSU, but are not ready to return home. Many youth overstay the mandated 23-hour, 59-minute limit for stays while the County secures appropriate next placements. Often youth are sent out of the county under these circumstances. Families require more flexible and responsive service continuums that would allow for additional discharge alternatives for CSU youth, such as an STRTP co-located on the Willow Rock campus, PHPs for Medi-Cal eligible youth, ISFC homes, staffed step-down respite and emergency foster homes,

and greater integration and coordination with existing Wraparound and mobile response services.

- ***Implementing COVID-19 health and safety protocols for staff and clients.*** Seneca remained committed to operating the CSU throughout the COVID-19 crisis, instituting a range of new protocols developed by its medical services team to ensure safety for clients, staff, and families. Seneca's COVID-19 response procedures have included guidelines for responding when staff or clients are ill, maintaining social distancing indoors, hand hygiene, cleaning and disinfecting surfaces, using personal protective equipment, limiting, and screening visitors, and providing care for youth who have tested positive or appear symptomatic.

Is Anyone Better Off?

IV. FY 20/21 Client Impact:
Seneca's success in supporting the priority population has prevented further traumatization of youth, decreased stress for their families, and assisted ACBH in minimizing the use of more costly and restrictive treatment settings. On average, over 70% of youth served at the CSU do not return within the next year. As a measure of its success helping families, among youth who discharged from the outpatient program in Seneca's most recent annual data, 95% had made measurable progress toward their treatment goals and 95% were diverted from a higher level of care after discharge.

Client Story: Seneca's CSU and partnering outpatient program recently collaborated to successfully support a young client and his family. The client, a 15-year-old mixed race male, was initially referred to the outpatient program for therapy and medication management from the CSU after he experienced a manic episode. His family previously experienced homelessness and recently moved, in order to access housing in Alameda County. The client's father was employed and therefore, the family was not able to qualify for Medi-Cal, however they were not able to afford the employee-sponsored health insurance. In the outpatient program, the client received therapeutic services from a clinician by phone and Zoom and received psychiatric services in person. During treatment, the client decompensated once and was readmitted to the CSU after experiencing a manic episode. The outpatient clinician coordinated with the family on how to safely transport the client to the CSU without law enforcement involvement. The outpatient clinician greeted the client and family upon arrival and supported his admission at the CSU. After the youth was stabilized, the outpatient clinician was able to connect with social workers from client's school district, who offered school-based therapy services. The outpatient clinician continued to hold case management and psychiatry services. The client's family was connected to a Medi-Cal Liaison, as well as other critical case management resources. After the client became eligible for Medi-Cal, the clinician coordinated with ACCESS for a referral to a local mental health provider who offered psychiatry services. The youth has not been readmitted to the CSU.

V. FY 20/21 Additional Information:
As described in Question 3, youth who are prepared to discharge from the CSU but are not ready to return home, require a more flexible and responsive service continuum to meet their needs. In addition, the following are challenges to engagement in CSU services and Seneca's suggested responses:

- **Access barriers:** Too frequently, youth in crisis are transported to hospital emergency departments, which can be chaotic environments not suited to stabilizing them. Options that would mitigate these barriers include (1) permitting CSU staff to meet youth in emergency departments or the community when the CSU census allows, (2) providing

consultation for law enforcement, hospital staff, teachers, etc., and (3) offering CSU information for caregivers.

- **Transportation barriers:** Once youth are placed on a WIC 5585 hold at the hospital and approved for transfer to the CSU, transportation can be delayed due to the prioritization schedule of the ambulance provider. Options to mitigate transportation barriers include identifying an alternative to County Emergency Medical Services (EMS) ambulance transportation when youth are safe to be transported.

VI. FY 21/22 Projections of Clients to be Served:
Seneca is not the current provider of CSU services.

VII. FY 21/22 Program or Service Changes:
Seneca is not the current provider of CSU services.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD # OESD 14

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

PROGRAM NAME: Language ACCESS Asian (AHS ACCESS)

Program Description: AHS ACCESS operates a designated Intake and Referral phone line to provide AAPI language speaking/cultural screenings, evaluate medical necessity, and determine service levels for community members requesting mental health services. Community outreach, psychoeducation, and home/field visist are provided to promote mental health awareness, help seeking, and service participation amongst AAPI populations. 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: AHS ACCESS provides services to consumers living in Alameda County, with primary focus on individuals and families who identify themselves as Asian Americans and Pacific Islanders. Consumers range in age from Children/Youth (0-15), TAY (16-25), Adults (26-59) to Older Adults (60+).

How Much Did We Do?

I. FY 19/20

a. **Number of clients served:**
   - Screening/linkage – served 384 unduplicated intake clients with 1,755 service contacts.
   - Crisis stabilization outpatient treatment - served unduplicated 99 clients.
   - Outreach/psychoeducation – served 898 community members (20 ZOOM wellness/psychoeducation sessions and in-person outreach events despite of COVID limitation)

How Well Did We Do?

II. Language Capacity for this program: Services are provided in AAPI languages including but not limited to: Cantonese (739), Mandarin (45), Vietnamese (64), Khmer (14), Korean (14), Japanese (6), Mien (2), and English (479). Interpretation for other AAPI languages (7) and other languages (11).

III. FY 20/21 Challenges: In response to the COVID-19 pandemic, social instabilities, and anti-Asian hate crimes, staff primarily provided mental health screening, service linkage, treatment on telehealth and phone. In-person sessions were scheduled per clients' needs.

For clients' and staff's safety, online psychoeducation and outreach sessions were primarily conducted thru ZOOM and only few in-person outreach events were held. It significantly affected the scope of outreach activities and the number of participants. Depending on clients' technology access, openness, and preferences for Telehealth services, initially there were increases in no shows and appointment cancelations. Due to the pandemic and social unrest, extra efforts were required to effectively address clients' chronic MH struggles and adjustment issues.

AAPI cultural and social barriers continued to lead to community members' hesitation and delays for seeking "mental health" and "professional" treatment. A good number of AAPI clients suffered from S/I, H/I and severe psychiatric symptoms upon the receipt of referrals.

Bilingual and culturally responsive MH providers are inadequate and there have been challenges for the recruiting process to fill staff openings. Clinician effort/time were thinly spread over all eligible clients under ACCESS Treatment Program and other BHCS services.

Is Anyone Better Off?

IV. FY 20/21 Client Impact: Provided culturally and linguistically responsive screening, service linkage, and safety planning to 384 unduplicated intake clients with 1,755 services/contacts.

Delivered Telehealth services and essential in-person sessions to 99 unduplicated ACCESS tx clients with assessment, treatment planning, medication support, individual therapy/rehab, group rehab, collateral, and case management services.

Partnered with AAPI PCP/CBO's to conduct 20 ZOOM wellness/psychoeducation sessions and in-person outreach events to reach out 898 community members despite of COVID limitation.

Set up AHS ACCESS YouTube Channel with audience-targeting wellness materials around interconnected themes of Self-care, Relationships, and Mental Health for a trial run.

Prepared video clips and slides about Impact from Community Violence in English, Chinese, Korean, and Vietnamese to address concerns from community members.

Coordinated with AAPI-focused Prevention Programs to foster trust building/working partnership and promote 2-way referral processes.

Developing AHS ACCESS mental health awareness website to raise mental health awareness and promote help seeking in AAPI community members.

- Case study: "Mr. Z" is a 56 years old Chinese male. He was born and raised in China. In his late-40s, he began to experience depressive symptoms and thus take psychotropic medications. After relocating with his family to the US in 2019, Mr. Z faced difficulties to acculturate to the new life due to cultural issues, language barriers, and the pandemic. The challenges exacerbated his depressive symptoms, which impaired self-care and occupational functioning. Through the referral to AHS ACCESS and subsequent crisis stabilization treatment, Mr. Z was assisted to make an informed decision on the choice of psychotropic medication for symptom management. In response to therapy, he effectively processed the triggers to his symptoms and learn coping skills to address his stressors. He has well positioned himself to enjoy his immigration life, resume exercise at local sport groups, and establish social circles and support."

V. FY 20/21 Additional Information: Post-event feedback from community members and service providers were collected, and clients and caregivers involved throughout treatment to improve outreach strategy and service quality.

VI. FY 21/22 Projections of Clients to be Served:

- Outreach and Linkage - 1,313 hours of service to 1,875 community members for outreach with the target that screening/linkage will be completed for 600 unduplicated clients

- The service was significantly affected by the pandemic in the past one and half years. Due to the uncertainty and unpredictability, the same projections are currently used for the coming year.

VII. FY 21/22 Program or Service Changes:

a. **Mobile "ACCESS" Service Linkage - Expedite screening and service linkage through trust building and multiple/easy access to culturally/linguistically responsive channels**
   - After the pandemic can be well managed, resume mobile outreach to enhance cultural engagement and help clients address life stressors/prioritize mental health needs
   - After the pandemic can be well managed, resume 3rd party site screening/service referral to leverage holistic health concept and help seeking pattern at AAPI-focused health clinics, community service centers, and school/religious settings
   - Further enhance the referral process through the collaboration with County Prevention Programs and AAPI-focused service providers

b. **Audience-targeting Outreach - Promote AAPI help-seeking through audience targeting outreach/psychoeducation at AAPI-focused cultural events and standing community meetings**
   - Conduct frequent online or in-person small/medium scale community education events to address cultural barriers and promote help-seeking in local communities
   - Provide audience targeting psyschoeducation at Asian-focused CBO's and standing community meetings of all natures to reach out active community leaders and members

c. **Mental Health Awareness Campaign - Address stigma, shame, & denial to raise mental health awareness/acceptance among AAPI communities through social/traditional media**
   - Expand the established AHS ACCESS YouTube Channel and launch a MH awareness website to disseminate audience-targeting materials (recovery stories, videos, infographic materials, etc.) on social media

d. **Service Delivery Decentralization - Increase case openings and service utilization by delivering services at welcoming community spots and via Telehealth**
   - Leverage Telehealth to deliver treatment services by addressing client's preference, limited staff availability, and mobility/transportation challenges
   - Allocate clinical staff by geographic clusters to deliver mobile/field-based treatment services at welcoming community spots or clients' places

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.

How Much Did We Do?

I. FY 20/21

a. **Number of clients served:** 475

How Well Did We Do?

II. Language Capacity for this program: English and Spanish

III. FY 20/21 Challenges: In direct response to the COVID19 public health emergency, Shelter in Place orders, and Executive Orders issued by the California Governor, La Clinica's services have been adapted to maintain the safety and well-being of both patients and staff while ensuring the continued provision of essential care. La Clinica has converted as many individual appointments as possible to phone or video appointments. We have a skeleton crew of staff in the office for walk-ins and high acuity patients. If a client is high risk and needs to be seen in person, the in-office staff will be able to support them. In April 2020, La Clinica transitioned to OCHIN Epic as its electronic health record system. While this new system will allow us to capture the requested patient data necessary for county reports, it has been challenging to make the transition to this new system while at the same time adapting services provided as a result of the COVID-19 pandemic and has taken much longer. In addition, successful linkage to lower levels of care is inconsistent as 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. With the addition of new ACCESS staff, it becomes more challenging to move through procedures as not everyone provides the same answers to questions. The timeliness e-form doesn't mirror the paper form and reduces confidence in reporting. The platform to enter this data still appears not to be functional. Additionally, we have noticed that many of the required forms for

providing mental health services available on the BHCS website are not updated, nor are they allowed to be used in a fillable pdf format. As we have transitioned to primarily remote work due to COVID the need for these forms in a functional format has increased. Changing documentation standards and service delivery without a final contract make it difficult to meet deliverables. Additionally, although the system change that made ACCESS the gatekeepers the services may be beneficial in the future, the current rollout has been challenging. This involves retraining staff to master an already complicated referral process. Finally, a lack of clarity around the NACT rules makes 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. ANSAs use was validated for highlighting an 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. There has been a decrease in BH trainees, which reduces the ability of the trained workforce to hire after graduation; many students have deferred training due to the pandemic. La Clínica continues to provide uncompensated care in the form of assisting clients who don't meet the threshold criteria for ACCESS services to find the right point of entry for their needs.

Is Anyone Better Off?

IV. FY 20/21 Client Impact: 475 clients were served in FY 20-21. The impact of La Clínica's ACCESS program is that Casa del Sol provides primary linguistic and cultural services for the priority population. La Clínica has a reputation for meeting the needs of Latinos in Alameda County and clients are familiar and comfortable coming to Casa del Sol for services. The current political situation impacts the community and may increase mental health distress, giving La Clínica the opportunity to address their mental health needs as they become emergent. La Clínica is geographically close to eight elementary schools and impacts school-aged children by providing services that are easily accessible. Furthermore, La Clínica continues to make an impact by increasing coordination with primary care to identify clients who would best be served in the specialty mental health setting. Client Story: La Clínica began providing services to a 36-year-old woman married with 2 children. She is from Guatemala, where she suffered sexual abuse and was separated from her parents since she was a baby. She grew up believing that her maternal grandparents were her biological parents. When she was six years old, both grandparents passed away, she learned the truth about her parents, and she was left to fend for herself. She suffers from PTSD, and with the pandemic, her symptoms became more pronounced. She often complained of pain, and after having many medical tests done, there has been no medical explanation for her pain. She was having suicidal thoughts and there were periods of time when her pain was so severe that she was bed bound for several days and subsequently could not take care of her children. She received services under the ACCESS program from 3/8/21 to 8/23/21. In the past six months, she has reported her pain has decreased significantly and she has learned to understand how her body has been impacted by sexual abuse and other past trauma. She tried medication before but was very quick to stop, fearing that she was becoming addicted to it. She was able to talk about her concerns with the medication, and now she feels comfortable taking it as prescribed. She reports that now she can see how the medication helps her feel more relaxed. She is back at her normal level of function and able to take care of her family. She has not been bed-bound in the past 6 months, and she reports no longer get consumed by her suicidal thoughts. She has learned to cope with her suicidal thoughts and ignore them by going out for walks, using grounding exercises, and positive self-talk. She is learning to set limits with her family and take care of her emotional needs.

V. FY 20/21 Additional Information: N/A

VI. FY 21/22 Projections of Clients to be Served: 450 Unduplicated Clients

VII. FY 21/22 Program or Service Changes: La Clínica plans to continue optimizing our Electronic Health Record System and developing protocols and workflows to help increase efficiency among the clinicians. We are exploring a curriculum to see if the feasibility of starting a mood disorder group for trans and non-binary teens.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 17

PROVIDER NAME: Berkeley Place

PROGRAM NAME: Residential Treatment for Co-Occurring Disorders

Program Description: Casa de la Vida is a 13-Bed Transitional Residential Facility & Day Program for adults with moderate to severe mental illness. Founded in 1971 as an alternative to psychiatric hospitalization, Casa de la Vida has provided treatment to hundreds of clients, aiding them in learning to manage their mental health symptoms and work toward independent living. The program is centrally located near Lake Merritt in Oakland, CA in a historic Julia Morgan home. The location is close to public transit, schools, parks and ample work opportunities for clients to take advantage of.

Target Population: Adults, 18-59 years old, with moderate to severe mental illness.

How Much Did We Do?

I. FY 20/21

a. **Number of clients served: 36**

A disastrous fire took place in August 2021 and no services have been taking place since then. Clients were relocated to different facilities. It is unclear if this program will continue with this provider or be released for a public bidding process (RFP). More information will be shared in future MHSA Plans.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT
OESD #: OESD 18

PROVIDER NAME: Bonita House

PROGRAM NAME: Wellness Center, Berkeley

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 Centers provide 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.

How Much Did We Do?

I. FY 20/21

a. **Number of clients served:** During this year, our Team at BWC served 13 Unduplicated Clients, which was significantly fewer than the contracted 23 Unduplicated clients. The shortfall was almost completely due the Center remaining in Shelter in Place, away from the actual location for the majority of the fiscal year. Recruiting new clients during the pandemic proved to be most difficult. We also fell significantly short of our contracted 428 Outpatient Service hours. Although we managed to open 7 existing clients to Outpatient services during the Shelter in Place, we billed for just 36 hours. We did, however, exceed our contracted MAA billing hours of 2500. The total MAA billing hours for the year was 3,184 with 2,728 of those hours being offered as Peer Support and Wellness service hours provided in the form of group rehabilitation and individual rehabilitation.

How Well Did We Do?

II. Language Capacity for this program: We have one Spanish speaking Peer Support Specialist who orients and supports Spanish-speaking clients. Currently, none of our BWC clients are requesting services in any language other than English. Even so, if the need arises at any stage of our processes with clients, we also have access to the County Language Line.

If requested, we are able to offer our consumers access to the Alameda County Behavioral Health Language Line in our meetings with them. Many languages other than English and

Spanish can be accessed through this line and our staff and clients just need to call the language line number and enter the following numbers for these particular languages:

- Press 1 for Spanish
- Press 2 for Mandarin
- Press 3 for Cantonese
- Press 4 for Vietnamese
- Press 5 for Farsi
- Press 6 for Russian
- Press 7 for Khmer (Cambodian)
- Press 8 for Korean
- Press 9 for Arabic
- Press 0 for All Other Languages and to Connect with an Operator

III. FY 20/21 Challenges: The biggest challenge of the next year will most certainly be our careful return to on-site services and managing the dynamic health and safety issues concerning COVID-19 and its variants. General uncertainty and anxiety continue to be commonplace among the general population. Re-connecting with our current clients who have either been completely out of touch or who we have had more inconsistent communications with will be a priority. We will also begin our strategies for Outreach and Engagement in the Berkeley Community, focusing on the TAY youth consumers, in order to increase our unduplicated clients and to make our services more accessible to a greater number of Berkeley residents.

Due to the increased need for telehealth services during Shelter in Place and the overall increase in technological accessibility, managing technology issues is also a constant challenge. We now offer a hybrid format for all of our groups, and clients can opt to meet with our staff individually on Zoom or the telephone. Our group meeting rooms are fully equipped with TVs for Zoom meetings and clients are given the Zoom ID and passwords if they prefer to join the groups electronically. Even so, challenges with our telehealth options remain. For example:

- Many residents do not have access to a device to access Zoom meetings. Some do not have phones either or are not wanting to engage in telephonic services. Our staff has, at times, worked with clients to help them develop a greater comfort level and ability with platforms like Zoom.
- Some clients do not yet fully understand and/or trust some components of telehealth.
- Connectivity issues due to location and/or quality of services and quality of their devices prevents some from engaging with telehealth services.
- The COVID-19 Pandemic and racial injustice is overwhelming to many and increased isolation is a byproduct of clients' increased anxiety and/or depression.
- Getting informed consents signed, assessments and treatment plans processed virtually is no longer valid. We must now get wet signatures on these documents once again, which proves to have its own sets of challenges, especially around deadlines and clients who still do not want to visit the center in person.
- Increasing comfort levels and productivity of Zoom groups, so that clients receive the highest level of care we offer.
- Adding new clients into the Wellness Center when they have never visited the facility or met staff in person and may not want to come in person yet.
- Our leadership transition with Jackie Anderson taking the Team lead as Program Manager.

- Intervening in meaningful ways when consumers are in crisis, especially when continuity of care has been most challenging during Shelter in Place.
- Focusing on our community outreach and engagement efforts in a way that increases our opportunities to serve a wider Berkeley population, especially TAY youth.

Is Anyone Better Off?

IV. FY 20/21 Client Impact: The combined results from the client Satisfaction Surveys given to our clients at the end of each quarter are as follows:

Throughout the year, a total of **63 clients** participated in the 4 Quarterly Satisfaction Surveys. The data was collected by our student trainees over the telephone and then collated.

The four statements presented to the clients were:

1. **"I like services that I receive here**." (53 of the 63 or 82% of the client respondents said they were either very satisfied or satisfied).
2. **"My engagement at the Wellness Center plays a meaningful role in my life**." (54 of the 63 or 83% said they were either very satisfied or satisfied).
3. "**I am better able to manage my physical and mental health needs better**" (60 of the 63 or 92% said they were either very satisfied or satisfied).
4. "**I can deal more effectively with my daily problems because of services I receive at BWC**." (52 of 63 or 80% of respondents said they were very satisfied or satisfied).

Reducing Stigma:

1. In team meetings we process and educate ourselves about mental health stigma and how it might apply to each one of our clients. We look for ways to reduce those stigmas and address them at an individual and family level. Below is a link to the webinar that we asked all our employees to attend each year. The topic of the training focuses on relating more empathetically with our clients, especially vial telehealth during the COVID-19 epidemic and how to exercise self-care while we are offering empathy to many clients in distress. https://www.cibhs.org/post/empathic-communication-and-engagement-behavioral-telehealth The above training consists of a 1.5 hour webinar plus handouts our staff downloaded to review.
2. We educate ourselves around the stigmas that serious mental health issues create for people. For example, we know from research that people with serious mental health issues are no more violent than the general public.
3. We facilitate daily positive interactions in our groups that promote connection and meaning. The topic of stigma is addressed in the majority of our daily groups, and there is signage on the Wellness Center walls that is meant to identify stigma reduction efforts.
4. We utilize Peer support specialists who have lived experience with mental health and substance use issues. This year we had a volunteer peer assist us in our virtual groups and at the Center for three months at BWC.
5. As an agency, we advocate for the reduction of mental health stigmatization and promote mental health awareness through the use of the "Green Ribbon" international symbol during May, the month for raising mental health awareness and reducing mental health stigma. We use different email signatures each month to raise awareness to different mental health issues and increase compassion towards all who have mental health struggles.

6. As a staff, we use our words carefully and help each other and our clients overcome any tendencies toward stereotypes and/or implicit biases against mental illness or substance use.
7. Our recovery model is strengths-based, so we focus on the positive components of our clients' lives and affirm their resilience, their potential, and their willingness to work on recovery one step at a time.

Create a welcoming environment:

1. When in the facility, our clients are greeted by staff who sit near the front entrance. Clients are kindly directed to the location of the group they wish to attend or the staff person with whom they are meeting.
2. We have beautiful, multi-cultural art work on the walls of the facility. The paintings set the tone for a joyful, celebratory and inviting community environment.
3. Our peer support specialists, clinicians and staff focus on being positive and present in groups and individual sessions each and every day.
4. During Shelter-in-place, our staff reaches out to their clients via phone on a regular basis and invites them to Zoom groups. We host Zoom groups every day and maintain the same welcoming and caring environment virtually as we do in person.
5. We apply our cultural competency skills when working with the African American, Latino and other minority populations. We create a space for them to share openly about their racial and ethnic challenges and how they impact their overall mental health. We identify the challenges affiliated with systemic racism and identify ways that each member can feel safe, supported, and empowered to reduce systemic racism.

V. FY 20/21 Additional Information: The Wellness Center has a new Program Manager, Jackie Anderson. Jackie has extensive experience working with consumers of all ages in Alameda County. She has been closely connected to BHI Wellness Centers, especially Casa Ubuntu, for over 3 years.

A .5 PTE clinician, Kris Ramirez, began working at in August of 2021 providing Individual therapy, group therapy, clinical assessments and treatment planning. He is culturally sensitive and uses evidenced-based therapeutic interventions. Kris has extensive experience with BHI policies and procedures, with our HER, Welligent, and with quality documentation standards.

VI. FY 21/22 Projections of Clients to be Served: Because of all the COVID-19-related challenges, we expect many challenges in meeting several of the 2021/2022 contracted guidelines for:

- 2,500 hours of MAA billable services (this projection was met by our team last year and we should be able to meet it again).
- 100 Peer Support and Wellness services (we should be able to meet and surpass this contracted expectation.)
- 428 hours of Outpatient service hours: Although we have recently added Medication Services to all Medi-Cal eligible clients and some of our Outpatient service hours should result from assessments done by our Nurse Practitioner, it will continue be a great challenge to meet the contracted 428 hours of Outpatient services simply because of the very limited number of Medi-Cal eligible clients currently enrolled at BWC.

VII. FY 21/22 Program or Service Changes: Our contract now allows us a MAA billing category for "Outreach and Engagement". We will begin spending hours each week outreaching into the Berkeley community in our attempt to engage new clients at the Wellness Center.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT
OESD # OESD 18

PROVIDER NAME: Bonita House

PROGRAM NAME: Wellness Center, Casa Ubuntu

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 Centers provide 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.

How Much Did We Do?

I. FY 20/21

a. **Number of Clients Served:** The Casa Ubuntu Team registered 35 Unduplicated Clients (or 88% of the contract), which is 5 fewer than our contracted 40 unduplicated clients. The 12% shortfall was almost completely due the Wellness Center remaining in Shelter in Place, away from the actual location for the majority of the fiscal year. Recruiting new clients during the social pandemics proved to be most difficult. In spite of all the great challenges presented by the Shelter in Place resulting from the complex pandemics, we still managed to meet and surpass our contracted 428 Outpatient Service hours. Throughout the fiscal year, we provided a total of 689 Outpatient Services hours in the form of assessments, treatment planning, individual therapy, group therapy, crisis management, case management, collateral support and medication services. Incredibly, our productive and focused team also surpassed the 4500 MAA billing contracted hours with a grand total of 5,460 MAA billing hours. Of those hours, 3,774 hours were recorded as Peer Support and Wellness Service hours being provided in the form of group rehabilitation and individual rehabilitation services.

How Well Did We Do?

II. Language Capacity for this program: We have one Spanish speaking Peer Support Specialist who orients and supports Spanish-speaking clients. She runs one Spanish-speaking social skills and support group each week. The group is regularly attended by 3 to 5 Spanish-speaking clients. If language assistance is necessary to better provide our services to any clients, we provide our

consumers access to the Alameda County Behavioral Health Language Line in our meetings with them. Many languages other than English and Spanish can be accessed through this line and our staff and clients just need to call the language line number and enter the following numbers for these particular languages:

- Press 1 for Spanish
- Press 2 for Mandarin
- Press 3 for Cantonese
- Press 4 for Vietnamese
- Press 5 for Farsi
- Press 6 for Russian
- Press 7 for Khmer (Cambodian)
- Press 8 for Korean
- Press 9 for Arabic
- Press 0 for All Other Languages or to Connect with an Operator

III. FY 20/21 Challenges: The biggest challenge of the next year will most certainly be our careful return to on-site services and managing the dynamic health and safety issues concerning COVID-19 and its variants. General uncertainty and anxiety continues to be commonplace among the general population. Re-connecting with our current clients who have either been completely out of touch or who we have had more inconsistent communications with will be a priority. We will also begin our strategies for Outreach and Engagement in the East Oakland Community, focusing on Latinx and African American consumers, in order to increase our unduplicated clients and to make our services more accessible to a greater number of Oakland residents.

Due to the increased need for telehealth services during Shelter in Place and the overall increase in technological accessibility, managing technology issues is also a constant challenge. We now offer a hybrid format for all of our groups, and clients can opt to meet with our staff individually on Zoom or the telephone. Our group meeting rooms are fully equipped with TVs for Zoom meetings and clients are given the Zoom ID and passwords if they prefer to join the groups electronically. Even so, challenges with our telehealth options remain. For example:

- Many residents do not have access to a device to access Zoom meetings. Some do not have phones either or are not wanting to engage in telephonic services. Our staff has, at times, worked with clients to help them develop a greater comfort level and ability with platforms like Zoom.
- Some clients do not yet fully understand and/or trust some components of telehealth.
- Connectivity issues due to location and/or quality of services and quality of their devices prevents some from engaging with telehealth services.
- The COVID-19 Pandemic and racial injustice is overwhelming to many and increased isolation is a byproduct of clients' increased anxiety and/or depression. Casa Ubuntu will work to be a safe place for our population to process these issues.
- Getting informed consents signed, assessments and treatment plans processed virtually is no longer valid. We must now get wet signatures on these documents once again, which proves to have its own sets of challenges, especially around deadlines and clients who still do not want to visit the center in person.
- Increasing the comfort levels and productivity of Zoom groups, so that clients receive the highest level of care we offer.

- Adding new clients into the Wellness Center when they have never visited the facility or met staff in person and may not want to come in person yet.
- Our leadership transition with Jackie Anderson taking the Team Lead as Program Manager and for Jackie to establish her unique vision and mission for Casa Ubuntu Wellness Center.
- Intervening in meaningful ways when consumers are in crisis, especially when continuity of care has been most challenging during Shelter in Place.
- Focusing on our community outreach and engagement efforts in a way that increases our opportunities to serve a wider Oakland population, especially among Latinx and African American families. Since we currently do not have an IPS staff member, we will need to hire that staff member as soon as possible, and increase our efforts at assisting clients with accomplishing their employment and education dreams and desires.

Is Anyone Better Off?

IV. FY 20/21 Client Impact: The combined results from the client Satisfaction Surveys given to our clients at the end of each quarter are as follows:

Throughout the year, a total of **61 Casa Ubuntu clients** participated in the 4 Quarterly Satisfaction Surveys. The data was collected by our student trainees over the telephone and then collated.

The four statements presented to the clients were:

1. **"I like services that I receive here**." (49 of the 61 or 80% of the client respondents said they were either very satisfied or satisfied).
2. **"My engagement at the Wellness Center plays a meaningful role in my life**." (49 of the 61 or 80% said they were either very satisfied or satisfied).
3. "**I am better able to manage my physical and mental health needs because of my participation at the Wellness Center**" (51 of the 61 or 84% said they were either very satisfied or satisfied).
4. "**I can deal more effectively with my daily problems because of services I receive at Casa Ubuntu**." (50 of 61 or 82% of respondents said they were very satisfied or satisfied).

Reducing Stigma:

1. In team meetings, we process together common mental health myths and resulting stigmas, and we educate ourselves about mental health stigma and how that dynamic might apply to each one of our clients. We look for ways to reduce those stigmas and address each recognizable one at an individual and family level. Below is a link to the webinar that we ask all our staff to attend once a year. The topic of the training focuses on relating more empathetically with our clients, especially vial telehealth during the COVID-19 epidemic and how to exercise self-care while we are offering empathy to many clients in distress.
   https://www.cibhs.org/post/empathic-communication-and-engagement-behavioral-telehealth
2. The above training consists of a 1.5 hour webinar including handouts, which our staff downloads to review. We have also incorporated this training into our agency Relias training modules.

3. Additionally, we educate ourselves around the specific stigmas that serious mental health issues create for people. For example, we know from research that people with serious mental health issues are no more violent than the general public.
4. We facilitate daily positive interactions in our groups that promote connection and meaning. The topic of stigma is addressed in the majority of our daily groups, and there is signage on the Wellness Center walls that is meant to identify stigma reduction efforts.
5. We utilize Peer support specialists who have lived experience with mental health and substance use issues. This year we had a volunteer peer assist us in our virtual groups and at the Wellness Center for three months at Casa Ubuntu.
6. As an agency, we advocate for the reduction of mental health stigmatization and promote mental health awareness through the use of the "Green Ribbon" international symbol during May, the month for raising mental health awareness and reducing mental health stigma. We use different email signatures each month to raise awareness to different mental health issues and increase compassion towards all who have mental health struggles.
7. As a staff, we use our words carefully and help each other and our clients overcome any tendencies toward stereotypes and/or implicit biases against mental illness or substance use.
8. Our recovery model is strengths-based, so we focus on the positive components of our clients' lives and affirm their resilience, their potential, and their willingness to work on recovery one step at a time.

Create a Welcoming Environment:

1. When our clients and staff are in the facility, our clients are greeted by staff who sit near the front entrance. Clients are kindly directed to the location of the group they wish to attend or the staff person with whom they are meeting.
2. We have beautiful, multi-cultural art work on the walls of the facility. The paintings set the tone for a joyful, celebratory and inviting community environment. The staff and the environment are cheerful, positive and encouraging.
3. Our peer support specialists, clinicians and staff focus on being positive and present in groups and individual sessions each and every day.
4. During Shelter-in-Place, our staff reaches out to their clients via phone on a regular basis and invites them into our virtual Zoom groups. We host Zoom groups every day and maintain the same welcoming and caring environment virtually as we do in person. Clients are given all the necessary information and training (if need be and desired) to join with us at all of our groups.
5. We apply our cultural competency skills when working with the African American, Latinx and other minority populations. We create a space for them to share openly about their racial and ethnic challenges and how they impact their overall mental health. We identify the challenges affiliated with systemic racism and identify ways that each member can feel safe, supported, and empowered to reduce systemic racism.

V. FY 20/21 Additional Information: The Wellness Center has a new Program Manager, Jackie Anderson. Jackie has extensive experience working with consumers of all ages in Alameda County. She has been closely connected to BHI Wellness Centers, especially Casa Ubuntu, for over 3 years.

A .5 PTE clinician, Kris Ramirez, began working at Casa Ubuntu as a team leader since August of 2020, providing Individual therapy, group therapy, clinical assessments and treatment planning. He is culturally sensitive and uses evidenced-based therapeutic interventions. Kris has extensive experience with BHI policies and procedures, with our EHR, Welligent, and with quality documentation standards

VI. FY 21/22 Projections of Clients to be Served: In spite of all the COVID-19 related challenges and only being in the facility with a hybrid model, we expect to meet all of the following 2021/2022 contracted guidelines of:

- 4,500 hours of MAA billable services
- Peer Support and Wellness services to 100 clients
- 1,220 hours of Outpatient service to 40 unduplicated clients

VII. FY 21/22 Program or Service Changes: Our contract now allows us a MAA billing category for "Outreach and Engagement". We will begin spending hours each week outreaching into the Oakland community in our attempt to engage new clients at the Casa Ubuntu Wellness Center.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT
OESD # OESD 18

PROVIDER NAME: BACS

PROGRAM NAME: Wellness Center, HEDCO House

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).

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.

How Much Did We Do?

I. FY 20/21

a. **Number of clients served:** 899

How Well Did We Do?

II. Language Capacity for this program: Hedco is able to assist people who speak English and Spanish, and utilizes the language line for other languages as needed

III. FY 20/21 Challenges: This fiscal year has been challenging in many forms, especially since the wellness center provides a safe, holistic space for people to come. Shelter in place was very hard for many of the people who contribute to the center's success, as they could not come in and support each other as they had in the past. Telephone check ins were conducted and some participants came regularly to check their mail and to utilize resources like charging station, lunches and snacks. Other challenges arose as participants were unable to see their friends, unable to come in to the center, and unable to access resources as easily as they had in the past. Since April, when the center moved towards fully opening, staff has become familiar with the many participants that frequent Hedco, and have provided housing support and other means of support to assist the most vulnerable with their needs.

Is Anyone Better Off?

IV. FY 20/21 Client Impact: Hedco has had multiple successes with participants this last fiscal year. One particular gentleman who had a history of homelessness and was living in someone's garage was assisted with finding a suitable place to live, and thus was moved out of the garage and into his own room in a shared housing complex. He has stated that his mental health has improved exponentially since finding the room and he recently was able to find full-time employment.

Another individual who has a history of homelessness and drug use has successfully transitioned into a program that provides room and board as well as drug and alcohol counselling. He recently came in to the center and explained to staff how he was doing better with his life choices and he had been clean and sober for over 2 months.

M. is a woman who has utilized the services at Hedco for many years. She has been homeless and admittedly struggled with addiction for over 20 years. M. has been meeting with staff regularly and has since was able to get her SSI, has been in sobriety for 4 months, and recently was placed in the navigation center to assist with more a permanent housing situation.

V. FY 20/21 Additional Information: The Fiscal year 20/21 we served 4,616 individuals here at Hedco Wellness Center. The center provides breakfast and lunch, Monday through Friday. During the pandemic, Hedco had an average of 430 individuals here every month for daily support. During the shelter in place Hedco's participants still had access to a charging table for their phones and other electronic equipment, snacks, hygiene kits, counselling, and hot lunches. Hedco was fundamental in providing the community members with the neccesities that they needed during the pandemic. Since the doors opened back up fully, Hedco still maintains a "whatever it takes" approach to meeting the participants where they are, and helping them to find resources for their basic needs.

VI. FY 21/22 Projections of Clients to be Served: Hedco is being well utilized since opening the doors fully. The daily average of clients through the door is 40, and with more services being offered like housing and employment resources, the center predicts to have an average of 60 participants or more in any given day.

VII. FY 21/22 Program or Service Changes: Most services were via phone, telehealth and in-person maintaining social distance.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT
OESD # OESD 18

PROVIDER NAME: BACS

PROGRAM NAME: Wellness Center, South County

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).

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.

How Much Did We Do?

I. FY 20/21

a. **Number of clients served:** 1,748

How Well Did We Do?

II. Language Capacity for this program: At the Fremont Wellness Center we provide services in Spanish and English, and we utilize the Language Line to support individuals in other languages.

III. FY 20/21 Challenges: This past year, experienced a dramatic shift from survival mode to revival mode. During shelter-in-place we were forced to limit in-person contact to outdoor support for our members. With the limited contact we were still able to offer food to individuals and families in need, but as the restrictions lifted and we were able to open up we switched our gears to focus more on reengaging members who had stopped utilizing the center which was a challenge as most of our members dispersed out into the community with no way for us to reach out to them. A particular challenge was keeping members aligned with the everchanging COVID-19 guidelines. Many participants looked to the Fremont Wellness Center for guidance relating to mask mandates, information about vaccines and current news related to Covid-19. Staff provided education and current information relating to Covid-19 and supported individuals in making decisions regarding vaccinations.

Is Anyone Better Off?

IV. FY 20/21 Client Impact: In the months of April- June 2021 the average attendance per day at the Fremont Wellness Center was 41 individuals. Out of the 41 in attendance, 4 of them were between the ages of 18-26, 28 of them were from the ages of 26-59 and 8 of them were 60 years of age and older. Of the average 41 individuals attending the Wellness Center on a daily basis during this quarter, 100% of them improved their daily functioning by receiving person-centered services at the Fremont Wellness Center. These services include: showers, hygiene kits, clean clothing, shoes, healthy meals, water, beverages, mail services, to-go prepared meals, pantry staples, fresh groceries, and counseling services.

Furthermore, the Fremont Wellness Center serves as a cooling center during extreme heat preventing unhoused individuals to become negatively impacted by extreme weather. All unhoused individuals demonstrated motivation to move indoors by inquiring about housing availability and engaging in counseling and connection to services with staff.

V. FY 20/21 Additional Information: In the months of April-June, the Fremont Wellness Center provided 150 meals a day, a total of 9,000. The total of meals, beverages, grocery deliveries, and snacks served to individuals and their families during this quarter is 14, 000. The Wellness Center had 14-16 participants who used the shower facility daily, a total of 840. Following the CDC and the County guidelines about COVID-19, we hosted a welcome back kick-off party as we re-opened full in-person services. The services provided in The Wellness Center included: computer access, landline phone to follow up with their primary care providers, carry out meals, a charging station where participants charge their electronic devices, beverages, snacks, shower services, linkage to resources, food pantry, mail services for unhoused participants, Food Stamp and other government benefits application assistance, governmental ID voucher, Bus/Bart passes, clothing and shoes, referral and linkage to housing resources. Services provided related to COVID-19 included: COVID-19 testing referrals, COVID-19 vaccination on site through Health Care for the Homeless, PPE (mask and hand sanitizer), hand clean washing station, educate participants about COVID-19, and passing and updating information related to COVID-19.

VI. FY 21/22 Projections of Clients to be Served: We project that the number of clients served this year will increase due to individuals looking to re-connect with mental health services. We believe it will increase to 1,800.

VII. FY 21/22 Program or Service Changes: The changes that we expect this year really depend on what the community we primarily serve needs but also the community at large.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT
OESD # OESD 18

PROVIDER NAME: BACS

PROGRAM NAME: Wellness Center, Townhouse

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).

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.

How Much Did We Do?

I. FY 20/21

a. **Number of clients served:** 1198

How Well Did We Do?

II. Language Capacity for this program: Our agency uses language assistance services that are free of charge for our clients to access. They can translate in any language, so we can best assist our clients. BACS employs personnel who work out of the Wellness Center who can speak Spanish, Cantonese and Mandarin fluently with partners who speak those languages.

III. FY 20/21 Challenges: Prior to our reopening our biggest challenge was reengaging former Towne House partners while ensuring we are extending our reach to capture and welcome new partners. One other barrier to our reopening was the ongoing changes to Covid-19 protocol and managing the confusion around this not just with staff, but our partners.

Is Anyone Better Off?

IV. FY 20/21 Client Impact: The Wellness Center provides a place where partners and their family members can come and receive housing/therapeutic services, case management services and local resources. Also, per our alameda contract under peer support and wellness services: Towne House Wellness Center tracks the engagement and peer support.

We track all interactions/engagements to capture in monthly MAA-billable activities. We also use inhouse census tracking to capture demographic information that will be utilized for reporting purposes on a quarterly and annual basis.

Partners who demonstrate and meet level need for mental health support and treatment are assisted with brokerage and linkage to ACCESS. Additionally, partners who demonstrate the need for a dual diagnosis program are supported with linkage to CenterPoint to address their AOD rehabilitation needs.

A former partner who utilized Towne House Wellness Center prior to pandemic closures returned during the reopening. Often times when he would come in, he would sit and just rest on the couch, minimally engaging in the milieu. With some encouragement staff was able to engage him in conversation and overtime in activities. He began attending our groups and actively participated. As the weeks went by, the partner slowly opened up to staff and would share his observations of what the wellness center used to be like and how he feels it is now. He went on to share that his opinion was that the center has improved greatly and that he appreciates all the mindfulness and wellness activities that were being offered. The partner shared that he has mental health struggles and mostly keeps to himself. During our reopening, staff asked if the partner would like to participate with the celebration by helping us throughout the event. The partner enthusiastically accepted and spent the day supporting the staff with greeting people, pointing folks to activities and explaining what we had to offer for the day. At one point the partner was so engaged that he led our end of day raffle activity. Over the course of his return to Towne House and the reopening day, the partner had immersed himself in all that Towne House had to offer him; food, activities, socialization time, and a sense of community. The partner came regularly and was no longer just sitting on the couch. Instead, the partner actively participated in groups, offered to help staff when needed, and began engaging in meaningful interactions with peers. One standout moment staff observed was the day the partner demonstrated acknowledgment and insight of his privilege. On this day the partner came with a bag full of men's underwear and socks, letting staff know that he was donating these items to the center for his peers who may need them. The partner went on to share, "I have more than I need and I have a family who provides. I'm here every day and I see that my peers need things, so if I have it, I'd like them to have it. Also, I heard we were starting a clothes pantry here so we could put this in there". That one act of generosity demonstrated so much more than a donation. What was interesting and amazing from a human behavior perspective was the partner sharing his identification of the intersectionality of his socioeconomic status (privilege) in comparison to his peers and living as someone struggling with mental health (disability) just as his peers do. This partner is someone who shared that he was isolative and hardly interacted with people, but was now accessing the part of his mental rationale that connected him having a surplus of items he can share (insight) and wanting to share with his community in need (compassion). Presently, our partner has now been elevated to the status of Peer Lead in the center. Staff noticed the need to include more peer based and led activities and when the moment came to identify a good candidate from our pool of partners, we unanimously voted on this partner. In this capacity, the partner supports the wellness center by assisting his peers in the milieu with meals and food support in the wellness center kitchen. The partner created his own schedule and dedicates a fulltime week Mon. – Fri. to supporting the center and his peers. The partner checks in with wellness staff regularly to gain support when needed and to gain support with employment development. The partner shared that his personal goal is to gain tangible work skills through the wellness center that may equate to possible employability in his future. The partner comes every day preparing snacks and making coffee for his peer and has integrated himself well into his peer community and with staff. Most recently the partner shared with staff that his family is really happy with how involved he is at the Towne House. The partner shared that he feels a sense of ownership and purpose in his role at the Towne House both personally and professionally.

V. FY 20/21 Additional Information: Having a safe place where people in our community can go where they can access resources to services, food, daily shelter, social interaction, and human kindness has proven to be a need. Our increasing weekly census reflects that since our doors have reopened, each week has seen more partners from the community coming in to utilize our center.

VI. FY 21/22 Projections of Clients to be Served: The reopening of our center has been picking up momentum, however, what makes predicting numbers is the pandemic. What we realize is though we have doors open and people are coming, there is an uncertainty on whether that will be a constant as services may once again become impacted by this virus. What we have been noticing in our weekly census is that on average we are seeing 160 partners per week, but that again can change depending on the course of this pandemic.

VII. FY 21/22 Program or Service Changes: The Towne House team is working to link with organizations/ agencies who provide shower services to support partners with keeping clean and working on ADL's. We are actively looking to link with and create partnerships with these providers and we are close to identifying an agency who can come to us and provide this support to our partners on a weekly basis.

Towne House is currently working to develop clothes pantry to offer clothing to our partners who demonstrate the need.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT
OESD # OESD 18

PROVIDER NAME: BACS

PROGRAM NAME: Wellness Center, Valley

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).

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.

How Much Did We Do?

I. FY 20/21

a. **Number of clients served:** 109

How Well Did We Do?

II. Language Capacity for this program: All Valley staff are English speaking, we have staff that speaks Farsi/Dari and we have utilized the language line when there is a language barrier, which occasionally happens.

III. FY 20/21 Challenges: The biggest challenge this year was being able to connect with and provide meaningful services during a pandemic and maintain all safety protocol. Ensuring that partners were fully informed of all safety precautions and following all protocol was very challenging as there was a lot of misinformation floating around and information constantly changing. The staff at Valley tried their best to be up-to-date with all the information and tried to ensure all partners were well informed and well equipped with basic need items and PPE.

Is Anyone Better Off?

IV. FY 20/21 Client Impact: During the pandemic where most social service agencies were closed, Valley, like many other BACS' programs was open to serve clients. Our means of providing support was a little different this year, but staff was there to support and meet the clients where they were at. Partners

expressed grattude for providing a space that they could turn to when everywhere else was closed. Many of our partners had no natural supports around them and had no other means of social interaction besides Valley. The weekly calls and check-in's allowed staff to assess the needs and safety of our partners; some of these calls led to safety planning and prevention of hospitlizations.

M.C is a partner that suffers from severe depression and anxiety and had a history of hospitalzations. She was isolated for years until she found Valley Wellness. Valley become part of her daily routine, she would take 2 buses to come to the center, have lunch and engage with staff and peers. The Shelter in Place was an extrmely challenging time for her; staff understanding the risk and safety concerns of not having her come to the center scheduled daily check-in's via phone and on Teams to ensure she was taking care of herself, had enough supplies and PPE. Staff would also drop by her place 1/week to provide her with supplies and in-person connection. M.C has repeatedly said that if it wasn't for Valley should would have been at John George Hospital and that she was very grateful for the support.

V. FY 20/21 Additional Information: Valley Wellness Center plays an important role in the Tri-Valley, as the region is fairly isolated from services that are provided in the cities of Alameda County. Many of the clients that VWC serves are those who are from this region and do not want to go to Oakland or Hayward, they want to remain here. That being said, housing and other immediate services are very limited. VWC helps clients cope with the absence, or slowness of such services, by meeting their daily needs. Staff hand out hygiene kits, snacks, sometimes clothing like socks and in the winter jackets and gloves. We empathize with our participants and do what we can to help someone.

VI. FY 21/22 Projections of Clients to be Served: VWC projects that we will have at least the same amount of people through the door, but with Covid-19 and partners being conditioned to stay home it might be a challenge to get some people back at the center. The virus has taken a toll on the mental health and wellness of the citizens of this country, so an increase in mental health services will be needed. Anticipated 200+ unduplicated to be served in 20/21.

VII. FY 21/22 Program or Service Changes: Since COVID restrictions have been lifted, Valley is fully open and serving clients in-person. If no other changes take place we hope to continue providing in-person support and increase outreach efforts.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT
OESD # OESD 18

PROVIDER NAME: PEERS

PROGRAM NAME: Consultant Support, POCC Support & Peer Support (WRAP Programming)

Program Description: WRAP is an evidence-based practice through which peers share stories, ideas and insights and come up with a personal plan for getting well and staying well. PEERS offered WRAP orientations virtually once per month, and facilitated six ongoing WRAP groups, one of which was in Spanish.

Target Population: These services predominatly serve 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.). *Transition Age Youth (TAY) ages 16-24 are also served or priovided stipeneded leadership opportunitiies

How Much Did We Do?

I. FY 20/21

a. **Number of clients served:** 378

How Well Did We Do?

II. Language Capacity for this program: English, Spanish

III. FY 20/21 Challenges: The primary challenge this year was that in-person programming was not safe, due to COVID-19. Our efforts to partner with another organization for a remote TAY WRAP group were unsuccessful. Despite our efforts to work with more than five potential partners, we were not able to set up a remote TAY WRAP group by the end of the fiscal year. We are committed to building at least one solid partnership for TAY WRAP early in FY 2021-22.

Is Anyone Better Off?

IV. FY 20/21 Client Impact: The WRAP group in Spanish that we run in collaboration with La Familia Counseling Service has been a crucial source of connection for participants, who primarily are Latinx elders and have been heavily isolated since March 2020. One participant, an elder Latina, returned to the group during FY 20-21 after not coming regularly for several years. She expressed to one WRAP facilitator, with whom she has had a long-standing connection through the group, that the group has been one of the key pillars of her wellness because she knows that whenever she needs it, she will find a safe space, encouragement, and hope through peer support. Being able to access that support during the pandemic has been important for her mental health.

Of participants surveyed across all groups, 95% agreed or strongly agreed that the group they attended was useful to them; 94% that the group helped them feel that mental health challenges are normal and common; and 89% that the group helped them learn more about their mental health and wellness.

V. FY 20/21 Additional Information: To engage participants in WRAP and maintain participation in our groups, we had to experiment with new methods of outreach in the remote environment. Persistence

and experimentation yielded the results we sought, and we were able to build and sustain participation even given the issues around the digital divide that all programs face.

95% of participants agreed or strongly agreed that the group they attended was useful to them; 94% that the group helped them feel that mental health challenges are normal and common; and 89% that the group helped them learn more about their mental health and wellness.

VI. FY 21/22 Projections of Clients to be Served: 350

VII. FY 21/22 Program or Service Changes: PEERS will continue to offer WRAP orientations virtually once per month, and to facilitate six ongoing WRAP groups, two of which will be in Spanish.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT
OESD # OESD 19

PROVIDER NAME: Hiawatha Harris, M.D., Inc./Pathways to Wellness Medication Clinic

PROGRAM NAME: Pathways to Wellness (Medication Support Services)

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, and 6. Outreach efforts made in the field by a psychiatric nurse specifically in North County to meet that client demand

Target Population: Pathways to Wellness provides services to children (5-9 years old), adolescents (10-17 years old), and adults (18-59 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.

How Much Did We Do?

I. FY 20/21

a. **Number of clients served:** 2,708

How Well Did We Do?

II. Language Capacity for this program: We reduce MH stigma by hiring staff that are diverse, are culturally competent, and who understand, embody, and implement the standards of the MHSA model of care. This includes a commitment to reduce mental health stigma through utilizing client centered assessment, strength-based services, trauma informed care, and culturally competent training within the psychiatric and social-behavioral frameworks of mental health care.

III. FY 20/21 Challenges: We have been still providing services to our clients despite being in a national pandemic for over a year and a half. Our struggles have been with retention of providers due to their stress related concerns of working via telemedicine. The ongoing pandemic has increased isolation for clients and reduced the ability to connect to much needed resources.

Is Anyone Better Off?

IV. FY 20/21 Client Impact: During the year of 2020-2021, we impacted clients through serving them throughout the entire year utilizing telemedicine services. We continue to provide services despite the pandemic and have reduced rates of no shows and timeliness with appointments due to our telemedicine outreach. We have been able to accommodate all referrals with appointments within 7 days or under who are discharged from the hospital. This year our referral to admission time has improved due to hiring an Intake physician.

Increasing Health Conditions: We have been providing health interventions that reduce the impacts of COVID19 pandemic. We provided a health fair giving vaccinations to the clients and introducing them to their providers. In addition, we had clients increase their access to vaccinations which contributed to less exposure to COVID19. We increased our outreach to outside providers coordinating medical records and health objectives. We were able get 82% of our total clients connected with a Primary Care Physician. This was an improvement from the previous fiscal year. We were able to reduce the number of psychiatric hospitalizations of clients enrolled into Pathways by 30%+ this fiscal year compared to last year. This also meant that in order to reduce hospitalizations, Pathways offered more time and appointments to clients who were open to us this fiscal year. As a direct result of COVID a number of our clients needed more assistance in finding housing, jobs and other types of treatment. i.e. AOD services, etc. We also noticed a trend throughout this fiscal year of new client referrals presenting with a much higher level of acuity than in the past and most importantly needing additional resources outside of Pathways "medication support" services this fiscal year.

Reduce mental health stigma: We reduce mental health stigma by hiring staff that are diverse, are culturally competent, and who understand, embody, and implement the standards of the MHSA model of care. This includes a commitment to reduce mental health stigma through utilizing client centered assessment, strength-based services, trauma informed care, and culturally competent training within the psychiatric and social-behavioral frameworks of mental health care. We were able to improve our engagement services and show rates with our African American mentally ill clients. Over 70% of our clients are people of color and this year we served over 900 African American mentally ill clients. In addition, we are finding that more clients are requesting to be seen in our clinics due to the diverse staffing levels that Pathways continues to offer each year.

Client Centered Assessment: is an ongoing service activity of gathering and analyzing collaborative information with the client. Together we help the client build community resources and tertiary interventions to reduce harm an increase resiliency. Assessment includes, but is not limited to, one or more of the following: medical necessity, mental status determination, analysis of the client's clinical history; gathering relevant cultural issues, analysis of behaviors and interpersonal skills, a review of family dynamics and diagnosis. Assessments view the client from a comprehensive social cultural lens keeping in mind the daily stressors a client may go through specifically if they are from an underserved population. Utilizing a social justice perspective of how race, class, culture, sexual orientation, and gender identity impact a person's expression of symptom and we ensure that clients are diagnosed correctly. We account for the impact of how these qualifiers can drive diagnosis including African Americans being disproportionally diagnosed with schizophrenia and other psychotic disorders when instead they have a trauma disorder. We at Pathways to Wellness differentiate between cultural and functional paranoia in symptoms and encourage an accurate portrayal of client symptoms. By focusing on what the client is experiencing in the world as who they are, we can differentiate between what is

Trauma Informed Care: In alignment with the MHSA standards of treatment and care, Pathways to Wellness utilizes trauma informed care which includes program participant empowerment and choice, collaboration among service providers and systems, ensuring physical and emotional safety and trustworthiness for program participants. When a client has been exposed to abuse, neglect, discrimination, violence, and adverse experiences, they are at risk for health-related issues especially mental health complications. By acknowledging the client's life experiences, our providers improve patient engagement, treatment adherence, medication management, and potential mental health recovery.

Strength Based Model: Our Strengths Based Model uses a set of values and philosophy of practice that encourages clients to become experts in their own mental health recovery. This includes the potential to recover from adversity through mutually identified strengths, community resources and other opportunities. Program staff and providers assist clients in assessing their strengths, establishing meaningful goals, and developing a recovery plan. Pathways to Wellness encourages program clients to recover from mental health and reclaim their lives. We focus on client strengths rather than deficits to increase self-worth and enhance the potential for mental health recovery. We encourage the participant to be an expert of their own recovery. We encourage a collective treatment approach as primary and essential while working together as copartners.

We provide ongoing culturally responsive trainings for our staff and our communities at large to better engage and serve African American consumers which represents the largest client population at Pathways. These trainings are provided to both our staff and to our community. We train providers about the complexity of trauma within the African American population and how to best serve their psychiatric and biopsychosocial needs.

Create a welcoming environment: Our welcoming environment includes providing a client driven comprehensive community-based specialty mental health services. We support adults ages 18 years and older living with a serious mental illness, at risk of or experiencing homelessness, who may also have a co-occurring substance use disorder, and/or who may be engaged in the criminal justice system. Our services implement a phased approach with the provision of intensive services during the early phase of treatment. When applicable, we see clients frequently within their first 90 days in order to ensure they are out of crisis and stabilized on their medications, and have community resources. Our waiting rooms are set up so that clients may experience a welcome home environment with decaf coffee and water provided daily, special food luncheons once a month, clothing and food drives, as well as our yearly mental health picnic for clients, and our consumer council that encourages participation from consumers. Clients are provided with art supplies while they wait for their appointments and are met with our engagement team to ensure they have their needs met and are welcomed.

V. FY 20/21 Additional Information: We were able to improve the amount of services provided by creating organization related to telemedicine. As a result, we were able to encourage on time services with a much lower no-show rate. We also transitioned fully onto an electronic medical records system which reduces wait times when sharing a client's chart between providers and staff. 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.

VII. FY 21/22 Program or Service Changes: Currently, we are providing ongoing telemedicine services. We have increased our data collection identifying high utilizers of services. We have been intervening at faster rates to reduce mental health crisis including a sharp decrease in hospitalizations and with zero incarcerations for the year.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT
OESD # OESD 19

PROVIDER NAME: Telecare

PROGRAM NAME: STEPS program

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.

How Much Did We Do?

I. FY 20/21

a. **Number of clients served:** 60

How Well Did We Do?

II. Language Capacity for this program: STEPS staff utilize a certified language line to provide services in languages other than English. They can, at times, access language capacity of other Telecare program staff in case of emergency. These languages include Spanish, Khmer, Urdu, Taiwanese, Cantonese.

III. FY 20/21 Challenges: The most significant issue during this FY was the COVID virus and response coordination. The STEPS program had partners living in congregate homes both licensed and unlicensed, in homeless shelters, and in independent housing. We supported our housing partner's with education for staff and residents in the congregate settings about hand washing and COVID 19 health and safety info. We were able to quickly purchase and distribute items like pre-paid cell phones, hygiene supplies, games/activities, food, and emergency items to provide to individuals in an effort to support them sheltering in place. We were also able to support some of the homes in accessing PPE – face-shields, gloves, face masks. We were able to continue to see partners in the community when some level 1 teams were only able to provide TeleHealth services. The overall response to the COVID crisis from the county, our community partners and Telecare were massive and protected our partners from the spread of the virus.

For the STEPS program, another significant challenge in the community is finding and securing affordable, independent housing.

Is Anyone Better Off?

IV. FY 20/21 Client Impact: STEPS partners had a decrease in hospital days and homeless days over the last year. Partners increased participation in primary care treatment and participation with their service

- Personal story: When "Ann" was referred to the STEPS team, she had disengaged from treatment and stopped taking medications. She had recently been sexually assaulted which resulted in a pregnancy. Her medical condition of diabetes was unmanaged, and she ended up in the ER on 2 occasions. Ann was also experiencing near daily suicidal thoughts and had made 1 attempt on her life 2 months earlier. Ann was willing to accept support and was quickly able to develop a supportive therapeutic relationship with her STEPS case manager. STEPS was able to support Ann with coordinating her primary and pre/post-natal care, as well as assist with care coordination for her new baby. STEPS supported Ann in maintaining her housing with emergency funds for back rent owed on her apartment, needed furniture/bedding for her family, and healthy low-cost food to improve her diabetes management. STEPS supported Ann in re-connecting to level 1 treatment team and restarting her medications to improve her mood and reduce her SI. STEPS supported Ann in connecting with a therapist for help dealing with past trauma and current stressors.

V. FY 20/21 Additional Information: Over the last year, STEPS has increased admission for community referrals and increased assessments/care coordination with Alameda County ACCESS to ensure that partners are receiving the best matched care to support their needs and reduce risk in the community.

VI. FY 21/22 Projections of Clients to be Served: STEPS average census over the last year has been around 25, falling a bit short of our 28-person census expectation. When STEPS has graduations, we are able to reach out to Alameda County service teams, sub-acute hospitals and crisis residential placements to provide needed support. We will continue to work diligently around maintaining our census at 28.

VII. FY 21/22 Program or Service Changes: There are no expected service or program changes in the next fiscal year.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT
OESD # OESD 20

PROVIDER NAME: Bonita House

PROGRAM NAME: Service Team/Individual Placement Services (IPS)

Program Description: Supported Independent Living Program is an interdisciplinary outpatient mental health program providing case management and rehab services to clients. The IPS component of the program sees work and preparing to work through acquiring job skills as a mental health intervention. The Employment Specialist collaborates with the case management, nursing and clinical staff to support clients in achieving their mental health and employment goals.

Target Population: Adults in Alameda County (18+) with SMI as well as individuals with co-occurring disorders

How Much Did We Do?

I. FY 20/21

a. **Number of clients served:** 3

How Well Did We Do?

II. Language Capacity for this program: English with access to interpretation services for all county threshold languages

III. FY 20/21 Challenges: Staff turnover lead to gaps in service provided to clients. Clients need consistency in treatment in order to be successful, new staff having to build rapport with clients translates to frustrated clients and decreased engagement. In addition to staff turnover providing job development earlier on in the pandemic was challenging especially as unemployment was high there were clients that were not interested in participating due to feeling like being in the community might be unsafe or the perception that employers weren't hiring. With the increase of vaccinations and decrease in cases this impact seems to be waning.

Is Anyone Better Off?

IV. FY 20/21 Client Impact: Clients interests in employment has improved. Clients that are motivated and focused on completing their goals remaining engaged and reach their desired outcomes of improving functionality in multiple facets of life.

V. FY 20/21 Additional Information: Due to staff turnover, the IPS staff lead is serving as support to 3 Bonita House programs untill fully staffed.

VI. FY 21/22 Projections of Clients to be Served: Staff shared between programs in the future; as we hire to fill positions we will consider using IPS services in other programs and sharing the staff to support program needs. During the first quarter of FY21/22 we have served 8 clients and the employment specialist continues to receive referrals and inquiries of interested clients.

VII. FY 21/22 Program or Service Changes: The previous employment specialist is no longer with the agency. We have backfilled the position with IPS employment specialist from other areas of the agency and continue to recruit to provide additional support.

PROVIDER NAME: Center for Independent Living (CIL)

PROGRAM NAME: Individual Placement Services (IPS)

Program Description: Work incentives benefits counseling. By working collaboratively with the ACBH Vocational Program, we offer training and technical support resources, training events, strategize participant engagement approaches, and assure service availability to all programs. There is no service charge to clients who receive these services.

Target Population: Adult participants in ACBH Wellness Centers' IPS programs

How Much Did We Do?

I. FY 20/21

a. **Number of clients served:** 76

How Well Did We Do?

II. Language Capacity for this program: Although all services were provided in English, various languages are supported via translation support.

III. FY 20/21 Challenges: The ongoing pandemic has impacted the numbers of IPS program participants actively seeking employment and the varying degrees of social-distancing protocols throughout the year have also impacted the numbers of in-person service provision. While I have successfully adopted Tele-Health service provision via video and telephone conferencing, it can occasionally be difficult to coordinate these services with certain participants who are unhoused or marginally housed and may or may not have access to video conferencing. There has also been significant turnover of Employment Specialist and Case Management Staff at the various wellness centers, with some positions remaining vacant for extended periods of time.

Is Anyone Better Off?

IV. FY 20/21 Client Impact: While significant numbers of participants are engaged in employment, *all* participants who have received Work Incentives Benefits Counseling have learned important information about how Social Security Disability benefits and Medi-Cal programs function and learned the rules and regulations surrounding earned income, asset limits, best practices for reporting income and asset management strategies. These learned skills are important for navigating the interface between employment and benefits and help to reduce a reluctance to pursue employment due to fear of losing benefits, and encourage confidence towards building an increased independence and ability to manage personal responsibilities.

As an example of a typical outcome of WIBC services: A participant was referred to me by an Employment Specialist from one of the wellness centers, needing to learn about how earned income will impact his SSI and Medi-Cal benefits. He has accepted a part time job and has longer term plans to pursue vocational rehab services to eventually obtain a full time occupation that will allow him to transition off of benefits completely. I taught him how to report his income to SSA to avoid any overpayments and getting cut off from his SSI benefits until he is ready to do so. I also successfully

helped him to start an application for a CalABLE account that will allow him to manage the asset/resource limits of SSI and Medi-Cal and save some of his earnings going forward. This will also allow him to learn money-management skills and empower him to feel more confident that he can continue to pursue his goals without any unnecessary complications and setbacks.

V. FY 20/21 Additional Information: The CIL does not yet capture client demographic information; Vocational Services (OESD 20) demographic percentages utilized as proxy to calculate.

VI. FY 21/22 Projections of Clients to be Served: I would expect the numbers of clients to be served in 2021-2022 to increase slightly, and would project somewhere between 75-100 unduplicated clients. However, due to the ongoing nature of the global pandemic and its impacts on economics, jobs, social distancing protocols, housing stability and availability, etc., it is difficult to be certain of how things will unfold.

VII. FY 21/22 Program or Service Changes: N/A

PROGRAM NAME: Vocational Program

Program Description: The ACBH Vocational Program (ACVP) is a county operated direct service program which is part of the Alameda County Behavioral Health System of Care. ACVP is one of four units under the umbrella of Vocational Services (Including units for Supported Employment Training and Technical Assistance, CalWORKs Mental Health, Administrative and ACVP Direct Service). ACVP is imbedded in 18 county operated and community based specialty mental health programs (including Conditional Release, the TRUST Clinic, Asian Health Services, Casa Del Sol, La Familia, Fred Finch Youth Center, West Oakland Health Clinic, Schrieber Center, Supported Housing).

The model of Supported Employment used by ACVP is evidence-based Individual Placement and Support (IPS). Our service approach is to partner with program participants and engage them around their unique interests and needs in finding a job, meet them in their community to identify employers, obtain and retain jobs, while continuing to collaborate with their clinical team and significant others to aid in their success. After a consumer is working, ACVP continues to work with them until the job is secure and the individual is satisfied with the job match. If they want a different job or lose the one secured, we keep working with them as long as they are interested and motivated to work.

There is a "zero exclusion" approach to recruiting consumers for services, which means that as long as they have expressed interest and are action oriented toward work, they will be engaged despite any presenting barrier.

Target Population: Assists youth (16-17 years old), Transitional Age Youth (TAY- 18-24 years old), and 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 (IPS) - Supported Employment. IPS services span all of Alameda County.

How Much Did We Do?

I. FY 20/21

a. **Number of clients served:** 269

How Well Did We Do?

II. Language Capacity for this program: ACBH Vocational Program has on staff direct service providers who are native speakers of Spanish, Korean and Tagalog. 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.

III. FY 20/21 Challenges: The challenge in this fiscal year has been the continuing impact of COVID-19 on our service delivery model. Staff have largely adjusted to virtual tele-health platforms in order to collaborate with integrated team members, provide consumers with direct services, and to engage with employers. Since the ‘re-opening’ of California on June 1st, staff have begun to engage employers face-to-face for job development activities. Many consumers have indicated they want to put their job

placements on hold to avoid infection, yet still want to talk with employment staff to stay motivated towards work or educational goals.

Another ongoing challenge 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 FY20-21, 5 out of 20 direct service positions were vacant (25% unit vacancy rate).

Is Anyone Better Off?

IV. FY 20/21 Client Impact: ACVP has a 31% 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=83) divided by the total number of people in the IPS program (n=269). Benchmarks set by the Westat IPS Collaborative include 30% fair standard, 40% good standard, and 50% exemplary standard.

ACVP helped participants start 116 new jobs during the FY 20-21 as well as maintain 26 positions with existing employers, for a total of 142 jobs (Individuals can have multiple job starts within a year; see list of employers and positions in **appendix**).

The IPS Supported Employment model follows these core practice principles:

1. Focus on Competitive Employment: Agencies providing IPS services are committed to competitive employment as an attainable goal for people with behavioral health conditions seeking employment. Mainstream education and specialized training may enhance career paths.
2. Eligibility Based on Client Choice: People are not excluded on the basis of readiness, diagnoses, symptoms, substance use history, psychiatric hospitalizations, homelessness, level of disability, or legal system involvement.
3. Integration of Rehabilitation and Mental Health Services: IPS programs are closely integrated with mental health treatment teams.
4. Attention to Worker Preferences: Services are based on each person's preferences and choices, rather than providers' judgments.
5. Personalized Benefits Counseling: Employment specialists help people obtain personalized, understandable, and accurate information about their Social Security, Medicaid, and other government entitlements.
6. Rapid Job Search: IPS programs use a rapid job search approach to help job seekers obtain jobs directly, rather than providing lengthy pre-employment assessment, training, and counseling. If further education is part of their plan, IPS specialists assist in these activities as needed.
7. Systematic Job Development: Employment specialists systematically visit employers, who are selected based on job seeker preferences, to learn about their business needs and hiring preferences.
8. Time-Unlimited and Individualized Support: Job supports are individualized and continue for as long as each worker wants and needs the support.

V. FY 20/21 Additional Information: For a case-in-point example of participant success and ACVP Supported Employment Services, please watch Josh's Back to Work testimonial and interview on YouTube (Turn on Subtitles/Closed Captioning): **https://www.youtube.com/watch?v=5v3JLL5zSnc;** also, despite challenges with the pandemic, the job placement rate went up 14% within the first six

VI. FY 21/22 Projections of Clients to be Served: 262 (172 served between July-Sept 2021; Avg. 10 new admits per month, with 9 months in FY remaining. 172+90 = 262)

VII. FY 21/22 Program or Service Changes: Once fully staffed, the Vocational Program intends to embed an IPS Employment Specialist in the Substance Use Disorder program, look to serving more supported housing individuals within CalAim and have further access and influence with the re-entry population.

Appendix

Sample Employers

ABODE SERVICES
ACORN APARTMENTS
AMAZON
ANIMAL INTERNAL MEDICINE & SPECIALTY SERVICES
APOLLO BEAUTY PRODUCTS
AUTOLECTRIC- CAR WASH
BC FORD
BERKELEY BOWL
BETTY'S PIER 29 RESTURANT
BIG LOTS
BRATPAK DOG KAMP
BURGER KING
CALIFORNIA ULTIMATE CLEANERS
COLOR ME MINE
COSTCO
DD RETAIL STORE
DD'S DISCOUNT STORE
DHL
DOLLAR TREE
DON'S TIRE
EL CERRITO PLAZA
EMERALD PACKAGING
E-WASTE & SOLAR RECYCLING CENTER
FEDERAL EXPRESS
FELTON INSTITUTE
FIVE GUYS BURGERS AND FRIES
FREMONT TIRE AND WHEEL
GEORGE'S AUTOMOTIVE SERVICES
GRAND AVENUE SHELL STATION
HOME DEPOT
HOSPITALITY HOUSE
JIFFY LUBE
KENTUCKY FRIED CHICKEN
LAMPS PLUS
LANDMARK EVENT SERVICES
LOTS OF LOVE CHILD CARE
MACY'S
MEAT COMPANY INC
MICHAEL'S
OAKLAND UNIFIED SCHOOL DISTRICT
OIL CHANGERS
PANDA EXPRESS
PAPASAN ROLLS AND BOWLS
PARTY CITY
PETCO
PUP TOWN DOG DAYCARE & BOARDING
QUEEN'S BEAUTY SUPPLY
RICH CITY RIDES
SAFEWAY
SALLY BEAUTY SUPPLY
SHOOTING STAR CAFÉ
SMART AND FINAL
STORAGE PRO
SUN HOP FAT GROCERY STORE
SUSHI A GO-GO
TARGET
TECHNIQUE SOLUTIONS INC.
TESLA MOTORS
TJ MAXX
TONY'S AUTO REPAIR
UPS
WALMART
WINDSOR POST ACUTE CARE OF HAYWARD
WON KEE SUPERMARKET

Sample Positions

Direct Support and Maintenance Specialist

Apprentice

Art Teacher/Retail Support

Assistant Manager

Associate

Attendant

Auto Mechanic

Beauty Advisor

Behavior Specialist

Car Wash Attendant

Care Giver

Cashier and Customer Service

Child care

Clerk

Community Programs Fellow

Concierge Service

Courtesy Clerk

Crew Member

Data Entry Clerk

Dishwasher

Dog Handler

Floor Associate

Floral Dept. Clerk

In Home Support Worker

Janitor

Kitchen Helper

Lighting Specialist

Loader

Lot Attendant

mail sorter

Material Handler

Merchandise Associate

Mounter/Helper

Oil Change Technician

Package Handler

Part runner

Peer Support Specialist

Personal Shopper

Prep Cook

Receptionist

Recycling Attendant

Retail Associate

Sales Associate

Special Services Associate

Stocking Associate

Teacher

Team associate

Technician

Tire and Wheel Tech

Unarmed Security

Utility Clerk

Vet Assistant

Warehouse

Warehouse Associate

Wood Worker

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 22

PROVIDER NAME: Bonita House

PROGRAM NAME: Planning Project to Develop African American Wellness focused hub

Program Description: Bonita House will contract with local expert consultants for a 12 month project to provide planning services for the development and design of a multi- dimensional African American Holistic Wellness Hub Complex.

Target Population: The Wellness Hub Complex will be focused on services and supports for the African American community of all ages.

Project Completed and Closed in FY 20/21

Additional Information: At this juncture, we have completed the Phase Two Operationalization of the African American Wellness HUB, which concluded on December 31, 2020.

The HUB's Scope of Work for Phase Two consisted of five deliverables and an allocation amount totaling $528,867. The Wellness HUB team submitted it's final report and has met those deliverables. The Office of Ethnic Services, in partnership with the Alameda County Behavioral Health (ACBH) Building Facility Manager and Alameda County General Services Agency (GSA) identified an outside architecutural team who completed their final Space Needs Assessment report for the African American Wellness HUB. The report presented three viable options and limitations for the procurement of the HUB. The partnership continues by explorating and examining the inventory of County owned facilites for the HUB and other potential suitable sites.

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.

How Much Did We Do?

I. FY 20/21

a. **Number of clients served:** 33

How Well Did We Do?

II. Language Capacity for this program: We primarily operate in English and have some limited capacity in Spanish, depending on residential shift.

III. FY 20/21 Challenges: We have had challenges getting the clients to attend groups daily. Challenges include but are not limited to management of depressive, psychotic and anxiety symptoms. Clients can become severely symptomatic and shut down to the point where we are struggling to get them to leave their room.

Is Anyone Better Off?

IV. FY 20/21 Client Impact: Being in a therapeutic environment where they can experience their mental health symptoms and get help in the moment has been very useful for our clients to the point where they are doing better at Refuge then they have at any placement that they have in the past.

V. FY 20/21 Additional Information: The support from outsider providers has been phenominal.

VI. FY 21/22 Projections of Clients to be Served: In the next year we hope to serve 35 clients.

VII. FY 21/22 Program or Service Changes: N/A

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.

How Much Did We Do?

I. FY 20/21

a. **Number of clients served:** 56

How Well Did We Do?

II. Language Capacity for this program: Schreiber Center utilizes translation services offered by ACBH. Due to the precautions taken currently related to COVID-19, clients are receiving services telephonically, in which case a translator is available by phone if needed. To date there are only English-speaking staff available to our clients.

III. FY 20/21 Challenges: Schreiber Center has been and continues to be impacted by COVID-19 in that clients are receiving telehealth, to ensure the safety and health of both clients and staff. During this FY, the vacant positions of Division Director and Psychiatrist were filled. Additionally, after a period of absence of the prior full-time clinician, another full-time clinician transferred into the role permanently. These changes allowed for the team to develop the infrastructure to begin to address the wait list for services that had been building.

Is Anyone Better Off?

IV. FY 20/21 Client Impact: Schreiber Center clients are noted to benefit from services anecdotally as well as evidenced by improvements in measurable treatment results. Our clients who engage in our mental health counseling are offered skills to help prevent future mental health distress and crises and report benefiting from our services. Schreiber clients report developing personal insight into their diagnosis and often improve relational and life skills. Our interventions also are noted to increase feelings of hope and resiliency.

Case Study: 24 year old Mexican-American male receiving medication management services with significant period of stability began experiencing an increase in mood and psychotic symptoms resulting in voluntary admittance into a psychiatric emergency services unit, contact with mobile crisis team, and stay at a crisis residential treatment facility. The Schreiber Center team was able to work together to increase services to include psychotherapy, collaborate and consult with ACBH providers to support management of client crisis, increase frequency of psychiatry appointments, and provide his family and support systems with resources and referrals. Ct was able to receive appropriate services, gain insights into his symptoms and diagnosis, learn how to navigate crisis supports, and increase his engagement in treatment.

V. FY 20/21 Additional Information: As mentioned previously in this report, Schreiber Center is impacted by COVID-19 in that clients are receiving telehealth from both the psychiatrist and clinician.

VI. FY 21/22 Projections of Clients to be Served: We anticipate providing services to at least 60 clients during the next FY. The Schreiber Center continues to be impacted by the COVID-19 pandemic and is providing telehealth services. As the pandemic restrictions ease, it is our goal to return to in person therapy services. It is also our goal to address all referrals on the wait list and to increase timely review of referrals.

VII. FY 21/22 Program or Service Changes: There are no planned changes with the Schreiber Center for the next fiscal year.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT
OESD # OESD 25

PROVIDER NAME: Fremont-PATH/Bay Area Community Health

PROGRAM NAME: Behavioral Health - Primary Care Integration Project

Program Description: Bay Area Community Health (BACH) 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.

How Much Did We Do?

I. FY 20/21

a. **Number of clients served:**
   - 511 total visits
   - 257 unduplicated

How Well Did We Do?

II. Language Capacity for this program: All of our PATH patients speak and understand English. We have not needed the use of a translator or had to bring another provider in for any language barrier issues. However, BACH does provide services in multiple languages.

One provider speaks English, Hindi, Punjabi, and Gujarati, and this provider in particular serves clients for those languages. Another provider speaks English and Tagalog, serving clients in those languages, as needed.

III. FY 20/21 Challenges: Our biggest challenge is working with patients that are “meds only” clients because it is harder to reach these patients who are “meds only” when compared to case-managed patients. Whenever we do get our patients to schedule a visit, they are not likely to complete lab orders or to meet with any radiology or specialist appointments. They require much more time from the Care Coordinator and Nurse Coordinator.

Is Anyone Better Off?

IV. FY 20/21 Client Impact: We have made considerable progress with MaCo. He is a 63-year-old man with multiple Primary Care diagnoses, in addition to his schizophrenia diagnosis.

We continue to address his uncontrolled diabetes and have sent him to two different endocrinologists, trying to find a doctor that will take the time and make the effort to help him.

It was thought that he might be experiencing dementia, and we sent him to our in-house neuropsychologist for evaluation. At this point, it was required he wear his glasses to the consultation,

and we had to complete the process of him getting a new pair, before they would schedule a neuropsychology visit.

He was evaluated and received a diagnosis of *Major Neurocognitive Disorder Due to Multiple Etiologies*. We continue to watch him closely and plan to reevaluate in 18 to 24 months, as directed.

We have home health checking in on him, multiple times a week, to make sure his diabetic medication is administered properly and follow up with the endocrinologist closely.

His A1c continues to lower and we keep him on a returning schedule of every 2 weeks.

V. FY 20/21 Additional Information: We have no additional information at this time.

VI. FY 21/22 Projections of Clients to be Served: We hope to increase the number of visits. COVID has directly affected the flow of clients into our office and unfortunately, that dynamic will not change until clients feel safe about leaving their homes. As a result, it is possible that in a few months, depending on the effects of COVID, more people can potentially be served.

VII. FY 21/22 Program or Service Changes: We have no changes projected.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT
OESD # OESD 25

PROVIDER NAME: The Alliance for Community Wellness dba La Familia Counseling Service/Early Childhood Integrated Program

PROGRAM NAME: Behavioral Health - Primary Care Integration Project – Silva Clinic

Program Description: Provide mental health services (i.e., screening, assessment, collateral, individual and group therapy, family engagement, individual and group rehabilitation, and plan development), crisis intervention, and case management/brokerage. Treatment includes additional Family Partner services. Providing specialized early childhood mental health services within the context of children's families/caretakers in the Central and South Alameda County area.

Services range from very brief assessment to short-term treatment lasting typically from nine to 12 months in duration. The Integrated Health Program works in close collaboration with the client's pediatrician and medical support staff and shall provide primarily on-site, short-term services.

In addition, clients may, when approved as clinically appropriate, continue to be seen by the Early Childhood Mental Health (ECMH) Program for longer-term services that are primarily home-based.

Target Population: Children, seven years of age or younger, and their families and or caregivers.

How Much Did We Do?

I. FY 20/21

a. **Number of clients served: 20**
   Of the 2,597 service hours per fiscal year approximately 832 hours were billed due to being down one full time clinician.
   i. 50% of clients receive multiple services per week (e.g., individual and family therapy, family therapy and collateral)
   ii. Referred at least 4 families to the Family Partner

How Well Did We Do?

II. Language Capacity for this program:

- Spanish Language - 13 clients/families, English language – 7 clients/families were served in each respective language during FY 20/21.
- Consumer Engagement
  i. 90% of participants engaged in at least 3 services per month
  ii. 90% of participants completed up to 9 months of treatment or more

III. FY 20/21 Challenges: This fiscal year brought several challenges, which created a barrier to serving more clients and families. We had one staff clinician within the Early Childhood Integrated- Silva Clinic program out on maternity leave and then deciding not to return to the program, and we currently have not been able to fill the position. Due to the Pandemic, our staff were less able to interact with medical providers at the clinic and warm handoffs between the medical provider and clinician were not possible, nor was the clinic office available to meet with families. The clinic decreased their hours and put in place pandemic practices, which also decreased incoming referrals and some client and family referrals that

came in were difficult to contact. We had the challenge of serving families and young children during the pandemic through telehealth, telephone, and occasional distant in-person meetings. Engaging young children on telehealth or phone was not easy, although our clinicians found more success with providing services to their caregivers or to older children as the community resources on-line increased. Other pandemic related challenges were less availability to contact clients and families due to illness or moving out of the area or into crowded living situations or other barriers that the families themselves faced.

Is Anyone Better Off?

IV. FY 20/21 Client Impact: Contractor's Family Partners shall work within Contractor's programs to assist families in accessing needed services, promoting independence and building advocacy skills.

Contractor's Family Partners shall collaborate with the primary mental health clinician to:

- Directly provide outpatient services;
- Promote access and linkages to services;
- Advocate with and on behalf of families;
- Assist families in increasing their support network;
- Provide mental health education and consultation to help families understand their role as their child's advocate and role model;
- Advocate for and champion family-driven practice;
- Act as a role model and mentor for parents whose children are receiving treatment services.

Client Story: As a Family Partner, I received a referral from the clinician that works with this family within the Early Childhood Integrated Silva Clinic program, and collaborated with the clinician to provide services. The clinician identified on the client's treatment plan that the mother wanted support to get her child academically evaluated, and the clinician recommended that the Family Partner help with the mother's stressors so that she could be more present to support the client to co-regulate. I provided services in the Spanish language and met the mother in February 2021, for weekly or bi-monthly sessions for over 7 months. The mother presented with extreme anxiety around her child's learning process when attending Kindergarten. I focused my interventions on helping this mother gain an understanding of her child's development. Initially the mother presented panicked that her child was not "normal" and needed help from the school district to assess her child. The child in her classes confused the letter "d" with "b" or "p" with "q". Mother was very worried that this was abnormal. Family Partner supported the mother to advocate by speaking with the child's teacher and find out what recommendations she may have for her child. I also normalized the learning process for a young child in Kindergarten so that the mother could decrease her worry. I provided the mother examples from my own life with raising my children and examples of how to promote her child in learning her letters and reading. Family Partner provided referrals to this family to the Hand in Hand parenting website; Hively parenting trainings and book club. I encouraged the mother to follow up with the referrals and the services that read books to children on line, in order to stimulate her child's interest in learning to read. Family Partner helped mother to be calm, normalized certain behaviors of the child, and referred her to specialized child development organizations. Over the course of this Family Partner's services to this family, the conversations between myself and the mother helped the mother to understand that her child was on tract and typical in her development to other children her age. Through these conversations, the Family Partner achieved the goal of helping the mother decrease her stress and worry and to be calmer with her child in order to be more available for the child's needs, such as co-regulation. The mother gained a better understanding of child development and decided to advocate

for her child by listening to the teachers and determining together when or if the child would need any additional academic support.

Other measurements of client impact from services:

- **Symptom Improvement**
  - 85% report a reduction in symptoms on the PSC-35 at discharge
  - 85% demonstrate CANS ratings reduction from 2's and 3's to mostly 0's and 1's at closings.

A case study of a 4-year-old client is being provided by a current clinician who works with the Early Childhood Integrated, Silva Clinic program:

I am a Licensed Clinical Social Worker who has been working in this field for approximately 4 and a half years. I have served several culturally diverse families in the community and provided culturally informed services. One of these families is a current ECMH Integrated- Silva Clinic client. I initially met my male client when he was 4 years old, worked with him and his mother for approximately 6-8 months, and transferred him to another clinician in the agency. The case was transferred back to me about a year ago when that clinician went on leave and I was able to reconnect with my client and his family. I have been working with this immigrant family of Mexican and Guatemalan descent since then. Parents are monolingual Spanish speakers while client and his siblings speak fluent English and Spanish. I have tailored my services to better serve this family in their own language and have used my similar cultural background to connect with this family, while learning about differences between our backgrounds. It was challenging to support this family at the early stages of therapy due to the family's level of stress, intensity of the child's behaviors, and difficulty engaging the mother in therapy. I was able to overcome this by providing empathy with the mother and interacting and building my relationship with the child through play. I have provided evidence-based practices, such as Brief Strategic Family Therapy techniques and Solution Focused Therapy techniques to support my client in reaching his goals and improve the parent-child relationship.

This child has improved in several ways while he has been in this program, such as being able to follow a routine/structure, express his emotions in a developmentally appropriate manner, have decreased and less intense tantrums, and be more flexible with changes that occur in his everyday life. His family functioning has improved and has built a stronger, healthier relationship with his mother. His mother has learned how to manage his tantrums, manage her own stress levels, enjoy quality moments with my client, learned to notice the child's cues, and has developed a daily routine to help support the child be successful in the home. This mother and child have been able to navigate their relationship during the pandemic and successfully finished a whole year of virtual learning together. This case will be closing in the next few weeks due to the client successfully meeting his goals in treatment.

V. FY 20/21 Additional Information: Long-term plans for the ECMH integrated – Silva Clinic program include building a new medical center where services by the medical providers at TVHC and the mental health providers from La Familia Counseling will be housed under one roof. The plans for this collaboration are already developed and hopefully the ground for the new center will be broken within a couple of years. At that point in time the full collaboration between the medical services provided and the mental health availability and services with warm hand offs to families with young children will be accessible to more of the community and a visible and welcoming center will be present for the vast multicultural families within the general Hayward area and surrounding cities. We are looking forward to the future of this development for the amazing collaborative project.

VI. FY 21/22 Projections of Clients to be Served: 25
We anticipate to hire a new clinician for the program and continue to provide additional services to our referrals from the clinic in collaboration with the medical providers for the young children and their families.

VII. FY 21/22 Program or Service Changes: N/A

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT
OESD # OESD 25

PROVIDER NAME: Oakland-PATH/LifeLong Medical Care - Eastmont

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.

How Much Did We Do?

I. FY 20/21

a. **Number of clients served:** 348

How Well Did We Do?

II. Language Capacity for this program: LifeLong provided 331 clients with services in English, 5 in Spanish and one person each in the following languages: Mandarin, Farsi, Khmer, and Korean. Language services are provided either by LifeLong staff or by accessing our Language Line. LifeLong uses Purple Communication to serve those needing American Sign Language interpretation.

III. FY 20/21 Challenges: LifeLong has offered limited in-person appointments to PATH patients during the COVID-19 pandemic. PATH Telehealth services were offered in leiu of in-person appointments. The PATH patient population experiences barriers to accessing services via telehealth such as access to technology and obtaining confidential space to speak with their provider. Patients are offered in-person appointments for issues requiring in person evaluation and home visits are being conducted for routine vital signs and phlebotomy collection. COVID-19 has also posed communication and collaboration challenges across the PATH team. Virtual team meetings are regularly scheduled to help address these issues.

Is Anyone Better Off?

IV. FY 20/21 Client Impact: Clients were provided with regular and timely Health Assessment screenings including BMI, Blood Pressure, Hb/A1c, and Lipid profile. These assessments provide vital information for overall health management, providing screenings needed for disease prevention, improving management of chronic disease, and improving overall health management and quality of life for PATH clients.

Primary care services were provided to at least six clients per week for the duration of the contract and often exceeded contract deliverables. Visits were recorded in LifeLong's Electronic Health Record (EHR) to document preventative care, urgent care, examinations, chronic disease management, medication management, and other health services.

LifeLong is dedicated to protecting the clients we serve from COVID-19. PATH clients are often more vulnerable to severe disease due to health conditions and age. All LifeLong staff are mandated to be vaccinated for COVID-19 (unless they have an approved exemption) and LifeLong has done extensive outreach to vaccinate our patients against COVID-19.

V. FY 20/21 Additional Information: There is currently a regional provider shortage which impacts our ability to quickly fill vacant provider positions. LifeLong is deeply invested in supporting the development of the health center workforce through our medical education programs including the Family Medicine Resident Program and Nurse Practitioner residency programs.

VI. FY 21/22 Projections of Clients to be Served: LifeLong expects to continue providing services to PATH clients in 21-22 and anticipates new enrollments regularly in the coming year. We look forward to our continuing partnership with the PATH program with the County.

VII. FY 21/22 Program or Service Changes: We anticipate continuing to add clinic hours into FY 21-22 as COVID-19 restrictions ease and hiring for vacant provider positions is completed.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT
OESD # OESD 25

PROVIDER NAME: Oakland-PATH/LifeLong Medical Care - Eden

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.

How Much Did We Do?

I. FY 20/21

a. **Number of clients served:** 29

How Well Did We Do?

II. Language Capacity for this program: LifeLong provided 28 clients with services in English. For clients whose primary language is not English services are provided either by LifeLong staff or by accessing our Language Line which provides interpretation in a number of languages including Spanish, Mandarin, Cantonese, Vietnamese, Farsi, Russian, Khmer, Korean, and Arabic.

III. FY 20/21 Challenges: The COVID-19 pandemic posed significant challnges to implementing services at the Eden program site, which opened just before the start of the pandemic. LifeLong has offered limited in-person appointments to PATH clients during the COVID-19 pandemic. PATH Telehealth services were offered in leiu of in-person appointments. In person serivces are ramping up and are anticipated to be provided 2 days per week by the end of 2021.

The PATH patient population experiences barriers to accessing services via telehealth such as access to technology and obtaining confidential space to speak with their provider. Patients are offered in-person appointments for issues requiring in person evaluation and home visits are being conducted for routine vital signs and phlebotomy collection. COVID-19 has also posed communication and collaboration challenges across the PATH team. Virtual team meetings are regularly scheduled to help address these issues.

Is Anyone Better Off?

IV. FY 20/21 Client Impact: Clients were provided with regular and timely Health Assessment screenings including BMI, Blood Pressure, Hb/A1c, and Lipid profile. These assessments provide vital information for overall health management, providing screenings needed for disease prevention, improving management of chronic disease, and improving overall health management and quality of life for PATH clients.

Primary care services were provided to at least six clients per week for the duration of the contract and often exceeded contract deliverables. Visits were recorded in LifeLong's Electronic Health Record (EHR) to document preventative care, urgent care, examinations, chronic disease management, medication management, and other health services.

LifeLong is dedicated to protecting the clients we serve from COVID-19. PATH clients are often more vulnerable to severe disease due to health conditions and age. All LifeLong staff are mandated to be vaccinated for COVID-19 (unless they have an approved exemption) and LifeLong has done extensive outreach to vaccinate our patients against COVID-19.

V. FY 20/21 Additional Information: After a long recruitment process, a nurse was recently hired for Eden PATH. There is currently a regional provider shortage which impacts our ability to quickly fill vacant provider positions. LifeLong is deeply invested in supporting the development of the health center workforce through our medical education programs including the Family Medicine Resident Program and Nurse Practitioner residency programs.

VI. FY 21/22 Projections of Clients to be Served: LifeLong expects to continue providing services to PATH clients in 21-22 and anticipates new enrollments regularly in the coming year. We look forward to our continuing partnership with the PATH program with the County.

VII. FY 21/22 Program or Service Changes: We anticipate continuing to add clinic hours into FY 21-22 as COVID-19 restrictions ease and hiring for vacant provider positions is completed.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT
OESD # OESD 25

PROVIDER NAME: Axis Community Health

PROGRAM NAME: Behavioral Health - Primary Care Integration Project

Program Description: ACBH is supporting the startup of a Mental Health Urgent Care Service for East County/Tri-Valley residents through the use of MHSA one-time funds in Fiscal Year 2021/2022 with potential for additional funding in future fiscal years.

The proposed Axis Community Health, Mental Health Urgent Care Center will be available to all members of the community, regardless of income or insurance status. Individuals and families with urgent mental health needs will be able to call for same-day appointments. During the COVID pandemic, mental health services will be provided via telehealth; long term plans will include a walk-in access point as well.

The Axis MH Crisis Center will also serve as a central entry point for assessment, triage, treatment, and care coordination for individuals seeking mental health treatment, regardless of insurance type or status**.** Like a medical urgent care setting, the MH Urgent Care Center will provide assessment and timely connection to services in a setting that is less costly than an emergency department.

Target Population: Community members in need of urgent mental health care.

How Much Did We Do?

I. FY 20/21

a. **Number of clients served: 672**

How Well Did We Do?

II. Language Capacity for this program: English: 485, Spanish: 152
Our Care Coordinator is Spanish speaking and is able to assist patients in both languages

III. FY 20/21 Challenges:

a. One of the largest program challenges this year was related to COVID. Our care coordinator has been working remotely all year, which makes communication with patients even more difficult than being able to see them face to face in the clinic. Often times patients would not return our calls, or would follow up much later.
b. Technical struggles – patients not being able to bring paperwork, lack of technology or transportation and delays in referral process.
c. Another struggle was locating the type of services we needed for patients who were facing unique situations due to COVID and the amount of services that were necessary to support this population. It seemed that resources were being tapped and there were waiting lists at some times.

Is Anyone Better Off?

IV. FY 20/21 Client Impact:

The care coordinator receives warm-handoffs from the health clinic and also behavioral health clinicians and links those patients with internal or external resources depending upon the unique patient need. The utilization of the care coordinator has increased capacity to provide behavioral health services in particular and has aided in decreasing our wait time from intake to being matched with a therapist. This is in part due to the care coordinators assistance in scheduling intakes and ensuring therapist schedules are full, and also due to linking/building rapport with patients who have had multiple no shows to medical or behavioral health visits in the past.

Care coordinators also act as linkage between systems of care, especially those patients stepping up/down from specialty services.

a. Case Example: Single mom who has physical (needs blood transfusions) and mental health struggles (depression), came in initially overwhelmed, unable to pay her electricity bills and didn't have enough money for food. She also lacks family support and has some trust issues from negative past experiences in health care. Has been working with our care coordinator on/off for 4 years. She has built trust with the care coordinator and "knows where to go when she needs help" (per care coordinator). Some of the things that occurred during their work together: referral and follow up with mental health counseling, worked on resume, got a job, working on promotion within the job, obtained child care (needed help completing initial and follow up applications for child care due to struggles with technology), applied for and secured low income housing, obtained Cal Fresh benefits, assistance communicating with PCP due to work hours. This patient comes in or calls from time to time and is extremely grateful for the support.

V. FY 20/21 Additional Information:

a. We tend to see some of the same patients multiple times because they often need connection to multiple resources, may need additional assistance or reminders and we ensure that we continue to follow up with patients until they are linked to services as much as possible. For every unique patient represented in this data, our care coordinators are following up with most of them multiple times, and sometimes on/off throughout the year.
b. Our care coordinators are absolutely essential to what we do at Axis. As our services and number of providers has expanded to meet the needs of our population, it has been essential to have support ensuring that patients are getting their SDOH needs met also.
c. Our care coordinators conduct SDOH screenings for all patients they seen so that we can ensure that we are inquiring about all potential needs and providing truly whole person care.
d. We created an opportunity for upward mobility amongst our care coordinators now that we have 4 of them total (only 1 represented by this funding).
e. Our care coordinator staff are happy and we have had 0 turnover in any of these position. The coordinator filling this position has remained with us since the start of this grant.
f. Our therapists and medical providers are also happy knowing that patients will be followed up with in ways they can't always fit into sessions.

VI. FY 21/22 Projections of Clients to be Served: The patient numbers for next fiscal year will likely be higher due to increase in our MHSA funding programs. While the IBHCC patient's contact numbers tend to remain fairly consistent year over year, the additional programming will lead to increased patient numbers.

VII. FY 21/22 Program or Service Changes: For this fiscal year we opened our new Axis Bridge Urgent Care program. Within this program we are seeing patients from the Tri-Valley regardless of their insurance type or ability to pay, ages 5+. The data is looking really good and we are excited to share that next year.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT
OESD # OESD 25

PROVIDER NAME: Alameda County Health Care for the Homeless(ACHCH)/LifeLong Medical Care

PROGRAM NAME: Behavioral Health - Primary Care Integration Project TRUST Clinic

Program Description: The TRUST Clinic is a multi-service clinic designed to improve the health status of people who are homeless, including providing assistance with housing and income supports.

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.

How Much Did We Do?

I. FY 20/21

a. **Number of clients served:** 1,862

How Well Did We Do?

II. Language Capacity for this program: The TRUST Clinic has staff fluent in English and Spanish. In FY2020-21, TRUST provided Spanish language support to 60 homeless patients. For individuals with other translation needs, TRUST utilizes a language line to ensure language needs are not a barrier to services.

III. FY 20/21 Challenges: As was true in all areas of healthcare, the COVID-19 pandemic brought many challenges to TRUST. The foundation of the TRUST model is low-barrier access, with walk-in capacity for behavioral health and primary care, and drop-in services including showers, snack, and a clothing closet to address basic needs of the homeless population. Prior to the pandemic, the TRUST Clinic had a vibrant waiting room space for patients to come drop in and get a cup of coffee, charge their phone, and see a provider.

From the beginning of the pandemic, TRUST was committed to remaining open and working to support access to services through urgent in-person visits and increased telehealth services. TRUST quickly developed robust protocols and opened a screening tent outside the clinic. As a result of offering LCSW, psychiatry, and psychological services via telehealth, no shows dropped. Additionally, LifeLong welcomed patients into the clinic who needed a private space for telehealth visits. While implementing COVID-19 safety protocols allowed the clinic to remain open, it resulted in long delays for walk-in face-to-face appointments, and the closure the waiting room.

As TRUST clinic staff have been balancing the provision of behavioral health and primary care with the ongoing COVID-19 efforts burnout and secondary trauma has occurred, resulting in some turnover in staffing. In response TRUST has made efforts to support staff retention through trainings, support, and increased scheduling flexibility.

Is Anyone Better Off?

IV. FY 20/21 Client Impact:

COVID-19 Response: The TRUST Clinic opened the first testing site in Alameda County specifically designed to serve the homeless community, with walk-up testing capacity. When the vaccine became available TRUST had a robust plan and converted the testing tent into a walk-up vaccine site. TRUST provided 1,248 COVID-19 tests and 508 vaccinations in FY20-21. TRUST clinical leadership was involved in the development and rollout of Project RoomKey in Alameda County, providing critical clinical support as Alameda County was building the service model for homeless individuals at greatest risk for COVID-19. and for those infected or exposed to infected individuals. TRUST was also a leader in identifying vulnerable individuals and successfully referred over 120 individuals into the hotels.

Clinic Services: In FY20-21 TRUST served 1,862 patients, providing 18,939 visits including 13,290 enabling services. This was both an increase over the previous year and a significant accomplishment, as many healthcare organizations saw a reduction in services due to COVID-19. One notable area of success was behavioral health telemedicine, where there was a large reduction in the no-show rate. This success has led to TRUST maintaining expanded telehealth services for behavioral health, while returning to in-person visits in the clinic.

People experiencing homelessness and those who use injection drugs are at increased risk of Hepatitis C virus (HCV) infections. Homeless individuals frequently are unaware of their diagnosis and those who are experience challenges engaging in treatment making this an important clinical intervention for this vulnerable population. TRUST was able to maintain a high cure rate for patients diagnosed with hepatitis C [87%] in FY21.

Patient experience data from TRUST Clinic show that 100% of patients would recommend TRUST Clinic to their friends and family members. In addition, 92% of patients who received a telemedicine visit reported a high degree of satisfaction with the care and support they received from the provider.

V. FY 20/21 Additional Information:

Media Coverage:
Bay Area counties take scattershot approach to vaccinating homeless people against COVID-19 (sfchronicle.com)

Alameda County Mobilizes to Get At-Risk Homeless Residents Into Hotels | KQED

Delta variant poses new threat to homeless communities in Oakland (oaklandside.org)

How a Bay Area clinic is helping provide vaccines to people experiencing homelessness - CNN

Patient Story:
At times individuals come to TRUST as new patients and the care teams quickly discovers that they are receiving disconnected care from multiple providers. In the spring of 2021, a 23-year-old homeless Guatemalan immigrant walked into TRUST for the first time. They presented with intrusive auditory hallucinations and command hallucinations. The team quickly learned that this young woman was receiving care from multiple providers, including an external case management team and a street medicine team, without any communication between providers. With disjointed care the patient was overwhelmed and struggling to develop connections with her care and as a result had been in and out of

care in the past. The TRUST Clinic behavioral health providers moved quickly to address this through facilitating biweekly care coordination meetings with the patient's multidisciplinary treatment team (primary care, registered nurses, consultation with a TRUST psychiatrist, therapy, and case managers). Through developing a shared plan, with the patient at the center identifying their goals, they have made significant progress towards their goals. The patient started abilify maintana- a long acting injectable medication, along with therapy, which has led to a significant reduction in symptoms. Additionally, the patient was support with obtaining housing and has begun work toward their goal of reconnecting with family.

VI. FY 21/22 Projections of Clients to be Served: 1,800

VII. FY 21/22 Program or Service Changes: The FY22 client projections reflects the increased COVID-19 related services (testing and vaccine) to homeless individuals who may receive primary care elsewhere but came to TRUST during the pandemic because the clinic remain accessible to the community.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 25

PROVIDER NAME: Alameda Health Consortium (AHC)

PROGRAM NAME: Pediatric Care Coordination Pilot

Program Description: In FY 21/22 ACBH began supporting an 18-month pilot to introduce care coordination activities for the pediatric systems within eight local Federally Qualified Health Centers (FQHCs) in Alameda County.

Each FQHC will hire 1 care coordinator (8 care coordinators in total). The Pediatric Care Coordinator will be responsible for linking pediatric clients to medical, behavioral, and social services in a preventative and comprehensive manner. This position will act as the liaison between the client and the community, and will serve to dissolve the silos between the Medical and Behavioral Health departments within the FQHCs. This role will also work to support young clients with the basic health and social needs to minimize their risks for entering the criminal justice system as adults.

The AHC will serve as the centralized hub for these care coordinators, providing technical assistance, peer-group formation, and problem-solving for the duration of this program. Furthermore, AHC will embed a process and outcome evaluation to assess impact, effectiveness, and long-term potential of the Pediatric Care Coordinator Program.

Target Population: Clients of the FQHC's that are 0-18 yrs of age.

I. FY 20/21 Outcomes

In FY 20/21 this program was not in existence, it began in FY 21/22. FY 21/22 data will be provided in the next MHSA Three Year Plan FY 23/24-25/26.

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.

How Much Did We Do?

I. FY 20/21

a. **Number of clients served:** There was a total of 472 persons at our nine scheduled trainings in FY 2020-2021. We had a total of 536 persons registered for the nine trainings.

How Well Did We Do?

II. Language Capacity for this program: Training and Technical Assistance is provided in English.

III. FY 20/21 Challenges: This will be the year that we hopefully will move from virtual presentations to later in the year we plan to have some ability to offer in person presentations, this shift will offer its own issues and difficulties. Considering in person trainings, we will need to deal with the issues of space and various logistics issues. The entire issue of requiring mask in order to attend trainings will need to be reviewed and a policy developed. While this entire year has been virtual, we have attracted a number of participants who do not live directly in the area one of the challenges will be how do we maintain contact with these providers when our presentations are offered in person.

Utilizing the virtual format has also expanded access to a number of experts and professionals that we are able to utilize for specific trainings. The team may not have the exposure to as large a group of experts if they need to travel to the Bay Area.

The trainings offered specific resources in terms of their individual topics that could be immediately utilized by the providers attending the training. There were a number of trainings that dealt with the

responses of the African American community to the pandemic with tools and resources that the prescriber can utilize as we move forward beyond this pandemic.

This year we also offered two trainings specifically regarding youth as a response to request from the community. The trainings were very well attended with increased interaction utilizing those tools available to us in a virtual format.

This year in response to community request and interest the AATA team has been busy offering technical assistance in response to request from various community organization.

A team member completed a training for behavioral health professional in the Alameda Health System's Highland campus "The Souls of Black Folk: Psychiatry, Medicine and Pharmacology" to increase the awareness of the various issues related to medication and specific interactions that impacts African Americans.

The team offered a Technical Assistance training "The African-American Patient: The Intersection of Psychiatry, Medicine and Pharmacology" this was offered for Alameda County medical leadership and their staff that work directly for Alameda County.

The team also had an opportunity to serve as panel expert for the Black Mental Health webinar series, offered by Alameda County Supervisor Keith Carson during the May for Mental Health month. This series covered a variety of topics important to the African American community.

Is Anyone Better Off?

IV. FY 20/21 Client Impact: The trainings have continued to engage a number of community providers a significant number of providers who have attend at least half of all of the trainings. This year the trainers were able to present specific and timely information related to improving providers' interaction with the African American and minority communities during this very difficult period of COVID. The participants were offered specific strategies and tools that could be utilized with the African American population in both identifying depression and anxiety and offering examples and explanations as to how these issues may present differently in the African American population due to a number of cultural factors.

This fiscal year we had an 88% overall participant show rate. This is an improvement from last fiscal years' numbers. We have found for a variety of reasons registrants were not able to attend the actual training. We believe that this is significant because it helps the team to understand, the overall need for this type of training in our community.

Reduce mental health stigma: Several of the trainings focused on a review of the areas of health inequalities that have been highlighted during the COVID pandemic. With clear information as to how these inequalities continue to support the stigma that continues to be found in the African American community. The presenters offered a specific training to a group of college students who were attempting to understand some of the overall challenges that they face with their behavioral health issues and why the students do not access these services although they are clearly needed. This training was one of the first steps in assisting in decreasing the stigma specifically as it relates to young African American males who have been experiencing an increase rate of suicide. These community educational programs begin to help decrease the stigma using information and clear resources that members of the

community can utilize. There were also a number of presentations that dealt with the lack of trust that a number of African Americans have in the overall health and behavioral health system.

While acknowledging that these issues still exist, the presenters offered concrete resources that can be utilized specific with the African American population. These included but we're not limited to information regarding African American professional organizations that are known to offer supportive services to the community for example specific professional organizations that offer a training and support in the African American community.

Create a welcoming environment: A number of the trainings offered by the Pathways to Wellness AATA team offered a variety of methods that can assist providers in terms of developing a welcoming environment. As a result of COVID and the increased need for culturally competent services for African American consumers – AATA increased the number of trainings required and offered for to the community. It has been a huge success and the community enjoys the various training methods that our presenters provide.

V. FY 20/21 Additional Information: Some of our Topics included: Recovery process for African Americans Post COVID-19. The training offered specific strategies that employers can utilize to support wellness among their employees, which helps staff to offer a more welcome environment for the clients. Trauma, Stress, Social Justice and PTSD. These trainings offered participants information regarding the symptoms or clusters associated with race base traumatic stress (RBTS) hopefully once providers understand this type of stress, they will be more sensitive in terms of both greeting and offering services to their African American and other minority clients. Youth Who Become Violent: Deconstructing the "Why". Lessons Learned from a Culturally Specific Dually Diagnosed Program for African Americans. Intimate Partner Violence during the COVID-19 Pandemic. This training offered providers strategies that can be used to screen clients for IPV and provide resources about intimate partner violence to clients during a Telehealth visit. Providing and Implementing Mental Health Support for at Risk African American Families.

Requested Technical Assistance and/or Special Trainings provided to:

- Alameda Health System – Highland & PHP Providers *The Souls of Black Folks: The intersection of Race, Psychiatry, Medicine and Pharmacology*
- UC Berkeley - *Black Mental Health Matters educational training for teachers & students*
- Family Education and Resource Center - *AAFOP You Are Not Alone Workshop*
- Lifelong Medical Providers
- Highland Hospital Medical Providers
- Kaiser Medical Providers
- Black Mental Health Webinar Series – *In Honor of Mental Health Month*

VI. FY 21/22 Projections of Clients to be Served: We projected 150 to 200 unduplicated participants in attendance for the year. We expected an average of 45 to 50 attendance at any given training. We hit our goals and will continue with the same goals for FY2021-22 as well as will continue to offer community education units for a number of our trainings. We have found that the webinar format makes it easier for more clinicians to attend and get CEU in order to stay current with their educational requirement during the pandemic.

VII. FY 21/22 Program or Service Changes: This year will be the year of change for AATA team we are projecting continue use of the virtual platform for the first trainings in this new year. However, we will

plan for 2 in-person trainings in June 2022. We will also be implementing some changes in the utilization of this platform that will offer more interaction with participants. There will be a greater focus on use of breakout rooms that offer participants a task to be completed in order for them to have a hands-on opportunity to utilize some of the tools and resources offered by the presenters.

They will also increase use of the polling devices and other interactive methods in order for the presenters to get a clear picture of the needs, see if participants are understanding content and hear requests from the participants in real time.

This year we will continue with our specific Diversity, Equity, Inclusion Learning Series for CBO Executive Directors and/or leaders from agencies in which they have been sending providers to attend our AATA trainings. This training series was developed in direct response to request from CBO provider participants at our trainings where they indicated they often were not empowered to institute necessary tools and/or make the programmatic changes needed to support their learnings from our AATA trainings. With this suggestion we decided it was now time in our third year to offer specific trainings for managerial staff of agencies who can direct appropriate changes within their organizations. This two-day training assists executive staff in understanding how diversity, equity and inclusion you can improve overall all services to their minority population.

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.

How Much Did We Do?

I. FY 20/21

a. **Number of clients served:** 44

How Well Did We Do?

II. Language Capacity for this program: The primary language that our program had to utilize this year was English. If we had encountered a client that spoke another language other than English, we would've utilized the Language Line Solution services that are offered through ACBHS. All forty-four participants spoke English.

III. FY 20/21 Challenges: For the 20/21 year we faced very similar challenges that we faced in 19/20 year of AfiyaCare. We continued to face challenges posed by the COVID-19 pandemic, which included: reaching clients, engaging clients, and completing necessary documentation. Due to safety reasons we stopped having in person support groups and in person one on one sessions. We changed our approach to virtual groups and telehealth appointments. This posed challenges with the population we were serving because there were several barriers that increased during 2020 including: housing, economic insecurities, maintaining a line of connection through cell phone service, in addition to dealing with the day to day challenges living with a severe mental illness. Many clients had a hard time engaging in the virtual support groups that we offered so we didn't have any participants that engaged in our virtual groups.

Is Anyone Better Off?

IV. FY 20/21 Client Impact: This fiscal year we believe that we made a great impact on the clients, families, and communities we served. One our impact measures stated that at least 60% of clients would have a reduction in admissions to John George Psychiatric Pavilion, Psychiatric Emergency Services/Crisis Stabilization Unit and inpatient, we saw that 100% of our clients had reduced their admissions to the abovementioned places. We connected 100% of our clients to benefit services needed which helped us exceed the impact measure of connecting at least 80% of clients eligible for General Assistance, CalWORKs, CalFRESH, and/or Medi-Cal who are not connected to these benefits upon their entry into

the program and who obtain these support/s within four months of their case being opened. We had at least 90% percent of clients who have a reduction in admissions to jail.

The client story shared was given by our behavioral health care navigator, Perrie Andersen, regarding one of the clients from his panel, the name of the client and persons in the story have been changed for HIPAA compliance. Mr. N was referred to Roots and the AfiyaCare program by probation. Mr. N came to AfiyaCare needing linkage to mental health services, a primary care doctor, connection to CalFresh benefits, and permanent housing. Mr. N needed help staying abreast of his appointments and guidance on navigating the many barriers he was facing when looking for permanent housing. Perrie was able to stay in weekly communication with Mr. N to help him navigate the many systems he had to get through.

From January 2021 to August 2021, Perrie has linked Mr. N to CalFresh benefits, a primary care physician at Roots, mental health services with our behavioral health clinician, Monika, and connection to permanent housing. Perrie helped Mr. N with a hotel voucher, connection to the Turning Point community cabins, and eventually a permanent apartment that he shares with his girlfriend. Perrie helped connect Mr. N to funds through Prop 47 to help with the security deposit and furniture for his apartment.

V. FY 20/21 Additional Information: N/A

VI. FY 21/22 Projections of Clients to be Served: We project and hope to increase the clients we serve in this upcoming fiscal year. We strive to serve a total of 40 unduplicated clients. We strive to always maintain a minimum panel of ten unique clients annually.

VII. FY 21/22 Program or Service Changes: The AfiyaCare team has grown and we have added an Outreach Specialist, Empowerment Program Coordinator, and Program Manager to our staff. This has helped us streamline our referral process and outreach coordination efforts.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT
OESD # OESD 27

PROVIDER NAME: Telecare Corporation

PROGRAM NAME: Adult Recovery, Outreach and Connection (AdROC) Program

Description: Telecare AdROC is a short-term (90 days) outreach-evaluation-triage program serving adults who are not already connected to the ACBH System of Care. AdROC members 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. AdROC conducts in-reach and engagement at inpatient facilities, CSUs, and CRPs, and conducts outreach and engagement to community locations and providers. AdROC staff provide linkages, supports, and resources to help clients stay in the least-restrictive , most self-sufficient, and recovery-oriented settings; reduce the need for inpatient and emergency room care; and improve mental health outcomes. Services are delivered by a team of case managers, peer support specialists, a team lead, and a clinical director. Services provided by the AdROC team including individual and group rehabilitation, crisis intervention, plan development, individual and group therapy, and targeted case management. The latter service links the consumer to needed resources and supports in the community such as housing, benefits, therapy, medication, and medical/dental services. 80% of the AdROC services are delivered in the community. AdROC is located in the Eastmont Town Center in Oakland, CA.

Target Population: Describe information about consumers'/ clients' age group (i.e., Children/ youth, Transitional Age Youth, Adults or Older Adults; and Partners' unique needs.

AdROC serves adult Alameda County residents, 18 years of age and older, who appear to be experiencing a mental health crisis; and/or are affiliated with one of the AdROC referral sources; and who are not already connected to the ACBH System of Care.

How Much Did We Do?

I. FY 20/21

a. **Number of clients served:** 68 individuals enrolled in the program; an additional 67 individuals were served in outreach but did not enroll.

How Well Did We Do?

II. Language Capacity for this program and number of people served in each language:
English and Spanish

III. FY 20/21 Challenges: The AdROC team faced a myriad of challenges typically encountered by a startup program: creating operational systems, processes policies and protocols; hiring and training up staff; building relationships with referral agencies; establishing an IT interface with ACBH for inputting and tracking data as well as conducting Medi-Cal and MAA claiming. In addition to these common and predictable challenges, the AdROC team also had to contend with the threat posed by Covid-19 to staff and client health and safety, and to modify its operational practices to comply with Covid-19 safety regulations and requirements. For example, the AdROC staff's ability to conduct regular outreach to inpatient facilities, CSUs and CRPs was disrupted when facilities were closed due to Covid outbreaks.

Is Anyone Better Off?

IV. FY 20/21 Client Impact: AdROC staff met Client D at JGPP just before he was discharged. He was homeless, actively using drugs, and reluctant to accept services. The AdROC peer specialist linked him to an emergency shelter and while he was there, the peer specialist would meet him in a nearby park and play basketball with him because that was an activity he said he liked to do. There were times when he would disappear for a while, but then he would return to the shelter and the peer specialist would re-establish contact with him and continue to build the relationship. Then she helped him get a job because he had no income. At discharge from AdROC, with his approval, Client D was referred to a Level 1 service team.

Client H was a middle-aged woman who had a recent history of cycling back and forth between hospitals in California and Nevada. Although she had been a Berkeley Mental Health client years ago, she had no current connections to providers in the ACBH adult system of care. She was homeless, actively using drugs and had no income because she wasn't getting her monthly SSI benefits. The AdROC team investigated and found out the problem was that her brother was her payee and he didn't want to give her her monthly SSI check when she was actively using. Client H's AdROC case manager worked with the brother to adopt a harm reduction approach to managing his sister's money, paying for housing at a local SLE, and providing her with a small weekly allowance. The AdROC peer specialist used motivational interviewing interventions with Client H to help her get in touch with her own internal motivation for change. This process of ultimately resulted in Client H being admitted to the Bonita House residential treatment program.

Client A was referred to AdROC as he was being discharged from JGPP. He had a recent history of frequent cycling in and out of PES and the hospital. His disruptive behavior and paranoid ideation often prevented him from benefiting from opportunities for treatment. His AdROC case manager helped him identify the ways medication helped improve how he felt and how he got along with others. This insight led him to increase his use of medication. The case manager also worked with Client A and his mother to reach agreements around her behavioral expectations of him that allowed him to move back into the family home.

V. FY 20/21 Additional Information: N/A

VI. FY 21/22 Projections of Clients to be Served: 35-40 clients per month.

VII. FY 21/22 Program or Service Changes: ACBH and Telecare are currently engaged in discussions regarding changes to the AdROC average monthly caseload and the reallocation of staff between AdROC and TAY ROC programs to better the manage service capacity of both programs.

Metrics	% of FY 20/21 AdROC clients that achieved the metric
Percent of clients who receive two or more visits within 30 days of their episode opening	97.5%

Percent of clients who receive four or more visits within 60 days of their episode opening date	79.5%
Percent of discharged Adult Engagement Services clients who have been successfully linked to a service program.	71%

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 who have been resistant to engage with MH Services or have disconnected from those services. IHOT attempts to connect them with psychiatric care and other community supports including medical support, housing, and social services. Each IHOT team consists of: a clinical lead, a licensed eligible clinician, a Peer Advocate and a MH Outreach Worker as well as a Family Advocate. The composition of the team allows us 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 or incarcerations. The team schedules appointments with participants, family members, friends, and other providers, as well as assists 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. We also provide services to older adults 60 years or older if referred by Access to IHOT.

How Much Did We Do?

I. FY 20/21

a. **Number of clients served:** We served 132 participants for June 30, 2020 to July 1, 2021. At the present time we are still serving 47 of those participants.

How Well Did We Do?

II. Language Capacity for this program: Our staff utilizes the Language Line to reach out to participants/family who speak languages other than English. We have used the language line most recently to translate for a family that speaks Mandarin. We have not encountered any language barriers at this time that cannot be support by accessing the language line.

III. FY 20/21 Challenges: Our team has continued to be fully operational during COVID-19. The team has found it a challenge to connect participants to resources as some of these resources were closed or limited during COVID-19. We continue to meet people where they are (in their homes, in encampments, and in the community). It has been challenging to embrace Zoom team meetings and infrequent face-to-face meetings with team members. However, during this unusual time, we have managed to continue with our services to participants and to take on new referrals. Our Family

The Elevate HOPE Team is looking to hire a Peer Advocate who would be a good fit for the team and will be able and willing to work with participants in the field. Our team is currently a cohesive team that work well with each other and with participants.

Is Anyone Better Off?

IV. FY 20/21 Client Impact: One hundred percent of our participants who were referred or who identified family members as support were referred to support groups like NAMI or FERC. Several family members were referred to NAMI groups who have the capacity to conduct groups in a language other than English. Our Family Support Group has met on a monthly basis (via Zoom during Covid 19) and has included family members from participants discharged from the Elevate HOPE Program. This allows for increased support for family members in the group. As many as 18 family members have participated in the online support group.

Out of 132 participants, at least 50 percent were linked to Mental Health, Social Services, Case Management, drug/substance abuse and Inpatient Psychiatric Programs.

Reduce mental health stigma: The staffing design of the IHOT Team (1 Peer Advocates, 1 Family Advocate, 1 MH Outreach Worker, 1 Mental Health Clinician and 1 Licensed Program Manager) enables us to provide services that reduce mental health stigma. The Peer Advocate offers individuals support, psychoeducation, and advocacy from a shared experience perspective and uses his/her experience to destigmatize mental health. Their lived experience and education enable them to meet our participants where they are and to model mental wellness through their own stories. The Family Advocate shares her own experience with her family member who suffers from mental health issues. The Mental Health Clinician and Clinical Program Manager bring knowledge of clinical interventions and Risk Assessment working from a Strengths based model.

- Our team operates from the Strengths Based model utilizing harm reduction in our approach with participants as well as Motivational Interviewing Our team deliberately does not use mental health jargon, labeling, or assumption making about participants choosing to focus on the participant as an individual.
- We meet participants in their community setting. During our challenges due to COVID-19, we still try as much as possible to meet in destigmatizing ways sometimes meeting at a park, someone's backyard, or next to their encampment.

Create a Welcoming Environment: The Abode IHOT Team creates a welcoming environment for our participants and families by consciously avoiding use of stigmatizing or overly clinical language. All our team members seek to engage our participants and families with empathy and regard for each participant's unique experience. Our approach is conversational and seeks to find common and shared experience that reduces anxiety and the stress that some participants and families have experienced when working with providers. We provide food or a meal as well as providing for other basic needs like clothing, a phone, toiletries. During COVID-19, we continue to strive to make a connection with our participants even if we are not able to share a meal with them. We ask our participants "Do you need something?" "Can I bring you some, water or food?" This goes a long way to offering a welcoming environment.

Contract Deliverables/Requirements: IV. C of IHOT Contract Objective:

Case Example: Da was referred to the IHOT because his brother reported serious decompensation. He was not willing to take medication or to be involved in any services. He was living with his mother who is moving away. The participant had been living with his mother and had little prospects for a new living situation. His brother reported that he was too deteriorated a Board and Care. IHOT worked with this participant and reconnected him to a Level One Service Team. We assisted in finding him housing in a group setting where he is doing well. Da is taking his medication and working with his Case Manager from the Level One Team. He is currently stable and has not been hospitalized or incarcerated in the past year.

V. FY 20/21 Additional Information: N/A

VI. FY 21/22 Projections of Clients to be Served: We would like to serve at least 50 referred participants and to serve at least 30-40 participants at any given point in time.

VII. FY 21/22 Program or Service Changes: For this upcoming year, we would like to offer more frequent family support groups (2 x monthly). Our continuing goal is that we would like to increase the capacity to our Family Support Group to include one group meeting during the day and possibly one held in the evening. At the present time we are offering Zoom group meetings. In addition, the Clinical Program Manager has a continuing goal to see that staff be trained in WRAP (Wellness, Recovery, Action Plan) and utilize these skills when engaging and working with participants. Staff has received training in Motivational Interviewing.

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.

How Much Did We Do?

I. FY 20/21

a. **Number of clients served:** 119 unduplicated clients served, which is more than twice as much as the contracted 50 unduplicated client target.

How Well Did We Do?

II. Language Capacity for this program: 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.

III. FY 20/21 Challenges: Biggest challenges of the next year will be the Shelter-in-Place mandate due to COVID 19. Includes the following:

- Physical outreach in community (e.g., client homes, inpatient settings, homeless encampments).
- Facilitating in person family or caregiver group per week has been challenging due to COVID 19. Providing family or caregiver group will be implemented via mobile devices (e.g., computers, telephones).
- Need for increase of fiscal budget for more staff to increase enrollment capacity and to expand services.

Is Anyone Better Off?

IV. FY 20/21 Client Impact: At least 32% of engaged clients were successfully linked to outpatient mental health services or rehabilitation and recovery services within the first 12 months of referral (Target =>50%). Workflow was significantly impacted by COVID 19 and primarily working remotely.

Reduce mental health stigma: Inclusive and non-judgmental, avoiding clinical language (jargon), linkages to community (e.g., homeless encampments, inpatient settings) and natural supports (e.g., family, friends), staff cultural awareness and competency.

Create a welcoming environment: Empathic, strong use of Motivational Interviewing, collaboration with natural supports.

Client story: **For confidentiality purposes pseudo initials are used in story below.*
SS is 27 year old African American male with a history of chronic homelessness, suicide attempts, setting himself on fire in 2019 resulting in the disfigurement of his face and burns over 60% of his body with skin fibrosing. Client formally lived in Contra Costa County where he has had numerous psychiatric and ED encounters. IHOT received a referral for SS. SS has had ongoing symptoms of SI and hopelessness with severe depression and disorganization. Client became addicted to heroin as a result of trying to self- medicate chronic pain associated with burns including nerve tingling all over his body and chronic scar tearing on his face, neck, and under arms resulting in open wounds sometimes leading to infections. Client's family relationships have become increasingly strained as SS is unable to be housed with family due to poor management of health symptoms. Client has complex needs surrounding mental and physical health and substance abuse. IHOT Staff began outreaching SS at grandmother's home and places he was known to frequent. IHOT was able to engage and build rapport. IHOT supported client to identify his needs and navigate Alameda County Behavioral Health services in order to receive a referral to a Full -Service Partnership (FSP). IHOT also supported SS with understanding the Community Health Record (CHR) and making an informed decision to sign an ISA for collaborative care through the CHR. IHOT provided a warm hand off to the Full Service Partnership, including consultation with FSP around ways to build rapport as well as supporting SS with his connection to mental health treatment and primary care for his on-going physical wellness. IHOT provided continued support until SS was fully and successfully linked to care. Upon closing him to IHOT services he was meeting with multiple FSP staff at least one to three times a week including the Clinical Case Manager, the Housing Navigator, the PSS, and psychiatrist. SS expressed he was happy with the services with the FSP that he was connected to and looked forward to working with them.

V. FY 20/21 Additional Information: Added 1.0 FTE Peer Support Specialist position.

VI. FY 21/22 Projections of Clients to be Served: We expect to meet the following contracted guidelines of:

- 3,525 hours of MAA billable outreach and engagement
- 25-30 unduplicated clients served (point in time)
- At least 50 unduplicated clients served annually
- One family or caregiver group per week

VII. FY 21/22 Program or Service Changes: Fill vacant 1.0 FTE Peer Support position.

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 severe mental illness, with the intention of connecting them with psychiatric care, psychotherapy, clinical case management, 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.

How Much Did We Do?

I. **Client Served**
   a. **Number of clients served:** One hundred and six (106) clients served

How Well Did We Do?

II. **Language Capacity for this Program:** La Familia IHOT has three (3) fluent Spanish-speaking staff. La Familia receives all of IHOT referrals who are either monolingual Spanish-speaking or prefer services in Spanish within Alameda County. Some staff who do not speak Spanish utilized the Alameda County Language Line to provide services for client and family members who are monolingual Spanish Speaking.

III. **Program Challenges: Clients Who Passed Away:** One (1) clients passed away during this Fiscal Year who received IHOT services within the previous 12 months. An Unusual Occurrence & Reporting Form was submitted by Program Supervisor for this client. A former consumer passed away during this Fiscal Year who was a consumer in IHOT in Fiscal Year 2017-2018. An Unusual Occurrence & Reporting Form was not submitted for the consumer as they were closed to La Familia IHOT in 2018. The IHOT staff who provided services to these clients supported the family of the clients who passed away.

Lack of In-Person Face-to-Face Mental Health Services: During Alameda County Shelter-in-Place, many mental health treatment providers are not providing services in the field and conducting home visits. The inability to provide services on the part of mental health treatment providers in the field has created barriers to providing referral and linkage services to IHOT clientele who already experience barriers to transportation and access to technology. IHOT staff have successfully advocated for some mental health treatment providers to provide in-person services, but this is a very rare case.

Barriers to Medi-Cal & Private Insurance: One (1) client in particular is currently experiencing barriers to mental health treatment due to their insurance plan. This individual's parent declines to disenroll the client from their insurance plan and so the client is not eligible for Medi-Cal or any Medi-Cal Services. The client must pay co-pays to their Level 3 clinic which the family cannot afford and of which is not covered by the client's insurance. The client is not able to be assigned to a higher level of care of which they meet the criteria, such as a Full Service Partnership, because the client cannot disenroll from their private insurance without their parent's consent.

Is Anyone Better Off?

IV. **Client Impact: Provide In-Person & Face-to-Face Support During Shelter-in-Place:** Many IHOT clients verbalized access to thier usual professional supports and community connections were drasticaly reduced during Shelter-in-Place. Many IHOT clients expressed continual gratitude for La Familia IHOT being a sole form of in-person and face-to-face support during Shelter-in-Place.

Support Families/Caregivers to Navigate Community Resources & Mental Health Care System: La Familia IHOT has provided education and information to family members and caregivers about the array of mental health resources that exist in the community, such as the Family Education & Resoure Center (FERC). IHOT dedicates much time to explaining to families of clients the continuum of care that exists in Alameda County (Level 1, Level 3, Full Service Partnership, Assisted Outpatient Treatment), the eligiblity criteria for each appropriate level of care, and the scope of such services. IHOT also provides education about the process of psychiatric hosptilization (51/50), such as critera for 51/50, how to initiatve 51/50 by calling the police, 51/50 hold, collaboration with staff at John George Psychiatric Hospital, discharge, and referral to community mental health resources.

IHOT Referral Linkage: La Familia IHOT has successfully connected many IHOT clients to specialty mental health services within Alameda County based on their level of care, such as Level 1, Level 3, and Full Service Partnerships (FSP). IHOT has also connected a significant percentage of IHOT clients to Assisted Outpatient Treatment (AOT). Many of these clients would not be aware of how to access these mental health services without the support of IHOT.

Provision & Delivery of Basic Needs: IHOT has encouraged client participant through incentives through providing basic needs to consumers and their families, such as delivering food, clothes, and other basic necessities as well as provided various gift cards, such as food vouchers (Subway and McDonald's), bus passes, and gift cards to Walmart and Grocery Outlet. La Familia IHOT has also connected clients to economic resources, such as supporting clients and families to complete applications for General Assistance, CalFresh/food stamps, and unemployment benefits. La Familia IHOT has also provided clients with legal resources in regards to issues of housing and immigration.

Case Study: La Familia was referred a young adult client who was isolating in his home and exhibiting verbal aggression with his elderly parents. La Familia IHOT Peer Support Specialist and IHOT Clinician listened to the struggles of parents manage the client's behavior and provide psychoeducation about mental illness. La Familia IHOT also coached the family on initiating a 5150 in the event of a psychiatric emergency. The family initiated a 5150 one day when the client was engaging in aggressive behaviors towards the family. The client was then psychiatrically hospitalized. After discharge, the client's aggressive behaviors drastically reduced him the home and the client began engaging with the family on a more consistent social basis. The client was very self-sufficient as evidenced by his ability to drive in the local downtown area and drive to social gatherings of extended family. The client then agreed to be referred to La Familia Level 1 Service Team Program.

V. FY 20/21 Additional Information: IHOT & Operation Safer Ground Collaboration: La Familia IHOT has received many new referrals from the Operation Safer Ground Program (Safer Ground). IHOT has developed a strong relationship with ABODE staff and collaborates with ABODE staff to refer and link Operation Safer Ground clients to mental health treatment, support client's document readiness to secure housing, and provide additional case management to Safer Ground residents, such as connecting a mother's children to receive services through Regional Center of the East Bay.

VI. FY 21/22 Projections of Clients to be Served: Ninety (90) clients projected to be served in FY 21/22

VII. FY 21/22 Program or Service Changes: All La Familia IHOT Staff will begin to utilize the Alameda County Care Connect Community Health Record in the process of providing IHOT services.

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 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, and assist with connections to community resources.

Target Population: IHOT serves adults (ages 18-59) throughout Alameda county 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. STARS TAY IHOT Program focuses on transitional age youth (TAY) ages 16-24 years old, throughout Alameda County.

Operational Budget:

How Much Did We Do?

I. FY 20/21: Number of clients served: 74

How Well Did We Do?

II. Please describe ways that the program strives to:

a. **Reduce mental health stigma:** The program works to meet clients where they are with the support of transition facilitators and family advocates who have personal lived experience with mental health, substance use, and / or previous homelessness. The individuals on the team have support and receive extra peer training to meet clients where they are and assist them in envisioning and attaining any identified future goals they may have. The peers and lead clinician hold the view that the struggles that a client may be managing do not define the individual but are simply a part of their overall life experience.

b. **Create a welcoming environment:** The team works hard to locate individuals first and then slowly create a relational connection with those individuals. They meet with the individuals they are working with in a caring and non-clinical manner in order to assist in gaining trust and to promote a relational connection. The team utilizes a variety of methods to engage individuals that they are trying to connect with. These methods include games, art, food, and activities such

as going to libraries or small walks. The team always seeks to connect with the individuals they are working with in a respectful manner and use the goals that the individual is interested in to help them see the benefit of connecting and linking with other treatment providers. The team expresses interest in the topics and goals that the individual has stated are important to them. The team will also work with other people that the individual has identified as important supports, once permission is given to include them and create specific supports for family who may be overwhelmed.

III. Language Capacity for this program: Currently IHOT has language capacity for Spanish and Punjabi

a. Sixty-seven clients were served primarily in English. Six clients received services in Spanish. One client received services in Arabic using the county language line as a translation service**.**

IV. FY20/21 Challenges: The biggest challenge impacting the program at this time is the global pandemic we continue to face. It makes connecting with clients in hospitals extremely difficult and it is harder for the team to utilize the resources that they have previously utilized to find and connect with clients. Client anxieties and occasional mental health related paranoia impact the client's desire to connect or increase their individual stress overall which causes more irritability, difficulty managing symptoms and isolation. We have attempted to utilize more collateral supports to connect and link clients. However, not all individuals have a trusted family support system that can be of help.

Another challenge has been working with anyone under 18. IHOT has attempted it a few times. However, it has often resulted in parents having extreme anxiety about the under aged youth being contacted by people they don't know. Effectiveness has been limited.

Is Anyone Better Off?

V. FY 20/21 Client Impact:

4 clients who were not linked anywhere
49 clients linked back to previous provider or IHOT bridged to a new provider
1 decided to stay with private insurance

a. The IHOT program offers a once monthly family support group using tele-health modalities. This group is co-facilitated by a clinician and a family advocate. At the initial IHOT assessment of a youth, family resources are also assessed and if appropriate families are invited to participate in a monthly family support group. Through participation in this group, a community of supportive families has developed. Family members can rely on each other and the shared lived experiences for support as their youth is being offered services. Participating family members also receive psycho-education from facilitators and other participants normalizing and supporting them in their experiences. This not only supports the family but also allows for the youth to be better served by the IHOT team.

b. In one family support group session a parent shared their frustration and disappointment at their youth's quitting a job due to boundary violations. The parent described feeling that this incident was evidence of the youth's inability to persevere and successfully complete life activities. Another group member, using their lived experience, was able to re-frame the situation as an example of the youth's progress in treatment and their developing ability to advocate for themselves. The facilitators validated the parent's experience and encouraged the

parent to re-connect and support the youth's decision, thereby strengthening the youth's progress in treatment as well as the parent – youth relationship.

VI. FY 20/21 Additional Information:

5 went to jail long term and could not be linked in jail
2 went to Villa Fairmont long term
1 became deceased.
1 moved out of county, state, or country
6 are still in the process of engaging with IHOT and are not linked to a program yet
5 are still in the process of engaging with IHOT and are linked to a program

VII. FY 20/21 Projections of Clients to be Served: Approx. 60

VIII. FY 20/21 Program or Service Changes: No current service changes.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT
OESD # OESD 27

PROVIDER NAME: Telecare Corporation

PROGRAM NAME: Transition Age Youth (TAY) ROC Program

Description: Telecare TAY ROC is a short-term (90 days) outreach-evaluation-triage program serving TAY youth who are not already connected to the ACBH System of Care. TAY ROC members include transition age youth 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. TAY ROC conduct in-reach and engagement at local inpatient facilities, CSUs, and CRPs. The team also provides outreach and engagement to other locations and organizations where TAY experiencing mental health crises are likely to be found. TAY ROC staff provide linkages, supports, and resources to help clients stay in the least-restrictive , most self-sufficient, and recovery-oriented settings; reduce the need for inpatient and emergency room care; and improve mental health outcomes. Services are delivered by a team of case managers, peer support specialists, a team lead, and a clinical director. Services provided by the TAY ROC team include individual and group rehabilitation, crisis intervention, individual and group therapy, plan development and targeted case management. The latter service links the consumer to needed resources and supports in the community such as housing, benefits, medication, therapy, and medical/dental services. 80% of the TAY ROC services are delivered in the community. TAY ROC is located in the Eastmont Town Center in Oakland, CA.

Target Population: Describe information about consumers'/ clients' age group (i.e., Children/ youth, Transitional Age Youth, Adults or Older Adults; and Partners' unique needs.

TAY ROC serves TAY youths 16 to 24 years of age who are Alameda County residents, who appear to be experiencing a mental health crisis; and/or are affiliated with one of the TAY ROC referral sources; and who are not already connected to the ACBH System of Care.

How Much Did We Do?

I. FY 20/21

a. **Number of clients served:** 38 TAY enrolled in the program; an additional 70 TAY were served in outreach but did not enroll.

How Well Did We Do?

II. Language Capacity for this program and number of people served in each language:
English and Spanish

III. FY 20/21 Challenges: The TAY ROC team faced a myriad of challenges typically encountered by a startup program: creating operational systems, processes policies and protocols; hiring and training up staff; building relationships with referral agencies; establishing an IT interface with ACBH for inputting and tracking data as well as conducting Medi-Cal and MAA claiming. In addition to these common and predictable challenges, the TAY ROC team also had to contend with the threat posed by Covid-19 to staff

and client health and safety, and to modify its operational practices to comply with Covid-19 safety regulations and requirements. For example, the TAY ROC staff's ability to conduct regular in-reach to inpatient facilities, CSUs and CRPs was disrupted when facilities were closed due to Covid outbreaks.

Is Anyone Better Off?

IV. FY 20/21 Client Impact: When she was referred to TAY ROC, Client B was selectively mute, neglected her health and personal hygiene, and was inconsistent about taking her medication. The TAY ROC peer specialist was able to engage Client B and successfully built a positive relationship with her. She began accompanying Client B to appointments with her PCP, and linked her to Sausal Creek for injectable medication. After 90 days with the TAY ROC program, Client B successfully transitioned to an adult Level 1 service team.

Client C was referred to TAY ROC while he was at JGPP. He was having frequent conflicts with his family to the point that they called the police to have him put out of the house. The TAY ROC family peer specialist met with Client C, let him talk and actively listened to what he had to say. She didn't judge, she didn't lecture, and she didn't offer advice. Instead she helped him get his driver's license because that was something he said was important to him. This success led to Client C to ask the family peer specialist for help in getting a job because this was also a personal goal. Initially he didn't want TAY ROC staff to speak with his parents, and staff waited until he did. One day he gave verbal permission for his case manager to call his parents, which she did. This small opening grew over time until eventually he and his parents reconciled. After 90 days in the TAY ROC program, Client C was linked to STARS and transitioned from the program.

V. FY 20/21 Additional Information:

VI. FY 21/22 Projections of Clients to be Served: 30-35 clients monthly

VII. FY 21/22 Program or Service Changes: ACBH and Telecare are currently engaged in discussions regarding changes to the TAY ROC average monthly caseload and the reallocation of staff between AdROC and TAY ROC programs to better the manage the service capacity of both programs.

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.

How Much Did We Do?

I. FY 20/21

a. Number of clients served: 370

How Well Did We Do?

II. Please describe ways that the program strives to:

a. **Reduce mental health stigma**: We used a trauma informed lens and harm reduction approach to meet clients where they are at. We address mental health sxs as the client experiences them and try not to use clinical language. We discuss diagnosis in general terms and then ask the client specifically how they experience the sxs and diagnosis. We also talk about diagnosis on a continuum and normalize that most of the general population experiences mental health sxs and diagnosis at some point.

b. **Create a welcoming environment**: By using the same trauma informed lens and harm reduction approach to meet the client where they are at. We utilize the Critical Time Intervention (CTI) model to build strong foundation and rapport so a client feels seen for who they are and who they are not, and welcomed.

III. Language Capacity for this program: We have staff who speak English and Spanish. We have access to a language line that we have used to be able to meet all language needs of our clients.

IV. FY20/21 Challenges: COVID-19. We were still working toward reaching our full census of 400 clients when COVID-19 became a pandemic and continues to be a big factor in the community and for

our partner's and staff. Most of the agencies we work with to get our referrals and connect clients for care closed. Many agencies are still on reduced hours and very limited client contact particularly the legal advocates and capacity issues. The virus has also left clients scared and created a surge in experienced mental health symptoms. Many of our clients are still fearful to meet in person. The impact the virus had on housing was good for some clients but presented as a barrier to others. Many of the shelters our client's access was (and some still are) not taking new clients.

Staffing Retention. Due to continued challenges with the workforce due to Covid-19, BACS has experienced challenges with retaining staff. While we still continue to work hard and meet the need for clients who also experience challenges due to Covid-19, we continue to engage in the community and provide services. We at BACS are a collaboration of healthcare providers, frontline workers and essential workers and we continue to provide services even though we have times of staff shortage.

Is Anyone Better Off?

V. FY 20/21 Client Impact: We are an agency that does "Whatever it Takes" and we as we worked through the Covid-19 pandemic, we continue to provide those services and meet clients where they are at and strive to provide them with a whole person care which means that support every individual with their unique needs whether it be connecting to housing, mental health services, medical resources or just outreaching to connect to the community to increase positive social engagement. Clients have expressed feeling that they have reached many of their goals and have graduated from our program after receiving their SSI. A success story that comes to mind is of a client who was connected with the Sage team in 2017. She was 24 years old and had recently lost her father who was her only natural support. This client had medical conditions that impaired her ability to work yet she expressed interest in wanting to go back to school to learn sign language. She has significant history of PTSD, depression and anxiety. Throughout the time working with BACS, she was able to get connected to medical services and was connected to specialist for her medical condition, therapy resources and received permanent housing through Landlord Liaison program. Client has enrolled into school for sign language and now has an emotional support dog that really helps with her PTSD symptoms. Client recently was able to be granted SSI and is feeling confident in her ability to live independently! These are the stories and so many other stories that show how the clients and BACS work together to improve the lives and continue to drive our mission of doing "Whatever it takes".

VI. FY 20/21 Additional Information:

VII. FY 20/21 Projections of Clients to be Served: 400

VIII. FY 20/21 Program or Service Changes:

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT
OESD # OESD 29

PROVIDER NAME: Felton Institute

PROGRAM NAME: Older Adult Service Team

Program Description: The Older Adult Service Team supports client recovery through a holistic and strength-based approach integrating the bio-psycho-social needs of older adult clients into our comprehensive care model. With a significant number of older adults needing this level of service, there continues to be a significant need for OAST's older adult specialty care that centers the unique needs of the older adult population. Service Teams are multi-disciplinary and coordinate community-based services to provide individually customized mental health care for people experiencing frequent setbacks or persistent challenges their recovery. The overarching goal is for clients to attain a level of autonomy within the community of their choosing.

Target Population: The Older Adult Service Team serves older adults (age 60+) 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.

How Much Did We Do?

I. FY 20/21

a. **Number of clients served:** 76

How Well Did We Do?

II. Language Capacity for this program: Psychiatric Nurse Practitioner has Arabic language capacity

III. FY 20/21 Challenges: OAST, now in its fourth year, experienced significant loss of staffing, including a reduced workforce due to COVID and increased attrition rate of clinical staff working the SMI population. The program highly values quality of care and is recruiting highly qualified individuals. The program is currently drawing support from other Felton teams to support the program while hiring for 2 clinical case managers and a program manager. The program will benefit from re-establishing key community relationships as new providers come on board. The program continues to build also the necessary connection to medical sites who are unaware of us as a whole, including skilled nursing facilities and medical providers who are unfamiliar with the need to collaborate on client treatment and discharge planning to successful discharge planning. Additional challenges include the loss of traditional community and social supports as a result of COVID closing many social programming, Adult Day Health Centers, and also at times limited access to clients in congregate care. Felton's core foci during the pandemic includes the persisting need to recalibrate and be creative in meeting clients' social, community, and day program needs during this time, which have provide structure and stability for many clients.

Is Anyone Better Off?

IV. FY 20/21 Client Impact: The COVID 19 Pandemic caused significant disruption and uncertainty in our staff and clients' lives. OAST has continuously provided essential community outreach based services to

our older adults who are an exceptionally vulnerable population with regards to COVID to maintain access to vital resources. Key impacts have included persistent support for clients to access medical care, housing, and connection to family and community. The program is proud to report that at present 100% (N=76) of clients are currently housed and 98% (N=76) of clients this past year have been connected to a primary health care provider, meeting our target quality measure which is currently at 75%. This is in large part due to the model of care; staff engage reticent individuals to obtain medical care and retain housing in light of housing instability. Additionally, the clinical team advocated for the differentiation of clients' specific needs within the care system, seeking out correct assessments of both psychiatric illness and underlying/undiagnosed neurocognitive disorders, including dementia which may be misdiagnosed as a mental health condition.

Another aspect of client impact included the program's continued work towards addressing the significantly increased vulnerability for psychiatric crises during the prolonged and challenging time of COVID. As seen in our impact measure target regarding the reduction of client's CSS, PHF, or psychiatric hospitalizations for clients served for at least 12 months (N=63) which is currently at 80%, 6 people experienced a decrease in CS, PHF, and/or psychiatric hospitalizations (9.5%) and 40 people experienced no change in CS, PHF, and/or psychiatric holds (63%) reflecting a total of 73% of people who remained stable or improved stability over the past 12 months. 14 people did experience an increase in CS, PHF, and/or psychiatric hospitalizations (22.2%). Of the clients who experienced an increase in hospitalizations, there are notable crossovers in episode counts which may explain the inflation of this number as a client who experiences a single crisis, is initially admitted to a CSU and within the same date admitted to psychiatric inpatient, leading to simultaneous episodes within identical time periods.

Case Study (Pseudonym used below and identifying information removed)

Gladys is a 63-year-old single African American cis-gender woman who lives with multiple chronic illnesses and 40+ years experience of Schizophrenia. She is close with family, her 90+ year old mother is her strongest advocate. Gladys communicates minimally verbally and isolates often, preferring to sit by herself. Currently her symptoms are increasingly residual, mostly negative symptoms; Gladys typically does not communicate without prompting and responds minimally to questions, nor does she not initiate any activity without prompting, and diminished socialization. At this time she does not report experiencing auditory or visual hallucinations but has historically experienced both. Gladys typically resides in a Licensed Board and Care and is well known by the Housing Support Program team. She requires and has through OAST received support accessing transportation, attending medical appointments and managing her finances. She requires prompting to eat, clothe and bathe. Gladys is very kind and sweet, beloved by her family and providers across her spectrum of care. It is worth noting that providers working with Gladys typically go above and beyond to advocate for her, ensure she feels safe and comfortable and go extra lengths to coordinate her care.

In the past year, Gladys has moved 4 times and been hospitalized 5 times d/t physical health issues. After each hospitalization, Gladys was discharged to a rehabilitation facility. OAST experienced a challenge in establishing communication with these providers. Often the rehabilitation facility would discharge her with little to no notice, to an independent living home and would not notify her family nor case managers. Throughout the stay at home order and much of 2020 and into 2021, OAST providers coordinated closely in collaboration w/ her family, PCP, Housing Support Program providers, and the staff at the rehabilitation facilities to persistently ensure that her transition to and from hospitals, facilities and new residences went as smoothly as possible, requiring significant support from an array of providers to age in place with dignity One significant positive outcome is that Gladys now resides at a Licensed Board and Care in Oakland that is close to her mother's home. Gladys, as 20+ year client with

significant illnesses.

V. FY 20/21 Additional Information: N/A

VI. FY 21/22 Projections of Clients to be Served: 90 -110

VII. FY 21/22 Program or Service Changes: The program has undertaken increased recruiting efforts and systematized a comprehensive clinical onboarding process for new staff as it anticipates hiring highly qualified individuals to serve our population; the program is committed to hiring a diverse staff who is reflective of the community served and to training and retention as program goals this upcoming year.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT
OESD # OESD 29

PROVIDER NAME: Multiple CBO's

PROGRAM NAME: Service Teams

Program Description: The Service Team supports clients by building and teaching coping skills, living skills, creating easy access to psychiatric care, and providing housing resources. These services assist adults with SMI to decrease or even diminish mental health symptoms in order to integrate into a community, successfully. Another important purpose of the Service Team program is to avoid and eliminate repeated patterns of psychiatric hospitalizations for our client adults.

The service design includes anywhere from weekly to monthly contacts of direct service. Alameda County Behavioral Health using Medi-Cal and Medicare funds currently funds the program. Hospitalizations and incarcerations are a meaningful problem in our area, which occur annually at an increased rate. Supporting our adult clients to understand their mental health symptoms, identify triggers, and manage those symptoms is an essential process of our program. Poor mental health negatively affects an individual's ***whole-person*** health, life expectancy, and their ability to envision as well as create their **best lives** through the Social Determinants of Health.

Target Population: Service Team Program assignment - typically due to their diagnosis and high utilization of emergency/urgent behavioral health systems. Adults 18-59, must have Medi-Cal, Medicare, or be uninsured. Private insurance is not accepted.

In FY 20/21 the Service Teams were not funded under MHSA. In FY 21/22 planning began to transform these programs from a medication support/case management model to the Full Service Partnership (FSP) model. Implementation for this change process will begin in FY 22/23 and may take several years for full transformation. FY 21/22 data will be provided in the next MHSA Three Year Plan FY 23/24-25/26.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT
OESD # OESD 30

PROVIDER NAME: La Familia

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.

How Much Did We Do?

I. FY 20/21 Number of clients served:

a. Sally's Place has provided Peer support Services to 90 unduplicated new guests and re-admitted 130 guests that had returned who required more support either with referrals or respite services.

How Well Did We Do?

II. Language Capacity for this program: Among the majority of the staff at Sally's Place, all speak English and here at Sally's we make an effort to have at least 1 Spanish speaker 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 at 1 -855- 938-0124.

III. FY 20/21 Challenges: Even though we have a current process on reaching the interested, pending and return guests that are on the waiting list still face challenges with matching the bed availability to the immediate need for respite services. Sometimes when the bed becomes available here at Sally's Place we have difficulty making contact with the next guest which sometimes results in a waitlist.
Sally's Place has continuously received referrals that exceeds the established bed capacity. That is, we have far more people who are interested – and qualify for – services at Sally's Place than we do available beds. 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 is also challenging when we receive a referral from a case manager, they will give a qualifying address for the guest, but once the guest arrives to Sally's Place, 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. We have 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 is with staff sharing 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.

Is Anyone Better Off?

IV. FY 20/21 Client Impact: During FY 2020/21 Sally's Place impacted 47 African Americans, 23 Caucasian, 5 Mexican/Mexican Americans, 81 Non-Hispanic or Non –Latino, 0 Vietnamese, 2 Asian, 1 American Indian or Alaska Native, 16 Another Race not listed, 4 Unknown, 1 Native Hawaiian or Other Pacific Islander, 0 Other Non –Caucasian community members.

Having only 40 guest's return for services at Sally's Place may mean that they were feeling better also connected to helpful supportive services.

Data shows that Sally's Place have served and supported 26 Females, 63 males and one unknown/unclassified.

According to our guest exiting survey most of the guests were pleased with the Peer support service given and felt hopeful even connected, after working 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. Also reminds the guest that Sally's place staff are here to support her/him/them with information and resources even after exiting Sally's Place. 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.

Reduce mental health stigma: Here at Sally's Place we do not focus on diagnosis; even the staff have lived experiences which they share with the guests to demonstrate how recovery and wellness are possible in spite of mental health stigma. The staff provide compassion and support to encourage, educate and teach many tools or ways to advocate for themselves are given while guests are using the respite services here at Sally's Place.

Create a welcoming environment: At Sally's Place we keep the house safe and clean at all times. Before guests arrive all the staff are made aware of the arrival date and time. The staff that are on shift on the designated date prepares the room for the guest to arrive. There are times the guest doesn't have transportation so the Peer Advocate will provide the transportation to Sally's Place free of charge. When

the guest arrives the two staff on shift comes to meet the guest at the door with introductions and one of the staff shows the guest around the house, to their room, and before completing necessary welcoming packet the staff ask the guest if they would like to sit down and caught their breath first and maybe have a bite to eat.

V. FY 20/21 Additional Information: The Peer Support Specialists have taken to this model of Peer Support and consumers movement of power of choice and the whole team takes pride in supporting, encourging , empowering and advocating for the guests that stay at Sally's Place or even the guests that just need over the phone referrals or peer counseling and resouce linking.

At Sally's Place Peer Respite we serve guest from age 18 and older. The youngest guest that received services from Sally's Place was 21 yrs. old and the oldest guest was 69 yrs. old.

Sally's Place has continued to collaborate and receiving referrals from ; Alameda County CBO'S programs such as; Alameda County Emergency Medical Services (EMS), CATT TEAM, Mobile Evaluation Team - Fremont Police Department, La Familia, Fred Finch, Cherry hill Sobering station, Cherry hill Detox station, John George Psychiatric Hospital, Jay Mahler, Berkeley Drop In Center, Alameda County Mental Health Network, Sausal Creek, Homeless Action Center –Oakland, Berkeley Mental Health, BACS, Social workers- Stanford Valley care Hospital, Alameda County Family services, Families and Friends.

VI. FY 21/22 Projections of Clients to be Served: Our goal for FY 2021/22 Sally's Place Peer Respite would be to serve and admit 144 guests with 109 of those guests unduplicated. Which means that we can only re-admit 3 guests a month for FY 2021/22.

VII. FY 21/22 Program or Service Changes: Sally's Place Peer Respite is still fairly a new program. We are the first Peer run Respite in Alameda County. We make constant changes but over all our service delivery model remains the same.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT
OESD # OESD 31

PROVIDER NAME: Felton Institute

PROGRAM NAME: 1st Onset: 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. The programs provide outreach and engagement, early intervention, and outpatient mental health services that include the following categories: mental health services, case management/ brokerage, medication support, crisis intervention. In addition, (re)MIND® and BEAM Alameda also provide Individual Placement and Support (IPS) supported employment and education services. The program goals of (re)MIND® and BEAM Alameda are designed to delay or prevent the onset of chronic and disabling psychosis and mood disorders, reduce individuals' hospitalizations and utilization of emergency services for mental health issues, improve the ability of program participants to achieve and maintain an optimal level of functioning and recovery as measured by functional assessment tools, connect participants with ongoing primary healthcare services and coordinate healthcare services with individuals' primary care providers, increase participants' educational and/or employment success, increase meaningful activity as defined by the individual, decrease social isolation, and assist participants with advocating for adjustment of medications to the minimum amount necessary for effective symptom control.

Target Population: Transition Age Youth (TAY) ages 15-24, who are experiencing the onset of first episode psychosis associated with serious mental illness (SMI) and severe mood disorder.

How Much Did We Do?

I. FY 20/21 Number of clients served: The Felton Early Psychosis Programs (re)MIND® and BEAM Alameda served a total 76 unduplicated program participants from July 1, 2020 to June 30, 2021. We have served 53 individuals in (re)MIND® and 23 individuals in BEAM.

How Well Did We Do?

II. Language Capacity for this program: Currently, our staffing language capacity includes English and Spanish. Overall, we served 70 clients in English and 6 clients in Spanish. In addition, we have prompt access to interpreter services as needed for other threshold languages.

III. FY 20/21 Challenges: During the past year of FY20/21, we faced challenges that impacted service delivery: COVID-19 and its impact on service delivery and lengthy staff vacancies (including administrative and peer support staff). To address the challenges due to COVID, we have developed a hybrid model of service delivery. We continued to provide face-to-face services to our TAY youth in the community as well as in our offices, using all COVID safety precautions. We provided in-person visits to all individuals who were assessed as high-risk and/or who did not have access to telehealth or phone communication, during shelter-in-place, and this was extended to new referrals. We also created accessibility for staff to be able to provide telehealth through Zoom for Healthcare and for faxes to be sent and received electronically. We strive to provide as many sessions as clinically appropriate via Zoom

and phone calls; however, many clients and their families prefer and require face-to-face contact. This has helped keep any clients and their families engaged with services.

In addition, we shifted the delivery of group support from face-to-face to virtual groups; we are currently providing both a Youth group and a Family Support group via Zoom once per week. This required a great deal of adaptability on the part of our staff, our clients and their families.

COVID and virtual services have created other challenges. One challenge was the negative impact on total hours of direct services provided to participants due to primarily providing services via phone or telehealth. Despite best efforts, some of the barriers were participants not answering the phone or responding to text messages, limited privacy in the home, and lack of access to personal phone or computer (for some). In addition, many clients are experiencing "Zoom fatigue"; they are less engaged via computer than they would be during face-to-face sessions.

With lengthy staff vacancies, it has been difficult to meet census and billing requirements. With fewer staff, there are fewer people to see clients and to bill for services; our remaining staff are working extremely hard to continue to provide excellent services. In order to reduce staff vacancies, Felton has developed better recruitment strategies; we have invested in a recruiting services called ICMS. This service aggressively seeks new recruits across a variety of job recruitment websites.

In addition, we have also reached out to local colleges, reentry programs and BestNOW. Over the past 3 months, the Felton (re)MIND® program has hired non-master's care manager who is bilingual, a Peer Support Specialist (a BestNOW! Graduate) and an additional SEES/IPS staff. Our only remaining vacancy is for a bilingual master's level care manager/therapist; Felton is currently actively recruiting for a qualified person to fill this position. With COVID restrictions lessening, we remain hopeful to be able to continue to provide the full scope of case management, psychiatric and employment/education services, with a return to meeting census and billing requirements.

Is Anyone Better Off?

IV. FY 20/21 Client Impact: For FY 2020/21, our Impact Objective was to have an 80% decrease in CS, PHF, and psychiatric hospital admissions for clients served for 12 months or more. During this reporting period, there were 23 clients who had received services for 12 months or more. Of these 23 clients, 19 individuals had at least one admission to CS, PHF, or psychiatric hospital in the previous 12 months before enrollment. 12 out of these 19 participants (63.2%) showed reduction in the total number of crisis stabilization or inpatient services episodes. While we were unable to reach the Impact Objective of having 80% of our clients have a reduction in the inpatient admissions, many of our clients experienced increased anxiety and paranoia as a result of the impact of COVID and its social isolation.

- A notable outcome related to reduction in inpatient services is that 8 of the 19 (42.1%) clients who had prior inpatient stays did not have any CS, PHF, or psychiatric hospital stays after entering the program. The Felton (re)MIND® program was successful in helping 42.1% of these participants re-integrate into the community and return home to their families. Thus, these clients were able to avoid the debilitating effects of any further hospitalizations.
- Another achievement is that the 4 clients excluded from the 19 above, because they had no history of inpatient care, continued to not have any inpatient stays as well; the Felton

Employment Services: In addition, during this period, 37 individuals received supported employment and education services. 19 out of 37 individuals successfully engaged in competitive employment, resulting in a job placement of 51.6%. In addition, 10 of these 37 participants also received educational services; many returned to high school and college. This was one of the treatment components most disrupted by the COVID-19 pandemic and shelter-in-place orders; however, staff was relentless in keeping program participants engaged in their employment and educational goals during a time of business closures, alarming unemployment rates and remote schooling.

Personal Client/Success Story: This year, the Felton (re)MIND® program had a number of success stories. On June 23rd, 2021, we held a virtual graduation ceremony for all the clients who successfully completed the program in FY20-21. Overall, the Felton (re)MIND® program had 9 clients successfully graduate from the; 8 attended the ceremony. We also had 20 current clients and their families attend as well. The Felton (re)MIND® program provided lunch for all participants via Uber Eats. Many of the graduates spoke eloquently about their experiences and how the Felton program helped them recover. Most current clients and their families reported that they were highly inspired to witness the progress that our graduates made during their time at Felton. All who attended were hopeful for their futures and grateful for the services received.

One client spoke very eloquently about their recovery journey. When they entered Felton services, they had been recently hospitalized at St. Mary's adolescent ward. Prior to their hospitalization, they had been a straight A student; however, they had a psychotic break in their junior year. With the support of their therapist and our psychiatrist, they were able to learn effective coping skills and develop an effective medication regimen. They were able to return and complete their high school courses; they graduated in June of this year. With the support of their care manager, they applied for and was accepted at 8 colleges around the country! They will be attending UC Santa Cruz this Fall; their care manager has linked them to counseling services on campus. They attributed their success to being in the Felton program and especially to their care manager.

V. FY 20/21 Additional Information: N/A

VI. FY 21/22 Projections of Clients to be Served: We are expecting to serve 100 unduplicated individuals in FY21/22.

VII. FY 21/22 Program or Service Changes: We continue to adapt our services due to the COVID pandemic. To address the challenges due to COVID, we have developed a hybrid model of service delivery. We continued to provide face-to-face services to our TAY youth in the community as well as in our offices, using all COVID safety precautions. We provided in-person visits to all individuals who were assessed as high-risk and/or who did not have access to telehealth or phone communication during shelter-in-place; we also provided in-person services to any client or family member who requested it. This was extended to new referrals. We also created accessibility for staff to be able to provide telehealth through Zoom for Healthcare and for faxes to be sent and received electronically. We strive to provide as many sessions as clinically appropriate via Zoom and phone calls; however, many clients and their families prefer and require face-to-face contact. This has helped keep many clients and their families engaged with services.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT
OESD # OESD 32

PROVIDER NAME: Crisis Support Services

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.

How Much Did We Do?

I. FY 20/21

a. **Number of clients served:**
   - Crisis Lines (1-800-309-2131) - 25,699 Duplicated Calls
   - National Suicide Prevention Lifeline (1-800-273-8255) - 11,195 Duplicated Calls
   - ACBH Access (1-800-491-9099) - 3,290 Duplicated Calls
   - Substance Use Helpline (1-844-682-7215) - 1,272 Duplicated calls

How Well Did We Do?

II. Language Capacity for this program: English mostly. Crisis Line Counselors have access to 24/7 interpreter services in more than 140 languages via Language Lines Solutions.

III. FY 20/21 Challenges: Covid-19 and the switch to working remotely created challenges in the first half of this fiscal year. Our aging phone system and electronic health records systems were challenging to use in a remote setting and prone to technological failure, negatively impacting service level. We updated our electronic health records system and phone system to state-of-the-art web-based systems in November and December of 2020 - significantly reducing the number of missed calls. The challenge with implementing new technology systems included retraining all crisis line counselors on how to use the systems, as well as rebuilding protocols and procedures that relied on those technologies.

The nature of the crisis line service has changed over the last 5 years with increases in call volume, intensity and handle time for each call. The crisis line and National Suicide Prevention Lifeline number are posted on the back of BART cards, school ID, and there has been an increased focus on crisis centers as alternatives to calling law enforcement in the media and public discourse.

Is Anyone Better Off?

IV. FY 20/21 Client Impact:

IMPACT MEASURES	IMPACT OBJECTIVES	ACTUAL IMPACT	Objective Met?
The percent of crisis line consumers with a risk level of 3 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. **"Data only available for December 2020 due to database and training related inconsistency. We will be able to report on data moving forward in the year."	At least 20%	59.6%	Yes
The number of duplicated crisis line consumers with risk level 3-5 who have been stabilized at the end of the call without law enforcement or hospital intervention.	440 duplicated consumers	777 duplicated consumers	Yes
The percentage of duplicated crisis line consumers with risk level of 3-5 who were stabilized by the end of the call without law enforcement or hospital intervention.	At least 80%	84.7%	Yes

Covid19 was mentioned in over 5,220 calls as a stressor and crisis line counselors provided emotional support and collaborative problem solving to those callers. In the light of the Black Lives Matter movement and increased media attention and public awareness on the police killing of people of color and people living with mental health challenges, the program refined our emergency protocols and intentionally worked to reduce the number of law enforcement interventions.

We focused on connecting people with the appropriate level of care as well as educating people about the various services across the crisis continuum of care. We strengthened our relationship with Amber House, Sally's Place, Anti-Police Terror Project: Mental Health First, Berkeley Mental Health, Family Education Resource Center, NAMI and ACBH Mobile Crisis Team with regular contact and referrals and staff presentations. We worked to minimize the use of law enforcement interventions by connecting callers to crisis clinics, the mobile crisis team, and providing follow up care. We provided education about services along the crisis continuum in 3,088 calls.

777 duplicated callers (84.7%) of medium-high risk calls were deescalated over the phone without the use of law enforcement intervention. 140 calls resulted in law enforcement intervention because a suicide attempt was in progress, assessment over the phone was not possible, or the person was likely to die without further intervention.

The number of follow ups calls to medium-high suicide risk callers increased by 166% from 279 calls in FY19 to 742 calls in FY21. The time spent on follow up calls increased 80.3% from 3,881 minutes in FY19 to 6,998 minutes in FY21.

This year saw an increase in contacts with people in medium to high risk for suicide, and providing them caring connections, encouragement, and a safety net through their crisis. The number of medium to high risk calls increased by 18% from 778 callers in FY20 to 917 callers in FY21. The time spent with people who have medium to high risk for suicide increased by 32.5% from 19,080 minutes in FY20 to 25,278 minutes in FY21.

Between March 19 and April 24th 2021 callers in Alameda County were given the option to answer a satisfaction survey question at the end of their call. Our phone system only allows one question at a time. Callers were automatically routed to question 1 “On a scale of 1 to 5, how likely are you to call again if you need help? 1 being very unlikely and 5 being very likely” from March 19th to April 4th 2021. Question 2 “On a scale of 1 to 5, how connected did you feel to the counselor? 1 being very disconnected and 5 being very connected” was surveyed from April 5th-April 24th 2021.

80.72% of callers rated their likelihood of calling to call again if they needed help at 3 or higher. [Quality objective set at 75%]

84.72% of callers reported feeling a sense of connection to the counselor. 61% of callers indicated that they felt “very connected” to the counselor. [Quality objective set at 75%]

We plan on running the survey throughout the year, alternating the questions month by month.

V. FY 20/21 Additional Information: N/A

VI. FY 21/22 Projections of Clients to be Served: We expect a 3% increase in call volume on all our lines

- Crisis Lines (1-800-309-2131) - ~26,470 Duplicated Calls
- National Suicide Prevention Lifeline (1-800-273-8255) - ~11,530 Duplicated Calls
- ACBH Access (1-800-491-9099) - ~3,400 Duplicated Calls
- Substance Use Helpline (1-844-682-7215) - ~1,310 Duplicated calls

VII. FY 21/22 Program or Service Changes: The program reduced the geographic region of the crisis line (1-800-309-2131) to accept calls from Alameda County area codes 510, 925, and 341, dedicating our limited resources to people in crisis living, working, going to school or has other current connection to Alameda County. Calls from other area codes are routed to a voicemail greeting where callers can connect to a crisis line counselor by pressing 1. If the caller does not press 1, they are given the National Suicide Prevention Lifeline number. The program will continue to expand follow up services for people with medium to high risk for suicide. The program will also play an integral role in the expansion of county-wide crisis services by making referrals to the appropriate crisis stabilization and crisis residential programs.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT
OESD # OESD 32

PROVIDER NAME: Crisis Support Services

PROGRAM NAME: Zero Suicide

Program Description: The Zero Suicide program includes 4 components: Hospital follow-up, Survivors of Suicide Attempt groups, Educational presentations at Santa Rita Jail, and outreach and education to health providers

Target Population: Each of the four components listed above has a specific population that it works to reach in an effort to address those working with high risk populations or to support individuals directly who are at high risk for dying by suicide due to recent hospitalization or history of an attempt.

How Much Did We Do?

I. FY 20/21

a. **Number of clients served:** 670

How Well Did We Do?

II. Language Capacity for this program:

English is the only language that services were available in with the exception of the Hospital Follow-up staff who have access to 24/7 interpreter services in more than 140 languages via Language Lines Solutions.

III. FY 20/21 Challenges:

With our local healthcare settings focused on supporting our communities with the impact of Covid19, requests for suicide prevention workshops in healthcare settings declined dramatically in general. Our solution was to begin hosting our own workshops online to better accommodate health care workers and their potentially impacted schedule. Since Jan 2021, we have offered to the community 2 types of workshops: 1) Suicide Prevention in Health Care Settings and 2) Healthcare Workers and Stress: Preventing and Managing Burnout. Providing virtual workshops has allowed us to reach healthcare workers that we would otherwise not have been able to see in their respective settings.

Regarding the Hospital Follow-up program, CSS had created relationships and plans for being on site at John George Psychiatric hospital on a weekly basis prior to Covid-19. The pandemic was a setback for those plans and CSS had to rely heavily on referrals from providers and also the crisis line to ensure this population was served. CSS provided over 120 contacts during the fiscal year and is continuing to educate providers both inside and outside of CSS to ensure appropriate referrals are made to the program.

Is Anyone Better Off?

IV. FY 20/21 Client Impact:

CSS has had challenges with starting its SOSA group for the past few years and the group finally launched in 2021. Recruitment for participants was made possible through continued outreach and the removal of attending in person as a barrier. The group took place in person and the participants

reported positive impact by reflecting on having a space to connect around their past suicide attempts, which is something they stated they can't talk to many people about.

"Healthcare Workers and Stress: Preventing and Managing Burnout" was a new offering this year and was created to be responsive to the needs of healthcare workers during Covid-19. The workshop received positive feedback from attendees and a number of participants attended more than once and invited colleagues to attend as well. The ability to address this emerging need is important at a time when the California Healthcare Foundation has published about the suicide risk increasing in healthcare settings. CSS understands that we can't expect our healthcare workers to remain highly attuned to the suicide risk of patients when they themselves are functioning at such a high stress level.

V. FY 20/21 Additional Information: N/A

VI. FY 21/22 Projections of Clients to be Served:

We expect a 5% increase in individuals served by this program assuming that Covid-19 will be less of a barrier during the 21-22 fiscal year.

VII. FY 21/22 Program or Service Changes:

The program will continue to host workshops geared toward healthcare professionals in addition to offering to go to clinics and agencies. We anticipate that this dual approach could help overcome some of the bandwidth barriers for healthcare providers. Additionally, adding more menu items for healthcare professionals could increase the interest during these challenging times. As an example, CSS added a burnout session during 20-21 and is working on adding a session with focus on safety planning in the healthcare setting in 21-22. This is a topic that attendees in prior sessions have shown interest in.

Regarding the SOSA group, the program plans on running the group in 8-week sessions continuously so that it's easier to do recruitment, intake, and placement with interested individuals. This is also in response to feedback from other providers stating that they are more likely to refer to a group that has a set schedule.

At this time, due to the risk and limited access to those settings, Santa Rita and Healthcare Setting presentations are anticipated to remain virtual at least throughout the end of 2021.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT
OESD # OESD 33

PROVIDER NAME: Family Service Agency of San Francisco

PROGRAM NAME: Deaf Community Counseling Services

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.

How Much Did We Do?

I. FY 20/21
Fremont Office: 7 adults served, 2 children served; Berkeley Office: 11 adults served, 2 children served; Private insurance (i.e., Kaiser, UHC, Humana): 18 adults/children; Uninsured: 1 adult/children

How Well Did We Do?

II. Language Capacity for this program: English and American Sign Language (ASL)
Clinical Case Managers/Therapists and Case Manager are fluent in ASL. DCCS provide accommodations such as Tactile Sign Language (for the Deaf-Blind) and including ASL interpreters for Deaf clients who meet with psychiatrists at Felton Institute for medication management.

III. FY 20/21 Challenges: 1) To increase numbers of staff as DCCS is understaffed due to increasing numbers of referrals, 2) To increase staff's access to clinical trainings, 3) To provide needed education to agencies and providers about intricacies and complications of running a Deaf program, and 4) To increase budget to provide ASL interpreters in compliant to the *Registry of Interpreters for the Deaf* standards about the need of having two ASL interpreters: "Team interpreting is the utilization of two or more interpreters who support each other to meet the needs of a particular communication situation. Depending on both the needs of the participants and agreement between the interpreters, responsibilities of the individual team members are rotated every 20-30 minutes and feedback may be exchanged. The decision to use a team rather than an individual interpreter is based on a number of factors, including, but not limited to 1) length and/or complexity of the assignment, 2) physical and emotional dynamics of the setting, and 3) avoidance of repetitive stress injuries (RSIs) for interpreters such as Carpel Tunnel Syndrome." *(https://rid.org/about-rid/about-interpreting/setting-standards/standard-practice-papers/)*

Is Anyone Better Off?

IV. FY 20/21 Client Impact: This past year, DCCS increased outreach efforts with current partnerships in lieu of in-person events and to maintain close ties for when such community events can resume. Before

COVID outbreak occurred, DCCS staff members were invited as guest lecturer and panelist/presenter at various Deaf Community events: 1) Camp Bloom in partnership with DCARA (Deaf Counseling, Advocacy and Referral Agency, 2) ASL Language Arts and Learning at Camp Arroyo in Livermore and California School for the Deaf Fremont, and 3) California School for the Deaf-Fremont Open House. The new Program Director (Selah Davison) met with Nancy Moser, Supervisor of Counseling and Vision Services at California School for the Deaf, Fremont and discussed about pilot program called Deaf Virtual Playroom for CSD students who have severe mental illnesses. Program Director was asked by a senior student/Junior NAD from California School for the Deaf to be the guest speaker to provide virtual presentation to Junior NAD members and the topic of the presentation was called *Navigating your Mental Health as a Student*. There was estimated to be ten students, two school counselors, and a teacher. Program Director was asked to present for Deaf Plus Adult Community Center (DPAC) staff about working with clients who have both Developmental Disabilities and Schizophrenia and over 10+ participants attended this training. Program Director was asked by Gallaudet University to be a panelist for the Black Deaf Healing of Kendall School Division II Memorial (Deaf institution) in honor of Louise B. Miller Foundation.

V. FY 20/21 Additional Information: There is an increasing number of referrals; however, DCCS is understaffed, and we are currently recruiting to universities and colleges to work with graduate interns (Western Oregon University and Gallaudet University). Division of Operations and Program Director are currently planning to develop DCCS internship program so students gain clinical experience. In addition to Medi-Cal referrals, DCCS are also getting referrals from private insurances. Kimberly Cohen resigned DCCS in March 2020 and in May 2021, Selah Davison replaced Kimberly as the Program Director. Lynn Vaino continues to provide support to DCCS as the Director of Operations to ensure fiduciary and equity responsibilities of the program to the funders. Case Manager retired on June 30, 2021.

VI. FY 21/22 Projections of Clients to be Served: The DCCS program hopes to serve up 20 adults and 10 for children. The current staff structure includes 2 Clinical Case Managers (licensed and registered LPHAs), Program Director, and Administrative Support staff. Through critical review, observations, and study of this program by staff in this program, the program acknowledges the need for additional Clinical Case Managers/Therapists, Case Manager, on-call ASL interpreters and Peer Support staff to enhance the level of direct services to increase Targeted Case Management, mental health services, and supportive groups to the Deaf/Hard of Hearing community.

VII. FY 21/22 Program or Service Changes: Program Director is in the progress of reconstructing service delivery system based on the integrated behavioral health model, which provides a comprehensive or "whole-care" services to Deaf clients. Research shows that this innovative model improves the well-being of the clients when their providers work together as a multidisciplinary team that address all the barriers and DCCS team can provide more effective psychosocial treatment to the clients. DCCS will become a model program where staff will collaborate with medical agencies and providers regarding the clients' well-being. DCCS/Felton continue to work on following COVID-19 regulations and to ensure that staff follows the protocols and to help support the clients to understand the COVID-19 protocols in the community. Program Director worked with Felton Institute's Communication team to create new DCCS logo and revamp webpage/social media. Two vlogs have been created about National Deaf-Blindness Awareness Month and that DCCS offices were reopening (while still wearing masks and practice social distancing).

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT
OESD # OESD 33

PROVIDER NAME: Felton Institute (*Family Service Agency of San Francisco*)

PROGRAM NAME: TA and Capacity Building (Alameda County Network of Mental Health Clients [ACNMHC])

Program Description: *Since this isn't a typical program contract, but rather a "Technical Assistant (TA)" contract for an organization, we approached this OESD report as an analysis and assessment of the ogranization.*

There are a total of 5 programs run by Peer staff:

1) Berkeley Drop-In Clinic: Increase peer support, social interaction, wellness, and recovery among mental health consumers. Provide safe and supportive environment for mental health consumers to receive services and engage in treatment.

2) Reaching Across: Increase peer support, social interaction, wellness, and recovery among mental health consumers. Provide safe and supportive environment for mental health consumers to receive services and engage in treatment.

3) BEST NOW!: Provide internship readiness, field placement and supportive services for behavioral health consumers interested in employment within the health systems.

4) Reach Out: Increase knowledge among consumers in and transitioning from mental health and board and care facilities about community-based resources and mental health consumers.

5) Tenant Support Program: Increase knowledge among mental health consumers about housing rights and accessing housing resources; and provide Support services to improve consumer's housing security.

Target Population: Consumers 18 yrs of age and older identified as Behavioral health consumers already funded through ACBH system.

- Have histories or current conditions of psychiatric disabilities.
- Identified as severe mental health illness or severe mental stress.
- Have experienced (or at risk of experiencing) related Psych hospitalizations, Tx placements, or episodes of incarcerations in the criminal justice system.
- Experiencing housing insecurities or,
- Experiencing problems with alcohol and/or drug abuse.

How Much Did We Do?

Across all operational segments of the organization, we provided and developed frameworks for identifying areas of improvement and suggested outcomes.

We reviewed all operating systems including **Program, Fiscal, HR, IT, and Training** requirements. We also met and coached ACNMHC's Board of Directors. Due to COVID -19 and their fragile infrastructure Felton had to set priority targets to not overwhelm the few and dedicated administrative staff. Additionally, Felton has continued to provide HR oversight and management; training, recruiting, and

onboarding support; IT training and system buildout; as well as provide chief executive coaching beyond the end of the contract on June 30,2021. It is our intent to leave ACNMHC with a strong enough infrastructure and operational plan to scale their services and to be a stronger County partner.

Program Operations:

Developed Organized Data/Report to better structure program descriptions and program Requirements.

Conducted and developed assessment reports to better understand the strengths and weaknesses of each of the programs and established a list of needs of services to assist/improve program functions across the organization. Analysis based on questionnaires with program managers from the following 5 programs:

1. Program: BEST NOW — Program Manager: Shawna Sanchagrin
2. Program: Reaching Across — Program Manager: Barbara Meyers
3. Program: Tenant Support Program — Program Manager: Chaleen-White Leach
4. Program: Reach Out — Program Manager: Charlie Jones
5. Program: Berkeley Drop In Center — Program Manager: Steven Buckles with support for ED,

Fiscal:

Provided an assessment and review of Fiscal Operations to highlight areas for stabilizing and improving the Fiscal Operations to benefit the organization, moving forward.

Methodology:

Information for this section was collected in the following ways:

- Review of current documentation including, but not limited to contracts, budgets, financial statements, and leases.
- Interview with key staff involved in providing fiscal support and operations.

Human Resources:

Provided an overview of the status of Human Resource Management and an analysis of the reasons why Human Resources, as an agency responsibility, needs to be re-engineered to maximize its 'enabling' contribution to the achievement of the Business/Operational Direction.

Methodology:

Information for this section was collected in the following ways:

- Review of current documentation and reports in relation to Human Resources.
- Interviews with key personnel involved in, or who have a major stake in the provision of Human Resource Management strategies and processes; and
- Mapping of a range of current HR processes.

Information Technology:

Provided an assessment for improving the Information Technology infrastructure and highlight some critical improvements that will benefit the organization.

Methodology:

Information for this section of the report was collected in the following ways:

- Assessment survey of the current Hardware, Software, Data and Telecommunication services.
- Interviews with the current stakeholders involved in providing IT services and managing the IT infrastructure.

Training, Research & Evaluation:

We focused on three general topics, in regard to training needs:

1. Description of the current work in the context of staff development structures and needs.
2. Current agency processes for training.
3. Training needs from the perspective of the current staff.

How Well Did We Do?

FY 20/21 Challenges: The major challenges found during the assessment process for the various program operations are outlined below.

1) Berkeley Drop-In Clinic:

- Current staffing is insufficient to support for continued growth of the program.
- Existing funding impedes successful accomplishment of program objectives such as, rent, office supplies, lack of staffing.
- Lack of quality control leaves risk of participants not receiving adequate training.
- Current contractual demands of contracts do not allow workflow to recruit quality candidates, but only to meet UDC numbers.

2) Reaching Across:

- Additional funding to support operational cost (rent, office supplies, additional staff)
- The center requires renovations and update on furniture.
- All computer equipment is outdated (The associate Director works from home to complete daily tracking for the program).

3) BEST NOW!:

- Existing funding impedes successful accomplishment of program objectives such as, rent, office supplies, lack of staffing.
- Lack of quality control leaves risk of participants not receiving adequate training.
- Improve Peer trainings in areas of
    - History/Value/Approach of Peers
    - Clinical skills such as, empathy, compassion, active listening, HIPAA and confidentiality
    - Professional skills development
    - Overview of ACBH systems of network
- Current contractual demands of contracts do not allow workflow to recruit quality candidates, but only to meet UDC numbers.

4) Reach Out:

- Concerns for staff/volunteer safety when they are conducting group in psychiatric hospitals.
- Attempts to resume groups at board and cares to try and meet contract outcome measurables.

- Integrating COVID policy and procedures from federal, state and county levels to meet agency and program needs.

5) Tenant Support Program:

- Existing funding impedes successful accomplishment of program objectives such as office space (limited space to conduct adequate services)
- The Housing Market in Alameda County does not meet the demands and needs of the community.
- Lack of quality control leaves risk of participants not receiving adequate training.
- Improved communication with Alameda County Staff when application is completed.

The major fiscal challenges found during the assessment process for the current state of the fiscal operations are outlined below:

- Finance Manager handles all of the fiscal operational duties and is overwhelmed. Not to mention they are also ready to retire
- Supporting accounting staff is limited
- Current accounting manual and internal control processes need to be updated
- Lack of online access to the accounting software for remote access
- Monthly, quarterly and annual financial management reporting needs improvement
- Scope of work in the contracts don't appear to be properly funded for direct and administrative services

The major Human Resources challenges found during the assessment of the current state of Human Resource Dept are outlined below:

- An integrated and centralized Human Resources function is mandatory.
- Professional Human Resources expertise is urgent.
- Integrated Human Resources strategy and planning is critical.
- Current administrative processes need an update or overhaul.
- All existing Human Resources documents needs to comply and must be updated to reflect current Federal and State Labor Law.

At an agency level, the HR function is distributed across several areas including:

- Recruitment and Retention
- On Boarding and New Hire Orientation
- Compliance
- Training and Education
- Employee and Legal Relations
- Personnel Administration/Processes and Policies

There is no mechanism currently existing that integrates these areas. In short, it is a function without a 'center', i.e., an organizationally legitimate focal point for the integration of strategic and operational HR information, and the development of effective and efficient responses.

The major IT challenges found during the assessment of the IT infrastructure are outlined below:

- A mixed-platform hardware environment that needs upgrading

- A need for proper charting and documentation platform that is secure and HIPAA/HITECH compliant
- Incorporation of both on-premises as well as cloud services for core IT needs
- A one-person IT team serving the whole organization that may not be sustainable
- A need for IT user trainings to increase productivity, competence, and compliance
- A need for remote access capabilities
- Hardware upgrades of desktops, laptops, server and networking equipment
- Implementation of an improved (cloud-based) charting and documentation platform
- Clear data storage-and-access policies that adhere to HIPAA and HITECH rules
- Improvement and upgrade of the current website
- Regular IT user trainings for staff that also aims to address HIPAA and HITECH compliancy
- Implementation of remote access capability for staff
- Identity and authentication management system for centralized access control of IT resources
- IT helpdesk platform to streamline requests and deliver help in an efficient manner

The major Training challenges found during the assessment of the Training needs are outlined below:

- The agency provides five programs with some similar roles, but also some distinct training needs.
- There is a possible need for more refined tools for data collection and tracking (for both program outcomes and staff development), which may require resources, as well as staff learning.
- There are currently multiple competing priorities for organizational advancement.

Stated Needs – Training, Data Collection and Data Reporting

- Create foundational training content and structure:
    - All staff go through Best Now peer training model
- Structure for embedding training, coaching and assessment of training impact that is agency-wide, but still meets individual program needs. For example, only Drop-In Center requires "front-desk training."
- Via training for Supervisors and Managers – possibly a full series: building confidence in their own decision making, use of progressive discipline and other management functions, management skills; dealing with performance challenges – specific to managing a peer-based workforce (e.g. trauma-informed, person-centered, boundaries, self-care, distinguishing personal issues vs. workplace issues). [Note: The Network wishes to do more thinking about these issues, while also creating policies and procedures to help support the workforce and managers).
- Training on "Outreach Strategies and Techniques" – from tracking and measuring success, to the specifics of conducting outreach and engagement for programs (e.g. tabling at events and on street, communicating their messages with flyers, helping individuals make linkages to the agency program that fits their needs, etc.).
    - How to increase outreach to underserved populations (women, LGBTQ)
    - Be able to reach more audiences, from those that are niche to a broader audience of clients
- How to make programs more gender responsive and inclusive (for women); increasing staff awareness of gender responsivity and inclusion

- De-escalation
- Use of technology, tech literacy, google suite of programs – development needs range from those with basic skills to those with advanced skills.

Is Anyone Better Off?

We were able to implement or begin implementing the following for Human Resources:

- New Hire Orientation (NHO) – staff have been invited to join Felton's quarterly NHO. An additional day will be dedicated for the ACNMHC staff. Felton HR team will design and program the orientation accordingly.
- Compliance Training – Felton HR conduct all ACNMHC staff compliance training such as Harassment, Diversity, HIPAA and ADA Training.
- Recruiting efforts, development of recruiting strategies, marketing and expanding network tools.
- The following documents needs to be updated:
    - Employee Handbook
    - Performance Evaluation
    - Coach and Counseling
    - Human Resources Policies and Procedures
    - Agency Leave of Absence
- Management HR Training

We were able to implement or begin implementing the following for Information Technology:

- Procure Salesforce Platform (CIRCE) as a case management tool for Reaching Across program
- Customization of system and development of reports completed
- General system staff training was completed as well as training to use Salesforce Survey module.

FY 20/21 Additional Information:

Here are the items that should be prioritized moving forward:

Program Operations:

- More extensive recruitment and outreach efforts in the community vs "word of mouth" to promote these programs to the community and consumers is necessary.
- All Staff are part time doing more work than allocated time in budget.

Fiscal:

- Re-evaluate budget and staffing model to better align with the scope of work in the contracts
- Assist with renegotiation of the contracts for additional funding
- Document and update the internal controls and accounting manual
- Implementation of either the online (cloud-based) version of the accounting software or a VPN system for remote access to the software
- Assist in recruiting and hiring a Senior Accountant to replace the Finance Manager
- Reviewed costs and vendor contracts for cost savings and efficiencies

Human Resources:

- The following documents needs to be updated:

    - Employee Handbook
    - Performance Evaluation
    - Coach and Counseling
    - Human Resources Policies and Procedures
    - Agency Leave of Absence
- Management HR Training
- Staff Communication such as newsletter
- A roll out of Management Retention Plan to retain strong and talented middle level managers.
- Continuing advice/guidance and support for ALL Employee and Legal Relations issues

Information Technology:

- Reaching out program is next for possible Salesforce (CIRCE) implementation, asl long as stakeholders are motivated and ready to re-engage.

Training, Research & Evaluation:

- Create training matrix with required/desired training cycle, content needed
- Refine training content and formats – i.e. differentiate learning, how to build in supervisory assessment of skills, ongoing coaching needed, etc.
    - Consider expanding HIPAA to focus on "confidentiality" broadly defined (e.g. moving beyond PHI, which they do not have a lot of, to issues of boundaries, ethics, etc.)
    - Develop MI for all staff (if desired, or just MI for Peers)
- Review HMIS and test possibilities for expanding tracking (e.g. Outcomes only? Outcomes and training? Outcomes across all programs?)
- Refine training schedule

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT
OESD # OESD 34

PROVIDER NAME: Alameda Family Services

PROGRAM NAME: School-based Behavioral Health

Program Description: The Outreach for School-Based Health Centers program is designed to bring awareness and information about how to identify early signs of mental illness in youth and connect those in need with the mental health services offered through the School-Based Health Centers. Efforts are targeted to reach potential responders and youth.

Target Population: Adult potential responders and high school age youth living in Alameda County.

How Much Did We Do?

I. FY 20/21

a. **Number of clients served:** 1,439

How Well Did We Do?

II. Language Capacity for this program: English 1,439

III. FY 20/21 Challenges: A major challenge was opening the year in distance learning. Towards the end of last Fiscal Year, we started to identify ways to engage youth and the knowledge that distance learning would continue was a driving force for staff to think creatively and strategically about how to engage students through new mediums so that we could provide outreach & information that was not only accessible to youth, but something they would actually access/engage in. Together with our Youth Advisory Board we increased our presence on Social Media platforms, started providing virtual workshops on relevant teen topics, and began ending our large campaigns with virtual Health Fairs that take place on non-synchronous learning days.

Another challenge that we faced at the beginning of the year was how to obtain evaluation feedback from participants now that services were virtual. We experimented with attaching incentives to the surveys and for classroom presentations, requesting that the teachers incorporate the survey as a part of their “exit tickets” (end of class assignment). Having teachers provide the survey as an “exit ticket” was very successful in increasing the number of youth who completed the survey. Additionally, staff have been compiling a list of students who sign up for the workshops and then submitting a follow up email with appreciations, resources, and the survey.

Is Anyone Better Off?

IV. FY 20/21 Client Impact: Outreach efforts are focused on increasing youth’s awareness of the mental health services at the health centers/telehealth. This includes how to identify the need in yourself or a peer, as well as how to refer and/or access the services. Our outreach events are focused on relevant teen mental health topics, with an emphasis on how youth can access support resources if they are impacted by any of these issues. Whether referred or seeking support on their own, youth who attend our virtual events or interact with our digital media are supported/provided written information about how to get linked to services whether it is through AFS or to an outside resource. We have continued producing the SBHC Snapshot, an interactive newsletter which included information and links to spread awareness of continued MH Services with SBHC and in the community with a highlight on crisis services

available, provide youth with important information on self-awareness of mental health status and strategies on how to prioritize self-care and their own mental health.

Our outreach events and program helped improve access to 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 in classrooms and through open virtual links, we provided information and resources directly to youth in a non-judgmental and easily accessible manner. Our outreach efforts also target school district and school site personnel who have relationships with all youth and can refer youth who would otherwise not seek services or support on their own.

V. FY 20/21 Additional Information: N/A

VI. FY 21/22 Projections of Clients to be Served: We plan to serve approximately the same number of students this upcoming year.

VII. FY 21/22 Program or Service Changes: The most significant change this year will be providing our services on-campus and in-person. Though we have a history of providing services in-person, the return to campus this year is impacted by the Delta variant. Once school resumes, we will be in communication with school administration, students, and our team about how to approach outreach events this academic year.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD # OESD 34

PROVIDER NAME: East Bay Agency for Children (EBAC)

PROGRAM NAME: School-based Behavioral Health: Castlemont Middle School, Castlemont High School and Roosevelt Middle School.

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.

How Much Did We Do?

I. FY 20/21

a. **Number of clients served:**

EBAC provided served a total of 6,165 unduplicated services to 26 clients (students enrolled) throughout the 20-21 school year within our Castlemont High and Roosevelt Middle school sites. At Castlemont, EBAC provided services to those who identified themselves as female, male, or transgendered while at Roosevelt services were provided to those who identified themselves as female or male. The total unduplicated services are within the following categories: Family and Caregiver Supports, School Culture and Climate, and Direct client related services and supports.

How Well Did We Do?

II. Language Capacity for this program:

While the data we collected informed us that the primary language needs at Castlemont and Roosevelt are unknown for the 6,165 services, our services were predominately provided in English. Staff spoke with students, caregivers, and site staff in English when conducting services.

III. FY 20/21 Challenges:

20-21 itself was a challenging year of being in-person, having to switch to online learning and re-entering the school sites during the last six weeks of instruction. During online learning, it was challenging to ensure our student's cameras in Zoom class were turned on. Often times those who did not have their cameras turned on, decrease in engagement and lack of social aspect with our students was documented. Those students who had difficulty engaging in online learning also displayed inconsistency in attendance, causing inconsistency in services provided by EBAC.

Additionally, parent/ family contact on a consistent basis was a challenge. Due to the pandemic, several families shared feeling stressed and/or overwhelmed while juggling home life and work. It was fast

moving at times for them and they sometimes were not in a position to talk about what's working, what's not working, and their needs.

Is Anyone Better Off?

IV. FY 20/21 Client Impact:

Over the course of the year, students were impacted at various times of the year. We had two male clients that have in the past really struggled with managing behavior. This included eloping, fighting, and inappropriate language most of the day. EBAC staff was able to give these clients more one to one attention, and mentorship, allowing for increased engagement, motivation, and eagerness to learn. The last two marking periods they have earned 4.0 grades and made the principles list. Both said they are looking forward to in person learning, and continuing their success.

V. FY 20/21 Additional Information:

One of our challenges this year has been related to data systems. Our team is working to ensure data is entered in atimely manner and county is recieving the information correctly. There are a lot of "unknowns" in the data. The staff are only collecting what is in the Alameda County Survey Monkey so we do not have any data on Veteran Status, Sex at Birth, Disability, etc.

VI. FY 21/22 Projections of Clients to be Served:

EBAC is not anticipating any changes to number of clients being served as there are no changes to the classroom size for the 21-22 school year. This year we will continue to partner with all available caregiver and collateral supports for each student.

VII. FY 21/22 Program or Service Changes:

EBAC is happy to collaborate with new OUSD staff at Roosevelt Middle School. During this time, we are actively learning about the roles and responsibilities between EBAC and new OUSD staff but will continue collaborating on how to best support the clients and their families.

EBAC continues to be flexible in providing services and working through COVID guidelines and restrictions with in-person services. Now that we are back in-person, there are more opportunities to work collaboratively with school staff to support client needs and connect with caregivers.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT
OESD # OESD 34

PROVIDER NAME: Fred Finch Youth Center

PROGRAM NAME: School-based Behavioral Health: Westlake Middle & High School, Montera Middle School, Oakland High School and Skyline High School

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.

How Much Did We Do?

I. FY 20/21

a. **Number of clients served:** 29 youth and their Families.

How Well Did We Do?

II. Language Capacity for this program: We provide all services in English and the use of conversational Spanish when needed. Our Family partner staff supported 4 of our Spanish speaking parents with navigating systems. All threshold languages are available via Alameda County Behavioral Health Language Phone Line when needed. Printed materials are available in English and Spanish.

III. FY 20/21 Challenges: Challenges during this fiscal year have been the impact of COVID-19 and services moving to telehealth/ distant learning at all of the school sites. We found the most impact at our newest school site Life Academy as we started off in distant learning which was a barrier to building community with the school. This impacted clinicians' ability to support and provide services related to the climate and culture of the school and linkage to resources within the school community. We also found it challenging to support youth with life skills through telehealth services such as opening a bank account, applying for identification card, or learning to use public transportation.

Is Anyone Better Off?

IV. FY 20/21 Client Impact: Though our MHSA funding we have been able to make an impact on a youth and their family. This youth was a senior in high school and not on track to graduate. Our staff was able to provide this youth with space to engage with an adult to support them in completing classwork, learning how to track their assignments, and teach them study skills to support the youth with passing their classes. This same youth also turned 18 and was able to seek the support of our family partner staff with filling out and completing all the necessary paperwork for them to obtain a copy of their birth certificate which allowed them to get an identification card and apply for social security. We also worked with this same youth in learning job skills (filling out applications, creating a resume, and job

interview skills). This youth who was not on track to graduate on time was able to obtain the credits necessary and graduated from high school, obtained a job, and a means to financially support themselves. We were able to support this youth over the summer with insuring they were connected to continued mental health services and connected them with housing support to foster their independence.

V. FY 20/21 Additionall Information: With the support of MHSA funding (which allows us to have a family partner) we have seen an increase in family engagement with services and engagement from caregivers in their youth's education.

VI. FY 21/22 Projections of Clients to be Served: 36 clients and their families

VII. FY 21/22 Program or Service Changes: No program or service changes are expected in FY21/22

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT
OESD #: OESD 34

PROVIDER NAME: Lincoln Child Center

PROGRAM NAME: School-based Behavioral Health: MLK, McClymonds, Skyline and Howard

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.

How Much Did We Do?

I. FY 20/21

a. **Number of clients served:**

How Well Did We Do?

II. Language Capacity for this program: All families reported their primary language as English. The assigned clinician was not bilingual in English/Spanish; however, we have a staff member who is designated as our bilingual Intervention Specialist and she was available to support the team with translation support during meetings and paperwork that was sent home.

III. FY 20/21 Challenges:
MLK: Family engagement has been a consistent challenge during the pandemic. Many of the families are experiencing higher rates of stress due to COVID restrictions, remote learning from home, employment, housing, and mental health/wellness. The team hosted three parent support groups to provide families with resources and develop a sense of community and families did not attend. The planning around the transition back to in person learning was a challenge, specifically balancing staffing concerns around health and safety protocols and student and family needs.

McClymonds: Engagement pre-pandemic was a barrier to providing consistent client care for the majority of our student at McClymonds and this continued during the year of distance learning. Throughout the pandemic and with the return to in person learning in the spring, staff struggled to engage students on a consistent basis. In fact, during the return to in person learning option in the spring, zero students enrolled in the CE/SDC class returned. For many families, the pandemic brought forth additional stressors related to unemployment, stable housing, poverty, and maintaining their own physical and mental health on top of the ongoing systemic trauma they endure on a daily basis. Many families packed up and left the Bay Area to live with family as a short term solution; however, for some the short term became permanent. Access to our high school students was limited and significantly impacted by access to working Chromebooks and sustainable internet.

Skyline: The main challenge was maintaining consistent engagement during the pandemic. Throughout the pandemic and with the return to in person learning in the spring, staff struggled to engage students on a consistent basis. For many families, the pandemic brought forth additional stressors related to unemployment, stable housing, poverty, and maintaining their own physical and mental health on top of the ongoing systemic trauma they endure on a daily basis. Many families packed up and left the Bay Area to live with family as a short term solution; however, for some the short term became permanent. Access to our high school students was limited and significantly impacted by access to working Chromebooks and sustainable internet. The relationships developed with our students became that of long distance relationship separated by a screen, and assessing the ongoing mental health of our students was an ongoing challenge.

Howard: The planning around the transition back to in person learning, specifically balancing staffing concerns around health and safety protocols and student and family needs was a consistent challenge during the spring. In addition, providing a consistent rotation of staff, both clinical and behavioral staff during the in person learning program was initially a challenge but once the staff were identified a consistent schedule was developed. Communication and coordination around health and safety protocols was inconsistent across school sites and challenging for parents to understand and follow.

Is Anyone Better Off?

V. FY 20/21 Client Impact:

MLK: Despite the initial challenges of providing Chromebooks and supporting families with sustainable internet and crash courses in ZOOM, we engaged every student in the 3-5 class and half of the students in the k-2 class during the distance learning era. We consistently provided group counseling and individual counseling via Telehealth and we joined Google classrooms or ZOOM classes on a daily basis. We welcomed back 3 of 4 students in the k-2 SDC class and 3 of 5 students in the 3-5 SDC class for the in person learning program and their attendance was consistent for the last six weeks of school. We appreciated one student in the 3-5 SDC class who graduated and will transition to middle school. The behavior team plans to continue providing services to students during ESY to generalize skill sets they learned in individual and group therapy to their community. There was consistent communication and collaboration with administration and school team regarding staffing and compliance with health and safety protocols.

McClymonds: Despite the challenges, the students demonstrated resilience. Many of our seniors took part in senior events and graduation via ZOOM. Four students participated on a regular basis in group therapy via Telehealth. Despite the challenges, the Lincoln team and teacher continued to collaborate on a regular basis to plan, coordinate services for students who were engaged, and to plan for how to welcome back students in the fall.

Skyline: Despite the challenges, the students demonstrated resilience. Many of our seniors took part in senior events and graduation via ZOOM. One of our graduating seniors was accepted into a seminary program as she pursues a career as a youth pastor.

Howard: Despite the initial challenges of providing Chromebooks and supporting families with sustainable internet and crash courses in ZOOM, we engaged on average six students each day during the distance learning era. We consistently provided group counseling and individual counseling via Telehealth and we joined Google classrooms or ZOOM classes on a daily basis. We welcomed back on average 4-6 students in the class for the in person learning program for the last six weeks of school. Although attendance was not as consistent, 7 of 8 students returned for in person learning at some

point during the last 6 weeks of school. Despite a rotation of staffing, the students responded well and were able to remain engaged and safe with no incidents that required hands-on interventions. We appreciated one student in the class who be promoted to the new 4/5 I-CE/SDC classroom in the fall. The behavior team plans to continue providing services to students during ESY to generalize skill sets they learned in individual and group therapy to their community.

V. FY 20/21 Additional Information: N/A

VI. FY 21/22 Projections of Clients to be Served:
MLK: After our graduating 5th graders are discharged, four (4) students will remain on the caseload in the 3-5 class and three (3) students in the k-2 class.

McClymonds: After our graduating seniors are discharged, six (6) students will remain on the caseload leaving space for incoming freshman and sophomores who will attend in person learning for the first time. We plan to participate in the summer BRIDGE program to support incoming freshman and sophomores in returning to school.

Skyline: After our graduating seniors are discharged, five (5) students will remain on the caseload leaving space for incoming freshman and sophomores who will attend in person learning for the first time.

Howard: After our graduating 3rd graders are discharged, seven (7) students will remain on the caseload.

VII. FY 21/22 Program or Service Changes:
MLK: At the beginning of the school year we plan to have a new full time clinician to support the SDC/CE classrooms. If enrollment increases and there is a clinical need, a second clinician will be hired. There will be no changes in the staffing of the one Behavior Intervention Specialist and she will continue to provide support over the summer.

McClymonds: At the beginning of the school year we plan to have a new full time clinician and part time case manager to support the SDC/CE classroom.

Skyline: At the beginning of the school year we plan to have a new full time clinician and part time case manager to support the SDC/CE classroom.

Howard: At the beginning of the school year we do not plan to have any changes to the classroom staffing for the third consecutive year.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT
OESD # OESD 34

PROVIDER NAME: Seneca Family Services

PROGRAM NAME: School-based Behavioral Health: ASCEND, Prescott, Sequoia and Think College Now

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.

How Much Did We Do?

I. FY 20/21

a. **Number of clients served: 1308**
    a. **SBBH at ASCEND: 385**
    b. **Prescott: 192**
    c. **Sequoia: 665**
    d. **Think College Now: 66**

How Well Did We Do?

II. Language Capacity for this program:

UE Coaches at CESDC/ICESDC utilize contracted agencies to provide in person/phone interpretation or translation as needed. Specific languages used and number of people served in each was not able to be tracked for FY 20/21.

UE Clinicians at SBBH/ASCEND were bilingual in English and Spanish and able to provide services in both languages as needed. UE Clinicians additionally utilize contracted agencies to provide in person/phone interpretation or translation as needed. Specific languages used and number of people served in each was not able to be tracked for FY 20/21.

III. FY 20/21 Challenges:

Primary challenges in FY 20/21 centered around navigating and adjusting to remote learning and then back to in-person due to the COVID-19 global pandemic. During the beginning of the year, across all four school sites, there was extensive overwhelming experience by both teachers, as they were required to develop new curriculum and teaching plans, as well as students and families who were adjusting to new schedules and technologies. There was a steep learning curve felt by all in launching this school year virtually and this impacted planning, time management, motivation and engagement of the majority of the school community. As the year progressed and students, families and teachers became more familiar with online platforms and routines, additional challenges arose around finding time within the

new structures for Tier 2 and Tier 3 student supports. Even though all groups were adjusting and becoming more skilled at navigating remote learning, experiences of physical and social isolation were adding to the impact of the pandemic and "Zoom fatigue" was an increasing barrier to students' engagement in class and motivation for learning. Lastly, while the transition back to in person learning was a huge celebration and a beacon of hope for many, it was also another primary challenge for this year. Following a year of adjustments, school teams and families had little time for planning their transitions to in-person/hybrid learning while at the same time, managing the physical and emotional safety needs of students and staff returning to their campuses following a year of separation.

Is Anyone Better Off?

IV. FY 20/21 Client Impact:

ASCEND Deliverable: Contractor shall provide family and caregiver services and support through parent and family engagement activities, 1-2 times per month. UE clinicians worked with school administration through the first half of the year to design and offer parent support groups and workshops at ASCEND. During the 3rd quarter of the year, these were able to be offered for the first time, Parent/Caregiver Support Groups in both English and Spanish were offered to support caregivers with behavior management at home, offering tools during distance learning, and emotional support for caregivers themselves.
Case Study: A parent who had participated on multiple occasions in the Parent/Caregiver Support Groups asked to stay after the group ended to "check-in" with the UE Clinicians (without other parents present). This mother was able to find the courage to share her deep concerns, fears, and anxieties about her child, or more importantly, about her challenges in knowing how to best support and guide her child. This parent spoke of her child as transgendered and was able to seek out assistance directly from the UE Clinicians about ways to deepen her understanding about her child's needs. UE Clinicians were able to brainstorm with this mother, suggest options for her child, share resources for her and offer ideas that were explored at length. UE Clinicians validated this mother's experience and discussed ways to find other parents possibly having similar experiences within the school community. UE Clinicians were able to offer suggestions on ways to manage specific challenges at home and offered continued support for mother in navigating a parenting challenge that she was feeling unequipped to handle. This parent shared deep appreciation and stated that she felt validated, understood, and supported by UE Clinicians. She also shared relief that the UE Clinicians would be available to continue to support both her and her child.

Sequoia Deliverable: Contractor shall support ongoing development and implementation of trauma-informed social-emotional learning curriculum into school-wide and classroom-based routines. UE coaches worked in collaboration with families, school administration and teachers to identify school wide social emotional needs. They developed and implemented SEL curriculum at the school level to address this and support schoolwide routines.
Case Study: During family wellness check-ins, caregivers expressed a concern about student's connectedness and wellbeing. In response, the Unconditional Education coach collaborated with the school principal and after school staff to create a grade-level social-emotional/wellbeing time called Squirrels' Treehouse. This is a recurring, once a month, 30-minute community meeting where students can come, share, and connect with their peers and staff across grade-level. There has been high engagement, positive responses and feedback from students, and families have expressed that students

look forward to this time to engage with their peers and that this space is helpful in feeling a sense of connectedness to support their wellbeing.

Prescott Deliverable: Contractor shall provide staff wellness activities ongoing through the development of initiatives that build camaraderie, promote self-care, and help staff to feel recognized, valued, and effective. The UE Coach collaborated with school leadership to create times and spaces to offer support for teachers regularly and throughout the year. The UE Coach offered individual and group spaces and activities for teachers' social emotional support, team building and connection and to celebrate successes.
Case Study: At the start of the year, there was a new teacher who was struggling to begin the year. New to the Prescott team and having to build relationships with families and students, all while designing online course curriculum and practices, the teacher sought additional wellness support. The Seneca UE Coach supported this teacher in establishing a work/life balance skills and routines to build realistic expectations and reduce overwhelm. The UE coach supported the teacher through one-on-one consultation and organized small groups of her peers to support planning classroom management strategies, structures for use in the virtual setting and to build community with her fellow Prescott teachers. Over time, this teacher was able to successfully establish her classroom expectations and planning for the year and incorporate consistent time for individualized intervention and attention with students preparing for mainstream transitions. The teacher was also able to support and fully implement mainstream transitions for her ICEC students into daily specialty classes (dance, music, gardening, and circus arts).

Think College Now Deliverable: Contractor shall provide professional development workshops for school staff 3-6 times annually. During the second half of the year The UE Coach worked with school administration to focus training and communication in support of active anti-racist work at TCN. The UE Coach supported development and delivery of PDs that incorporated re-envisioning the school's theory of action to better align with the anti-bias and anti-racism viewpoints amongst the staff.
Case Study: As of the 3rd Quarter of the 2020-21 school year there was only one black teacher at TCN. This teacher has expressed feelings of isolation, stereotyping and racial inequality during her short time at TCN. During a whole team conversation about race during a professional development workshop, this teacher expressed that she is finally feeling like she is building connections with her colleagues as well as feeling comfortable to advocate for herself and her students of color against traditional TCN practices that stem from white supremacy/fragility. This UE Coach collaborated with the principal to provide anti-bias/anti-racist trainings and shareable resources while also furnishing safe space for the staff to engage in courageous conversation about racism/white supremacy and how it shows up at TCN. This teacher described her gratitude for this Unconditional Education Coach and the Seneca partnership with TCN for, "continuing to push the staff past their discomfort to uncharted territory that many schools are afraid to go to in order to do great work."

V. FY 20/21 Additional Information: During our "End of Year Partner Survey," we asked for feedback about how the impact of Seneca staff and partnerships have had on the school communities. Responses from staff at our partner programs indicate an appreciation for ongoing efforts to address staff and family wellness and to promote connection and community during this challenging year:

"[The partnership] has a very positive impact on our community. I think our community has become more inclusive and people have become more aware of equity issues."

"The UE Coach's work on the cultural leadership team has brought many new ideas to campus."

"The Seneca team was able to provide support in so many ways to individual students and teachers, as well as to the school as a whole, in ways that would not have been possible otherwise. The attention and care they were able to provide to students in need was invaluable."

"The Seneca partnership helped immensely with their presence at our school on a daily basis, getting to know the students and vice versa. Our student population may have deficits or social issues or just needing an adult to give them that reassurance to be able to be the best they can be and show progress and confidence to their teachers and their peers."

"The Seneca partnership was very instrumental at creating a school culture that responded to the student/families that we serve. The partnership was critical in that culture/climate was not just the administration duty but a separate and functional branch of our school site. This way teachers and administration could focus on academics and Seneca took care of creating a structure of Social/Emotional learning for our site."

"I've really appreciated the voices, perspectives and presence of the members of the [Seneca] team I'm acquainted with. Including their contributions to pushing the needle at our school on anti-racism and addressing anti-Blackness."

VI. FY 21/22 Projections of Clients to be Served: We project the number of students, parents/caregivers and school staff served to be approximately the same or decrease by 200-300. This decrease could potentially reflect the shift back to majority in-person activities and events which would decrease the overall attendance of some functions specifically related to client and caregiver counts. Student interactions may also decrease slightly as we find balance again between group online formats and individual supports.

VII. FY 21/22 Program or Service Changes: We will no longer be providing MHSA funded support at one of the CESDC/ICESDC schools, Place at Prescott. Instead, the UE coach funded position will be in partnership with Oakland Academy of Knowledge (formerly Howard Elementary). We are currently in assessment with our school partners to determine which contract deliverable will be the primary focus of this new partnership. While the overall goals will remain to build capacity of the whole school to provide trauma-informed, inclusive, and welcoming support for CESDC/I-CESDC students and the entire student body, the specific activities may change depending on the needs of the school and student population.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD # OESD 34

PROVIDER NAME: STARS

PROGRAM NAME: School-based Behavioral Health: East Oakland Pride Elementary School

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.

How much did we do?

I. **FY 20/21**
   a. **Client's served:** The staff at East Oakland Pride served roughly 49 unduplicated clients during the 2020-2021 school year.

How well did we do?

II. **Language capacity for this program and number of people served in each language:** Our team at East Oakland Pride consists of 2 full time staff members and one part time staff member. Amongst the team, we have one bilingual (Spanish speaking) clinician. Of the youth served this school year, approximately 26 youth identified as Latinx and spoke Spanish or were bilingual (English/Spanish speaking).

III. **FY 20/21 challenges*:*** Our clinicians had minimal access to the student body during the summer of 2020 and thus there were not many services provided during that time. MHSA services were not provided in August 2020 as clinicians were orienting to new school year and managing distance learning challenges. Early in the school year (August/September/October 2020), coordinating with teaching staff and conducting family outreach virtually provided a challenge; however, the EOP clinicians and school administrators partnered to develop a system to better coordinate care, particularly when supporting and reaching out to families in crisis. We found that there was a need for more creative and flexible outreach approaches for students and families during shelter in place and distance learning. The EOP clinicians worked to establish more regular outreach to teaching staff and partnered to identify and offer more regularly scheduled groups. There continues to be a need for additional supports for Mam speaking families in the school community and we have not been able to find the resources to appropriately service them. We have been able to better serve undocumented families considering their fear of using or applying for medi-cal by using MHSA funds. We have also faced some challenging with restarting our parent group during this past school year. We have offered virtual parent groups throughout the year but have not had any parents from East Oakland Pride participate.

Is anyone better off?

IV. FY 20/21 Client impact: Over the course of the school year, we have been able to provide individual and group support as well as crisis management for youth at East Oakland Pride. We were also able to provide in person support during the spring when youth returned to campus during the hybrid learning period. We provided Tier 1 and Tier 2 support to the school community to improve social emotional outcomes (Direct client services and support), by offering ongoing 1:1 services to 10 youth, conducting a 3rd grade classroom workshop throughout the school year, and providing social skills and coping skills groups and virtual classroom push ins. We provided support for families in need (outreach to students and families) by offering parent coaching sessions, family outreach, family meetings and family crisis support throughout the school year. We provided support to teachers/school staff through regular staff consultations and participation in COST meetings.

Case studies/success stories: Throughout the school year, we provided an ongoing classroom workshop for one of the 3rd grade classrooms that was identified as having significant challenges. The class was experiencing struggles related to attendance/participation, motivation, and social isolation. To support with these challenges, beginning in November of 2020, and continuing through the end of the school year, we provided an average of 2 workshops per month for the classroom (12 sessions total). Our clinician provided strength-based play activities (sometimes to smaller groups in the class depending on needs/themes that week, though most often to the whole class) aimed at building community amongst the students, fostering social interaction, strengthening communication, and increasing emotional identification and class motivation. The class was able to achieve regular attendance during the school year (19-25 students present daily), increased class engagement and participation, increased group cohesion, and strengthened ability to communicate needs and emotional experiences.

Another notable example involved one on one support for a 2nd grader. This youth was referred due to angry outbursts, persistent irritability that impacted his relationships with peers and staff, and frequent "shutting down" in class. Our clinician provided 1:1 support during the last few of months of the school year, teaching him skills to build awareness of his anger cues and triggers as well as supporting him with building a coping skills toolkit. By the end of the school year, he increased insight into his anger triggers, regularly used breathing exercises to manage anger, and learned healthy and safe ways of expressing anger. He was more present and engaged in class, and though the full impact on his interactions with peers was unclear, it was believed that he was less irritable during social interactions. He reported enjoying the support, and the plan is to invite him to participate in MHSA groups in the Fall to further support the enhancement of his social skills and relationships.

V. FY 20/21 Additional information: While we are able to provide support for our Spanish speaking families with the assistance of our full-time bilingual clinician, we still lack resources to support the fairly large Mam speaking population at the school. Any resources the county is aware of to provide translation support for these families would be most helpful.

VI. FY 21/22 Projections of clients to be served: As school has resumed in person instruction, we anticipate reaching a larger group of youth this school year. We hope to support at least 75

unduplicated clients this fiscal year. We also hope to increase outreach to families and ideally increase engagement in a parenting support group.

VII. **FY 21/22 Program service changes**: We intend to continue to provide the support outlined in our contract and hope to increase our offerings of teacher trainings and opportunities for parent engagement.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT
OESD # OESD 35

PROVIDER NAME: East Bay Agency for Children (EBAC)

PROGRAM NAME: Community-based Outreach & Consultation

Program Description: EBAC's Fremont Healthy Start Program engages, encourages, and trains potential community responders, primarily family members of youth and children but also school staff and community members, about ways to recognize and respond to early signs of mental illness.

Target Population: Adults (18+) who are potential community responders, primarily family members of youth and children but also school staff and community members.

How Much Did We Do?

I. FY 20/21

a. **Number of clients served:** 1,397

How Well Did We Do?

II. Language Capacity for this program: Cantonese, Farsi, Hindi, Korean, Mandarin, Pashto, Punjabi, Spanish, Urdu, and English

III. FY 20/21 Challenges:

- The lack of adequate and accessible mental health supports in certain languages is concerning, with the increased number of clients disclosing mental health issues and an anticipated wave of new clients seeking support.
- Uncertainty regarding vaccines and mask wearing are making some clients stressed.
- Financial and COVID-related stressors make it difficult for families to focus on anything other than their basic needs.
- Families have increased concerns for their children's mental health and behavior challenges.
- Clients experiencing loss are hesitant to discuss their grief.
- Technology barriers impact clients' access to mental health and other services and limit social connections.
- With many county offices closed, many families have difficulty accessing services. Our staff also continue to work remotely, but we have made access easier by devoting time to assist clients in how to use technology. We also have a drop box where clients can deliver documents.
- Anxiety and uncertainty when raising children, who many times have been left alone with no socialization, increased.

Is Anyone Better Off?

IV. FY 20/21 Client Impact: Staff helped clients feeling stressed about socialization after COVID restrictions were lifted by offering coping strategies. Staff also shared up-to-date recommendations and news to ease families' concerns and address misinformation. Clients passed this on to their families and social networks - an invaluable asset, as hearing these messages from someone in their own circle is highly effective. Staff also used motivational interviewing to identify potential areas for further education and intervention.

There were 132 Protective Factors Surveys (PFS) completed, with 90 showing an improvement in one domain. We had 140 completed satisfaction surveys and following is a summary of results: 100% reported that the support they received form EBAC was helpful, 100% reported that the support EBAC provided was the right approach for them, 100% reported that they liked the EBAC staff member(s) that worked with them, 100% reported that the EBAC program/staff was respectful of their family background and language, and 98% reported that it was very easy or easy to get services at this program. There was no feedback on how the program could be improved. The feedback on what the program did well varied from being pleased to receive service in their language, grateful for being enrolled into Medi-Cal, no longer having to worry about how to pay for a health insurance premium, staff are knowledgeable, and staff are helpful.

Case study: Staff helped a mother whose abusive husband abandoned the family. The client lost her job due to a misunderstanding and had no other revenue. She was highly stressed and worried about paying rent. Our staff linked the client to legal resources, referred her to counseling and other services, and assisted her in applying for food stamps and health insurance. The client shared that the support she received helped her to become resourceful and strong for her children.

V. FY 20/21 Additional Information: We learned much about implementing new data and service systems. There were changes made in our database that had unintended consequences. Rolling out new systems takes time and patience as staff adjust to new procedures while simultaneously meeting clients' needs. Also, wellness checks, while important, are time consuming and draining for staff. It was their tendency to want to check in with everyone at once, but some structure was important so that they could remain present with families, especially with emotions so high for all involved. We learned to give staff structure about how to spend their time each day so that they could appropriately pace themselves. We also learned the importance of the staff/client contact to reduce client isolation. Clients expressed gratitude that staff took the time to do the well checks, especially in their own language. Assisting clients with how to use technology is key to helping families feel connected and informed.

VI. FY 21/22 Projections of Clients to be Served: 1,000 outreach and education contacts.

VII. FY 21/22 Program or Service Changes: Since FY 20/21 evaluation results were overwhelmingly positive, we do not plan to make any significant programmatic changes for FY 21/22. There will be more intentionality in ensuring that clients fully understand the PFS survey questions, as we assume this is why the results were not higher in showing an improvement.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD # OESD 35

PROVIDER NAME: Mental Health Association of Alameda County (Family Education and Resource Center FERC)

PROGRAM NAME: Community-based Outreach & Consultation

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).

Target Population: Family members and caregivers of loved ones with a severe mental illness (SMI) or a severe emotional disturbance (SED) living in Alamadea County.

How Much Did We Do?

I. FY 20/21

a. **Number of clients served:** 2,279

How Well Did We Do?

II. Language Capacity for this program: English: 1778; Spanish: 203 (bi-lingual staff); Vietnamese: 9 (bi-lingual staff); The following languages were served using the Language Line: Farsi – 30; Mandarin – 21; Cantonese – 5; Arabic – 4; Tagalog – 4

III. FY 20/21 Challenges: The program has been challenged in hiring throughout FY 2020-21: We have seen a significant reduction in the number of job applicants for our open positions. Given that the majority of our program staff have been and continue to be female, this hiring challenge may be due to a pandemic trend in which women have left the workforce because of caregiving and home-schooling responsibilities. This hiring challenge has been experienced across our agency programs.

Is Anyone Better Off?

IV. FY 20/21 Client Impact: The Program provided 514 outreach contacts. The program met this deliverable which resulted in the six new projects: 1) POCC Black Men Speak: First time Annual FERC REACH Racial Trauma Community event; 2) Oakland Promise – Ongoing Mental Health for Youth Series with FERC; 3) Delta Sigma Theta Bay Area Sorority Chapter: new Annual Mental Health Townhall for the Black Community (collaboration with FERC); 4) Amazon Employees Worldwide: Annual November Mental Health Forum; 5) Union City Family Center (UCFC)– FERC now leads an African American Family Members' Monthly Support Group; 6) First Annual FERC Community Resource Fair **–** Held virtually with 10 CBOs and 4 NAMI Alameda County Chapters.

The program exceeded this deliverable with 13 virtual outreach and engagement activities, a 50% increase from the prior fiscal year. The program provided 45 virtual peer and social support groups throughout the year. **:** The program partnered with OFE to recruit and train 5 Spanish Speaking volunteers to lead Parent Cafes in Spanish for Family Member/Caregivers (Outreach/Engagement); The program recruited 3 volunteers for: 1) CIT training, the Consumer Perspective; 2) for Lunch Hour presentations on Mental Health/Diagnoses and Medications and 3) for Peer/Social Support Group

programming (for Family Members and their Loved Ones): FERC Friday Bingo group. The program held 10 virtual monthly support groups throughout the year (covering all four regions of the county).

Client Story #1: Our Family Advocate had a Family Member whose Loved One (daughter) had been homeless for two years, diagnosed with schizoaffective and SUD. The Family Member called the FERC Warmline because her daughter was at John George on a 5150. Our Family Advocate (FA) helped the Family Member fill out an AB1424, and the FA reached out to BACS. The Family Member reported that her daughter was adamant that as soon as she would be discharged from the hospital, she would be back on the streets, and was insistent that she did not want any help. With the support of the FA, the Family Member was able to get additional family members involved; the FA spoke to a cousin who was close with the Family Member 's daughter. The cousin was able to convince their LO to go to Amber House. The Family Member 's daughter has had some ups and downs since, but the family is more prepared now, and the FA speaks with the Family Member frequently to check in, support her self-care and answer questions. The Daughter has recently moved into a board and care, and the Family Member says she is doing well.

Client Story #2: Our Family Advocate (FA) had a Family Member who called the Warmline because he was having difficulties with his Loved One (son) who was experiencing first time symptoms of psychosis. His Loved One did not believe he had a mental health condition and the Family Member didn't know what to do. The FA provided the Family Member with resources such as crisis support, IHOT, AB1424. Subsequently the Family Member called crisis support during an episode with his Loved One and they were able to diffuse the crisis situation and prevent another 5150. While the Family Member had all the resources he needed, he still needed emotional support. The FA was in contact with him for over 3 months offering emotional support, encouraging him to join support groups for Family Members (FERC and NAMI), coaching him in his own self-care, educating him about mental illness, how it can impact a Loved One and their Family Member. The FA provided the Family Member with a variety of ways he could talk to his son about mental health. The Family Member called to tell his FA that he had had an extensive, frank, and compassionate conversation with his son about mental health and that his son was opening to the idea that he is living with a SMI. The Family Member shared that his Loved One had started working with a psychiatrist and was successfully taking his prescribed medications. The Family Member reported to the FA that this had brought them closer together; later, the Family Member proudly shared that he and his Loved One had achieved a milestone by going on a first vacation together.

Client Story #3: Our Family Advocate (FA) had a Vietnamese speaking-only Family Member who did not know what to do about her Loved One (husband) who was having increasing signs of depression, aggression, and psychosis. The Family Member was also concerned about the safety of her family. FERC was her first introduction to mental health. The FA explained to the Family Member what mental health was, how it can impact a person and a family. The FA discussed ways in which the Family Member could protect her family and ways in which she could take care of herself as a caregiver. The FA also helped bring in the Family Member's relatives to increase the Family Member's safety. The FA suggested that she work with the Family Member's children so that everyone could be on the same page. With this in place, the Family Member is now in a safe place with a supportive network and her family now knows what to do during a crisis. Although their Loved One continues to struggle with anosognosia, the family

is able to recognize the negative effects of stigma and is developing resilience as they strive to support their Loved one and move him towards ongoing treatment.

V. FY 20/21 Additional Information: The program experienced four trends that may be pandemic related and possibly attributed to the increase in individuals experiencing mental health conditions and social isolation: FERC experienced a 57% increase in Warm Line calls in FY 2020-21 (when compared to FY 2019-20); the program experienced a 60% increase in monthly Support Group offerings; the weekly Peer/Social support group: FERC Bingo Fridays for Family Members and their Loved Ones experienced a 45% increase in participants when compared to FY 2019-20; out of the 8 categories of needs-based resources requested for by the program's Parent Café participants across the year, the top two were: #1, Mental Health Resources and #2, Support Groups for Moms and Dads. A final significant trend became apparent in the monthly CIT training program in which there was an increase in the participation of officers from jurisdictions outside Alameda County. Across the year, 48% of the officers in attendance worked in Alameda County jurisdictions and 52% worked in jurisdictions outside the county (33% from other Bay Area jurisdictions and 19% from jurisdictions outside the Bay Area – as far north as Tahoe County and as far south as Kern County).

VI. FY 21/22 Projections of Clients to be Served: The agency (and FERC program) is committed to an ongoing process of adopting and engaging in actions focused on long term change to address the issue of racism, white privilege and the resulting systemic inequalities for African Americans and people of color. In FY 2020-21 the agency contracted a Diversity Equity and Inclusion (DEI) specialist to: assess all agency policies and practices; to conduct a listening campaign utilizing focus groups (Affinity Group Listening Sessions) to hear from all staff on how policies and practices are perceived and received. Themes related to racism and race issues, with a focus on the experience of equity, inclusion and diversity were collected. The report will be provided to agency employees in early FY 2021-22 and will provide information on readiness, data, themes and recommendations for policy, practice, and organizational improvement. The agency also sent over 500 Client Satisfaction Surveys out in FY 2020-21. The results indicated that 95% of MHAAC clients strongly agreed/agreed that working with the program helped them understand their own mental health needs or their loved one's mental health needs. 100% of MHAAC clients strongly agreed/agreed that they received services or supports in their preferred language. 92% of MHAAC clients strongly agreed/agreed that their Advocate or Family Partner provided them with the resources they needed, and 93% of MHAAC clients strongly agreed/agreed that they would refer their family and friends to the Mental Health Association of Alameda County.

VII. FY 21/22 Program or Service Changes: N/A

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT
OESD # OESD 37

PROVIDER NAME: Bay Area Community Services (BACS)

PROGRAM NAME: Re-entry Treatment Teams

Program Description: The Re-entry Treatment Teams (RTT) are a multidisciplinary treatment and case management program that serves adults who were previously incarcerated or involved in the criminal justice system. The program pairs clinical staff with peer case managers with lived experience in systems impact from the criminal justice system to meet the broad range of client needs. The program uses an eighteen month "critical time intervention"-based framework, providing intensive services and wraparound resources during the initial stabilization phase and then transitions the client to community care and supports.

Target Population: Adults, 18-59 years old, who were involved in the criminal justice system and have a severe mental illness (SMI)

How Much Did We Do?

I. FY 20/21

a. **Number of clients served:** 139

How Well Did We Do?

II. Language Capacity for this program: the RTT treatment has staffing that fluent in both English and Spanish, and had no barriers to providing services to partners with the language of choice. In addition, Bacs has invested in a language line service, in the event any partner is referred and needing services translated in a language that our current staffing can not provide.

III. FY 20/21 Challenges: As the program continue to provide services through the pandemic their were challenges around engagement, and connecting partners to community resources. Many of our partnerships closed their doors during the pandemic, which limited the programs ability to connect to supports such as: social services, social security, day programs, feeding programs and AA/NA groups. In addition, housing resources became very scarce during this fiscal year, as many landlords stopped new tenants from leasing or reduce bed availability to try and combat with the spread of covid, as a result, affected program outcomes to permanent housing.

Is Anyone Better Off?

IV. FY 20/21 Client Impact: During this fiscal year, we saw a decrease in hospitalizations and incarcerations. On average, less than 2 hospitalizations or incarcerations occurred per month.

V. FY 20/21 Additional Information: there was an increase of partners meeting with RTT psychiatry services than the previous fiscal year. Due to Covid related matters, staffing was also challenging to navigate, as we had staffing that needed to stop working to be with family or address their own matters related to COVID-19.

VI. FY 21/22 Projections of Clients to be Served: We project to serve between 100-140 partners collectively between both cohorts during this physical year. As the programs ramp up from adjustments during covid, we project to see an increase in census as mandates are lifted.

VII. FY 21/22 Program or Service Changes: We will continue to build staffing for the program, and increase community engagements this fiscal year. We are prioritizing strategy to increase psychiatry services within the program in hopes to reduce partners need to access services from multiple providers and make their ability remain connected easier to manage.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 37

PROVIDER NAME: La Familia

PROGRAM NAME: Re-entry Treatment Teams

Program Description: The Re-entry Treatment Teams are a multidisciplinary treatment and case management program that serves adults who were previously incarcerated or involved in the criminal justice system. The program pairs clinical staff with peer case managers with lived experience in systems impact from the criminal justice system to meet the broad range of client needs. The program uses an eighteen month "critical time intervention"-based framework, providing intensive services and wraparound resources during the initial stabilization phase and then transitions the client to community care and supports.

Target Population: Adults, 18-59 years old, who were involved in the criminal justice system and have a severe mental illness (SMI)

How Much Did We Do?

I. FY 20/21

a. **Number of clients served:** 49

How Well Did We Do?

II. Language Capacity for this program: RTT served 49 clients in English.

III. FY 20/21 Challenges: The COVID-19 pandemic safety measures posed challenges to program implementation, particularly in the early part of the fiscal year (prior to vaccination access). The limited capacity to have in-person interactions between staff and clients led to some challenges in rapport building, as well as challenges in completing tasks in a timely manner (i.e. documentation, clinical staff assessing over the phone was a significant challenge and as a result, they took longer to complete the initial and annual assessments). Additionally, prior to increased vaccination rates, staff were not able to transport clients to important appointments; this resulted in a slowing down of progress on some of the clients' case management goals.

RTT's support services budget appeared to decrease significantly from the previous fiscal year – this decrease limited our ability to help clients with their housing, basic needs, etc. Additionally, with a more limited support services budget, we have not been able to offer as many milestone incentives to keep clients engaged in the treatment program, due to prioritizing the funds for basic needs. Many RTT clients present to treatment as resistant to the recommendation to participate in a psychiatric assessment. Clients report a variety of reasons as to why they do not want to be involved with a psychiatrist – for example: they report a negative history of psychiatric treatment; they state that they do not want to be dependent on medication, etc. Clients may earn $30 for participation in a psychiatric evaluation. However, many clients still refuse to consider it as an option. Perhaps if the milestone incentive were greater than $30, we would see more clients be open to meeting with a psychiatrist and get them in the door and get the information directly from the doctor. Over the past year, we had a number of clients who completed the maximum time allotted for treatment with RTT but continued to require ongoing support and treatment. RTT staff have reported a common experience of referring clients for ongoing care via ACCESS

and having the clients report to them that the treatment they were referred to was not sufficient to meet their needs. These clients appeared to struggle to engage with their new provider, and RTT staff were not able to refer these clients for a higher level of care, rather, ACCESS stated that any referral must come from the treatment team the client was already referred to. The problem then becomes the refusal of former RTT clients to engage further with new treatment team, and therefore not get the referral to the higher level of care that they seem to require. RTT staff have reported a feeling of overall frustration with the system and that these clients – despite the significant progress made while with RTT – may end up decompensating.

Unfortunately, RTT clients do occasionally recidivate and end up incarcerated after they have commenced treatment with us (often due to probation violations or other more minor infractions). When this happens, it is common for the clients to be incarcerated for a few days to a few weeks (and RTT will hold their spot for them, so long as it is not a prolonged incarceration – i.e., months or more). During this challenging time, clients appear to really appreciate and rely on the supportive relationships that they have created with RTT staff. Clients will reach out to RTT staff and ask to have phone calls and/or video visits. These visits are often not free, and the clients do not have the resources to pay for them. This creates a situation where RTT staff have to decide to engage with a client who is asking for support, or pay for the visit and not get reimbursed (i.e., RTT staff cannot bill any services for clients when they are in a locked-out setting, such as Santa Rita Jail). Supervisor/Leadership work hard to navigate these tricky waters and ensure that staff and clients are appropriately cared for, but it is a challenge that continues to come up.

RTT is contracted for 1 FTE clinician and 2 FTE peer counselors. Unfortunately, RTT has struggled to fill the second peer counselor position since our lead peer counselor took a leave and then resigned late in the fiscal year. Despite being short-staffed, RTT staff continue to support our clients with their case needs.

Is Anyone Better Off?

IV. FY 20/21 Client Impact: RTT is a voluntary program, and while individuals referred to our program are often prompted to do so at the recommendation/urging of Probation, getting clients to engage is often the first challenge that staff will encounter. In the past fiscal year, once we were able to schedule/have the client show up for their intake, staff were very successful in engaging clients initially in treatment – in fact, over 90% of new RTT clients had two or more treatment sessions within the first 30 days of admission. Unfortunately, we do see some clients drop off after this first month.

Our clinical and case management staff collaborate well to help clients identify and start making progress towards case management goals as soon as they are open to RTT. A good number of RTT clients were successfully linked with Prop 47 housing funds, and/or they were connected to the Hayward Annex for housing assistance, and/or staff were able to successfully apply for COVID-related rent relief on behalf of clients. Clients in need of support regarding employment were referred to - and connected with - the Reentry Employment Program or Prison-to-Employment Program (within La Familia), or to employment services through BOSS, or - in the case of a couple clients late in the fiscal year – clients were connected with the trucking program we recently became aware of called FreeWorld. Throughout the challenging year, RTT staff continued to provide basic needs to clients, such as delivering food, other basic necessities, and gift cards to support client access food and transportation.

Client Story: a 29-year-old Mexican-American male was referred to RTT by his Probation Officer. The client was initially referred to the Reentry Employment Program, but the client stated that he was not ready to work until/unless his mental health symptoms were better controlled. The client reported ongoing and

significant audio and visual hallucinations. The client also disclosed a history of depersonalization episodes and stated that he was experiencing one of these episodes when he picked up his most recent charge (a sexual offense). The client stated that he is terrified of pain but that he never wants to be alive – he stated that he has made plans in the past to kill himself, but that he was "not strong enough to do it." In addition to the client's psychotic symptoms, he reported ongoing anxiety, panic attacks, severe social anxiety, and symptoms consistent with a mood disorder (manic episodes followed by severe depression). The client also disclosed regular methamphetamine and marijuana use. When the client commenced treatment, he was on the verge of being kicked out of his parents' home. Due to the severity of the client's initial symptoms, the client's RTT clinician met with him twice a week during the assessment phase. The client's clinician was able to help connect the client with a psychiatrist for a psychiatric evaluation. RTT staff linked the client to The Bread Project (a program focused on cooking skills – food prep and baking). The client successfully completed the program and reported that he is happy when he is cooking and identifies it as a new self-care/coping tool. RTT staff also worked closely with the client's Probation Officer and parents and were able to get the client admitted to a Dual Diagnosis residential treatment program in Alameda County. In the nearly 5 months that the client has been in that treatment setting – while continuing to stay connected to both his RTT clinician and peer counselor – the client has reported a sharp decline in nearly all of his problematic mental health symptoms. The client reported that he has a strong friendship with his roommate in treatment – identified as the first real friend he has ever had. Also of note, the client has been able to sustain this longest period of sobriety from methamphetamines (outside of incarceration). RTT staff are working to help the client successfully transition out of his Dual Diagnosis treatment program within the coming months – the client and his current roommate are supportive of each other and are interested in finding a place together and the client has even expressed an interest in finding employment. The mental health treatment and case management support provided by RTT staff, along with the collaboration with the client's Dual Diagnosis residential treatment provider, have led the client to become increasingly independent and his overall functioning has improved significantly.

V. FY 20/21 Additional Information: Housing continues to be the primary and most urgent case management need for clients. RTT staff work hard to link clients to any-and-all resources available within the county, but if we were able to help financially as well (e.g., with a deposit and first months' rent to get clients going, etc.), that would be significant. The times when we have been able to get clients connected to housing quickly are when we see faster and more sustained success. Our current support services budget allows us to support clients with approximately $100 per month (for all basic needs), and does not afford us the capability to help more directly with housing.

RTT clients are high need clients; we have 1 FTE clinician who often ends up being stretched thin to meet the significant demands of clients. If we were able to have 2 FTE clinicians to go with our 2 FTE peer counselors, we would be much better equipped to serve our clients while avoiding staff burn out and turnover.

VI. FY 21/22 Projections of Clients to be Served: For the upcoming fiscal year, we plan to be fully staffed and to subsequently be able to increase our caseload to maintain an average of 40 clients.

VII. FY 21/22 Program or Service Changes: We hope to be able to continue to increase our ability to provide in-person support for clients (RTT staff are all vaccinated and will continue to offer resources to client who have questions about – or want to access – the COVID-19 vaccine).

RTT staff have been trained on the Alameda County Care Connect Community Health Record and will be encouraged to utilize the platform.

OESD #38 (formerly FSP 7)
PROVIDER NAME: Alameda County Homeless Action Center (HAC)
PROGRAM NAME: Alameda County Supplemental Security Income Program (SSI) and Social Security Disability Insurance Program (SSDI) Advocacy Services Project
Program Description: HAC Provides SSI/SSDI advocacy to increase the number of Alameda County residents facing moderate to severe mental health issues who are approved for SSI/SSDI benefits.
Target Population: individuals with moderate to severe mental and individuals released from or about to be released from Santa Rita Jail, Glenn Dyer Detention Facility, or the State prison system.

How Much Did We Do?

I. Number of clients served: 392

How Well Did We Do?

II. Language Capacity for this program and number of people served in each language:
Languages spoken by Staff during FY 20-21 and Number of clients:

Arabic	4
Cambodian/Khmer	2
Cantonese	1
English	324
Farsi/Persian	1
French	0
Korean	2
Mandarin	2
Portuguese	0
Spanish	16
Vietnamese	0

Languages spoken by clients but no staff:

Pashto	2
Hindi	1
Farsi	1
Language not identified	36

III. FY 20/21 Challenges: Our full staff worked remotely for the entire FY, with the exception of a small team of in-office staff who showed up daily to sort and hand out mail, and our exceptional outreach Team who helped us connect with SSI/SSDI clients in encampments and other places when they couldn't come to us. We moved our drop-in legal services, intakes, and client referrals to phone, mail, and email. The subset of our clients or would-be clients whose disabilities and/or housing status make those methods of communication challenging are already the ones who face the largest hurdles in the Social Security disability application process. With the extra barrier of not being able to drop in and complete an intake or reach their attorney without a scheduled appointment, some of them fell off our radar entirely. 47 of our BHCS-funded cases were closed when the clients disappeared.

Visits to the jail were discontinued, so our strategy with those referrals changed as well, to the jail's short-session videoconference system. We made an effort to reach out to all jail clients referred to us, even if the circumstances normally wouldn't merit an SSI application, because they were so isolated at the jail during COVID It was in many ways easier to reach clients than when we had to physically travel to the jail, but because the paperwork had to travel separate from the interview, it was more difficult to get a claim started.

Social Security claims processing slowed considerably. Cases where there was not enough medical evidence for a favorable decision had been on hold for months as the fiscal year started, waiting for a remote hearing or remote exam to be scheduled, a process in which all but the most obviously disabled clients did not get a reasonable timeline or the same chances of convincing a decision maker of their need for benefits. Clients, like everyone, tended to avoid healthcare settings if not having COVID symptoms, so building a record of disability was more difficult. We worked with our evaluating psychologists to try to bridge this gap, but it took them a while to pivot to remote exams. Phone exams would allow only a fraction of the usual battery of exams to be given, and although by July we had two psychologists providing remote video exams via Teams, but it was initially only available to clients with their own phone or computer to participate. At this writing, phone and video exams and phone and video hearings are still the only options for our clients.

Is Anyone Better Off?

IV. FY 20/21 Client Impact: Our clients enjoyed over 80 favorable disability determinations in the fiscal year, despite the severe slowdown of decisions that resulted from SSA's operational changes in the pandemic. Another three cases had favorable outcomes without a disability determination: we helped a client obtain proof of birth to qualify for age related benefits, helped another stop an SSA overpayment from lowering his monthly benefits, and one client became employed to the extent she no longer needed or qualified for disability benefits.

Case Study: We appreciate most the stories where a client is initially suspicious or otherwise not comfortable with HAC or the services we provide. Because of the nature of disability claims – long and

quite personal — the relationships we have with clients often change over time. Mrs G. had a severe and longstanding personality disorder, diagnosed as early as grade school according to her records. Her 'maladaptive' patterns of interaction had remained stable over time, and like many with her diagnosis she had held a number of jobs, but none for long. She did not see her own part in the loss of jobs or relationships, but by the time she reached us she had seen so many relationships with employers, friends, family, and service providers end badly that she had no reason to think it would work out any differently with HAC. Her attorney's position was, "Yes, she is difficult to work with. And she's not going to like me, but I'm going to get her on disability anyway, because she deserves my help as much as anyone." And she did. Her attorney, R, gathered all her medical records as soon as their initial meeting was over and obtained a detailed letter of diagnosis from her treating provider. She submitted these and earned the ultimate success for the client, a win at the initial stage of the process. No disappointing denial, no length appeals. Mrs. G. knew that most people were denied at the initial stages of the process, and seemed almost pleased, but continued to have a distrustful and antagonistic relationship with her attorney even as they went to the Social Security office to finish the claim and start her benefits rolling. With her first check, Mrs. G, who had been living in her car, rented a hotel room for a week to shower and rest comfortably. However, her small dog that lived in the car with her was not allowed, and threatened to get her kicked out of the hotel. R. offered to look after the dog while Mrs. G stayed in the hotel. It was not part of her job, but she loved dogs and wanted to help Mrs. G. Mrs. G. distrustfully accepted. She came to the office each day to visit her dog, making sure the dog was cared for, and admonishing R for various things. On the last day of the stay, well-rested with her dog intact and seemingly happy, she presented R with a greeting card, containing a sincere thank you message written inside. It was completely out of character, and as such it was incredibly touching for all of us, especially R.

V. FY 20/21 Additional Information: N/A

VI. FY 21/22 Projections of Clients to be Served: This depends on the rate at which Social Security decides cases and the portion of those decisions that are favorable. It's hard to project this because of continuing pandemic impacts, but based on the past two years we would expect to serve a minimum of 400 clients. That includes approximately 250 cases still pending from the past FY, and new cases up to our maximum capacity under this contract of 560 rolling.

VII. FY 21/22 Program or Service Changes: N/A

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT
OUSD # 38 (formely FSP 7)

PROVIDER NAME: Bay Area Legal Aid (BayLegal)
PROGRAM NAME: Alameda County Supplemental Security Income Program (SSI) and Social Security Disability Insurance Program (SSDI) Advocacy Services Project
Program Description: BayLegal Provides SSI/SSDI advocacy to increase the number of Alameda County residents facing moderate to severe mental health issues who are approved for SSI/SSDI benefits.
Target Population: Individuals with moderate to severe mental and individuals released from or about to be released from Santa Rita Jail, Glenn Dyer Detention Facility, or the State prison system.

How Much Did We Do?

I. FY 20/21

a. **Number of clients served:** 328

How Well Did We Do?

II. Language Capacity for this program and number of people served in each language:
BayLegal served clients in English (307), Spanish (6), Arabic (2), Burmese (2), Cantonese (2), Mandarin (1), Farsi (3), Tagalog (2), Mon-Khmer (1), and Vietnamese (2).

III. FY 20/21 Challenges: The ongoing COVID-19 pandemic presented significant challenges to service delivery in FY 20/21, particularly in ways the pandemic affected communication with clients. For instance, clients often rely on public libraries or other public spaces—which were closed for months—to access their email. USPS delays in processing mail particularly affected homeless clients who use General Delivery and made obtaining necessary signatures more difficult. Clients sometimes do not have a stable address, move in and out of Santa Rita Jail or medical facilities, and experience periods of homelessness. All of these issues slowed services and delayed communications between staff and clients.

The closure of Social Security Administration (SSA) offices due to the pandemic also presented a unique set of challenges. BayLegal staff effectively transitioned to submitting most documents to SSA electronically. However, the SSA field offices are understaffed, the offices are generally closed to the public except for limited appointments, and hearings were held virtually. Clients have the right to an in-person hearing, so they had to consent to a virtual hearing to progress their case. BayLegal worked with clients to ensure they could attend virtual hearings and brought clients into the Oakland office as needed to attend hearings in special conference rooms retrofitted to comply with all safety protocols.

Despite these challenged, staff continued to obtain positive outcomes for clients, including initial approvals, successful virtual hearings, on the record decisions, Appeals Council and federal court remands, and effective policy advocacy with SSA and CDSS.

Is Anyone Better Off?

IV. FY 20/21 Client Impact: BayLegal served 328 clients with 356 cases in FY 20/21. BayLegal closed 169 cases: 7 cases assisted clients with advice and counsel, 19 cases assisted clients with brief services, and 143 cases assisted clients with extended services. Of extended service cases, 109 cases assisted clients with Administrative Agency Decisions, 9 cases assisted clients with court decisions, 15 cases assisted clients with extensive services not resulting in settlement or court or administrative action, 1 case assisted a client with a negotiated settlement with litigation, and 9 cases assisted clients with other

extensive services. Clients with closed extended representation cases received the following benefits: accessed client's rights to the justice system, including obtaining jurisdiction over a threshold issue, obtaining standing for a client, and preventing wrongful jurisdiction; obtained, preserved, or increased disability, age-related, and maintenance benefits; and obtained other access to justice such as a referral or other monetary benefit. Monetary benefits for clients from back awards and lump-sum settlements, reductions or eliminations of claimed amounts, cost savings, and benefits totaled $2,622,214.

BayLegal's ACBH contract, Section IV Contract Deliverables and Requirements sets the following goal: 15% or fewer cases will be closed without obtaining benefits for the following reasons: loss of contact, insufficient merit to proceed, change in eligibility status, or client withdrawal. BayLegal's rate for cases closed without obtaining benefits due to loss of contact, insufficient merit to proceed, change in eligibility status, or client withdrawal was 11%. BayLegal successfully accomplished this goal.

BayLegal's ACBH contract, Section IV Contract Deliverables and Requirements sets the following goal: achieve an SSI/SSDI allowance rate at least equal to that of the national average approval rate. In the *SSI Annual Statistical Report, 2019,* the national 2018 allowance rate was 43.5%.[4] BayLegal's FY 20/21 allowance rate for closed cases was 73%. BayLegal successfully accomplished this goal.

The client story below illustrates the work funded by this grant. *Client name changed to protect confidentiality:
Quondra D.* was living in temporary housing but was not in a supportive environment. After an incident, she was arrested and sent to Santa Rita Jail. BayLegal had previously helped Quondra obtain SSI benefits and her attorney once again stepped in to help her obtain benefits once she was released. Quondra's attorney worked with her social worker and the Public Defender's Office to determine her release date and set up housing and other social services. Quondra's attorney reviewed medical and eligibility documents and filed for SSI benefits. When Quondra was released, BayLegal and her social worker had already set up housing for her and connected her with Bay Area Community Services Homeless Engagement Action Team to provide further support. Quondra's SSI application was approved with nearly $5,000 in back payments covering the time from when she was released to when her application was approved. Quondra is now in a supportive environment, is stably housed, and is able to take care of herself.

V. FY 20/21 Additional Information: Cases with the Social Security Administration (SSA) and the California Department of Developmental Services (DDS) are generally moving more slowly due to the ongoing pandemic. SSA and DDS are both understaffed and SSA field offices are generally closed to the public. Cases with DDS are sometimes stalled awaiting a consultative examination that DDS staff has been unable to schedule due to the lack of in-person appointments, or client or clinician objections to an in-person appointment.

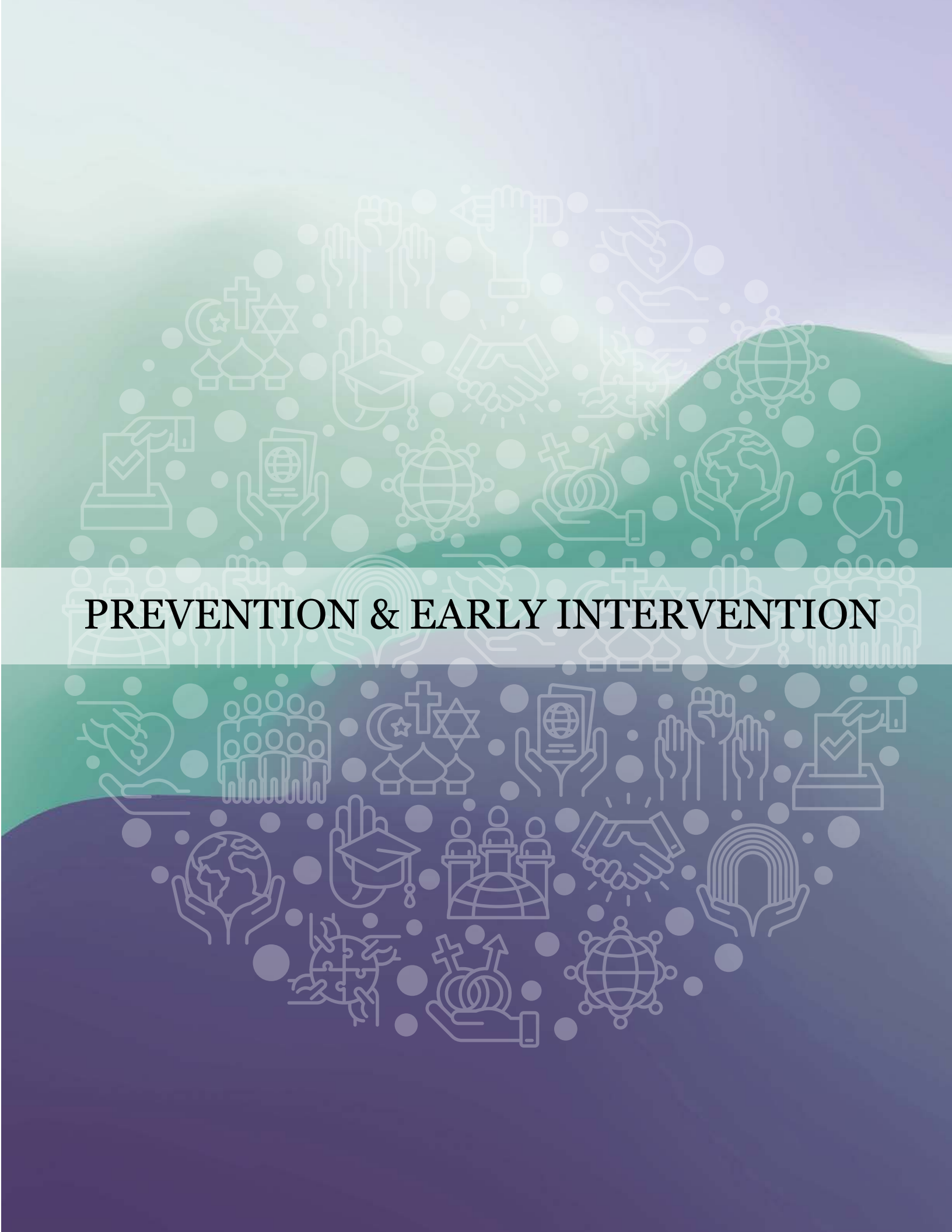
Despite these challenges, BayLegal continued to advocate for its clients. In part with BayLegal's advocacy, SSA established "vulnerable population liaisons" in field offices to help facilitate applications and address barriers to processing claims, appeals, appointment of representative, and other forms as part of SSA's COVID workgroup. In September, SSA plans to roll out a new online tool to make it easier to establish a protective filing date or application lead similar to California's GetCalFresh.org tool. BayLegal hopes that these changes will increase service access for its clients and result in more benefit

[4] This is the latest national allowance rate published directly by the Social Security Administration. https://www.ssa.gov/policy/docs/statcomps/ssi_asr/2019/ssi_asr19.pdf.

awards.

VI. FY 21/22 Projections of Clients to be Served: BayLegal estimates the number of clients to be served in FY 21-22 to be approximately 300. Clients will be represented at all stages of SSI/SSDI applications, and staff will advocate for clients with SSA and DDS.

VII. FY 21/22 Program or Service Changes: Due to the ongoing pandemic, in-person services have shifted to remote whenever possible. The Oakland office is open on a limited basis for walk-in clients. The SSI/SSDI advocacy project is supported by a remote attorney of the week who calls back clients looking for assistance. The attorney of the week screens for eligibility and merit, provides advice or brief service as needed, and adds clients to the referral list for representation.



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.

- 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.

Program Outcomes & Impact: PEI Data Report FY 20-21 (includes PEI and UELP data)

PERFORMANCE INDICATORS: How Much Did We Do?

Program Totals	Total		PEI		UELP	
	#	%	#	%	#	%
TOTAL	99,059	100%	38,233	39%	60,826	61%

PERFORMANCE INDICATORS: How Well Did We Do?

Demographics

AGE CATEGORIES	Total		PEI		UELP	
	#	%	#	%	#	%
Children/Youth (0-15 yrs.)	13,534	13%	10,490	24%	3,044	5%
Transition Age Youth (16-25 yrs.)	7,405	7%	2,113	5%	5,292	9%
Adult (26-59 yrs.)	34,154	32%	9,164	21%	24,990	41%
Older Adult (60+ yrs.)	7,054	7%	637	1%	6,417	11%
Declined to answer	1,255	1%	322	1%	933	2%
Unknown	41,776	40%	21,626	49%	20,150	33%
TOTAL	**105,178**	**100%**	**44,352**	**100%**	**60,826**	**100%**

VETERAN STATUS	Total		PEI		UELP	
	#	%	#	%	#	%
Yes	183	<1%	75	<1%	108	<1%
No	32,709	35%	10,726	35%	21,983	36%
Declined to answer	306	<1%	279	<1%	27	<1%
Unknown	58,681	64%	19,973	64%	38,708	63%
TOTAL	**91,879**	**100%**	**31,053**	**100%**	**60,826**	**100%**

SEXUAL ORIENTATION	Total		PEI		UELP	
	#	%	#	%	#	%
Gay/Lesbian	1,395	1%	319	1%	1,076	2%
Heterosexual/Straight	31,846	32%	10,173	26%	21,673	36%
Bisexual	148	<1%	125	<1%	23	<1%
Questioning/Unsure	53	<1%	39	<1%	14	<1%
Queer	915	1%	161	<1%	754	1%
Declined to answer	8,344	8%	8337	21%	7	<1%
Unknown	57,274	57%	20,054	51%	37,220	60%
Another orientation not listed	128	<1%	69	<1%	59	<1%
TOTAL	**100,103**	**100%**	**39,277**	**100%**	**60,826**	**100%**

CURRENT GENDER IDENTITY	Total		PEI		UELP	
	#	%	#	%	#	%
Female	36,199	36%	9,565	24%	26,634	43%
Male	15,244	15%	4,180	10%	11,064	18%
Transgender	247	<1%	182	<1%	65	<1%
Genderqueer	77	<1%	77	<1%	0	0%
Questioning/unsure of gender identity	42	<1%	24	<1%	18	<1%
Declined to answer	7,233	7%	7,233	18%	0	0%
Unknown	41,881	41%	18,875	47%	23,006	38%
Another identity not listed	120	<1%	81	<1%	39	<1%
TOTAL	**101,043**	**100%**	**40,217**	**100%**	**60,826**	**100%**

SEX ASSIGNED AT BIRTH	Total		PEI		UELP	
	#	%	#	%	#	%
Female	40,007	44%	13,307	43%	26,700	43%
Male	18,706	21%	8,449	28%	10,257	17%
Declined to answer	2,177	2%	2,176	7%	1	<1%
Unknown	30,569	33%	6,701	22%	23,868	39%
TOTAL	**91,459**	**100%**	**30,633**	**100%**	**60,826**	**100%**

DISABILITY STATUS	Total		PEI		UELP	
	#	%	#	%	#	%
Communication Domain Subtotal	303	<1%	219	<1%	84	<1%
Cognitive (exclude mental illness; include learning, developmental, dementia, etc.)	2,522	2%	103	<1%	2,419	4%
Physical/mobility	324	<1%	65	<1%	259	<1%
Chronic health condition	681	1%	400	1%	281	<1%
None	29,944	29%	14,155	34%	15,789	26%
Declined to answer	6,527	6%	6,527	16%	0	0%
Unknown	43,306	42%	19,848	47%	23,458	39%
Another disability not listed	18,862	18%	326	1%	18,536	30%
TOTAL	**102,469**	**100%**	**41,643**	**100%**	**60,826**	**100%**

CURRENT GENDER IDENTITY	Total		PEI		UELP	
	#	%	#	%	#	%
Female	36,199	36%	9,565	24%	26,634	43%
Male	15,244	15%	4,180	10%	11,064	18%
Transgender	247	<1%	182	<1%	65	<1%
Genderqueer	77	<1%	77	<1%	0	0%
Questioning/unsure of gender identity	42	<1%	24	<1%	18	<1%
Declined to answer	7,233	7%	7,233	18%	0	0%
Unknown	41,881	41%	18,875	47%	23,006	38%
Another identity not listed	120	<1%	81	<1%	39	<1%
TOTAL	**101,043**	**100%**	**40,217**	**100%**	**60,826**	**100%**

SEX ASSIGNED AT BIRTH	Total		PEI		UELP	
	#	%	#	%	#	%
Female	40,007	44%	13,307	43%	26,700	43%
Male	18,706	21%	8,449	28%	10,257	17%
Declined to answer	2,177	2%	2,176	7%	1	<1%
Unknown	30,569	33%	6,701	22%	23,868	39%
TOTAL	**91,459**	**100%**	**30,633**	**100%**	**60,826**	**100%**

DISABILITY STATUS	Total		PEI		UELP	
	#	%	#	%	#	%
Communication Domain Subtotal	303	<1%	219	<1%	84	<1%
Cognitive (exclude mental illness; include learning, developmental, dementia, etc.)	2,522	2%	103	<1%	2,419	4%
Physical/mobility	324	<1%	65	<1%	259	<1%
Chronic health condition	681	1%	400	1%	281	<1%
None	29,944	29%	14,155	34%	15,789	26%
Declined to answer	6,527	6%	6,527	16%	0	0%
Unknown	43,306	42%	19,848	47%	23,458	39%
Another disability not listed	18,862	18%	326	1%	18,536	30%
TOTAL	**102,469**	**100%**	**41,643**	**100%**	**60,826**	**100%**

PRIMARY LANGUAGE	Total		PEI		UELP	
	#	%	#	%	#	%
English	43,504	42%	13,219	31%	30,285	49%
Spanish	19,359	19%	8,411	20%	10,948	18%
Cantonese	2,645	3%	168	<1%	2,477	4%
Mandarin	1,030	1%	117	<1%	913	2%
Vietnamese	673	1%	86	<1%	587	1%
Farsi	622	1%	76	<1%	546	1%
Arabic	138	<1%	95	<1%	43	<1%
Tagalog	403	<1%	101	<1%	302	<1%
Declined to answer	1,983	2%	1,983	5%	0	0%
Unknown	18,632	18%	18,583	43%	49	<1%
Another language not listed	14,762	13%	86	<1%	14,676	24%
TOTAL	**103,751**	**100%**	**42,925**	**100%**	**60,826**	**100%**

RACE	Total		PEI		UELP	
	#	%	#	%	#	%
American Indian or Alaska Native	481	<1%	139	<1%	342	1%
Asian	24,447	24%	1,358	4%	23,089	38%
Black or African American	5,649	6%	4,471	12%	1,178	2%
Native Hawaiian or other Pacific Islander	3,455	4%	237	<1%	3,218	5%
White	4,477	5%	3,049	8%	1,428	2%
other Race	1,921	2%	8,059	21%	13,532	22%
Declined to answer	21,591	21%	1,921	5%	0	0%
Unknown	36,457	37%	18,418	49%	18,039	30%
TOTAL	**98,478**	**100%**	**37,652**	**100%**	**60,826**	**100%**

ETHNICITY/CULTURAL HERITAGE	Total		PEI		UELP	
	#	%	#	%	#	%
Hispanic or Latino:						
Caribbean	24	<1%	12	<1%	12	<1%
Central American	2,441	3%	1,599	4%	842	1%
Mexican/Mexican American/Chicano	7,139	7%	2,589	7%	4,550	7%
Puerto Rican	89	<1%	20	<1%	69	<1%
South American	366	<1%	191	<1%	175	<1%
Another Hispanic/Latino ethnicity not listed	10,201	10%	4,050	11%	6,151	10%
Hispanic or Latino Subtotal:	20,260	21%	8,461	23%	11,799	19%
Non-Hispanic and Non-Latino:						
African	783	1%	57	<1%	726	1%
African American	3,396	3%	3,249	9%	147	<1%
Asian Indian/South Asian	1,309	1%	122	<1%	1,187	2%
Cambodian	7,107	7%	35	<1%	7,072	12%
Chinese	4,131	4%	203	<1%	3,928	6%
Eastern European	46	<1%	46	<1%	0	0%
European	277	<1%	277	1%	0	0%
Filipino	1,585	2%	309	1%	1,276	2%
Japanese	23	<1%	19	<1%	4	<1%
Korean	843	1%	11	<1%	832	1%
Middle Eastern	72	<1%	72	<1%	0	0%
Vietnamese	1,167	1%	89	<1%	1,078	2%
Other Non-Hispanic or Non-Latino ethnicity not listed	13,603	14%	236	1%	13,367	22%
Non-Hispanic and Non-Latino Subtotal:	34,342	34%	4,725	13%	29,617	49%
More than one ethnicity	317	<1%	317	<1%	0	0%
Unknown Ethnicity	38,959	40%	19,847	54%	19,112	32%
Declined to answer	3,530	4%	3,530	9%	0	0%
TOTAL	**97,408**	**100%**	**36,880**	**100%**	**60,528**	**100%**

Prevention & Early Intervention 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 Outcomes & Impact: PEI Data Report FY 20/21

Program Name:	Blue Skies Mental Health Wellness Team	
Organization:	Alameda County Public Health	
PEI Program # and Name:	PEI 1A School Based MH Consultation in Preschools	
Type of Report (Choose one):	Annual	
PEI Category (choose one):		
Priority Area (place and X next to all that apply):	X	Childhood Trauma
		Early Psychosis
		Youth/TAY Outreach and Engagement
		Cultural and Linguistic
		Older Adults
	X	Early Identification of Mental Health Illness

Box A: Please provide a brief program description (character limit 1,000).

BSMWT was established in 2015 in collaboration with a Project Launch grant effort between First 5 Alameda County and ACPHD. The program was designed to support efforts of integrating mental health prevention into the public health MPCAH department that would allow home visiting programs to have access to Early Childhood Mental Health System of Care and to have linkage segues with ACBH and other programs serving young families with mental health concerns.

Box B: Number of individuals served during this fiscal year through MHSA funding.	
Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	0
Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	67
Number of unduplicated individual family members served indirectly by your program:	35
Grand total of unduplicated individuals served:	**102**

Box C: Demographics of individuals served during this fiscal year through MHSA funding.

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	35
Transition Age Youth (16-25 yrs.)	9
Adult (26-59 yrs.)	58
Older Adult (60+ yrs.)	
Declined to answer	
Unknown	
TOTAL	**102**

VETERAN STATUS	
Yes	
No	
Declined to answer	
Unknown	67
TOTAL	**67**

SEXUAL ORIENTATION	
Gay/Lesbian	
Heterosexual/Straight	
Bisexual	
Questioning/Unsure	
Queer	
Declined to answer	
Unknown	67
Another group not listed	
TOTAL	**67**
If another group is counted, please specify:	

CURRENT GENDER IDENTITY	
Female	81
Male	21
Transgender	
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	
Another identity not listed	
TOTAL	**102**
If another identity is counted, please specify:	

PRIMARY LANGUAGE	
English	47
Spanish	17
Cantonese	
Chinese	
Vietnamese	
Farsi	
Arabic	
Tagalog	
Declined to answer	
Unknown	
Another language not listed	
TOTAL	**67**
If another language is counted, please specify:	

SEX ASSIGNED AT BIRTH	
Male	81
Female	21
Declined to answer	
Unknown	
TOTAL	**102**

DISABILITY*** STATUS	
Communication Domain	
Vision	
Hearing/Speech	
Another type not listed	
Communication Domain Subtotal	**0**
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	1
Physical/mobility	2
Chronic health condition	
Disability Subtotal	**3**
None	99
Declined to answer	
Unknown	
Another disability not listed	
TOTAL	**102**
If another disability is counted, please specify:	

RACE	
American Indian or Alaska Native	
Asian	1
Black or African American	44
Native Hawaiian or other Pacific Islander	
White	
Other Race	3
Declined to answer	6
Unknown	13
TOTAL	**67**
If another race is counted, please specify:	

Ethnicity/Cultural Heritage (Please choose only one per individual)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	4
Mexican/Mexican American/Chicano	5
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	11
Total Hispanic or Latino	**20**

If Non-Hispanic or Non-Latino, please specify:	
African	
African American	42
Asian Indian/South Asian	1
Cambodian	
Chinese	
Eastern European	
European	1
Filipino	
Japanese	
Korean	
Middle Eastern	
Vietnamese	
Other Non-Hispanic or Non-Latino ethnicity not listed	
Total Non-Hispanic or Non-Latino	**44**
More than one ethnicity	
Unknown Ethnicity	3
Declined to answer	
EHTNICITY TOTAL	**67**

Box D: Program <u>successes/accomplishments</u> of the past year with one example or case study that the agency is particularly proud of. Note: 1,000-character limit.

In this case, the mother was originally seen by the Nurse Family Partnership Program in her second trimester. After observing symptoms, the client was referred to the BSMWT clinician who continued to assess the client and provide weekly therapy and case management support. The client was referred to the Pathways to Wellness Clinician and was able to receive psychiatric care and medication management where client's symptoms began to decrease. During weekly teletherapy sessions, the clinician encouraged the mother to maintain her prenatal care and she was able to deliver a healthy baby who is now being supported by client, her mother, her NFPP Public Health Nurse and the BSMWT clinician.

Box E: Program challenges of the past year and how the agency mitigated challenges? Note: 1,000-character limit.

The team came together with the support of the Program Manager and devised a schedule of deployment debriefing sessions where staff could discuss the impacts of their sudden deployments. The BSMWT also provided a link with Beverly Kyer, Trauma Specialist, who provided meditation workshops and information sessions for MPCAH staff to attend who were working in the face of COVID traumas. The team offered support to the MPCAH Home Visiting SOC for all deployed staff for 6 months. The BSMWT additionally kept active caseloads. The team manager also engaged in the process of hiring three new behavioral health clinicians via the Alameda Healthy Start Initiative grant and there were numerous interviews conducted to hire new staff.

Box F: Program lessons learned of the past year? Note: 1,000-character limit.

I learned that working through a pandemic dramatically changed the focus of the team working in a large public health care system based on departmental needs. Team members need and required more effective/supportive supervision meetings during pandemic times. Hiring and incorporating new team members and blending a team can be challenging. Pandemic can impact service delivery as home visiting models cease and virtual and teletherapy began. Clinicians had to adjust to this new format. Clients still sought early childhood mental health service during crisis times**.**

Prevention & Early Intervention 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. This evaluation report was provided in coordination and partnership with Alameda County Behavioral Health and the Unserved/Underserved Ethnic Language Population (UELP) programs and their community partners:

- Afghan Coalition
- Asian Health Services
- Bay Area Community Health
- Center for Empowering Immigrants & Refugees
- Diversity in Health Training Institute
- 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.

In 2014, Alameda County Behavioral Health (ACBH) worked with seven Unserved/Underserved Ethnic Language Population (UELP) programs to develop and administer an outcome-based survey. The survey was administered again in 2015. The outcome-based survey was revised in 2016 and separated into two different data tools – the UELP Community Health Assessment and the UELP Community Wellness Client Satisfaction Survey. Each of the UELP providers vetted and implemented the new tools in 2017.

The current UELP system has now expanded to a total of 13 providers, serving additional ethnic and language groups. This report is about the 2020/2021 evaluation.

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.

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) *Preventive Counseling (PC)* services, designed for clients who are showing early signs and symptoms of a mental health concern. Responses to the client satisfaction survey were analyzed separately for *Prevention* and *PC* services to measure any differences between the two types of services. The health assessment is only given to *PC* clients. The evaluation used mixed methods. To better understand the meaning of survey responses, ACBH also conducted focus groups with the UELP program participants.

KEY FINDINGS

The client satisfaction survey and focus groups were used to assess the program outcomes. The critical findings of the analysis are summarized below. During fiscal year 2020-2021, a total of 668 respondents from all 13 of the UELP programs completed the survey.

In FY 20/21, the data shows that UELP providers in total produced:

- 9,135 *Prevention* events, which is a 22% increase from last year and a 15% increase over pre-pandemic FY 18/19;
- 70,239 people were served at these *Prevention* events (duplicated count); and
- 1,174 unique clients were served through *PC* services, which is an 8% increase in the number of clients served in FY 19/20.

In FY 20/21, both assessment tools assessed the impact of the three core strategies (Outreach and Engagement; Mental Health Consultation; and Early Intervention services) across the following outcomes:

- Forming and Strengthening Identity
  Prevention services enhance self-efficacy. Ninety-two percent of *Prevention* and eighty-four percent of *PC* respondents reported feeling better about themselves.

- Changing Individual Knowledge and Perception of Mental Health Services
  Providers are working towards changing the perception and narrative around mental health. Ninety-three percent of *Prevention* respondents and eighty-nine percent of *PC* respondents reported having a stronger belief that most people with mental health experiences can grow, change, and recover. 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 help clients build and reduce the risk of social isolation. Ninety-four percent of *Prevention* respondents and eighty-six 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 improved their ***parenting skills*** and learned how to parent in America. Ninety-four percent of *Prevention* respondents and eighty-five percent of *PC* respondents reported feeling more connected to their culture and community. Due to the COVID-19 pandemic activities have moved to online spaces, Focus Group participants said that this makes it easier for them to participate in the programs. However, there was a decrease in the mention of participants connecting to their culture during the Focus Groups this year.

- 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, housing, food, and financial services. Ninety percent of *Prevention* respondents and eighty-two 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 ***linguistically and culturally competent*** programs. Ninety-seven percent of *Prevention* respondents and 95% of *PC* respondents said that staff were sensitive to their cultural backgrounds and understood what they are going through. Ninety-nine percent of *Prevention* and PC respondents reported that program staff treated them with dignity and respect. Additionally, ***staff*** were said to be among the most beneficial parts of the program in the open-ended responses.

This is reflected in the high percentage of *Prevention* (97%) and *PC* (96%) respondents agreeing that they would recommend this program to a friend or family member. Despite largely providing online services since March of 2020, the UELP agencies are still able to provide a welcoming and inviting atmosphere that is safe for clients.

ADDITIONAL FINDINGS

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. More than half (72%) of *PC* respondents reported fewer crises, which is a large increase compared to last year (57%).

Focus group respondents suggested that participation might be more sustainable if the groups ***continued online***. They find it more convenient because they do not have to find transportation or take more time out of their day. When asked what they would like to see more of on the client satisfaction survey respondents wanted more help with ***mental health*** and focus group respondents mentioned that they wanted ***youth programming*** to help them with their mental health.

EVALUATION LIMITATIONS

Although this annual evaluation data continues to show positive results, it has several limitations in our assessment methods, including the small sample size, the lack of comparison group, and the subjective nature of qualitative assessment and analysis. ACBH will continue to work with the program evaluator to better capture the results of PEI programs and the longer-term impact on client

MHSA Program #: PEI 1

PROVIDER NAME: La Familia Counseling Services

PROGRAM NAME: Outreach, Education & Consultation for Unaccompanied Immigrant Youth (UIY)

Program Outcomes & Impact: UELP Prevention Data Report FY 20/21

Program Name:	Unaccompanied Immigrant Youth Outreach (UIY)	
Organization:	La Familia Counseling Services	
PEI Program # and Name:	PEI 1D Unaccompanied Immigrant Youth Outreach (UIY)	
Type of Report (Choose one):	Annual	
PEI Category (choose one):	Outreach	
Priority Area (place and X next to all that apply):	x	Childhood Trauma
		Early Psychosis
	x	Youth/TAY Outreach and Engagement
	x	Cultural and Linguistic
		Older Adults
	x	Early Identification of Mental Health Illness

Box A: Please provide a brief program description (character limit 1,000).

Unaccompanied immigrant youth (UIY) are minors who make dangerous journeys across borders to flee extreme violence, traumatic experiences, and economic deprivation in their home countries. The UIY team provides linguistically and culturally responsive trauma informed services, outreach and preventive counseling, stabilization, identification of early signs of mental illness, and linkages to various resources/supports to a population sensitive to acculturation and challenges navigating new systems.

Box B: Number of individuals served this fiscal year through MHSA funding.

Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	52
Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	56

Number of unduplicated individual family members served indirectly by your program:	45
Grand total of unduplicated individuals served:	**153**

Box C: Demographics of individuals served during this fiscal year through MHSA funding.

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	
Transition Age Youth (16-25 yrs.)	
Adult (26-59 yrs.)	
Older Adult (60+ yrs.)	
Declined to answer	
Unknown	
TOTAL	

SEXUAL ORIENTATION	
Gay/Lesbian	
Heterosexual/Straight	
Bisexual	
Questioning/Unsure	
Queer	
Declined to answer	
Unknown	
Another group not listed	
TOTAL	

VETERAN STATUS	
Yes	
No	
Declined to answer	
Unknown	
TOTAL	

NOTE: Demographic data is not available for this program report.

CURRENT GENDER IDENTITY	
Female	
Male	
Transgender	
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	
Another identity not listed	
TOTAL	
If another identity is counted, please specify:	

PRIMARY LANGUAGE	
English	
Spanish	
Cantonese	
Chinese	
Vietnamese	
Farsi	
Arabic	
Tagalog	
Declined to answer	
TOTAL	

SEX ASSIGNED AT BIRTH	
Male	
Female	
Declined to answer	
Unknown	
TOTAL	

DISABILITY*** STATUS	
Communication Domain	
Vision	
Hearing/Speech	
Another type not listed	
Communication Domain Subtotal	
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	
Physical/mobility	
Chronic health condition	
Disability Subtotal	
None	
Declined to answer	
Unknown	
Another disability not listed	
TOTAL	

RACE	
American Indian or Alaska Native	
Asian	
Black or African American	
Native Hawaiian or other Pacific Islander	
White	
Other Race	
Declined to answer	
Unknown	
TOTAL	

Ethnicity/Cultural Heritage (Please choose only one per individual)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	
Mexican/Mexican American/Chicano	
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	
Total Hispanic or Latino	

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	
Total Non-Hispanic or Non-Latino	
More than one ethnicity	
Unknown Ethnicity	
Declined to answer	
EHTNICITY TOTAL	

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of. Note: 1,000-character limit.
One family the UIY team worked with came from Honduras to the United States in 2019. The family of 4 included a pregnant mother. It had experienced some hardships caused by COVID 19, including homelessness. The family wanted to remain in the Bay Area, so the children's education would not be interrupted. They were also expecting to reunify with their son who was shortly to be released from custody of the Office of Refugee and Resettlement. Being an undocumented family made it difficult to obtain secure housing as well as reach financial stability. After tireless advocacy, UIY staff secured a placement at LaFamilia's shelter, where the entire family (including the newborn) successfully settled in. Luis was able to be reunited with his family. Luis has been receiving UIY preventive counseling services since then, showing great promise toward reaching treatment goals.

Box E: Program challenges of the past year and how did the agency mitigate challenges? Note: 1,000-character limit.
Challenges include: decreases in participant engagement, participant difficulty in accessing basic needs over a sustained period of time (including Medical enrollment support); difficulty developing data tracking systems to document supports offered to unique individuals/families. Challenges also occurred when assessing each individual situation to identify the appropriate tier of needed support. Most cases the team has worked with this year seem to benefit from more acute interventions, as well as wrap around services rather than preventive services. UIY team mitigated these challenges by adapting service delivery models to provide more in-person services (through more home visiting and community events) as well as strengthening partnerships with community agencies and school districts (even as school re-openings continue to be uncertain).

Box F: Program lessons learned of the past year? Note: 1,000-character limit.
Due to COVID 19 and continued school closures, we have learned that in order to maximize participant's engagement, UIY staff needs to perform, at a minimum, the initial visit in person. This fosters a greater sense of trust, and it provides more efficient ways to explain how UIY programming can benefit participants. The outcomes continue to be increased engagement rates and increased awareness around programs that are accessible to the UIY community. Our team has also learned that the trusting relationships with the community created over many years have shown increased participation and better disposition to receive COVID 19 testing and vaccines.

Box G: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
G.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e. mental health treatment services):	5

G.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e. mental health treatment services):	0
G.3: Types of treatment individuals were referred to (list types) (500-character limit):	EPSDT programs Children's Hospital EPSDT and La Familia EPSDT School Based Mental Health Services
G.4: Unduplicated number of individuals who participated in referred program at least one time:	2
G.5: Average duration of untreated mental illness in weeks:	8 weeks
G.6: Average number of days between referral and first participation in referred treatment program:	61 days

Box H: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
H.1: Who is/are the underserved target population(s) your program is serving (e.g. TAY, Southeast Asian) (500 Characters):	Unaccompanied Immigrant Youth and Children of Migrant Families - these are immigrant youth and children who are predominately Spanish speaking and are, by definition, newcomers to the United States.
H.2: Number of paper referrals to an ACBH PEI-funded program:	Currently, UIY has limited ability to provide an amount of paper referrals to an ACBH PEI-funded program.
H.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	56
H.4: Average number of days between referral and first participation in referred PEI program:	0
H.5: Describe how your program encouraged access to services and follow through on above referrals (500 Characters):	Typically, UIY obtains referrals and advocated for the continuum of care through regular COST meetings. Engagement and follow through are often a result achieved by developing strong rapport with participants and community partners.

Box I: For <u>Outreach, Suicide Prevention, and Stigma Reduction</u> programs, please provide information for unduplicated potential responders (i.e., those who are in a position to identify early signs of potentially severe mental illness provide support, and or refer individuals who need treatment) reached. ***(Note: For Prevention, Early Intervention, Access & Linkage programs, this section is optional.)***

Number of Responders:	
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):
Schools	*Students, teachers, administrative staff, parents, other school-site service providers*
Community	*Community organizers, CBO staff*
Other CBOs	*Attorneys, legal staff*

MHSA Program #: PEI 5

PROVIDER NAME: Cultura y Bienestar (La Clinica)

PROGRAM NAME: Outreach, Education & Consultation for Latino community

Program Outcomes & Impact: UELP Prevention Data Report FY 20/21

Program Name:	Cultura Y Bienestar	
Organization:	La Clinica de La Raza, Inc.	
PEI Program # and Name:	PEI 5, Outreach, Education & Consultation (Latino) - La Clinica	
Type of Report (Choose one):	Annual	
PEI Category (choose one):	Prevention	
Priority Area (place and X next to all that apply):		Childhood Trauma
		Early Psychosis
		Youth/TAY Outreach and Engagement
	x	Cultural and Linguistic
		Older Adults
	x	Early Identification of Mental Health Illness

Box A: Please provide a brief program description (character limit 1,000).
Cultura y Bienestar (CyB), La Clinica's UELP MSHA Prevention and Early Intervention program, serves Latinos throughout Alameda County through a three-agency collaboration. La Clinica de La Raza, the lead agency, serves Latinos in Northern Alameda County, La Familia Counseling Services serves the Central region, La Familia's East Bay serves the East County region, and Tiburcio Vasquez Health Center serves the Southern region of Alameda County.

Box B: Number of individuals served this fiscal year through MHSA funding.	
Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	13016
Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	369
Number of unduplicated individual family members served indirectly by your program:	NA
Grand total of unduplicated individuals served:	13385

Box C: Demographics of individuals served this fiscal year through MHSA funding.

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	1386
Transition Age Youth (16-25 yrs.)	1418
Adult (26-59 yrs.)	8160
Older Adult (60+ yrs.)	1245
Declined to answer	
Unknown	1176
TOTAL	**13385**

SEXUAL ORIENTATION	
Gay/Lesbian	181
Heterosexual/Straight	6102
Bisexual	2
Questioning/Unsure	5
Queer	8
Declined to answer	2
Unknown	7083
Another group not listed	2
TOTAL	**13385**
If another group is counted, please specify:	

VETERAN STATUS	
Yes	47
No	6253
Declined to answer	9
Unknown	7076
TOTAL	**13385**

CURRENT GENDER IDENTITY	
Female	9998
Male	2482
Transgender	8
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	3
Unknown	891
Another identity not listed	3
TOTAL	**13385**
If another identity is counted, please specify:	

PRIMARY LANGUAGE	
English	2123
Spanish	10915
Cantonese	
Chinese	
Vietnamese	
Farsi	
Arabic	
Tagalog	
Declined to answer	
Unknown	
Another language not listed	347
TOTAL	**13385**
If another language is counted, please specify:	

SEX ASSIGNED AT BIRTH	
Male	9717
Female	2396
Declined to answer	1
Unknown	1271
TOTAL	**13385**

DISABILITY*** STATUS	
Communication Domain	
Vision	5
Hearing/Speech	8
Another type not listed	
Communication Domain Subtotal	**13**
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	2
Physical/mobility	11
Chronic health condition	226
Disability Subtotal	**239**
None	5057
Declined to answer	
Unknown	8072
Another disability not listed	4
TOTAL	**13385**
If another disability is counted, please specify:	

RACE	
American Indian or Alaska Native	
Asian	16
Black or African American	162
Native Hawaiian or other Pacific Islander	
White	186
Other Race	12503
Declined to answer	
Unknown	518
TOTAL	**13385**
If another race is counted, please specify:	

Ethnicity/Cultural Heritage (Please choose only one per individual)	
If Hispanic or Latino, please specify:	
Caribbean	12
Central American	842
Mexican/Mexican American/Chicano	4548
Puerto Rican	69
South American	174
Another Hispanic/Latino ethnicity not listed	5734

Total Hispanic or Latino	**11379**
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	2006
Total Non-Hispanic or Non-Latino	2006
More than one ethnicity	
Unknown Ethnicity	
Declined to answer	
EHTNICITY TOTAL	**13385**

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of. Note: 1,000-character limit.

This year CyB has continued to have a far-reaching impact with 1:1 prevention and early intervention participants. We also have continued educating behavioral health professionals in our communities to better prepare them in their work with the Latinx community. In our PEI work, we have supported couples navigating pandemic-related stressors, supported adolescents in decreasing feelings of isolation, sadness and worry. We have offered parents tools for parenting in this challenging time of home schooling and pandemic-related trauma, including navigating the cultural and linguistic challenges of on-line education, and supported older adults in feeling connected in the loneliest moments of lockdown. Online services allowed an increase of participation of Latin men. Our programs successfully implemented a robust telehealth services component and a curriculum development committee was launched in January. We also delivered close to 60 virtual events and surpassed our goals by far.

Box E: Program challenges of the past year and how the agency mitigated challenges? Note: 1,000-character limit.

Community outreach and traditional healing events were challenging since they used to be in person and are often massive events. We transformed some of these events into drive-through encounters and virtual gatherings. Successful linkages numbers were difficult to meet. We still found that overwhelmed agencies had difficult times responding to our client's calls. As many agencies had to adapt to on-line and telehealth services this past year, Cultura y Bienestar has had the additional challenge of navigating cultural and linguistic disparities in these mediums. This has required walking our community through technological barriers, advocating for access to laptops and Wi-fi and supporting them to adapt to different ways of relating through the screen. In the face of these challenges, CyB successfully launched women's, men's, and adolescent and parenting circles using a virtual model.

Box F: Program lessons learned of the past year? Note: 1,000-character limit.

We have reaffirmed that preventive mental health programs play a vital role during the pandemic to provide much-needed emotional support and help mitigate the devastating effects of isolation, despair, and uncertainty among vulnerable populations. We also reaffirmed the importance of providing care for the caregiver during these difficult times, including regular check-ins, compassionate and trauma-informed communication and vicarious trauma awareness as well as building strong working relationships among team members to support each other. With the increased influx of referrals to our PEI services this past year, we have learned the importance of having a streamlined referral process. We have been able to put this in place while keeping our open-door policy to ensure access for our diverse community. We have also come up with more successful behavioral health triage processes, ensuring community members receive the necessary level of care for their mental health needs.

Box G: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
G.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e. mental health treatment services):	15
G.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e. mental health treatment services):	53
G.3: Types of treatment individuals were referred to (list types) (500-character limit):	Outpatient mental health clinic (IBH, CDS, La Familia, TVHCP Psychiatric and Mental Health Clinic, Traditional Healers, Substance Abuse treatment, Fred Finch, Willow Rock Center, Access Line
G.4: Unduplicated number of individuals who participated in referred program at least one time:	15
G.5: Average duration of untreated mental illness in weeks:	7 weeks
G.6: Average number of days between referral and first participation in referred treatment program:	n/a

Box H: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
H.1: Who is/are the underserved target population(s) your program is serving (e.g. TAY, Southeast Asian) (500 Characters):	n/a
H.2: Number of paper referrals to an ACBH PEI-funded program:	n/a
H.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	n/a
H.4: Average number of days between referral and first participation in referred PEI program:	2
H.5: Describe how your program encouraged access to services and follow through on above referrals (500 Characters):	n/a

Box I: For Outreach, Suicide Prevention, and Stigma Reduction programs, please provide information for unduplicated potential responders (i.e., those who are in a position to identify early signs of potentially severe mental illness provide support, and or refer individuals who need treatment) reached. ***(Note: For Prevention, Early Intervention, Access & Linkage programs, this section is optional.)***	
Number of Responders:	**NA**
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):

MHSA Program #: PEI 6

PROVIDER NAME: Asian Health Services

PROGRAM NAME: Outreach, Education & Consultation for Asian Pacific Islander Community

Program Outcomes & Impact: UELP Data Report FY 20/21

Program Name:	PEI 6 Outreach, Education & Consultation	
Organization:	Asian Health Services	
PEI Program # and Name:	PEI 6 Outreach, Education & Consultation (East Asian)	
Type of Report (Choose one):	Annual	
PEI Category (choose one):	Prevention	
Priority Area (place and X next to all that apply):	x	Childhood Trauma
		Early Psychosis
	x	Youth/TAY Outreach and Engagement
	x	Cultural and Linguistic
	x	Older Adults
	x	Early Identification of Mental Health Illness

Box A: Please provide a brief program description (character limit 1,000).

The AHSSMH Prevention Program advocates for emotional wellness in underserved AAPI communities in Alameda County. Our goals are to improve culturally competent preventive early intervention services; popularize the awareness of emotional wellness, and strengthen community's knowledge of wellness practices and resources. Our free services include community outreach, educational workshops, consultation, preventive counseling, case management, and support groups.

Box B: Number of individuals served this year through MHSA funding.

Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	3017
Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	43

Number of unduplicated individual family members served indirectly by your program:	NA
Grand total of unduplicated individuals served:	**3060**

Box C: Demographics of individuals served this fiscal year through MHSA funding.

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	161
Transition Age Youth (16-25 yrs.)	408
Adult (26-59 yrs.)	861
Older Adult (60+ yrs.)	699
Declined to answer	931
Unknown	
TOTAL	**3060**

SEXUAL ORIENTATION	
Gay/Lesbian	
Heterosexual/Straight	170
Bisexual	
Questioning/Unsure	
Queer	
Declined to answer	
Unknown	2889
Another group not listed	1
TOTAL	**3060**
If another group is counted, please specify:	

VETERAN STATUS	
Yes	
No	117
Declined to answer	1
Unknown	2942
TOTAL	**3060**

CURRENT GENDER IDENTITY	
Female	421
Male	1041
Transgender	5
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	1593
Another identity not listed	
TOTAL	**3060**
If another identity is counted, please specify:	

PRIMARY LANGUAGE	
English	577
Spanish	
Cantonese	2293
Chinese	120
Vietnamese	1
Farsi	
Arabic	
Tagalog	
Declined to answer	
Unknown	28
Another language not listed	41
TOTAL	**3060**
If another language is counted, please specify: Mien, Korean, Bangali	

SEX ASSIGNED AT BIRTH	
Male	410
Female	1099
Declined to answer	
Unknown	1551
TOTAL	**3060**

DISABILITY*** STATUS	
Communication Domain	
Vision	
Hearing/Speech	
Another type not listed	
Communication Domain Subtotal	**0**
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	
Physical/mobility	1
Chronic health condition	
Disability Subtotal	**1**
None	91
Declined to answer	
Unknown	2968
Another disability not listed	
TOTAL	**3060**
If another disability is counted, please specify:	

RACE	
American Indian or Alaska Native	
Asian	2672
Black or African American	40
Native Hawaiian or other Pacific Islander	56
White	
Other Race	19
Declined to answer	
Unknown	273
TOTAL	**3060**
If another race is counted, please specify:	

Ethnicity/Cultural Heritage (Please choose only one per individual)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	
Mexican/Mexican American/Chicano	
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	10
Total Hispanic or Latino	**10**
If Non-Hispanic or Non-Latino, please specify:	
African	
African American	40
Asian Indian/South Asian	2
Cambodian	2
Chinese	2472
Eastern European	
European	
Filipino	41
Japanese	
Korean	37
Middle Eastern	
Vietnamese	28
Other Non-Hispanic or Non-Latino ethnicity not listed	47
Total Non-Hispanic or Non-Latino	**2669**
More than one ethnicity	
Unknown Ethnicity	381
Declined to answer	
EHTNICITY TOTAL	**3060**

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of. Note: The box has a 1,000-character limit.
At the onset of the pandemic, we partnered with local housing units to provide programs to low-income families and seniors, including: 1) Utilizing virtual platforms for emotional education/support, 2) Phone consultation by the AHS Nurse Practitioner Intern, 3) Outreach specialists provided emotional support for those who needed further care, 4) Linkage and referral for services offered to other residents, 5) Provided hundreds of care packets with essential safety and wellness items. The program also partnered closely with medical providers to engage AAPI immigrant parents into our series of parenting classes. Our program hosted two series of workshops for parents, mostly AAPI mothers to learn parenting skills, to connect with others, and to voice their struggles facing layers of distress during the pandemic.

Box E: Program challenges of the past year and how did the agency mitigate challenges? Note: 1,000-character limit.
With the onset of the pandemic and shelter in place orders, our preventive counseling services moved to telehealth platforms with limited face-to-face programming. We were able to successfully transition most of our programming, but limited in our support groups due to safety guidelines and community member reluctance to use telehealth. We offered more individuals and phone check-ins and delivered wellness resources routinely. We are currently assessing client interest and safety of in-person groups and hope to restart support groups this fiscal year. We also further established a stronger social media platform in multi languages. Our program leveraged internal and external resources to network with community partners to further engage community clients to the virtual workshops and seminars.

Box F: Program lessons learned of the past year? Note: The box has a 1,000-character limit.
During this year there were some key lessons learned: 1) Continue development of telehealth platform. Digital outreach will be needed to further diversify services to meet client needs. 2) In-person services are highly valuable as not all community members want to continue with telehealth methods. 3) County systems (INSYST, CG, UELP) reporting methods are challenging to manage when telecommuting due to systems limitations. 4) Onboarding new staff takes longer and greater resources during the pandemic due to virtual processes.

Box G: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
G.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e. mental health treatment services):	2 in treatment program
G.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e. mental health treatment services):	0

G.3: Types of treatment individuals were referred to (list types) (500-character limit):	1 client entered SMH 01PHA6 ACCESS MH Adult Program. 1 client entered Fred Finch family counseling.
G.4: Unduplicated number of individuals who participated in referred program at least one time:	1
G.5: Average duration of untreated mental illness in weeks:	0
G.6: Average number of days between referral and first participation in referred treatment program:	1

Box H: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
H.1: Who is/are the underserved target population(s) your program is serving (e.g. TAY, Southeast Asian) (500 Characters):	Serving East Asian children, youth, TAY, adult, and older adults. Majority of clients served are monolingual East Asian language speaking.
H.2: Number of paper referrals to an ACBH PEI-funded program:	43
H.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	37
H.4: Average number of days between referral and first participation in referred PEI program:	10 days
H.5: Describe how your program encouraged access to services and follow through on above referrals (500 Characters):	Outreach specialists work closely with preventive counselors to have warm hand-off during case transfers. Meet and greet session is set up to allow inquiries and expectations of services. Progressively engage and structure services with brief assessment and goal setting.

Box I: For Outreach, Suicide Prevention, and Stigma Reduction programs, please provide information for unduplicated potential responders (i.e., those who are in a position to identify early signs of potentially severe mental illness provide support, and or refer individuals who need treatment) reached. ***(Note: For Prevention, Early Intervention, Access & Linkage programs, this section is optional.)***	
Number of Responders:	**3969**
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):
2 live on Zoom parenting support groups and 2 Live on Zoom youth support groups	21 live parents and family participants; 26 live youth participants
4 virtual hosted and co-hosted community events with religious, clinic and city gov.	140 community members live participants; 24 You Tube viewers
2 in-person community vaccination events tabling at local parks	106 community members at tabling
8 live virtually monthly workshops with mental health advocates, students, and professionals	110 parents and community members; 23 youth live participants; and 96 You Tube viewers
4 live on Zoom monthly workshops partnered with EBALDC senior centers	143 seniors and families; 8 You Tube viewers
2 virtual educational workshops partnered with non-profit organizations	71 live participants and 26 You Tube viewers
2 video educational topical workshop production on You Tube	27 You Tube viewers
2 in-person educational workshop in high school setting	24 high school students
30 telehealth/telephone individual outreach consultations	5 parents; 11 seniors; 1 youth, 9 community members; 4 community leaders
Outreach material 1: care package to senior center, providers and community members	590 seniors; 24 providers; 15 community members
Outreach channel 2: Youth Mental Health Booklet	200 youth
Outreach channel 3: School website – Digital Parent Tips on Youth Mental Health	751 Asian youth, parents, and families
Outreach channel 4: Trauma impact info card by mail	150 families; 72 schools; 200 community members via clinic
Outreach channel 5: Asian Health Services social media platform, such as We Chat and Facebook	1092 community viewers

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 South East Asian Community

Program Outcomes & Impact: UELP Data Report FY 20/21

Program Name:	Reviving Our Youths' and Adults' Aspirations (ROYAA)	
Organization:	The Center for Empowering Refugees and Immigrants (CERI)	
PEI Program # and Name:	PEI 6 Outreach, Education & Consultation (Southeast Asian)	
Type of Report (Choose one):	Annual	
PEI Category (choose one):	Prevention	
Priority Area (place and X next to all that apply):	X	Childhood Trauma
	X	Early Psychosis
	X	Youth/TAY Outreach and Engagement
	X	Cultural and Linguistic
	X	Older Adults
	X	Early Identification of Mental Health Illness

Box A: Please provide a brief program description (character limit 1,000).

CERI provides culturally-relevant mental health/social services to SEA communities, reaching over 1000 clients. We offer preventive counseling, community events, workshops, and support groups for elders, adults, children, and TAY. We link clients to resources and information related to basic needs and human rights, such as housing, voting, food security, medical care, legal support, and culturally-tailored interventions such as gardening, meditation, art and drama therapy, knitting, and movement.

Box B: Number of individuals served this fiscal year through MHSA funding.	
Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	10122
Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	111
Number of unduplicated individual family members served indirectly by your program:	NA
Grand total of unduplicated individuals served:	10233

Box C: Demographics of individuals served this fiscal year through MHSA funding.

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	385
Transition Age Youth (16-25 yrs.)	446
Adult (26-59 yrs.)	6937
Older Adult (60+ yrs.)	2401
Declined to answer	
Unknown	64
TOTAL	**10233**

VETERAN STATUS	
Yes	41
No	8969
Declined to answer	8
Unknown	1216
TOTAL	**10233**

SEXUAL ORIENTATION	
Gay/Lesbian	53
Heterosexual/Straight	8509
Bisexual	16
Questioning/Unsure	1
Queer	375
Declined to answer	5
Unknown	1266
Another group not listed	8
TOTAL	**10233**
If another group is counted, please specify:	

CURRENT GENDER IDENTITY	
Female	6538
Male	3202
Transgender	27
Genderqueer	
Questioning/unsure of gender identity	1
Declined to answer	
Unknown	465
Another identity not listed	
TOTAL	**10233**
If another identity is counted, please specify:	

PRIMARY LANGUAGE	
English	2379
Spanish	1
Cantonese	
Chinese	
Vietnamese	582
Farsi	9
Arabic	
Tagalog	
Declined to answer	
Unknown	
Another language not listed	7262
TOTAL	**10233**
If another language is counted, please specify: Burmese, Cambodian, Dari, Karen, Punjabi	

SEX ASSIGNED AT BIRTH	
Male	3178
Female	6464
Declined to answer	
Unknown	591
TOTAL	**10233**

DISABILITY*** STATUS	
Communication Domain	
Vision	9
Hearing/Speech	37
Another type not listed	19
Communication Domain Subtotal	**65**
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	2405
Physical/mobility	215
Chronic health condition	36
Disability Subtotal	**2656**
None	5025
Declined to answer	
Unknown	2465
Another disability not listed	22
TOTAL	**10233**
If another disability is counted, specify:	

RACE	
American Indian or Alaska Native	6
Asian	10027
Black or African American	17
Native Hawaiian or other Pacific Islander	3
White	40
Other Race	69
Declined to answer	
Unknown	71
TOTAL	**10233**

If another race is counted, please specify: Latino Multiracial

Ethnicity/Cultural Heritage (Please choose only one per individual)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	
Mexican/Mexican American/Chicano	
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	38
Total Hispanic or Latino	**38**
If Non-Hispanic or Non-Latino, please specify:	
African	
African American	
Asian Indian/South Asian	13
Cambodian	7070
Chinese	208
Eastern European	
European	
Filipino	44
Japanese	
Korean	29
Middle Eastern	
Vietnamese	1004
Other Non-Hispanic or Non-Latino ethnicity not listed	1380
Total Non-Hispanic or Non-Latino	**9748**
More than one ethnicity	
Unknown Ethnicity	447
Declined to answer	
EHTNICITY TOTAL	**10233**
If another ethnicity is counted, please specify: Persian, Iranian, Buthanese, Burman, Chin, Hmong, Indonesian, Kachin, Karen, Karenni, Lao, Leu, Malaysian, Mien, Mon, Nepalese, Pakistani, Rakhain, Shan, Sri Lankan, Tamil, Taiwanese, Thai, Tibetan, Other East Asian, Other South East Asian)	

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of. Note: 1,000-character limit.

We developed a social media strategy with over 900 subscribers. We successfully engaged the 1.5 generation providing groups, individual outreach, and COVID emergency funds. We launched online town halls addressing anti-Asian violence and anti-Black racism with 60 participants each time. We increased our ability to connect members to public benefits; provided 40,000+ meals, held two vaccine clinics, multiple testing days, and scheduled 100s of individuals for vaccines/testing off site. CERI leveraged our UELP funds to increase sustainability of services through private foundations, FEMA, CalHOPE, and COVID funds. Saveth lost her parents during the genocide and as emotionally/physically abused. She said, "Prior to CERI, I wanted to take my life. Now I want to live." This year, we supported Saveth with preventive counseling and accessing public benefits and medical appointment. Saveth found support in groups and purpose through contributing her skills by sewing masks funded by CERI.

Box E: Program challenges of the past year and how did the agency mitigate challenges? Note: 1,000-character limit.

This past year has been incredibly challenging with the global pandemic and rise in anti-Asian hate violence, which has led to an increase in isolation for our community members and an increase in PTSD and other mental health symptoms. We have had to increase visits to homes and provide town halls/support groups on safety in the community. With many people out of work and children doing online learning, families were financially stressed and connection to public benefits was crucial. Access to technology and internet access has continued to be an issue. Addressing access includes ensuring clients and staff have reliable internet connection, purchasing or asking for donations of phones, laptops and tablets, and providing tutorials on how to use Zoom. With less in-person contact, communication within the team is critical and we have added an online director's meeting, regular facilitator's meetings, and staff training.

Box F: Program lessons learned of the past year? Note: 1,000-character limit.

A lesson we relearned this year was the importance of groups for our community members, who often feel unheard and unseen. Being diligent about going to homes, using Zoom and relying on outdoor activities, such as field trips with COVID-19 safety protocols, to connect community members has been essential for our community. We thought it would be difficult for our elders to get on Zoom and we were wrong. With support, our elders made the transition with ease. Putting in the work early, going to homes, working with families, and calling have been integral. We also relearned the importance of partnerships. Working with Samuel Merritt's Occupational Therapy Program and ARTogether, we expanded our online programs for children and youth. We worked with World Central Kitchen, Phnom Penh, Cross Bay Mutual Aid, Nyum Bai, Cambodian Street Food, and Monster Pho, among others to distribute over 40,000 meals. We also expanded collaborations with other UELP providers to increase services.

Box G: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
G.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e. mental health treatment services):	2
G.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e. mental health treatment services):	n/a
G.3: Types of treatment individuals were referred to (list types) (500-character limit):	John Georg, I-HOT
G.4: Unduplicated number of individuals who participated in referred program at least one time:	2
G.5: Average duration of untreated mental illness in weeks:	unknown
G.6: Average number of days between referral and first participation in referred treatment program:	7

Box H: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
H.1: Who is/are the underserved target population(s) your program is serving (e.g. TAY, Southeast Asian) (500 Characters):	Southeast Asian - youth, TAY, older adults, low-income, LQBTQ
H.2: Number of paper referrals to an ACBH PEI-funded program:	13
H.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	13
H.4: Average number of days between referral and first participation in referred PEI program:	7 days
H.5: Describe how your program encouraged access to services and follow through on above referrals (500 Characters):	CERI sought and received funding to provide outpatient therapy to clients in need of more services after preventive counseling. For outside referrals, we make calls, form partnerships with outside agencies, provide transportation and visits.

Box I: For Outreach, Suicide Prevention, and Stigma Reduction programs, please provide information for unduplicated potential responders (i.e., those who are in a position to identify early signs of potentially severe mental illness provide support, and or refer individuals who need treatment) reached. ***(Note: For Prevention, Early Intervention, Access & Linkage programs, this section is optional.)***

Number of Responders:	
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):
Buddhist Temples	7 Monks, Burmese and Cambodian
Vaccine/Testing Clinics	4 public health nurses, 3 volunteers
Zoom Burmese Cultural Fairs	6 community leaders
OUSD Intern Program	21 MSW Interns/MFT Trainees
Online Vietnamese LGBTQ forum	11 community leaders
Reground	37 community leaders
CalHope Team meetings	12 crisis counseling workers
Qtviet Café Collective Spring Showcase	492 community leaders/artists' viewers
Non-profit ARTogether	1 executive director, 3 artists, 3 volunteers
Samuel Merritt College OTs	7 OT students, 1 OT
CBO Asian Prisoner Support Committee	7 re-entry coordinators
UC Berkeley	40 undergraduate students
SEA Coalition	30 community organizers

MHSA Program #: PEI 6

PROVIDER NAME: Bay Area Community Health

PROGRAM NAME: Outreach, Education & Consultation for East Asian Community

Program Outcomes & Impact: UELP Data Report FY 20/21

Program Name:	Arise: Asian Wellness Project	
Organization:	Bay Area Community Health	
PEI Program # and Name:	PEI 6 Outreach, Education & Consultation (East Asian) Health Center)	
Type of Report (Choose one):	Annual	
PEI Category (choose one):	Prevention	
Priority Area (place and X next to all that apply):		Childhood Trauma
		Early Psychosis
	X	Youth/TAY Outreach and Engagement
	X	Cultural and Linguistic
	X	Older Adults
		Early Identification of Mental Health Illness

Box A: Please provide a brief program description (character limit 1,000).

Arise: Asian Wellness Project is a Mental Health Prevention and Early Intervention program that aims to promote emotional and mental well-being through education and consultation. We provide FREE workshops, individual preventative counseling, support groups, and community events for youth, adults, and families of the East Asian Community in South Alameda County. We also assist with connecting participants to care and resources.

Box B: Number of individuals served this fiscal year through MHSA funding.

Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	794
Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	79
Number of unduplicated individual family members served indirectly by your program:	NA
Grand total of unduplicated individuals served:	**873**

Box C: Demographics of individuals served this fiscal year through MHSA funding.

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	19
Transition Age Youth (16-25 yrs.)	92
Adult (26-59 yrs.)	592
Older Adult (60+ yrs.)	482
Declined to answer	
Unknown	21
TOTAL	**873**

VETERAN STATUS	
Yes	
No	565
Declined to answer	
Unknown	308
TOTAL	**873**

CURRENT GENDER IDENTITY	
Female	647
Male	189
Transgender	17
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	20
Another identity not listed	
TOTAL	**873**
If another identity is counted, please specify:	

SEX ASSIGNED AT BIRTH	
Male	170
Female	587
Declined to answer	
Unknown	116
TOTAL	**873**

SEXUAL ORIENTATION	
Gay/Lesbian	700
Heterosexual/Straight	2
Bisexual	1
Questioning/Unsure	
Queer	
Declined to answer	
Unknown	100
Another group not listed	
TOTAL	**873**
If another group is counted, please specify:	

PRIMARY LANGUAGE	
English	152
Spanish	
Cantonese	14
Chinese	637
Vietnamese	
Farsi	
Arabic	
Tagalog	
Declined to answer	
Unknown	20
Another language not listed	50
TOTAL	**873**
If another language is counted, please specify: Korean	

DISABILITY*** STATUS	
Communication Domain	
Vision	2
Hearing/Speech	2
Another type not listed	
Communication Domain Subtotal	**4**
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	
Physical/mobility	3
Chronic health condition	1
Disability Subtotal	**4**
None	202
Declined to answer	
Unknown	663
Another disability not listed	
TOTAL	**873**
If another disability is counted, please specify:	

RACE	
American Indian or Alaska Native	
Asian	827
Black or African American	
Native Hawaiian or other Pacific Islander	5
White	12
Other Race	1
Declined to answer	
Unknown	28
TOTAL	**873**
If another race is counted, please specify: Latino	

Ethnicity/Cultural Heritage (Please choose only one per individual)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	
Mexican/Mexican American/Chicano	
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	8
Total Hispanic or Latino	**8**

If Non-Hispanic or Non-Latino, please specify:	
African	
African American	
Asian Indian/South Asian	6
Cambodian	
Chinese	685
Eastern European	
European	
Filipino	
Japanese	1
Korean	53
Middle Eastern	
Vietnamese	
Other Non-Hispanic or Non-Latino ethnicity not listed	2
Total Non-Hispanic or Non-Latino	**748**
More than one ethnicity	
Unknown Ethnicity	117
Declined to answer	
EHTNICITY TOTAL	**873**
If another ethnicity is counted, please specify: East Asian	

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of. Note: 1,000-character limit.

This year, we doubled our individual prevention clients from 36 to 79 compared to last year. One of our success stories for this year is through our referral process. Our Arise staff were able to help an 18-year old student referred by her school, who had suicidal ideation and self-harm. Through our counseling sessions and home visits, our MHS provided our client and family with skills on how to manage family conflict, learn skills for stress management, time management, family communication, and peer communication. Using a strength-based approach, we build on our client's passion of baking to share with the peer support group members to improve her self-esteem and communication with peers. In addition, we connected her with community resources, college application information, and financial aid. The client and her family expressed gratitude for helping her and appreciated our multiple approaches. Additionally, we were happy to hear that our client got accepted to UC Davis.

Box E: Program challenges of the past year and how did the agency mitigate challenges? Note: 1,000-character limit.

Due to the pandemic, many of our community events including school events were cancelled. Adjusting to the pandemic challenge, we offered services through telehealth. We conducted our workshops and community events through Zoom. We engaged with your and community members by posting our flyers at boba shops and Asian grocery stores. We targeted and engaged with our Chinese population through WeChat, and KaKao for the Korean population. We worked closely with school counselors and administrators to establish the referral process to connect with students and their families who needed our services.

Box F: Program lessons learned of the past year? Note: 1,000-character limit.

We learned by incentivizing our participants, especially our senior population, we were able to recruit more people to attend our events and workshops. By collaborating closely with school administrators, we were able to reach more students and connect them to our Arise program. When working with students, we learned it is imperative to work with their families to improve and enhance outcomes.

Box G: For programs that refer individuals with severe mental illness, please provide information for the categories below:

G.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e. mental health treatment services):	1
G.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e. mental health treatment services):	7

G.3: Types of treatment individuals were referred to (list types) (500-character limit):	Psychotherapy, SMH, legal aid
G.4: Unduplicated number of individuals who participated in referred program at least one time:	8
G.5: Average duration of untreated mental illness in weeks:	6
G.6: Average number of days between referral and first participation in referred treatment program:	5

Box H: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
H.1: Who is/are the underserved target population(s) your program is serving (e.g. TAY, Southeast Asian) (500 Characters):	East Asians (Chinese, Korean, Japanese) in South Alameda County; all ages (we have clients ranging from 8-93)
H.2: Number of paper referrals to an ACBH PEI-funded program:	n/a
H.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	2
H.4: Average number of days between referral and first participation in referred PEI program:	7
H.5: Describe how your program encouraged access to services and follow through on above referrals (500 Characters):	We promoted our programs using flyers, WeChat, Kakao talk. We informed clients of appropriate services based on their language and cultural needs that PEI programs can provide. We provided follow up with patients and the referral agency by phone, email, etc.

Box I: For Outreach, Suicide Prevention, and Stigma Reduction programs, please provide information for unduplicated potential responders (i.e., those who are in a position to identify early signs of potentially severe mental illness provide support, and or refer individuals who need treatment) reached. ***(Note: For Prevention, Early Intervention, Access & Linkage programs, this section is optional.)***	
Number of Responders:	**200**
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):
Mid-Autumn Festival Virtual Event	*Community members*

Thankful Heart Virtual Event	*Community members*
Lunar New Year Virtual Event	*Parents, community members*
Mother's Day Event	*Community members*
Mental Health Consultations: high school	*2 vice principals, 8 counselors*
Educational Workshops: (virtual): Positive Parenting, COVAX, Anti-Asian Racism	*100+ parents*

MHSA Program #: PEI 6

PROVIDER NAME: Richmond Area Multi-Services, Inc.

PROGRAM NAME: Outreach, Education & Consultation for Asian Pacific Islander Community

Program Outcomes & Impact: UELP Data Report FY 20/21

Program Name:	Pacific Islander Wellness Initiative	
Organization:	Richmond Area Multi-Services, Inc.	
PEI Program # and Name:	PEI 6 Outreach, Education & Consultation (Pacific Islander)	
Type of Report (Choose one):	Annual	
PEI Category (choose one):	Prevention	
Priority Area (place and X next to all that apply):		Childhood Trauma
		Early Psychosis
	X	Youth/TAY Outreach and Engagement
	X	Cultural and Linguistic
	X	Older Adults
	X	Early Identification of Mental Health Illness

Box A: Please provide a brief program description (character limit 1,000).

Pacific Islander Wellness Initiative (PIWI) is a prevention and early intervention mental health program of RAMS in collaboration with long-standing and trusted Pacific Islander community-based organizations. PIWI provides culturally responsive and in-language preventive counseling, psycho-education, mental health consultation, and outreach and engagement services, including navigation, translation, and interpretation assistance to Pacific Islander residents of Alameda County.

Box B: Number of individuals served this fiscal year through MHSA funding.

Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	19358

Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	43
Number of unduplicated individual family members served indirectly by your program:	NA
Grand total of unduplicated individuals served:	**19401**

Box C: Demographics of individuals served this fiscal year through MHSA funding.

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	66
Transition Age Youth (16-25 yrs.)	88
Adult (26-59 yrs.)	661
Older Adult (60+ yrs.)	288
Declined to answer	2
Unknown	18296
TOTAL	**19401**

SEXUAL ORIENTATION	
Gay/Lesbian	3
Heterosexual/Straight	537
Bisexual	
Questioning/Unsure	
Queer	
Declined to answer	
Unknown	18861
Another group not listed	
TOTAL	**19401**
If another group is counted, please specify:	

VETERAN STATUS	
Yes	8
No	724
Declined to answer	
Unknown	18669
TOTAL	**19401**

CURRENT GENDER IDENTITY	
Female	548
Male	272
Transgender	
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	18581
Another identity not listed	
TOTAL	**19401**
If another identity is counted, please specify:	

PRIMARY LANGUAGE	
English	18895
Spanish	1
Cantonese	
Chinese	
Vietnamese	
Farsi	
Arabic	
Tagalog	
Declined to answer	
Unknown	
Another language not listed	505
TOTAL	**19401**

SEX ASSIGNED AT BIRTH	
Male	517
Female	260
Declined to answer	
Unknown	18624
TOTAL	**19401**

If another language is counted, please specify: Fijian, Marshallese, Native Hawaiian, Samoan, Tongan

DISABILITY*** STATUS	
Communication Domain	
Vision	
Hearing/Speech	
Another type not listed	
Communication Domain Subtotal	**0**
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	
Physical/mobility	
Chronic health condition	
Disability Subtotal	**0**
None	933
Declined to answer	
Unknown	18408
Another disability not listed	
TOTAL	**19401**
If another disability is counted, please specify:	

RACE	
American Indian or Alaska Native	20
Asian	120
Black or African American	11
Native Hawaiian or other Pacific Islander	3113
White	10
Other Race	76
Declined to answer	
Unknown	16051
TOTAL	**19401**
If another race is counted, please specify:	

Ethnicity/Cultural Heritage (Please choose only one per individual)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	
Mexican/Mexican American/Chicano	
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	4
Total Hispanic or Latino	**4**
If Non-Hispanic or Non-Latino, please specify:	
African	
African American	
Asian Indian/South Asian	4
Cambodian	
Chinese	10
Eastern European	
European	
Filipino	
Japanese	
Korean	
Middle Eastern	
Vietnamese	
Other Non-Hispanic or Non-Latino ethnicity not listed	3296
Total Non-Hispanic or Non-Latino	**3346**
More than one ethnicity	
Unknown Ethnicity	16051
Declined to answer	
EHTNICITY TOTAL	**19401**
If another ethnicity is counted, please specify: Chammoro, Fijian, Native Hawaiian, Indo Fijian, Marshaleese, other Pacific Islander, Samoan, Tongan, other South East Asian	

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of. Note: 1,000-character limit.
All but one of our objectives were met for FY 20-21. We completed: 60 community events; 16 psycho-educational workshops (bilingual Tongan/English and Samoan/English);10 Talanoa4Wellness (support groups); 3 cultural-based educational workshops (topics included Who are Pacific Islanders: identity, diaspora, and mental health, education and mental health. We developed 24 promotional materials; completed 28 mental health consultations (faith leaders, community leaders, coaches, high school teachers and staff working with PI youth); 6,119 in-person home visits (family wellness check-up and distributing nutritious food boxes, hygienic care packages, gift cards, etc.). We delivered 144 prevention visits and 90% of the visits were conducted via phone calls, emails and Zoom. We completed 6 MH referrals and successful linkages (1 was referred to the ACCESS program via AHS and 5 were referred to services outside of ACBH). We did 36 screening and assessments and had 31 unduplicated clients in preventive counseling.

Box E: Program challenges of the past year and how did the agency mitigate challenges? Note: 1,000-character limit.
Conducting in-person and outreach and engagement activities to build rapport and trust, navigating clients through PIWI non-clinical to clinical services was limited due to the pandemic. Meeting the preventive counseling count continues to be challenging as well as we still need to increase awareness of the PIWI program and having a presence at community events. Creating social media content to spread awareness was time-consuming and required more specialized skills, software, and apps. Building relationships with providers and school systems require time, layers of communication, and filtering through systems barriers.

Box F: Program lessons learned of the past year? Note: 1,000-character limit.
The pandemic revealed critical challenges and changes that were not anticipated. Our office was closed and 90% of our activities sifted to online platforms (Zoom, Teams, WebEx, Google Meets, FaceTime, texts, and telephone calls) requiring new learning to better understand the functionality of such platforms. We needed a lot of time to examine existing processes and to adapt to disseminate and complete online forms (surveys/consent forms). We examined our workplan to identify solutions or tactics to address the way we operate as a direct service provider. Our focus shifted to support the community in meeting basic needs and to provide information on COVID. Offering group therapy looks to be ideal for this population and even younger people find this setting to be less intimidating that a 1:1. Participants identified and recruited other family members, peers, church members, friends, and colleagues, and their own children to participate in PIWI program activities.

Box G: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
G.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e. mental health treatment services):	1

G.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e. mental health treatment services):	6
G.3: Types of treatment individuals were referred to (list types) (500-character limit):	SMH services; long term counseling services; higher level case management
G.4: Unduplicated number of individuals who participated in referred program at least one time:	7
G.5: Average duration of untreated mental illness in weeks:	0 days
G.6: Average number of days between referral and first participation in referred treatment program:	10 days

Box H: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
H.1: Who is/are the underserved target population(s) your program is serving (e.g. TAY, Southeast Asian) (500 Characters):	Pacific Islanders (Samoans, Tongans, Hawaiians, Fijians, Marshallese, Guamanians, Micronesians), Youth, TAY, parents, adults, elders, students
H.2: Number of paper referrals to an ACBH PEI-funded program:	36
H.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	31
H.4: Average number of days between referral and first participation in referred PEI program:	4
H.5: Describe how your program encouraged access to services and follow through on above referrals (500 Characters):	Staff encourages community members to seek and to use help to address mental health concerns early. Staff reached out to families of loved ones who died due to the pandemic to inform them about PIWI services. All staff work as a team to support the clients seeking PIWI services.

Box I: For Outreach, Suicide Prevention, and Stigma Reduction programs, please provide information for unduplicated potential responders (i.e., those who are in a position to identify early signs of potentially severe mental illness provide support, and or refer individuals who need treatment) reached. ***(Note: For Prevention, Early Intervention, Access & Linkage programs, this section is optional.)***	
Number of Responders:	**63**

Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):
Schools	*2 vice principals*
Churches	*20 church leaders; 6 parents*
Cultural affinity groups	*4 mentors*
Colleges	*5 college professors, 3 peers*
Community centers	*4 providers*
Event Centers	*3 community leaders*
Festivals	*4 community leaders*
Convening	*8 mental health providers*
Other	*4 police officers*
Note on Demographics in Box C	*16k "unknown" recipients of daily and weekly food distribution*

MHSA Program #: PEI 6

PROVIDER NAME: Korean Community Center of the East Bay

PROGRAM NAME: Outreach, Education & Consultation for Asian Pacific Islander Community

Program Outcomes & Impact: UELP Data Report FY 20/21

Program Name:	Asian Community Wellness Program	
Organization:	Korean Community Center of the East Bay (KCCEB)	
PEI Program # and Name:	01RZ1: PEI 6 Outreach, Education & Consultation (East Asian)	
Type of Report (Choose one):	Annual	
PEI Category (choose one):	Outreach	
Priority Area (place and X next to all that apply):		Childhood Trauma
		Early Psychosis
		Youth/TAY Outreach and Engagement
	x	Cultural and Linguistic
		Older Adults
		Early Identification of Mental Health Illness

Box A: Please provide a brief program description (character limit 1,000).

Asian Community Wellness Program (ACWP) is a prevention and early intervention (PEI) program funded by Alameda County Behavioral Health Care Services (BHCS) addressing mental health and wellness needs in the underserved East Asian communities. Our goal is to improve access to culturally responsive mental health services, reduce stigma, and strengthen Asian communities' knowledge and experience in wellness practices and community resources. ACWP provide the following services: 1) Outreach and Education, 2) Preventive Counseling, 3) Mental Health Consultation and Training.

Box B: Number of individuals served this fiscal year through MHSA funding.

Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	2155

Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	55
Number of unduplicated individual family members served indirectly by your program:	NA
Grand total of unduplicated individuals served:	**2210**

Box C: Demographics of individuals served this fiscal year through MHSA funding.

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	92
Transition Age Youth (16-25 yrs.)	555
Adult (26-59 yrs..)	862
Older Adult (60+ yrs.)	470
Declined to answer	
Unknown	231
TOTAL	**2210**

SEXUAL ORIENTATION	
Gay/Lesbian	
Heterosexual/Straight	275
Bisexual	
Questioning/Unsure	1
Queer	25
Declined to answer	
Unknown	1908
Another group not listed	
TOTAL	**2210**

If another group is counted, please specify:

VETERAN STATUS	
Yes	
No	163
Declined to answer	
Unknown	2047
TOTAL	**2210**

CURRENT GENDER IDENTITY	
Female	847
Male	238
Transgender	
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	1113
Another identity not listed	13
TOTAL	**2210**

If another identity is counted, please specify:

PRIMARY LANGUAGE	
English	931
Spanish	9
Cantonese	170
Chinese	156
Vietnamese	3
Farsi	1
Arabic	
Tagalog	9
Declined to answer	
Another language not listed	931
TOTAL	**2210**

If another language is counted, please specify: Cambodian Korean

SEX ASSIGNED AT BIRTH	
Male	803
Female	277
Declined to answer	
Unknown	1180
TOTAL	**2210**

DISABILITY*** STATUS	
Communication Domain	
Vision	
Hearing/Speech	
Another type not listed	
Communication Domain Subtotal	**0**
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	5
Physical mobility	2
Chronic health condition	
Disability Domain Subtotal	**7**
None	128
Declined to answer	
Unknown	2075
Another disability not listed (see below)	
TOTAL	
If another disability is counted, please specify:	**2210**

RACE	
American Indian or Alaska Native	18
Asian	1301
Black or African American	2
Native Hawaiian or other Pacific Islander	14
White	104
Other Race	449
Unknown	332
TOTAL	2210
If another race is counted, please specify: Multiracial	

Ethnicity/Cultural Heritage (Please choose only one per individual)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	
Mexican/Mexican American/Chicano	
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	32
Total Hispanic or Latino	**32**

If Non-Hispanic or Non-Latino, please specify:	
African	
African American	2
Asian Indian/South Asian	46
Cambodian	
Chinese	395
Eastern European	
European	
Filipino	
Japanese	11
Korean	689
Middle Eastern	
Vietnamese	25
Another Non-Hispanic/Latino ethnicity not listed (see below)	117
Total Non-Hispanic or Non-Latino	**1289**
More than one ethnicity	
Unknown ethnicity	889
Declined to answer	
ETHNICITY TOTAL	**2210**
If another ethnicity is counted, please specify: Leu, Nepalese, Taiwanese, Other East Asian, Other South East Asian	

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of. Note: 1,000-character limit.

1) ACWP engaged many Korean elders in using virtual platforms to: promote wellness, reduce social isolation during shelter in place, and build leadership to be community ambassadors to raise mental health awareness and reduce stigma around mental health in the API community. 2) KCCEB engaged socially isolated API elders with wellness checks to access health, mental health, safety needs, and provided social and emotional support. We have reached out to over 300 elders in the community – they were most vulnerable with low socioeconomic status and severe isolation. Many elders expressed gratitude for the support they received, stating that they live alone without any family members near. We were able to connect many elders to meal delivery, social services, health, and mental health support as needed. 3) Build new partnerships and strengthen old partnerships with other CBO's and agencies to better serve our API community, especially to address anti-Asian violence happening in the API community.

Box E: Program challenges of the past year and how did the agency mitigate challenges? Note: 1,000-character limit.

1). Continuing to meet the overwhelming increased needs and demands of the API community. Throughout the COVID-19 pandemic and shelter-in-place, Korean and other API community members were facing an ongoing array of crisis (i.e. unemployment, food insecurity, social isolation, vaccination access barriers, anti-Asian violence, and trauma triggers, etc.). Because of the ongoing crisis and needs of the Korean community, KCCEB continued to address the urgent need of the most vulnerable populations by providing free meals, EDD (unemployment insurance) navigation support, safety kits, and by addressing the health and mental health needs of the community. 2). Engaging and following up with referred preventive counseling clients to complete enrollment and initiate services. Despite high referrals, registration was low due to client's challenges in adapting to remote and telehealth counseling. We continue to be persistent in outreach and registering with multiple follow ups.

Box F: Program lessons learned of the past year? Note: 1,000-character limit.

1) Be prepared and build capacity to promptly adapt to changing circumstances. Our capability to be flexible and adjust to the changing environment is fundamental in ensuring that our clients and community members continue to access and utilize the services they need, especially during critical times such as the pandemic. 2) The importance of strong community collaboration and partnership with local community-based organizations to support vulnerable API populations and leveraging our collective voice and power to address the ongoing COVID crisis. For example, our K-Coalition and other API partners advocating for multiple vaccination sites for API monolingual speaking community members, especially API elders. We partnered with API community organizations to address anti-Asian violence and to provide safe space for survivors to get support to heal from trauma, piloted self-defense classes, and hosted an API heritage event to show solidarity of API communities.

Box G: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
G.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e. mental health treatment services):	0
G.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e. mental health treatment services):	2
G.3: Types of treatment individuals were referred to (list types) (500-character limit):	Individual weekly therapy to address major depressive disorders, PTSD, and complex traumas. Clients ae being seen by LCSW, MFT, and licensed psychologists with psychiatric support for medication maintenance with necessary.
G.4: Unduplicated number of individuals who participated in referred program at least one time:	2
G.5: Average duration of untreated mental illness in weeks:	4-6 weeks
G.6: Average number of days between referral and first participation in referred treatment program:	5 - 20 days depending on initial appointments

Box H: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
H.1: Who is/are the underserved target population(s) your program is serving (e.g. TAY, Southeast Asian) (500 Characters):	Underserved target population included 75% East Asians (Chinese, Korean, Japanese, and Mongolian) and 25% other populations (South East Asian, mix-Asians, Middle Eastern, African, non-Asian). ACWP mainly service youth, TAY, and adults.
H.2: Number of paper referrals to an ACBH PEI-funded program:	35
H.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	22
H.4: Average number of days between referral and first participation in referred PEI program:	5-10 days
H.5: Describe how your program encouraged access to services and follow through on above referrals (500 Characters):	Wellness counselors reached out to clients to perform wellness checks over the phone or telehealth. Counselors make 4-5 attempts to engage clients to follow through with registration and enrollments, with support from teachers, school staff, and family members.

Box I: For Outreach, Suicide Prevention, and Stigma Reduction programs, please provide information for unduplicated potential responders (i.e., those who are in a position to identify early signs of potentially severe mental illness provide support, and or refer individuals who need treatment) reached. ***(Note: For Prevention, Early Intervention, Access & Linkage programs, this section is optional.)***

Number of Responders:	
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):
Cultural & Wellness Events (7): festivals, cultural wellness, leadership, and COVID-19	*community members and leaders, children, youth, TAY, families and adults and older adults, CBO staff*
MH Workshops (12): Understand MH (depression, anxiety, S/I, trauma), screening and detecting MH symptoms	*community members and leaders, youth, TAY and adults and older adults and graduate students*
MH Trainings (3): cultural, impact of S/I and prevention, MH crisis and COVID-19	*community based professionals (school-based staff, community-based worker staff)*
Mental Health Consultation (30): MH signs and symptoms among youth, access MH Tx, MH stigma, MH referrals	*CBO's, professionals (school-based staff, community-based worker staff, caregivers), family members*
Newsletters (6): Healthy NY, seeking MH health care, sexual consent, self-care wellness, trauma	*general community members and CBO's professionals*
Tabling/Distributing materials (5): meal delivery, vaccine clinic, virtual events, community events	*community members and leaders, children, youth, TAY and adults and older adults*
Wellness Support Group (3): Taiji for Wellness, Jikimee Leadership, Anti-Asian Violence and Trauma	*Korean elder community members, API community elders*
PV phone, virtual, office visits (29): MH screening, referral, and community resource support	*community members and family members, youth, adults, older adults*
PV home visits (4): MH screening, referral, and community resource support	*community members and family members, youth, adults, older adults*
Preventive Counseling via virtual and phone (22); individual counseling	*community members and family members, youth, adults, older adults*

MHSA Program #: PEI 7

PROVIDER NAME: Afghan Wellness Center

PROGRAM NAME: Outreach, Education & Consultation for South Asian/Afghan Community

Program Outcomes & Impact: UELP Data Report FY 20/21

Program Name:	Afghan Wellness Project	
Organization:	Afghan Coalition	
PEI Program # and Name:	PEI 7 Outreach, Education & Consultation (Afghan) Afghan Coalition	
Type of Report (Choose one):	Annual	
PEI Category (choose one):	Prevention	
Priority Area (place and X next to all that apply):	X	Childhood Trauma
	X	Early Psychosis
	X	Youth/TAY Outreach and Engagement
	X	Cultural and Linguistic
	X	Older Adults
	X	Early Identification of Mental Health Illness

Box A: Please provide a brief program description (character limit 1,000).

AWP provides services to individuals and families at risk for serious mental health issues, decreases stigma through education/awareness, and prevents mental illness form becoming disabling. AWP bridges the language/cultural gaps between community members and mental health. AWP works with individuals that are isolated, trauma exposed, immigrants, families under stress, at risk youth and many individuals at risk of serious mental health issues by providing PEI services in Dari, Pashto, and English.

Box B: Number of individuals served this fiscal year through MHSA funding.

Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	2403

Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	76
Number of unduplicated individual family members served indirectly by your program:	NA
Grand total of unduplicated individuals served:	**2479**

Box C: Demographics of individuals served during this fiscal year through MHSA funding.

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	238
Transition Age Youth (16-25 yrs.)	266
Adult (26-59 yrs.)	1258
Older Adult (60+ yrs.)	441
Declined to answer	
Unknown	276
TOTAL	**2479**

SEXUAL ORIENTATION	
Gay/Lesbian	1
Heterosexual/Straight	1493
Bisexual	
Questioning/Unsure	1
Queer	3
Declined to answer	
Unknown	980
Another group not listed	1
TOTAL	**2479**
If another group is counted, please specify:	

VETERAN STATUS	
Yes	4
No	511
Declined to answer	1
Unknown	1963
TOTAL	**2479**

CURRENT GENDER IDENTITY	
Female	1791
Male	610
Transgender	1
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	77
Another identity not listed	
TOTAL	**2479**
If another identity is counted, please specify:	

PRIMARY LANGUAGE	
English	597
Spanish	
Cantonese	
Chinese	
Vietnamese	1
Farsi	66
Arabic	1
Tagalog	
Declined to answer	
Unknown	
Another language not listed	1814
TOTAL	**2479**
If another language is counted, please specify: Dari, Pashto, Urdu	

SEX ASSIGNED AT BIRTH	
Male	610
Female	1791
Declined to answer	
Unknown	78
TOTAL	**2479**

DISABILITY*** STATUS	
Communication Domain	
Vision	2
Hearing/Speech	
Another type not listed	
Communication Domain Subtotal	**2**
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	7
Physical/mobility	19
Chronic health condition	9
Disability Subtotal	**35**
None	398
Declined to answer	
Unknown	2044
Another disability not listed	
TOTAL	**2479**
If another disability is counted, please specify:	

RACE	
American Indian or Alaska Native	
Asian	2221
Black or African American	31
Native Hawaiian or other Pacific Islander	
White	118
Other Race	74
Declined to answer	
Unknown	35
TOTAL	**2479**
If another race is counted, please specify:	

Ethnicity/Cultural Heritage (Please choose only one per individual)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	
Mexican/Mexican American/Chicano	
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	35
Total Hispanic or Latino	**35**
If Non-Hispanic or Non-Latino, please specify:	
African	
African American	31
Asian Indian/South Asian	
Cambodian	
Chinese	
Eastern European	
European	
Filipino	
Japanese	
Korean	
Middle Eastern	
Vietnamese	
Other Non-Hispanic or Non-Latino ethnicity not listed	2221
Total Non-Hispanic or Non-Latino	**2252**
More than one ethnicity	
Unknown Ethnicity	192
Declined to answer	
EHTNICITY TOTAL	**2479**
If another ethnicity is counted, please specify: Afghan, East Asian	

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of. Note: 1,000-character limit.

An Afghan young man has recently arrived in the U.S. with his family. This client was feeling sad and anxious about the new life changing events he was experiencing. Client shared that he was having feelings of sadness, frustration, and anxiety for not being able to speak the English language and not having meaningful activities. After establishing rapport with client, he was able to express his frustrations and concerns which he reported was "very helpful and effective". Client was connected to youth workers who were able to assist him in improving his English abilities, which client stated was helpful for him. During his weekly counseling sessions, client appeared much more positive, and after several sessions, client shared more positivism and was feeling more confident about his abilities he stated that he would prepare himself to take the DMV permit test in the summer time. Another accomplishment was our food bank that distributed food boxes to 50 families per week.

Box E: Program challenges of the past year and how did the agency mitigate challenges? Note: 1,000-character limit.

All services were provided remotely relying heavily on technology to bring programming and assistance to clients. One challenge was connecting clients to technology and providing the most in-need clients with devices so that they could participate in our workshops/events/prevention counseling, communicate with family members and learn about resources, including COVID-19 relief. We hired an Elderly Outreach Worker who taught clients how to download and use apps such as Zoom, WhatsApp, and social media sites. Another challenge was supporting youth who, due to in-person school cancellations, had become disengaged, depressed, and broke off communication with parents. We mitigated this by ramping up tutoring efforts as a means to support students. A new tutoring program was established using peer volunteer tutors to match struggling students with high school/college aged tutors who assisted with academics and provided guidance and support.

Box F: Program lessons learned of the past year? Note: 1,000-character limit.

Afghan TV and social media are very effective means of outreach to our community. We saw increased participation with virtual events due to more flexibility. This is consistent with several prevention clients who preferred telehealth for counseling services for the convenience of it. Outreach to clients one-by-one was also very effective. For those clients without transportation, we discovered that phone, SMS, and emails were an efficient way to share information. For youth, we saw an influx in tutoring requests due to online learning that caused Afghan youth to suffer academically. We learned that through tutoring youth's academics improved but also their mental health as it provided mentorship and much-needed social interactions. We continue to adjust between in-person services and remote depending on the needs of our clients. Lastly, the pandemic reiterated the importance of hosting Consortium meetings to educate health care professionals about Afghan culture.

Box G: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
G.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e. mental health treatment services):	3
G.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e. mental health treatment services):	4
G.3: Types of treatment individuals were referred to (list types) (500-character limit):	Most individuals were referred to a psychiatrist who could evaluate them further and possibly prescribe medication. Some clients were referred to psychologists and other licensed mental health professionals.
G.4: Unduplicated number of individuals who participated in referred program at least one time:	All referred clients participated at least one time in referred programs.
G.5: Average duration of untreated mental illness in weeks:	Average of 2 weeks
G.6: Average number of days between referral and first participation in referred treatment program:	Average of 14 days

Box H: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
H.1: Who is/are the underserved target population(s) your program is serving (e.g. TAY, Southeast Asian) (500 Characters):	The majority of participants in our program come from Afghanistan, while some participants are served who come from India and Iran. We serve Immigrant and Refugee populations and their families.
H.2: Number of paper referrals to an ACBH PEI-funded program:	39
H.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	26
H.4: Average number of days between referral and first participation in referred PEI program:	3 to 5 days

H.5: Describe how your program encouraged access to services and follow through on above referrals (500 Characters):	Encouraging clients that are referred by decreasing their fear and/or stigma to mental health services, providing them with information regarding available resources (in a culturally appropriate manner), and emphasizing the need for them to be engaged in services.

Box I: For Outreach, Suicide Prevention, and Stigma Reduction programs, please provide information for unduplicated potential responders (i.e., those who are in a position to identify early signs of potentially severe mental illness provide support, and or refer individuals who need treatment) reached. ***(Note: For Prevention, Early Intervention, Access & Linkage programs, this section is optional.)***

Number of Responders:	
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):
Substance Abuse on 7/30/20	*Virtually, 8 youth*
MH Consortium meeting (outreach), 9/3/20	*5 youth, 58 adults, 10 seniors, 29 general community, 5 faith leaders*
Suicide prevention with Nazanin, 9/25/20	*8 youth and 1 community leader*
Fremont Resource Day, 10/29/20	*26 CBOs, 131 total present*
Faith setting: Mohommadia Masque, 11/27/20 (Hayward)	*35 young adults, 40 adults, 10 faith leaders, 10 community leaders, 2 CBOs, 10 family members*
Psychoeducation: Grief and Loss with Dr. Masoud, 10/30/20s	*Virtual, 2 youth, 7 adults towards the general community*
Support group: MH Stigma Reduction with Youth in October	*Virtual, 18 youth, 3 families served towards the general community*
Support group: MH Wellness with Youth in November	*Virtual, 7 families served toward the general community*
Support group: MH Leadership and Empowerment in December	*Virtual, 15 families served towards the general community*
MH Consultation, 1/4/21 – Outreach Children's Health	*Virtual, 38 health care professionals, 5 general community members*
Psychoeducation: Substance Abuse with Nazanin, 2/5/21	*Virtual,47 people served towards the general community*
MH Consultation – Hayward Unified School District, 2/21	*Child welfare professional, attendance supervisor, Newcomer Service Coordinator, School Counselor*

MHSA Program #: PEI 7

PROVIDER NAME: Filipino Advocates for Justice

PROGRAM NAME: Outreach, Education & Consultation for Filipino Community

Program Outcomes & Impact: UELP Data Report FY 20/21

Program Name:	Filipino Community Wellness Program	
Organization:	Filipino Advocates for Justice	
PEI Program # and Name:	PEI 7 Outreach, Education & Consultation (Filipino)	
Type of Report (Choose one):	Annual	
PEI Category (choose one):	Prevention	
Priority Area (place and X next to all that apply):		Childhood Trauma
		Early Psychosis
	X	Youth/TAY Outreach and Engagement
	X	Cultural and Linguistic
	X	Older Adults
		Early Identification of Mental Health Illness

Box A: Please provide a brief program description (character limit 1,000).

FAJ's 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.

Box B: Number of individuals served this fiscal year through MHSA funding.

Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	1391
Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	36

Number of unduplicated individual family members served indirectly by your program:	NA
Grand total of unduplicated individuals served:	**1427**

Box C: Demographics of individuals served this fiscal year through MHSA funding.

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	124
Transition Age Youth (16-25 yrs.)	868
Adult (26-59 yrs.)	261
Older Adult (60+ yrs.)	158
Declined to answer	
Unknown	16
TOTAL	**1427**

SEXUAL ORIENTATION	
Gay/Lesbian	
Heterosexual/Straight	644
Bisexual	2
Questioning/Unsure	1
Queer	343
Declined to answer	
Unknown	394
Another group not listed	43
TOTAL	**1427**
If another group is counted, please specify:	

VETERAN STATUS	
Yes	
No	60
Declined to answer	
Unknown	1367
TOTAL	**1427**

CURRENT GENDER IDENTITY	
Female	1067
Male	324
Transgender	5
Genderqueer	
Questioning/unsure of gender identity	2
Declined to answer	
Unknown	14
Another identity not listed	20
TOTAL	**1427**
If another identity is counted, please specify:	

PRIMARY LANGUAGE	
English	1132
Spanish	
Cantonese	
Chinese	
Vietnamese	
Farsi	
Arabic	
Tagalog	293
Declined to answer	
Unknown	
Another language not listed	2
TOTAL	**1427**
If another language is counted, please specify:	

SEX ASSIGNED AT BIRTH	
Male	315
Female	1041
Declined to answer	
Unknown	71
TOTAL	**1427**

DISABILITY*** STATUS	
Communication Domain	
Vision	
Hearing/Speech	
Another type not listed	
Communication Domain Subtotal	**0**
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	
Physical/mobility	1
Chronic health condition	
Disability Subtotal	**1**
None	19
Declined to answer	
Unknown	1407
Another disability not listed	
TOTAL	**1427**
If another disability is counted, please specify:	

RACE	
American Indian or Alaska Native	
Asian	1374
Black or African American	5
Native Hawaiian or other Pacific Islander	
White	12
Other Race	6
Declined to answer	
Unknown	30
TOTAL	**1427**
If another race is counted, please specify: Latino	

Ethnicity/Cultural Heritage (Please choose only one per individual)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	
Mexican/Mexican American/Chicano	
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	6
Total Hispanic or Latino	**6**
If Non-Hispanic or Non-Latino, please specify:	
African	
African American	5
Asian Indian/South Asian	30
Cambodian	
Chinese	125
Eastern European	
European	
Filipino	1159
Japanese	
Korean	
Middle Eastern	
Vietnamese	21
Other Non-Hispanic or Non-Latino ethnicity not listed	3
Total Non-Hispanic or Non-Latino	**1343**
More than one ethnicity	
Unknown Ethnicity	78
Declined to answer	
EHTNICITY TOTAL	**1427**
If another ethnicity is counted, please specify: Afghan, Other South East Asian	

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of. Note: 1,000-character limit.

Increased outreach efforts to older adults resulted in participation of low-wage workers affected by the pandemic in addition to elder caregivers. Youth and TAY participants were able to incorporate mental health and create healing spaces in social causes such as racial justice, anti-AAPI violence and COVID awareness. Participating in these social movements provided healing experiences for those who were most affected. Weekly support groups and peer led workshops continued to provide youth/TAY/adults with culturally competent and meaningful connections during quarantine. We are particularly proud of a new youth leader that was able to mobilize new members and recruit new leaders. Shortly after joining, they wrote and performed poetry for AAPI cultural events.

Box E: Program challenges of the past year and how did the agency mitigate challenges? Note: 1,000-character limit.

The mental health specialist left the organization in November, causing a gap for counseling services until a replacement was hired in February. The pandemic was a substantial challenge for most of the older adult participants due to lack of access to technology allowing them to participate virtually. The creation of Zoom tutorials in-language helped mitigate this. Challenges in transitioning in new peer leaders was mitigated by strengthening connections among peer leader cohorts. Weekly support groups were offered via Zoom and utilized platforms like Discord and Instagram to communicate with youth/TAY and recreate community spaces.

Box F: Program lessons learned of the past year. Note: 1,000-character limit.

Patience and willingness to adapt to 'new norms' are essential for us to continue to serve, especially older adults and working TAY who were more difficult to reach in the beginning. Having a centrally-located school site simplifies leveraging relationships with adults to support youth. Through expanded outreach, having youth come from different areas across Alameda County and school sites brings varying perspectives to diversify and enhance discussions.

Box G: For programs that refer individuals with severe mental illness, please provide information for the categories below:

G.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e. mental health treatment services):	n/a

G.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e. mental health treatment services):	n/a
G.3: Types of treatment individuals were referred to (list types) (500-character limit):	n/a
G.4: Unduplicated number of individuals who participated in referred program at least one time:	n/a
G.5: Average duration of untreated mental illness in weeks:	n/a
G.6: Average number of days between referral and first participation in referred treatment program:	n/a

Box H: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
H.1: Who is/are the underserved target population(s) your program is serving (e.g. TAY, Southeast Asian) (500 Characters):	Filipino and other AAPI youth, TAY and adult, including immigrants and LGBTQ
H.2: Number of paper referrals to an ACBH PEI-funded program:	n/a
H.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	n/a
H.4: Average number of days between referral and first participation in referred PEI program:	n/a
H.5: Describe how your program encouraged access to services and follow through on above referrals (500 Characters):	n/a

Box I: For <u>Outreach, Suicide Prevention, and Stigma Reduction</u> programs, please provide information for unduplicated potential responders (i.e., those who are in a position to identify early signs of potentially severe mental illness provide support, and or refer individuals who need treatment) reached. ***(Note: For Prevention, Early Intervention, Access & Linkage programs, this section is optional.)***	
Number of Responders:	
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):
Virtual/Telehealth	*Youth, TAY, LGBTQ+, Elder Caregivers.*
Social media	*Community-at-large.*

MHSA Program #: PEI 7

PROVIDER NAME: Afghan Path toward Wellness (International Rescue Committee (IRC)

PROGRAM NAME: Outreach, Education & Consultation for Afghan Community

Program Outcomes & Impact: UELP Data Report FY1 20/21

Program Name:	Afghan Path Towards Wellness (APTW)	
Organization:	International Rescue Committee	
PEI Program # and Name:	PEI 7 Outreach, Education & Consultation (Afghan)	
Type of Report (Choose one):	Annual	
PEI Category (choose one):	Prevention	
Priority Area (place and X next to all that apply):		Childhood Trauma
		Early Psychosis
		Youth/TAY Outreach and Engagement
	x	Cultural and Linguistic
		Older Adults
	x	Early Identification of Mental Health Illness

Box A: Please provide a brief program description (character limit 1,000).
Afghan Path Towards Wellness (APTW): Providing wellness and psychosocial support services to the Afghan community of North Alameda County. Primary services include preventative counseling, psychoeducational and educational workshops, community events, socials support groups, wellness assessments, and community provider and leader trainings.

Box B: Number of individuals served this fiscal year through MHSA funding.	
Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	837
Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	65
Number of unduplicated individual family members served indirectly by your program:	NA
Grand total of unduplicated individuals served:	902

Box C: Demographics of individuals served this fiscal year through MHSA funding.

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	68
Transition Age Youth (16-25 yrs.)	224
Adult (26-59 yrs.)	550
Older Adult (60+ yrs.)	5
Declined to answer	
Unknown	55
TOTAL	**902**

SEXUAL ORIENTATION	
Gay/Lesbian	2
Heterosexual/Straight	689
Bisexual	
Questioning/Unsure	
Queer	
Declined to answer	
Unknown	211
Another group not listed	
TOTAL	**902**
If another group is counted, please specify:	

VETERAN STATUS	
Yes	1
No	781
Declined to answer	2
Unknown	118
TOTAL	**902**

CURRENT GENDER IDENTITY	
Female	750
Male	97
Transgender	
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	55
Another identity not listed	
TOTAL	**902**
If another identity is counted, please specify:	

PRIMARY LANGUAGE	
English	86
Spanish	4
Cantonese	
Chinese	
Vietnamese	
Farsi	175
Arabic	12
Tagalog	
Declined to answer	
Unknown	1
Another language not listed	624
TOTAL	**902**
If another language is counted, please specify: Dari, Nepali, Pashto	

SEX ASSIGNED AT BIRTH	
Male	389
Female	671
Declined to answer	
Unknown	
TOTAL	**1060**

DISABILITY*** STATUS	
Communication Domain	
Vision	
Hearing/Speech	
Another type not listed	
Communication Domain Subtotal	**0**
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	
Physical/mobility	
Chronic health condition	
Disability Subtotal	**0**
None	782
Declined to answer	
Unknown	120
Another disability not listed	
TOTAL	**902**
If another disability is counted, please specify:	

RACE	
American Indian or Alaska Native	
Asian	768
Black or African American	2
Native Hawaiian or other Pacific Islander	
White	
Other Race	46
Declined to answer	
Unknown	86
TOTAL	**902**
If another race is counted, please specify:	

Ethnicity/Cultural Heritage (Please choose only one per individual)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	
Mexican/Mexican American/Chicano	2
Puerto Rican	
South American	1
Another Hispanic/Latino ethnicity not listed	4
Total Hispanic or Latino	**7**
If Non-Hispanic or Non-Latino, please specify:	
African	
African American	2
Asian Indian/South Asian	
Cambodian	
Chinese	
Eastern European	
European	
Filipino	
Japanese	
Korean	
Middle Eastern	
Vietnamese	
Other Non-Hispanic or Non-Latino ethnicity not listed	780
Total Non-Hispanic or Non-Latino	**782**
More than one ethnicity	
Unknown Ethnicity	113
Declined to answer	
EHTNICITY TOTAL	**902**
If another ethnicity is counted, please specify: Afghan	

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of. Note: 1,000-character limit.

COVID-19 has had significant implications on individuals' sense of community, has increased stressors, and has exacerbated underlying mental health conditions among the Afghan community. APTW's support groups have provided social support, education on stress coping techniques, and opportunities for sharing of COVID-19 related resources. Clients shared feedback that the virtual support groups helped them feel connected, cope with stressors, and promote their families' resilience.

One client in particular was experiencing seizures, side effects to medications, depression and anxiety. The PEI caseworker supported her with learning techniques to reduce stress and anxiety, such as controlling intrusive thoughts to breathing exercises while providing emotional support. Eventually, this client was able to identify her own self-worth and her condition quickly improved.

Box E: Program challenges of the past year and how did the agency mitigate challenges? Note: 1,000- character limit.

Access to adequate technology and digital literacy skills are a barrier to clients engaging with our virtual services, now conducted over Zoom. We were pleased to be able to provide laptops and tablets to APTW clients and teach digital literacy skills. With the support of the APTW team, clients were able to attend virtual English classes, connect their children to their virtual classes, and attend Zoom sessions for counseling or psychosocial support groups. California's Shelter in Place order posed challenges to ensuring confidentiality for all UELP programming, since participants share homes with children and spouses. Programming often involves building trust with clients and having sensitive conversations about mental health. To mitigate these concerns, the UELP team has completed extra trainings on domestic violence, mandated reporting, and has developed strategies for creating 'safe spaces' and cultivating boundaries for clients who are 'sheltering in place.'

Box F: Program lessons learned of the past year? Note: 1,000-character limit.

In Year II of the grant, IRC significantly benefited from prioritizing internal collaboration across IRC's programs, as well as partnership with community providers. To promote access and increase internal referrals, the APTW team conducted a presentation with all IRC staff on the different components of the program to encourage cross-referrals. The UELP team has collaborated with Partnership for Trauma Recovery, Diversity in Health Training Institute and Afghan Coalition on referrals and community resources. Most recently, the UELP Team collaborated with UC Berkeley and the Afghan Clinic to provide a community event focusing on debunking vaccine myths. The UELP Team shared information to all of our clients about COVID-19 via WhatApp, email, text and phone to ensure clients were accessing linguistically appropriate services.

Box G: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
G.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e. mental health treatment services):	1
G.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e. mental health treatment services):	4
G.3: Types of treatment individuals were referred to (list types) (500-character limit):	Clients were referred to both short term and long-term therapy at community-based clinics and behavioral health programs at their local hospitals.
G.4: Unduplicated number of individuals who participated in referred program at least one time:	5
G.5: Average duration of untreated mental illness in weeks:	2
G.6: Average number of days between referral and first participation in referred treatment program:	7

Box H: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
H.1: Who is/are the underserved target population(s) your program is serving (e.g. TAY, Southeast Asian) (500 Characters):	Afghan
H.2: Number of paper referrals to an ACBH PEI-funded program:	6
H.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	5
H.4: Average number of days between referral and first participation in referred PEI program:	14
H.5: Describe how your program encouraged access to services and follow through on above referrals (500 Characters):	Strategies revolve around 1:1 coaching on resources, and education re: myths about seeking mental health support. If/when a client is willing to be referred, support with transport, registration, logistics is offered. The team follows up to ensure a smooth transition.

Box I: For <u>Outreach, Suicide Prevention, and Stigma Reduction</u> programs, please provide information for unduplicated potential responders (i.e., those who are in a position to identify early signs of potentially severe mental illness provide support, and or refer individuals who need treatment) reached. ***(Note: For Prevention, Early Intervention, Access & Linkage programs, this section is optional.)***	
Number of Responders:	**NA**
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):

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 Outcomes & Impact: UELP Data Report FY 20/21

Program Name:	South Asian Community Health Promotion Services	
Organization:	The Hume Center	
PEI Program # and Name:	PEI 7 Outreach, Education & Consultation (So. Asian)	
Type of Report (Choose one):	Annual	
PEI Category (choose one):	Prevention	
Priority Area (place and X next to all that apply):		Childhood Trauma
		Early Psychosis
	X	Youth/TAY Outreach and Engagement
	X	Cultural and Linguistic
	X	Older Adults
	X	Early Identification of Mental Health Illness

Box A: Please provide a brief program description (character limit 1,000).

When life becomes too overwhelming, that result can bring changes in how an individual thinks, feels, and acts. The South Asian program offers prevention and early intervention services for individuals, couples, and families in distress. These sort-term culturally sensitive and language specific services offer support aimed at developing knowledge and skills to work through life challenges effectively.

Box B: Number of individuals served this fiscal year through MHSA funding.	
Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	4564
Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	93
Number of unduplicated individual family members served indirectly by your program:	NA
Grand total of unduplicated individuals served:	**4657**

Box C: Demographics of individuals served this fiscal year through MHSA funding.

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	181
Transition Age Youth (16-25 yrs.)	360
Adult (26-59 yrs.)	3929
Older Adult (60+ yrs.)	187
Declined to answer	
Unknown	
TOTAL	**4657**

VETERAN STATUS	
Yes	
No	2956
Declined to answer	
Unknown	1701
TOTAL	**4657**

SEXUAL ORIENTATION	
Gay/Lesbian	17
Heterosexual/Straight	2581
Bisexual	2
Questioning/Unsure	5
Queer	
Declined to answer	
Unknown	2049
Another group not listed	3
TOTAL	**4657**
If another group is counted, please specify:	

CURRENT GENDER IDENTITY	
Female	2812
Male	17987
Transgender	
Genderqueer	
Questioning/unsure of gender identity	12
Declined to answer	
Unknown	25
Another identity not listed	3
TOTAL	**4657**
If another identity is counted, please specify:	

SEX ASSIGNED AT BIRTH	
Male	2812
Female	1798
Declined to answer	
Unknown	47
TOTAL	**4657**

DISABILITY*** STATUS	
Communication Domain	
Vision	
Hearing/Speech	
Another type not listed	0
Communication Domain Subtotal	**0**
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	
Physical/mobility	6
Chronic health condition	9
Disability Subtotal	**15**
None	2726
Declined to answer	
Unknown	1816
Another disability not listed	100
TOTAL	**4657**

PRIMARY LANGUAGE	
English	198
Spanish	
Cantonese	
Chinese	
Vietnamese	
Farsi	262
Arabic	
Tagalog	
Declined to answer	
Unknown	
Another language not listed	2406
TOTAL	**4657**
If another language is counted, please specify: Indi, Nepali, Punjabi, Urdu	

RACE	
American Indian or Alaska Native	
Asian	3716
Black or African American	3
Native Hawaiian or other Pacific Islander	24
White	323
Other Race	57
Declined to answer	
Unknown	534
TOTAL	**4657**
If another race is counted, please specify:	

Ethnicity/Cultural Heritage (Please choose only one per individual)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	
Mexican/Mexican American/Chicano	
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	40
Total Hispanic or Latino	**40**
If Non-Hispanic or Non-Latino, please specify:	
African	
African American	3
Asian Indian/South Asian	1015
Cambodian	
Chinese	33
Eastern European	
European	
Filipino	19
Japanese	
Korean	24
Middle Eastern	
Vietnamese	2
Other Non-Hispanic or Non-Latino ethnicity not listed	2929
Total Non-Hispanic or Non-Latino	**4023**
More than one ethnicity	
Unknown Ethnicity	594
Declined to answer	
EHTNICITY TOTAL	**4657**
If another ethnicity is counted, please specify: Persian Iranian, Afghan, Bhutanese, Nepalese, Pakistani, Taiwanese, Other East Asian, Other South East Asian	

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of. Note: 1,000-character limit.

We saw many successes and accomplishments this past year as we continued to use telehealth platforms which helped de-stigmatize seeking out of services by allowing anonymity, took away barriers such as needs for transportation and childcare and helped increase access to care. We were able to offer 10 support groups this year, 2 in Farsi, 4 in Nepali, 3 in English, and 1 in Hindi. Each were well attended. Through telehealth, we were able to reach South Asian community members in hard to reach areas county wide and collaborate with faith healers and community leaders to help normalize emotional wellness conversations. We established stronger relationships with many South Asian mental health stakeholders, providing MH consultations and helping to bridge service gaps. As a result of this outreach we saw an increase in referrals to our program, especially for family work focused on the impacts of the pandemic.

Box E: Program challenges of the past year and how did the agency mitigate challenges? Note: 1,000- character limit.

The biggest challenges continued to be our inability to work in the community, especially not being able to host or attend community events. Once the vaccine roll-out began, our outreach workers did start meeting with the community outdoors, passing out print materials to connect them to resources and helping them decrease isolation to minimize the impacts of the pandemic. The other challenge we experienced was in keeping youth engaged. In the past, we would meet with them in person and utilize art, sports, board games and other interactive activities to help build rapport and encourage continued engagement. However, on telehealth it was more difficult to connect with youth. Many did not have safe/confidential spaces at home and they were experiencing Zoom fatigue. We had to begin to think outside of the box, find online activities or utilize things that most youth would have access to at home to do art projects. We also offered for some youth to come into the clinic if they felt safe.

Box F: Program lessons learned of the past year? Note: 1,000-character limit.

Some lessons learned were: a) Importance of community building – need to continue to train community leaders and faith leaders on how to respond to emotional wellness needs in the community, b) Importance of telehealth services even after the pandemic is over. It really helps to increase access to care, c) Support groups are so important, even when there are only a few community members present. They help in normalizing emotional wellness conversations, d) Prevention work so needed in the South Asian community. We need to advocate for more funding to help increase these services, e) The pandemic continued to remind us that we must wear different hats when serving immigrant communities.

Box G: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
G.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e. mental health treatment services):	10
G.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e. mental health treatment services):	20
G.3: Types of treatment individuals were referred to (list types) (500-character limit):	Alameda County & Contra Costa County Outpatient at the Hume Center, Tri-City Health, EAP programs, private health insurance, college/university health programs, Kaiser
G.4: Unduplicated number of individuals who participated in referred program at least one time:	n/a
G.5: Average duration of untreated mental illness in weeks:	n/a
G.6: Average number of days between referral and first participation in referred treatment program:	n/a

Box H: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
H.1: Who is/are the underserved target population(s) your program is serving (e.g. TAY, Southeast Asian) (500 Characters):	This program serves individuals from the unserved and underserved South Asian community, more specifically those from India, Pakistan, Bhutan, Nepal, Sri Lanka, Bangladesh, and Burma.
H.2: Number of paper referrals to an ACBH PEI-funded program:	5
H.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	2
H.4: Average number of days between referral and first participation in referred PEI program:	n/a
H.5: Describe how your program encouraged access to services and follow through on above referrals (500 Characters):	n/a

Box I: For Outreach, Suicide Prevention, and Stigma Reduction programs, please provide information for unduplicated potential responders (i.e., those who are in a position to identify early signs of potentially severe mental illness provide support, and or refer individuals who need treatment) reached. ***(Note: For Prevention, Early Intervention, Access & Linkage programs, this section is optional.)***

Number of Responders:	
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):
10 Schools	*18 school counselors, 3 social workers, 10 principals, 2 school nurses, 10 administrators*
Community/Faith leaders	*100+ leaders in Nepalese, Bhutanese, Punjabi, Persian, Pakistani and Asian Indian communities*
CBOs	*Mental health providers, doctors, nurses, social workers, DV counselors, peer/resource specialists*
South Asian grocery stores	*Unlimited community members*
South Asian restaurants	*Unlimited community members*
Faith based establishments	*Unlimited community members, 5 faith leaders*
Colleges and universities	*Professors, administrators, counselors, students*
South Asian Grocery Stores	*Community Leaders, Community Members*
South Asian Restaurants	*Community members*

MHSA Program #: PEI 8

PROVIDER NAME: Native American Health Center (NAHC)

PROGRAM NAME: Outreach, Education & Consultation for Native American Community

Program Outcomes & Impact: UELP Data Report FY 20/21

Program Name:	Native American Prevention Center	
Organization:	Native American Health Center, Inc	
PEI Program # and Name:	81112	
Type of Report (Choose one):	Annual	
PEI Category (choose one):	Prevention	
Priority Area (place and X next to all that apply):	X	Childhood Trauma
		Early Psychosis
	X	Youth/TAY Outreach and Engagement
	X	Cultural and Linguistic
	X	Older Adults
	X	Early Identification of Mental Health Illness

Box A: Please provide a brief program description (character limit 1,000).

We provide an integrated approach that incorporates a number of evidence-based practices, culturally responsive programming or trainings on mental health. To meet the PEI requirements as specified in our contract, we work to increase access to mental health services to underserved communities by implementing culturally and linguistically responsive services.

Box B: Number of individuals served during this fiscal year through MHSA funding.

Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	524

Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	72
Number of unduplicated individual family members served indirectly by your program:	NA
Grand total of unduplicated individuals served:	**596**

Box C: Demographics of individuals served this fiscal year through MHSA funding.

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	262
Transition Age Youth (16-25 yrs.)	138
Adult (26-59 yrs.)	174
Older Adult (60+ yrs.)	22
Declined to answer	
Unknown	
TOTAL	**596**

SEXUAL ORIENTATION	
Gay/Lesbian	
Heterosexual/Straight	
Bisexual	
Questioning/Unsure	
Queer	
Declined to answer	
Unknown	596
Another group not listed	
TOTAL	**596**
If another group is counted, please specify:	

VETERAN STATUS	
Yes	6
No	325
Declined to answer	6
Unknown	259
TOTAL	**596**

CURRENT GENDER IDENTITY	
Female	287
Male	300
Transgender	
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	9
Another identity not listed	
TOTAL	**596**
If another identity is counted, please specify:	

PRIMARY LANGUAGE	
English	589
Spanish	6
Cantonese	
Chinese	
Vietnamese	
Farsi	
Arabic	
Tagalog	
Declined to answer	
Unknown	
Another language not listed	1
TOTAL	**596**
If another language is counted, please specify:	

SEX ASSIGNED AT BIRTH	
Male	239
Female	276
Declined to answer	
Unknown	81
TOTAL	**596**

DISABILITY*** STATUS	
Communication Domain	
Vision	
Hearing/Speech	1
Another type not listed	
Communication Domain Subtotal	**0**
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	
Physical/mobility	
Chronic health condition	
Disability Subtotal	**0**
None	47
Declined to answer	
Unknown	549
Another disability not listed	
TOTAL	**596**
If another disability is counted, please specify:	

RACE	
American Indian or Alaska Native	29
Asian	18
Black or African American	64
Native Hawaiian or other Pacific Islander	1
White	13
Other Race	208
Declined to answer	
Unknown	11
TOTAL	**596**
If another race is counted, please specify: Latino (89), other (4)	

Ethnicity/Cultural Heritage (Please choose only one per individual)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	
Mexican/Mexican American/Chicano	
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	200
Total Hispanic or Latino	**200**
If Non-Hispanic or Non-Latino, please specify:	
African	
African American	64
Asian Indian/South Asian	
Cambodian	
Chinese	
Eastern European	
European	
Filipino	
Japanese	
Korean	
Middle Eastern	
Vietnamese	
Other Non-Hispanic or Non-Latino ethnicity not listed	64
Total Non-Hispanic or Non-Latino	**264**
More than one ethnicity	
Unknown Ethnicity	34
Declined to answer	
EHTNICITY TOTAL	**298**
If another ethnicity is counted, please specify:	

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of. Note: 1,000-character limit.

Food Security Project: We were extremely proud of or Food Security Project. We were able to hold this part of the program in person. This gave us real time insight to some of the real needs of our youth, families and elders. In the past, parent participation has been difficult. Due to the home visits our connection. Annual Youth/family GONA: our GONA was so well attended we decided to hold two this year. We have learned so much from this pandemic and having to work virtually. There is value in being able to reach the participants that cannon come in physically. Virtual programming will continue to be a part of our programming moving forward. We were able to re-implement our Elders Program in the beginning of 2021 with bringing back our staff that had to be reassigned due to COVID-19. Since her return, the Elders Program is going strong. They continue to receive support from our Traditional Healer during regular check-ups.

Box E: Program challenges of the past year and how did the agency mitigate challenges? Note: 1,000-character limit.

The impact of COVID-19 has been immense as we all know. One of the biggest impacts has been the loneliness and isolation our youth, families and elders have been experiencing. The cancellation of major events for another year (Powwows, ceremonies, and family gatherings) and access to resources drying up due to being over inundated. We were able to mitigate these challenges by going virtual, making regular calls to our participants to check in and visit a little when we deliver their weekly food boxes. The in-person visits were healing for both participants and for staff. The visits made the youth, families, and elders feel heard, and the staff could see the positive impact of the visits and check-ins.

Box F: Program lessons learned of the past year? Note: 1,000-character limit.

We continue to see there is a value in seeing each other (staff and community members). We saw the negative effects of isolation and loneliness on everyone. We realize now how important our gatherings are to foster wellness in our community.

We also learned that we can use virtual learning beyond our current situation. We will be utilizing virtual platforms moving forward. Even though access can be an issue for some, the positive impact outweighs the barriers.

Most of all, that we are being tested and we as a community perceiver and find the light in the dark. We roll up our sleeves, put on the hip boots and work together to make beautiful things happen.

Box G: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
G.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e. mental health treatment services):	n/a
G.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e. mental health treatment services):	n/a
G.3: Types of treatment individuals were referred to (list types) (500-character limit):	n/a
G.4: Unduplicated number of individuals who participated in referred program at least one time:	n/a
G.5: Average duration of untreated mental illness in weeks:	n/a
G.6: Average number of days between referral and first participation in referred treatment program:	n/a

Box H: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
H.1: Who is/are the underserved target population(s) your program is serving (e.g. TAY, Southeast Asian) (500 Characters):	Native American Health Center's mission is to provide comprehensive services to improve the health and well-being of American Indians, Alaska Natives, and residents of the surrounding communities, with respect for cultural and linguistic differences.
H.2: Number of paper referrals to an ACBH PEI-funded program:	n/a
H.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	n/a
H.4: Average number of days between referral and first participation in referred PEI program:	n/a

H.5: Describe how your program encouraged access to services and follow through on above referrals (500 Characters):	Our program encourage access to mental health services through the direct connection (warm handoff) to a Behavioral Health clinician, and ensured engagement via follow-up call from the consulting provider and community health worker. Reminder phone calls for appointments are also made to decrease the no-show rate. In response COVID-19, we have provided virtual and telehealth follow-ups for program participants

Box I: For <u>Outreach, Suicide Prevention, and Stigma Reduction</u> programs, please provide information for unduplicated potential responders (i.e., those who are in a position to identify early signs of potentially severe mental illness provide support, and or refer individuals who need treatment) reached. ***(Note: For Prevention, Early Intervention, Access & Linkage programs, this section is optional.)***	
Number of Responders:	**NA**
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):

MHSA Program #: PEI 10

PROVIDER NAME: Partnership for Trauma Recovery (PTR)

PROGRAM NAME: Outreach, Education & Consultation for Partnerships for African Community

Program Outcomes & Impact: UELP Data Report FY 20/21

Program Name:	African Communities Program	
PEI Category (choose one):	Prevention	
Priority Area (place and X next to all that apply):		Childhood Trauma
		Early Psychosis
		Youth/TAY Outreach and Engagement
	X	Cultural and Linguistic
		Older Adults
		Early Identification of Mental Health Illness

Box A: Please provide a brief program description (character limit 1,000).
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 behavioral health care, psychosocial, and case management support for those who have fled violence and persecution in their home countries.

Box B: Number of individuals served this fiscal year through MHSA funding.	
Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	912
Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	30
Number of unduplicated individual family members served indirectly by your program:	NA
Grand total of unduplicated individuals served:	942

Box C: Demographics of individuals served this fiscal year through MHSA funding.

SEX ASSIGNED AT BIRTH	
Male	393
Female	411
Declined to answer	
Unknown	138
TOTAL	**942**

DISABILITY*** STATUS	
Communication Domain	
Vision	
Hearing/Speech	
Another type not listed	
Communication Domain Subtotal	**0**
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	
Physical/mobility	1
Chronic health condition	
Disability Subtotal	**1**
None	198
Declined to answer	
Unknown	741
Another disability not listed	
TOTAL	**942**
If another disability is counted, please specify:	

RACE	
American Indian or Alaska Native	
Asian	2
Black or African American	835
Native Hawaiian or other Pacific Islander	
White	23
Other Race	2
Declined to answer	
Unknown	80
TOTAL	**942**
If another race is counted, please specify: Latino (8).	

Ethnicity/Cultural Heritage (Please choose only one per individual)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	
Mexican/Mexican American/Chicano	
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	18
Total Hispanic or Latino	**18**
If Non-Hispanic or Non-Latino, please specify:	
African	726
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	726
Total Non-Hispanic or Non-Latino	**726**
More than one ethnicity	
Unknown Ethnicity	198
Declined to answer	
EHTNICITY TOTAL	**942**
If another ethnicity is counted, please specify: Eritrean, Cameroonian, Congolese, Ethiopian, Kenyan, Sudanese, Tigrinya, Tutsi	

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of. Note: 1,000-character limit.

PTR's African communities program provided counseling to 24 unique clients, facilitated 15 psychoeducational workshops, 3 educational workshops, 3 support groups; hosted and co-hosted 8 community events, provided MH consultation for 46 community members, prevention visits for 64 potential clients, and distributed communication materials on 5 local listservs that reach CBOs throughout the Bay Area. One of the successes was facilitating psychoeducational workshops by identifying the mental health-related needs and tailoring workshops to specific community groups through a community-based healing approach, to normalize and destigmatize mental health issues. PTR engaged African newcomer youth remotely through the psychosocial support group, mentorships, and coaching. PTR has also maximized reach to African communities in the Bay Area through diversifying outreach approaches and partnering with universities, associations, CBOs, and non-profit organizations.

Box E: Program challenges of the past year and how did the agency mitigate challenges? Note: 1,000-character limit.

PTR's main challenge continued to be entering client information in the InSyst system. The majority of our clients are asylum seekers, many of whose immigration status is currently uncertain. Given their past histories of trauma and insecure legal status, consenting to share personal information reported in InSyst causes stress and anxiety for some clients. Additional barriers to entering InSyst data include 2020 changes in immigration policies, stigma, fear of being racially profiled, and systemic discrimination in services. To respond to this, PRT created a unique consent form, tip-sheet, and user-friendly referral form for UELP clients that indicate the information shared in InSyst, and the level of protection guaranteed by Alameda County. The fact that PTR was able to provide prevention visits for 64 potential clients and conduct mental health consultations for 46 community members is an auspicious sign of PTR's ability to increase the number of PEI counseling clients.

Box F: Program lessons learned of the past year? Note: 1,000-character limit.

Engaging community, faith, and CBO leaders and getting buy-in and trust from them created an enabling environment to reach out more broadly, and to collaborate with more stakeholders to contextualize, tailoring our workshops and events to meet the needs of the communities. This assistance in contextualizing, tailoring mental health issues for specific communities, increasing language access, and diversifying outreach strategies allowed PTR to better meet community needs. The diverse perspectives, ethics and experiences of PTR staff, all of whom are immigrants were relatable to the community we serve, also informed programming. Weaving mental health issues into different needs and stressors of the communities has increased acceptance among community members and enabled staff to easily transfer key messages around mental health issues. The engagement of African youth student associations based in universities helped us to have additional human resources.

Box G: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
G.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e. mental health treatment services):	18
G.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e. mental health treatment services):	0
G.3: Types of treatment individuals were referred to (list types) (500-character limit):	PTR referred clients to our in-house pro-bono psychiatrists for psychiatric care, and provided internal referrals for individual and group psychotherapy with our staff clinicians and clinical interns, with the consent of the client/caregiver.
G.4: Unduplicated number of individuals who participated in referred program at least one time:	15
G.5: Average duration of untreated mental illness in weeks:	Three to four weeks
G.6: Average number of days between referral and first participation in referred treatment program:	30

Box H: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
H.1: Who is/are the underserved target population(s) your program is serving (e.g. TAY, Southeast Asian) (500 Characters):	African refugees, asylum seekers, and immigrants in general who live in North and South Alameda County
H.2: Number of paper referrals to an ACBH PEI-funded program:	0
H.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	0
H.4: Average number of days between referral and first participation in referred PEI program:	0

H.5: Describe how your program encouraged access to services and follow through on above referrals (500 Characters):	African Communities Wellbeing Coordinators coordinated various activities, including prevention visits, case management, and outreach meetings, they encouraged the community to increase their health-seeking behavior, including access to these services.

Box I: For <u>Outreach, Suicide Prevention, and Stigma Reduction</u> programs, please provide information for unduplicated potential responders (i.e., those who are in a position to identify early signs of potentially severe mental illness provide support, and or refer individuals who need treatment) reached. ***(Note: For Prevention, Early Intervention, Access & Linkage programs, this section is optional.)***

Number of Responders:	
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):
Remote Zoom calls	*8 youth, adult community members, 10 CBOs, community leaders*
Phone calls	*64 potential clients, African student associations, youth from school, religious leaders, and CBOs*
Social media (Facebook, Instagram)	*African communities who live here and outside of US*
WhatsApp group	*African student association and different community's association groups*

MHSA Program #: PEI 19

PROVIDER NAME: Diversity in Health Training Institute (DHTI)

PROGRAM NAME: Outreach, Education & Consultation for Partnerships for Middle Eastern Community

Program Outcomes & Impact: UELP Data Report FY 20/21

Program Name:	Sidra Community Wellness Program	
Organization:	Diversity in Health Training Institute	
PEI Program # and Name:	PEI 19 Outreach, Education, & Consultation (Middle-Eastern)	
Type of Report (Choose one):	Annual	
PEI Category (choose one):	Prevention	
Priority Area (place and X next to all that apply):		Childhood Trauma
		Early Psychosis
	X	Youth/TAY Outreach and Engagement
	X	Cultural and Linguistic
	X	Older Adults
	X	Early Identification of Mental Health Illness

Box A: Please provide a brief program description (character limit 1,000).

Sidra Community Wellness Program (SIDRA) launched in July 2019. The purpose of SIDRA is to promote healing, wellness and mental health among Middle Eastern and North African communities in Alameda County.

Box B: Number of individuals served this fiscal year through MHSA funding.

Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	607
Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	54

Number of unduplicated individual family members served indirectly by your program:	NA
Grand total of unduplicated individuals served:	**661**

Box C: Demographics of individuals served this fiscal year through MHSA funding.

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	56
Transition Age Youth (16-25 yrs.)	201
Adult (26-59 yrs.)	3099
Older Adult (60+ yrs.)	5
Declined to answer	
Unknown	
TOTAL	**661**

SEXUAL ORIENTATION	
Gay/Lesbian	
Heterosexual/Straight	453
Bisexual	
Questioning/Unsure	
Queer	
Declined to answer	
Unknown	208
Another group not listed	
TOTAL	**661**
If another group is counted, please specify:	

VETERAN STATUS	
Yes	1
No	248
Declined to answer	
Unknown	412
TOTAL	**661**

CURRENT GENDER IDENTITY	
Female	499
Male	108
Transgender	
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	54
Another identity not listed	
TOTAL	**661**
If another identity is counted, please specify:	

PRIMARY LANGUAGE	
English	46
Spanish	1
Cantonese	2
Chinese	
Vietnamese	
Farsi	32
Arabic	29
Tagalog	
Declined to answer	
Unknown	
Another language not listed	542
TOTAL	**661**
If another language is counted, please specify: Arabic, Arabic Algerian, Arabic Moroccan, Arabic Syrian Lebanese, Arabic Yemen	

SEX ASSIGNED AT BIRTH	
Male	113
Female	528
Declined to answer	
Unknown	
TOTAL	**661**

DISABILITY*** STATUS	
Communication Domain	
Vision	
Hearing/Speech	
Another type not listed	0
Communication Domain Subtotal	**0**
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	
Physical/mobility	
Chronic health condition	
Disability Subtotal	**0**
None	123
Declined to answer	
Unknown	538
Another disability not listed	
TOTAL	**661**
If another disability is counted, please specify:	

RACE	
American Indian or Alaska Native	
Asian	44
Black or African American	6
Native Hawaiian or other Pacific Islander	2
White	587
Other Race	22
Declined to answer	
Unknown	
TOTAL	**661**
If another race is counted, please specify: Other Race includes: Multiracial, Latino	

Ethnicity/Cultural Heritage (Please choose only one per individual)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	
Mexican/Mexican American/Chicano	
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	22
Total Hispanic or Latino	**22**
If Non-Hispanic or Non-Latino, please specify:	
African	
African American	
Asian Indian/South Asian	3
Cambodian	
Chinese	
Eastern European	
European	
Filipino	
Japanese	
Korean	
Middle Eastern	
Vietnamese	
Other Non-Hispanic or Non-Latino ethnicity not listed	586
Total Non-Hispanic or Non-Latino	**621**
More than one ethnicity	
Unknown Ethnicity	18
Declined to answer	
EHTNICITY TOTAL	**661**
If another ethnicity is counted, please specify: Arab, Assyrian, Middle Eastern – North African, Other South Asian, Other South East Asian	

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of. Note: 1,000-character limit.
We were successful in engaging our targeted communities despite the pandemic challenges. This was via the psycho-educational workshops we offered to groups of mothers and youth (males), embedding art and expressive art to the sessions. We held community events where we had conversations on spirituality, fun activities for families, and cultural music. We are proud of our success in building relationships and collaborations with schools and CBOs. Among our success stories this year, one MENA mother who fled from a domestic violence environment and didn't have any support. The Sidra team (MHS and Outreach workers) has provided her with emotional support, linkages to different resources which helped her in restoring her life, housing with rental assistance for 1 year, food assistance, educational/career guidance, and legal services.

Box E: Program challenges of the past year and how did the agency mitigate challenges? Note: The box has a 1,000-character limit.
The continuous prevalence and presence of COVID-19 have affected our work with MENA communities. When we were just starting to build strong relationships and trust with community members and partners, the remote and virtual methods of service made it hard for us to connect especially with the youth population. We lost the interaction with the young MENA students especially since maintaining privacy has become a big issue for them. They live in low-income housing and quite a good number within the household. Although we have success in building trust with parents, gaining more visibility as a resource among the community, we have had challenges finding Arabic-speaking clinical staff to hire to respond to the client's needs. However, we are adding more endeavors in addressing the challenges by seeking more partnerships as a support.

Box F: Programs lessons learned of the past year? Note: 1,000-character limit.
This year validated what we learned in the first year of our program launch, that women are key to successfully reaching the community as they are key gatekeepers. We learned that when mothers are satisfied, they become our advocates and champions for Sidra not only within their families but also in the outside world (i.e. schools). We also learned that in order to reach males (fathers/husbands), we need to use a different narrative to destigmatize mental health services, and we have seen that home visits can help change the dynamics of the discussion. This was clearer for us this year with the overwhelming impact of the pandemic on the population that the presence and availability of mental health providers from the community is a great necessity.

Box G: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
G.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e. mental health treatment services):	1
G.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e. mental health treatment services):	0
G.3: Types of treatment individuals were referred to (list types) (500-character limit):	Client was referred to a LMFT who speaks the language and understands the culture of the client to be treated for complicated grief which hinders the client from having a functional, health and productive life.
G.4: Unduplicated number of individuals who participated in referred program at least one time:	n/a
G.5: Average duration of untreated mental illness in weeks:	n/a
G.6: Average number of days between referral and first participation in referred treatment program:	n/a

Box H: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
H.1: Who is/are the underserved target population(s) your program is serving (e.g. TAY, Southeast Asian) (500 Characters):	Middle Eastern and North African communities, Arabic and Persian/Farsi speaking communities, mothers and grandmothers, youth, transitional age youth, older adults, women, men
H.2: Number of paper referrals to an ACBH PEI-funded program:	0
H.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	n/a
H.4: Average number of days between referral and first participation in referred PEI program:	n/a

H.5: Describe how your program encouraged access to services and follow through on above referrals (500 Characters):	We encourage access to services through a warm handoff to introduce services to the organization. Sidra team arranges for a Zoom meeting with client and organization representative to assess services needed and for registration process. Thereafter, Sidra team continues to follow up.

Box I: For <u>Outreach, Suicide Prevention, and Stigma Reduction</u> programs, please provide information for unduplicated potential responders (i.e., those who are in a position to identify early signs of potentially severe mental illness provide support, and or refer individuals who need treatment) reached. ***(Note: For Prevention, Early Intervention, Access & Linkage programs, this section is optional.)***

Number of Responders:	
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):
Digital Storytelling screening (online)	*MENA Arabic-speaking youth and males*
Afara Celebration Day (online)	*MENA Arabic-speaking members and youth*
Eid Aldha Celebration (online)	*MENA Arabic-speaking members and youth*
Yalda Night (online)	*MENA Farsi-speaking communities*
Digital Storytelling Cultural Education workshop (online)	*MENA Arabic and Farsi-speaking youth*
Community event: Parent's Night with West Oakland Middle School (online)	*MENA Arabic-speaking mothers, community members, school staff*
Community event around linkages and resources with Bay Area Plan (online)	*MENA Arabic-speaking mothers and Bay Area Plan staff members*
Psycho-ed workshop with KIPP Bridge (online)	*MENA Arabic-speaking mothers and KIPP Bridge staff members*
Art workshop groups in collaboration with Safe Passages (online)	*MENA Arabic-speaking mothers*
Support groups with mothers	*MENA Arabic-speaking mothers*
Psycho-ed workshops - Autism	*MENA Arabic-speaking mothers*
Psycho-ed workshops – Gratitude, Communication, Skills, COVID-19, etc. (online)	*MENA Arabic-speaking mothers*
MHCs with WOMS staff, OIHS, Wright Institute, CSM, Mills College (online)	*Diverse ethnic population, staff members, counselors and partners, graduates*

MHSA Program #: PEI 1B

PROVIDER NAME: Center for Healthy Schools and Communities

PROGRAM NAME: School-Based Mental Health Access and Linkage

Program Outcomes & Impact: PEI Data Report FY 20/21

Program Name:	School-Based Mental Health Access and Linkage	
Organization:	Center for Healthy Schools and Communities	
PEI Program # and Name:	PEI 1B School-Based Mental Health Access & Linkage in Elementary, Middle & HS – CHSC	
Type of Report (Choose one):	Annual	
PEI Category (choose one):	Access and Linkage	
Priority Area (place and X next to all that apply):		Childhood Trauma
		Early Psychosis
		Youth/TAY Outreach and Engagement
		Cultural and Linguistic
		Older Adults
	X	Early Identification of Mental Health Illness

Box A: Please provide a brief program description (character limit 1,000).

Coordination of Services Team or COST is a strategy used to integrate behavioral health and other health care supports for students through a referral and triage process. Through COST, a universal referral system is used by teachers and staff to flag students identified as needing support. Referrals are reviewed by a team consisting of school staff and service providers that collaborate to determine the best intervention and/or support service for students. PEI funds currently aid in the implementation of the COST strategy in 276 schools across 14 school districts in Alameda County.

Box B: Number of individuals served this fiscal year through MHSA funding.

Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	2990

Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	3683
Number of unduplicated individual family members served indirectly by your program:	NA
Grand total of unduplicated individuals served:	6673

Box C: Demographics of individuals served this fiscal year through MHSA funding.

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	
Transition Age Youth (16-25 yrs.)	
Adult (26-59 yrs.)	
Older Adult (60+ yrs.)	
Declined to answer	
Unknown	12932
TOTAL	**12932**

SEXUAL ORIENTATION	
Gay/Lesbian	7
Heterosexual/Straight	45
Bisexual	4
Questioning/Unsure	5
Queer	2
Declined to answer	7860
Unknown	
Another group not listed	
TOTAL	**7923**
If another group is counted, please specify:	

VETERAN STATUS	
Yes	
No	
Declined to answer	
Unknown	
TOTAL	**0**

CURRENT GENDER IDENTITY	
Female	888
Male	995
Transgender	13
Genderqueer	3
Questioning/unsure of gender identity	4
Declined to answer	6901
Unknown	
Another identity not listed	
TOTAL	**8804**
If another identity is counted, please specify:	

PRIMARY LANGUAGE	
English	5661
Spanish	3522
Cantonese	162
Chinese	116
Vietnamese	86
Farsi	74
Arabic	95
Tagalog	96
Declined to answer	170
Unknown	
Another language not listed	39
TOTAL	**11560**

SEX ASSIGNED AT BIRTH	
Male	5321
Female	4873
Declined to answer	2049
Unknown	23
TOTAL	**7393**

DISABILITY*** STATUS	
Communication Domain	
Vision	12
Hearing/Speech	135
Another type not listed	
Communication Domain Subtotal	**147**
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	46
Physical/mobility	32
Chronic health condition	357
Disability Subtotal	**435**
None	3503
Declined to answer	6200
Unknown	
Another disability not listed	304
TOTAL	**10589**
If another disability is counted, please specify:	

RACE	
American Indian or Alaska Native	113
Asian	1218
Black or African American	1732
Native Hawaiian or other Pacific Islander	220
White	1436
Other Race	
Declined to answer	1595
Unknown	
TOTAL	**6314**
If another race is counted, please specify:	

Ethnicity/Cultural Heritage (Please choose only one per individual)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	60
Mexican/Mexican American/Chicano	512
Puerto Rican	3
South American	19
Another Hispanic/Latino ethnicity not listed	53
Total Hispanic or Latino	**647**
If Non-Hispanic or Non-Latino, please specify:	
African	16
African American	762
Asian Indian/South Asian	96
Cambodian	31
Chinese	172
Eastern European	6
European	31
Filipino	292
Japanese	15
Korean	8
Middle Eastern	61
Vietnamese	77
Other Non-Hispanic or Non-Latino ethnicity not listed	191
Total Non-Hispanic or Non-Latino	**1758**
More than one ethnicity	259
Unknown Ethnicity	
Declined to answer	3048
EHTNICITY TOTAL	**5712**
If another ethnicity is counted, please specify:	

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of. Note: 1,000-character limit.
Implementation of COST referral system across 276 schools in 14 school districts in Alameda County has successfully and crucially served over 6,000 students and families who needed behavioral health support and services. The COVID-19 pandemic underscored the value and impact of COST to identify and provide holistic supports to students and families, such as basic needs, hotspots, and behavioral health services. One school district used COST to identify foster care students and families who need more support. An elementary school foster student, who had never been to school, received academic interventions and behavioral health support that greatly impacted her academics and behavioral health. COST connected the foster family to community resources. To support a family with three students in different schools, COST teams across sites collaborated to connect all students with mental health support and conduct a home visit to connect the family with counseling and other resources.

Box E: Program challenges of the past year and how did the agency mitigate challenges? Note: 1,000-character limit.
The COVID-19 pandemic and distance learning continued to be a challenge in implementing COST and engaging students and families. In almost all cases COST teams, therapy and mental health services went viral. However, throughout the year some districts were able to offer in-person learning hubs for students who were struggling with distance learning and integrate in-person counseling and supports. Often the severity of health and economic issues families faces were dire and families were often harder to reach. Many COST team members have conducted more home visits to support students and families, as well as participating in school site-based distribution of needed resources to families.

Box F: Program lessons learned of the past year? Note: 1,000-character limit.
School districts leveraged the existing infrastructure of COST and its strong multidisciplinary team to increase access and provide linkages to services virtually. Teams continued to meet, identify students and families in need and provide support and access to mental health and other basic resources such as food, housing support, health support and access to needed technology. All districts continued to utilize COST as a way to identify needed resources, from an individual to community level, and to support families and build on existing relationships. For some teams, the pivot to virtual meeting enables more team members to participate regularly, and some meetings may remain virtual even as schools reopen. Other virtual services, such as developing support groups across school sites, also proved really effective in linking students with one another. Utilizing technology to improve access to services will continue, along with maintaining in-person supports and services.

Box G: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
G.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e. mental health treatment services):	3029
G.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e. mental health treatment services):	n/a
G.3: Types of treatment individuals were referred to (list types) (500-character limit):	Individuals were referred to school-based mental health treatment programs and non-school based services: individual or group counseling/therapy, crisis intervention, individualized behavior support, family counseling, and parent workshops.
G.4: Unduplicated number of individuals who participated in referred program at least one time:	3029
G.5: Average duration of untreated mental illness in weeks:	n/a
G.6: Average number of days between referral and first participation in referred treatment program:	16.4

Box H: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
H.1: Who is/are the underserved target population(s) your program is serving (e.g. TAY, Southeast Asian) (500 Characters):	Transitional-aged and foster youth, LGBTQ-identifying youth, boys and young men of color, unaccompanied immigrant youth, food and shelter insecure youth and families, and English as a second language youth.
H.2: Number of paper referrals to an ACBH PEI-funded program:	n/a
H.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	n/a
H.4: Average number of days between referral and first participation in referred PEI program:	n/a
H.5: Describe how your program encouraged access to services and follow through on above referrals (500 Characters):	Strategies that increase access & follow up: partnerships with family outreach workers, CBOs, information sharing through family workshop, and professional learning for staff, building relationships with students.

Box I: For Outreach, Suicide Prevention, and Stigma Reduction programs, please provide information for unduplicated potential responders (i.e., those who are in a position to identify early signs of potentially severe mental illness provide support, and or refer individuals who need treatment) reached. ***(Note: For Prevention, Early Intervention, Access & Linkage programs, this section is optional.)***	
Number of Responders:	**NA**
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):

MHSA Program #: PEI 1C

PROVIDER NAME: Jewish Family and Community Services East Bay

PROGRAM NAME: Early Childhood Mental Health Outreach and Consultation

Program Outcomes & Impact: PEI Data Report FY 20/21

Program Name:	Early Childhood Mental Health Outreach and Consultation	
Organization:	Jewish Family and Community Services East Bay	
PEI Program # and Name:	Early Childhood Mental Health Outreach and Consultation	
Type of Report (Choose one):	Annual	
PEI Category (choose one):	Outreach	
Priority Area (place and X next to all that apply):	X	Childhood Trauma
		Early Psychosis
		Youth/TAY Outreach and Engagement
	X	Cultural and Linguistic
		Older Adults
	X	Early Identification of Mental Health Illness

Box A: Please provide a brief program description (character limit 1,000).
Early Childhood Mental Health Outreach and Consultation is a prevention and early intervention program that promotes the social, emotional, and behavioral health of children in early education programs. Consultants help build the capacity of staff, programs, systems, and families to increase the understanding of children's behaviors to prevent, identify, and reduce the impact of trauma, mental health and developmental challenges among young children. The aim is early identification of mental illness in children, parents/caregivers, and all ECE staff.

Box B: Number of individuals served this fiscal year through MHSA funding.	
Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	14

Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	NA
Number of unduplicated individuals in your program served who show early signs of forming a more severe mental illness:	25
Grand total of unduplicated individuals served:	**39**

Box C: Demographics of individuals this fiscal year through MHSA funding.

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	28
Transition Age Youth (16-25 yrs.)	
Adult (26-59 yrs.)	7
Older Adult (60+ yrs.)	4
Declined to answer	
Unknown	
TOTAL	**39**

SEXUAL ORIENTATION	
Gay/Lesbian	
Heterosexual/Straight	11
Bisexual	
Questioning/Unsure	
Queer	
Declined to answer	
Unknown	28
Another group not listed	
TOTAL	**39**
If another group is counted, please specify:	

VETERAN STATUS	
Yes	
No	25
Declined to answer	
Unknown	14
TOTAL	**39**

CURRENT GENDER IDENTITY	
Female	24
Male	15
Transgender	
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	
Another identity not listed	
TOTAL	**39**
If another identity is counted, please specify:	

PRIMARY LANGUAGE	
English	14
Spanish	16
Cantonese	4
Chinese	
Vietnamese	
Farsi	
Arabic	
Tagalog	
Declined to answer	
Unknown	
Another language not listed	
TOTAL	**39**

SEX ASSIGNED AT BIRTH	
Male	4
Female	10
Declined to answer	
Unknown	
TOTAL	**14**

Communication Domain	
Vision	
Hearing/Speech	
Another type not listed	
Communication Domain Subtotal	**0**
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	
Physical/mobility	
Chronic health condition	
Disability Subtotal	**0**
None	39
Declined to answer	
Unknown	
Another disability not listed	
TOTAL	**39**
If another disability is counted, please specify:	

RACE	
American Indian or Alaska Native	
Asian	7
Black or African American	12
Native Hawaiian or other Pacific Islander	
White	6
Other Race	
Declined to answer	
Unknown	
TOTAL	**25**
If another race is counted, please specify:	

Ethnicity/Cultural Heritage (Please choose only one per individual)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	4
Mexican/Mexican American/Chicano	11
Puerto Rican	1
South American	
Another Hispanic/Latino ethnicity not listed	
Total Hispanic or Latino	**16**
If Non-Hispanic or Non-Latino, please specify:	
African	
African American	12
Asian Indian/South Asian	2
Cambodian	
Chinese	4
Eastern European	1
European	
Filipino	3
Japanese	
Korean	
Middle Eastern	
Vietnamese	
Other Non-Hispanic or Non-Latino ethnicity not listed	
Total Non-Hispanic or Non-Latino	**22**
More than one ethnicity	
Unknown Ethnicity	1
Declined to answer	
EHTNICITY TOTAL	**39**
If another ethnicity is counted, please specify:	

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of. Note: 1,000-character limit.
One program accomplishment this year is Lockwood CDC hosting a virtual community event that focused on how music supports social and emotional development. The event reached other early childhood programs in the community as well as families. The children performed by dancing and reciting poems. The mental health consultant discussed ways in which music can be used for healing, connection, and coping. The event was a huge success.

Box E: Program challenges of the past year and how did the agency mitigate challenges? Note: 1,000-character limit.
COVID-19 has had a huge impact on the work that consultants do. Due to shelter in place, safety regulations it was difficult to observe children and teachers in the classroom. Ways that consultations collaborated with sites to troubleshoot this is to use technology to facilitate observation. Consultants participated in Zoom Circle Times and met with teachers via Zoom (or other platforms). Being about to meet virtually allowed for less missed meetings and more flexibility with scheduling. Parents seemed to understand and were supportive of the process. Some challenges were faced regarding Wi-Fi connections and level of understanding about how to use various technology devices and programs. However, everyone worked together to support one another.

Box F: Program lessons learned of the past year? Note: 1,000-character limit.
This year taught us to be patient, flexible, and more empathetic. We also learned that self-care is extremely important. We learned more about our strengths as individuals as well as a team. Teachers tapped into new skills and learned that teaching can happen any and everywhere.

Box G: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
G.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e. mental health treatment services):	n/a
G.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e. mental health treatment services):	n/a
G.3: Types of treatment individuals were referred to (list types) (500-character limit):	n/a

G.4: Unduplicated number of individuals who participated in referred program at least one time:	n/a
G.5: Average duration of untreated mental illness in weeks:	n/a
G.6: Average number of days between referral and first participation in referred treatment program:	n/a

Box H: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
H.1: Who is/are the underserved target population(s) your program is serving (e.g. TAY, Southeast Asian) (500 Characters):	n/a
H.2: Number of paper referrals to an ACBH PEI-funded program:	n/a
H.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	n/a
H.4: Average number of days between referral and first participation in referred PEI program:	n/a
H.5: Describe how your program encouraged access to services and follow through on above referrals (500 Characters):	n/a

Box I: For Outreach, Suicide Prevention, and Stigma Reduction programs, please provide information for unduplicated potential responders (i.e., those who are in a position to identify early signs of potentially severe mental illness provide support, and or refer individuals who need treatment) reached. ***(Note: For Prevention, Early Intervention, Access & Linkage programs, this section is optional.)***	
Number of Responders:	
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):
Early childhood centers	*1 school (2 classrooms), 6 teachers, 1 site principal*

MHSA Program #: PEI 1E

PROVIDER NAME: Alameda Family Services

PROGRAM NAME: School-Based Mental Health Outreach

Program Outcomes & Impact: PEI Data Report FY 20/21

Program Name:	School-Based Mental Health Outreach	
Organization:	Alameda Family Services	
PEI Program # and Name:	PEI 1E School-Based Mental Health Outreach	
Type of Report (Choose one):	Annual	
PEI Category (choose one):	Outreach	
Priority Area (place and X next to all that apply):		Childhood Trauma
		Early Psychosis
	X	Youth/TAY Outreach and Engagement
		Cultural and Linguistic
		Older Adults
		Early Identification of Mental Health Illness

Box A: Please provide a brief program description (character limit 1,000).

The School-Based Mental Health Outreach program is designed to bring awareness and information about how to identify early signs of mental illness in youth and connect those in need with the mental health services. 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 our outreach efforts. A specific focus is placed on empowerment and self-identification.

Box B: Number of individuals served this fiscal year through MHSA funding.

Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	1304

Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	135
Number of unduplicated individual family members served indirectly by your program:	NA
Grand total of unduplicated individuals served:	1439

Box C: Demographics of individuals served this fiscal year through MHSA funding.

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	367
Transition Age Youth (16-25 yrs.)	1072
Adult (26-59 yrs.)	
Older Adult (60+ yrs.)	
Declined to answer	
Unknown	
TOTAL	**1439**

SEXUAL ORIENTATION	
Gay/Lesbian	1
Heterosexual/Straight	17
Bisexual	7
Questioning/Unsure	2
Queer	5
Declined to answer	
Unknown	1407
Another group not listed	
TOTAL	**1439**
If another group is counted, please specify:	

VETERAN STATUS	
Yes	
No	
Declined to answer	
Unknown	1439
TOTAL	**1439**

CURRENT GENDER IDENTITY	
Female	80
Male	44
Transgender	2
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	1313
Another identity not listed	
TOTAL	**1439**
If another identity is counted, please specify:	

PRIMARY LANGUAGE	
English	46
Spanish	3
Cantonese	
Chinese	
Vietnamese	1
Farsi	1
Arabic	
Tagalog	1
Declined to answer	
Unknown	1386
Another language not listed	
TOTAL	**1439**
If another language is counted, please specify:	

SEX ASSIGNED AT BIRTH	
Male	43
Female	83
Declined to answer	
Unknown	1313
TOTAL	**1439**

DISABILITY*** STATUS	
Communication Domain	
Vision	
Hearing/Speech	
Another type not listed	
Communication Domain Subtotal	**0**
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	
Physical/mobility	
Chronic health condition	
Disability Subtotal	**0**
None	
Declined to answer	
Unknown	1439
Another disability not listed	
TOTAL	**1439**
If another disability is counted, please specify:	

RACE	
American Indian or Alaska Native	3
Asian	432
Black or African American	110
Native Hawaiian or other Pacific Islander	3
White	435
Other Race	
Declined to answer	
Unknown	456
TOTAL	**1439**
If another race is counted, please specify:	

Ethnicity/Cultural Heritage (Please choose only one per individual)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	1
Mexican/Mexican American/Chicano	3
Puerto Rican	1
South American	2
Another Hispanic/Latino ethnicity not listed	5
Total Hispanic or Latino	**12**
If Non-Hispanic or Non-Latino, please specify:	
African	7
African American	3
Asian Indian/South Asian	1
Cambodian	
Chinese	3
Eastern European	1
European	8
Filipino	7
Japanese	1
Korean	
Middle Eastern	
Vietnamese	2
Other Non-Hispanic or Non-Latino ethnicity not listed	
Total Non-Hispanic or Non-Latino	**33**
More than one ethnicity	
Unknown Ethnicity	1394
Declined to answer	
EHTNICITY TOTAL	**1439**
If another ethnicity is counted, please specify:	

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of. Note: 1,000-character limit.
As distance learning extended into this school year, we continued to build an active internet presence. By the end of quarter 4, our SBHC Instagram account surpassed 400 followers of which most are current or former AUSD students. Our teamwork, creativity, and resourcefulness have allowed us to continue our outreach and health education services in new ways including a monthly health education newsletter, workshop series, and virtual health fairs. Our Youth Advisory Board (YAB) members assist in sharing content that is relevant and youth-friendly. A recent success story involves a student who accessed our services and joined YAB after our presentation in the Encinal Mental Health Matters Class. A few weeks into joining YAB, she asked the Health Centers Supervisor for MH support. The HCS assisted the student in accessing our MH services and alerted the clinician team to the student's referral. The student received ongoing services from one of our school-based clinicians.

Box E: Program challenges of the past year and how did the agency mitigate challenges? Note: 1,000-character limit.
A major challenge was opening up the year in distance learning. Towards the end of last FY, we started to identify ways to engage youth and the knowledge that distance learning would continue was a driving force for staff to think creatively and strategically about how to engage students through new mediums so that we could provide outreach and information that was not only accessible to youth, but something they would actually access/engage in. Together with our Youth Advisory Board, we increased our presence on social media platforms, started providing virtual workshops on relevant teen topics, and began ending our large campaigns with virtual health fairs that take place on non-synchronous learning days.

Box F: Program lessons learned of the past year? Note: 1,000-character limit.
This year provided AFS with a number of new techniques, approaches, and allowance for creativity to connect with youth. We learned how to navigate social media, putting systems in place to not only share, but interact with youth digitally. We learned the impact of utilizing multiple modalities to share information. Physical flyers, social media, email blasts, Google Classrooms, texting applications, and word of mouth through both your and key faculty such as school psychologists.

Box G: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
G.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e. mental health treatment services):	40

G.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e. mental health treatment services):	90
G.3: Types of treatment individuals were referred to (list types) (500-character limit):	Individual therapy, group therapy, family therapy, substance abuse treatment, & case management
G.4: Unduplicated number of individuals who participated in referred program at least one time:	116
G.5: Average duration of untreated mental illness in weeks:	n/a
G.6: Average number of days between referral and first participation in referred treatment program:	n/a

Box H: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
H.1: Who is/are the underserved target population(s) your program is serving (e.g. TAY, Southeast Asian) (500 Characters):	Youth that identify as LGBTQ, first generation immigrants, Black, Muslim, Latin-x, Asian, and Filipino as well as youth that would otherwise not access mental health services without the support and encouragement of a trusted adult.
H.2: Number of paper referrals to an ACBH PEI-funded program:	n/a
H.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	n/a
H.4: Average number of days between referral and first participation in referred PEI program:	n/a
H.5: Describe how your program encouraged access to services and follow through on above referrals (500 Characters):	n/a

Box I: For Outreach, Suicide Prevention, and Stigma Reduction programs, please provide information for unduplicated potential responders (i.e., those who are in a position to identify early signs of potentially severe mental illness provide support, and or refer individuals who need treatment) reached. ***(Note: For Prevention, Early Intervention, Access & Linkage programs, this section is optional.)***	
Number of Responders:	**2368**
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):
Large awareness and prevention campaigns: suicide prevention, teen dating violence, mental health	*Students, community members (248 youth, 55 adults)*
Mental health hosted drop-ins in response to national and local crisis	*Students (9)*
Workshop series: Mental health, body image, holiday coping	*Students, teachers 103 youth, 8 adults*
Classroom presentations: Mental health matters and navigating life, depression and suicide, harm	*Students, teachers 706 youth, 7 adult)*
YAB	*Students (26 youth)*
Island high and ASTI outreach	*Students, teachers 75 youth, 40 adults*
Self-care and mental health (health fair and IG campaign)	*Students, teachers, community 181 youth, 48 adults*
AUSD Youth Mental Health Forum	*Students, teachers, community (40 youth, 10 adults*
Freshman Orientations and 8th Grade Family Night	*Students, parents (215 youth, 90 adults)**not reported as clients served*
City Council and school board presentations on youth mental health	*Community members (70 adults)**not reported as clients served*
Various meetings with school district personnel on youth mental health	*School district personnel (21 adults)**not reported as clients served*
Presentation at community functions: Rotary Club, PTA MH Council, Mayor's Town Hall	*Community members (77 adults)**not reported as clients served*
SBHC Snapshot (health education newsletter) quarters 1-4.	*Students, school staff, community (200 youth, 88 adults)**not reported as clients served*

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

MHSA Program #: PEI 3

PROVIDER NAME: Mentor on Discharge ® - Post Crisis Peer Mentoring

PROGRAM NAME: Geriatric Assessment and Response Team

Program Outcomes & Impact: PEI Data Report FY 20/21

Program Name:	Geriatric Assessment and Response Team (GART)	
Organization:	Alameda County Behavioral Health	
PEI Program # and Name:	PEI 3 - Geriatric Assessment Response Team	
Type of Report (Choose one):	Annual	
PEI Category (choose one):	Early Intervention	
Priority Area (place and X next to all that apply):		Childhood Trauma
		Early Psychosis
		Youth/TAY Outreach and Engagement
		Cultural and Linguistic
	X	Older Adults
		Early Identification of Mental Health Illness

Box A: Please provide a brief program description (character limit 1,000).

The Geriatric Assessment & Response Team/ACBH/GART is an Alameda County Behavioral Health field-based support team that provides brief, voluntary behavioral health treatment to older adults. The goal of the Geriatric Assessment & Response Team (GART) is to provide recovery strategies and alternatives to hospitalization and to enhance opportunities for independence, resiliency, wellness, and quality of life. Services may include assessment, treatment coordination, medication support, counseling, case management, and crisis support services.

Box B: Number of individuals served this fiscal year through MHSA funding.

Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	94
Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	NA

Number of unduplicated individual family members served indirectly by your program:	
Grand total of unduplicated individuals served:	**94**

Box C: Demographics of individuals served this fiscal year through MHSA funding.

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	
Transition Age Youth (16-25 yrs.)	
Adult (26-59 yrs.)	
Older Adult (60+ yrs.)	15
Declined to answer	
Unknown	
TOTAL	**15**

SEXUAL ORIENTATION	
Gay/Lesbian	
Heterosexual/Straight	14
Bisexual	
Questioning/Unsure	
Queer	
Declined to answer	
Unknown	1
Another group not listed	
TOTAL	**15**
If another group is counted, please specify:	

VETERAN STATUS	
Yes	
No	
Declined to answer	
Unknown	
TOTAL	**0**

CURRENT GENDER IDENTITY	
Female	7
Male	8
Transgender	
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	
Another identity not listed	
TOTAL	**15**
If another identity is counted, please specify:	

PRIMARY LANGUAGE	
English	15
Spanish	
Cantonese	
Chinese	
Vietnamese	
Farsi	
Arabic	
Tagalog	
Declined to answer	
Unknown	
Another language not listed	
TOTAL	**15**
If another language is spoken, please specify:	

SEX ASSIGNED AT BIRTH	
Male	7
Female	8
Declined to answer	
Unknown	
TOTAL	**15**

DISABILITY*** STATUS	
Communication Domain	
Vision	
Hearing/Speech	
Another type not listed	
Communication Domain Subtotal	**0**
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	
Physical/mobility	0
Chronic health condition	
Disability Subtotal	**0**
None	
Declined to answer	
Unknown	15
Another disability not listed	
TOTAL	**15**
If another disability is counted, please specify:	

RACE	
American Indian or Alaska Native	
Asian	1
Black or African American	4
Native Hawaiian or other Pacific Islander	5
White	
Other Race	
Declined to answer	
Unknown	5
TOTAL	**15**
If another race is counted, please specify:	

Ethnicity/Cultural Heritage (Please choose only one per individual)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	
Mexican/Mexican American/Chicano	
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	
Total Hispanic or Latino	**0**
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	
Total Non-Hispanic or Non-Latino	**0**
More than one ethnicity	
Unknown Ethnicity	15
Declined to answer	
EHTNICITY TOTAL	**15**
If another ethnicity is counted, please specify:	

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of. Note: 1,000-character limit.
GART collaborated with Safer Ground to provide support to older adults housed in hotels during the pandemic. GART provided consultation, supporting counseling, linkage, and brief treatment to individuals needing services and mental health support. Case ex: 66 y/o male referred from Safer Ground dur to symptoms causing him to be at risk of being removed from the hotel. Ct also had low-income, long history of being unhoused, and struggled with physical issues. The client's symptoms included, suicidal ideation, depression, auditory hallucinations, anxiety, relational discord and agitation toward others. Within 6 months of treatment, the client began to address long-standing trauma and their impact on his current behaviors and choices. He learned tools to better manage anger and developed insight into how his anger impacted others. At discharge, GART referred him to long-term psychotherapy services and due to improvements was also placed in permanent supportive housing for seniors.

Box E: Program of the past year and how did the agency mitigate challenges? Note: 1,000-character limit.
As a field-based program, the pandemic caused many challenges in navigating how to safely continue to provide services to our clients and new referrals. GART also saw a decline of referrals this past year, but did provide consultation and navigation to many individuals and providers. GART was able to pivot to successfully incorporate telehealth and phone-based services in order to continue to provide treatment for clients and assessments for new referrals. Hiring has been a challenge this year and GART is still without an RN, which is critical for many reasons, including older adults frequently have co-occurring medical conditions and establishing rapport and engagement.

Box F: Program lessons learned of the past year? Note: 1,000-character limit.
GART has learned that telehealth and phone-based platforms are a good supplement to ongoing fiend-based face-to-face services for some older adults and hope to be able to continue as needed post-pandemic. We continue to notice potential service gaps for older adults that have symptoms may be better explained by dementia as well as individuals experiencing homelessness.

Box G: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
G.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e. mental health treatment services):	15 individuals met criteria for specialty mental health and were opened to the GART ACBH specialty mental health program.

G.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e. mental health treatment services):	n/a
G.3: Types of treatment individuals were referred to (list types) (500-character limit):	Outpatient psychotherapy and psychiatry, inpatient providers, day treatment programs and rehabilitation centers, case management, peer support, friendly visitors, language specific providers, SUD, housing/homeless resources. Referrals to Alzheimer's Association and Daybreak with co-occurring dementia dx.
G.4: Unduplicated number of individuals who participated in referred program at least one time:	Unknown
G.5: Average duration of untreated mental illness in weeks:	Ranges from 1 month to 40+ years
G.6: Average number of days between referral and first participation in referred treatment program:	24 to 72 hours.

Box H: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
H.1: Who is/are the underserved target population(s) your program is serving (e.g. TAY, Southeast Asian) (500 Characters):	Older adults, 60 years and older
H.2: Number of paper referrals to an ACBH PEI-funded program:	None. GART does not typically refer to PEI programs
H.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	None. GART does not typically refer to PEI programs
H.4: Average number of days between referral and first participation in referred PEI program:	None. GART does not typically refer to PEI programs
H.5: Describe how your program encouraged access to services and follow through on above referrals (500 Characters):	GART is a hybrid PEI and ACBH specialty mental health program. Once services end with GART, clinicians refer to non-PEI programs for long term care and develop a discharge plan with the client to engage their natural support systems.

Box I: For <u>Outreach, Suicide Prevention, and Stigma Reduction</u> programs, please provide information for unduplicated potential responders (i.e., those who are in a position to identify early signs of potentially severe mental illness provide support, and or refer individuals who need treatment) reached. ***(Note: For Prevention, Early Intervention, Access & Linkage programs, this section is optional.)***	
Number of Responders:	**0**
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):

MHSA Program #: PEI 4

PROVIDER NAME: Peers Envisioning and Engaging in Recovery Services (PEERS)

PROGRAM NAME: Everyone Counts Campaign (EEC)

Program Outcomes & Impact: PEI Data Report FY 20/21

Program Name:	Everyone Counts Campaign (ECC)	
Organization:	Peers Envisioning and Engaging in Recovery Services (PEERS)	
PEI Program # and Name:	PEI 4 Stigma & Discrimination Reduction Campaign- "Everyone Counts" - Peers Envisioning and Engaging in Recovery Services	
Type of Report (Choose one):	Annual	
PEI Category (choose one):	Stigma and Discrimination Reduction	
Priority Area (place and X next to all that apply):		Childhood Trauma
		Early Psychosis
		Youth/TAY Outreach and Engagement
	X	Cultural and Linguistic
		Older Adults
		Early Identification of Mental Health Illness

Box A: Please provide a brief program description (character limit 1,000).

The Everyone Counts Campaign (ECC) is PEERS' primary anti-stigma program. The ECC aims to reduce stigma and discrimination against people with mental health experiences and to promote social inclusion through three strategies: Empowerment (Spirituality and Special Messages groups), Outreach (Lift Every Voice and Speak (LEVS), the African American ECC (action team, anti-stigma support groups and outreach events), and Communications (website, email, social media).

Box B: Number of individuals served this fiscal year through MHSA funding.

Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	273

Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	NA
Number of unduplicated individual family members served indirectly by your program:	NA
Grand total of unduplicated individuals served:	**273**

Box C: Demographics of individuals served this fiscal year through MHSA funding.

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	
Transition Age Youth (16-25 yrs.)	
Adult (26-59 yrs.)	46
Older Adult (60+ yrs.)	12
Declined to answer	215
Unknown	
TOTAL	**273**

SEXUAL ORIENTATION	
Gay/Lesbian	1
Heterosexual/Straight	32
Bisexual	2
Questioning/Unsure	1
Queer	1
Declined to answer	233
Unknown	
Another group not listed	3
TOTAL	**273**
If another group is counted, please specify: Poly	

VETERAN STATUS	
Yes	1
No	53
Declined to answer	219
Unknown	
TOTAL	**273**

CURRENT GENDER IDENTITY	
Female	47
Male	16
Transgender	
Genderqueer	
Questioning/unsure of gender identity	1
Declined to answer	209
Unknown	
Another identity not listed	
TOTAL	**273**
If another identity is counted, please specify:	

PRIMARY LANGUAGE	
English	47
Spanish	3
Cantonese	
Chinese	
Vietnamese	
Farsi	
Arabic	
Tagalog	
Declined to answer	219
Unknown	
Another language not listed	4
TOTAL	**273**

If another language is counted, please specify: Khmer, Tibetan, Hindu, Gujrati, Punjabi, Nepali, Amharic, Tigrina

SEX ASSIGNED AT BIRTH	
Male	
Female	
Declined to answer	
Unknown	273
TOTAL	**273**

DISABILITY*** STATUS	
Communication Domain	
Vision	
Hearing/Speech	1
Another type not listed	
Communication Domain Subtotal	
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	1
Physical/mobility	
Chronic health condition	1
Disability Subtotal	**2**
None	26
Declined to answer	236
Unknown	
Another disability not listed	9
TOTAL	**273**
If another disability is counted, please specify: Depression, PTSD, schizophrenia, bipolar	

RACE	
American Indian or Alaska Native	2
Asian	3
Black or African American	32
Native Hawaiian or other Pacific Islander	
White	17
Other Race	10
Declined to answer	209
Unknown	
TOTAL	**273**
If another race is counted, please specify: More than one race, Latino	

Ethnicity/Cultural Heritage (Please choose only one per individual)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	1
Mexican/Mexican American/Chicano	4
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	
Total Hispanic or Latino	**5**
If Non-Hispanic or Non-Latino, please specify:	
African	1
African American	10
Asian Indian/South Asian	
Cambodian	1
Chinese	
Eastern European	
European	7
Filipino	
Japanese	
Korean	
Middle Eastern	
Vietnamese	
Other Non-Hispanic or Non-Latino ethnicity not listed	8
Total Non-Hispanic or Non-Latino	**27**
More than one ethnicity	1
Unknown Ethnicity	
Declined to answer	240
EHTNICITY TOTAL	**273**
If another ethnicity is counted, please specify: Native American, Indigenous, Tibetan, Moor, Jewish	

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of. Note: 1,000-character limit.
Outreach efforts and the renaming of the African American Everyone Counts Campaign – now called Black Wellness and Resilience – drew participants to the anti-stigma support groups. This was particularly notable during a year of fully remote services, when reaching new participants who had not previously been engaged in PEERS programs has been challenging. Some members of the African American Action Team were trained to facilitate the anti-stigma support groups, providing an additional leadership opportunity for African American mental health consumers. The first-ever Virtual Summit, Lift Every Voice and Speak: The Power of Voice, drew 36 participants for the four-hour event. LEVS speakers were actively involved in planning and implementing the event, which focused on telling your story for change and wellness.

Box E: Program challenges of the past year and how did the agency mitigate challenges? Note: 1,000-character limit.
The primary challenge this year was that in-person programming was not safe, dur to COVID-19. Finding partners to host speaking engagements for our Lift Every Voice and Speak (LEVS) speaker's bureau was challenging early in the year. We mitigated this challenge by reaching out to organizations that were holding virtual events and by hosting our first LEVS summit.

Box F: Program lessons learned of the past year? Note: 1,000-character limit.
Special Messages groups continued to provide connections and peer support during a year of intense isolation. In addition to peer support around message receiving and voice hearing, PEERS staff made multiple referrals to health, employment, hunger, housing and transportation services. Healing Arts Workshops at Laney College, Conscious Voices, BESTNow! All focused on meditation, mindfulness, and healing and were received with enthusiasm by attendees. The lesson we learned through this was that Healing Arts workshops proved to be a useful way to reach potential new participants, as attendees expressed interest in Hope & Faith, Black Wellness & Resilience, and Lift Every Voice and Speak programs.

Box G: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
G.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e. mental health treatment services):	n/a
G.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e. mental health treatment services):	n/a
G.3: Types of treatment individuals were referred to (list types) (500-character limit):	n/a

G.4: Unduplicated number of individuals who participated in referred program at least one time:	n/a
G.5: Average duration of untreated mental illness in weeks:	n/a
G.6: Average number of days between referral and first participation in referred treatment program:	n/a

Box H: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
H.1: Who is/are the underserved target population(s) your program is serving (e.g. TAY, Southeast Asian) (500 Characters):	We serve mental health consumers, particularly African Americans, as well as community members at large (through our anti-stigma campaigns).
H.2: Number of paper referrals to an ACBH PEI-funded program:	We referred many participants to multiple PEERS programs, but none of these constituted paper referrals for appointments.
H.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	n/a
H.4: Average number of days between referral and first participation in referred PEI program:	n/a
H.5: Describe how your program encouraged access to services and follow through on above referrals (500 Characters):	n/a

Box I: For Outreach, Suicide Prevention, and Stigma Reduction programs, please provide information for unduplicated potential responders (i.e., those who are in a position to identify early signs of potentially severe mental illness provide support, and or refer individuals who need treatment) reached. ***(Note: For Prevention, Early Intervention, Access & Linkage programs, this section is optional.)***	
Number of Responders:	**94**
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):
Community college (virtual)	*21 students and student support staff*
Mental health conference (virtual)	*73 consumers, family members, and peer providers*

MHSA Program #: PEI 12

PROVIDER NAME: Crisis Support Services of Alameda County

PROGRAM NAME: Text Line

Program Outcomes & Impact: PEI Data Report FY 20/21

Program Name:	Text Line Program	
Organization:	Crisis Support Services of Alameda County	
PEI Program # and Name:	PEI 12 Text Line	
Type of Report (Choose one):	Annual	
PEI Category (choose one):	Suicide Prevention	
Priority Area (place and X next to all that apply):		Childhood Trauma
		Early Psychosis
	X	Youth/TAY Outreach and Engagement
		Cultural and Linguistic
		Older Adults
	X	Early Identification of Mental Health Illness

Box A: Please provide a brief program description (character limit 1,000).

The program provides brief crisis intervention and emotional support to individuals via text/SMS modality with emphasis on school aged youths and TAY.

Box B: Number of individuals served this fiscal year through MHSA funding.

Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	267
Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	NA
Number of unduplicated individual family members served indirectly by your program:	NA

Grand total of unduplicated individuals served:	**267**

Box C: Demographics of individuals served this fiscal year through MHSA funding.

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	17
Transition Age Youth (16-25 yrs.)	15
Adult (26-59 yrs.)	7
Older Adult (60+ yrs.)	1
Declined to answer	0
Unknown	227
TOTAL	**267**

SEXUAL ORIENTATION	
Gay/Lesbian	2
Heterosexual/Straight	3
Bisexual	5
Questioning/Unsure	1
Queer	1
Declined to answer	2
Unknown	253
Another group not listed	
TOTAL	**267**
If another group is counted, please specify:	

VETERAN STATUS	
Yes	
No	3
Declined to answer	
Unknown	**264**
TOTAL	**267**

CURRENT GENDER IDENTITY	
Female	24
Male	8
Transgender	1
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	231
Another identity not listed	3
TOTAL	**267**
If another identity is counted, please specify:	

PRIMARY LANGUAGE	
English	267
Spanish	
Cantonese	
Chinese	
Vietnamese	
Farsi	
Arabic	
Tagalog	
Declined to answer	
Unknown	
Another language not listed	
TOTAL	**267**
If another language is counted, please specify:	

SEX ASSIGNED AT BIRTH	
Male	
Female	
Declined to answer	
Unknown	267
TOTAL	**267**

DISABILITY*** STATUS	
Communication Domain	
Vision	
Hearing/Speech	
Another type not listed	
Communication Domain Subtotal	**0**
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	
Physical/mobility	
Chronic health condition	
Disability Subtotal	**0**
None	
Declined to answer	
Unknown	267
Another disability not listed	
TOTAL	**267**
If another disability is counted, please specify:	

RACE	
American Indian or Alaska Native	
Asian	7
Black or African American	1
Native Hawaiian or other Pacific Islander	
White	2
Other Race	
Declined to answer	
Unknown	257
TOTAL	**267**
If another race is counted, please specify:	

Ethnicity/Cultural Heritage (Please choose only one per individual)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	
Mexican/Mexican American/Chicano	
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	0
Total Hispanic or Latino	**0**

If Non-Hispanic or Non-Latino, please specify:	
African	
African American	
Asian Indian/South Asian	2
Cambodian	
Chinese	1
Eastern European	
European	
Filipino	
Japanese	
Korean	
Middle Eastern	1
Vietnamese	
Other Non-Hispanic or Non-Latino ethnicity not listed	
Total Non-Hispanic or Non-Latino	**4**
More than one ethnicity	
Unknown Ethnicity	263
Declined to answer	
EHTNICITY TOTAL	**267**
If another ethnicity is counted, please specify:	

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of. Note: 1,000-character limit.

The program provides on demand crisis support to individuals including those who may have a history of trauma when interfacing with the mental health system. One texter reported managing frequent and intense suicidal urges, as well as urges to self-harm and use substances to cope. The texter works collaboratively with program staff and volunteers to disable the suicide means and to make a safety plan. The texter shared their identity as an African American woman with mental illness and trauma and "this world is not for me and has never been." Because of her lived experience, the texter often times declined referrals to higher levels of care. The text line program is available to provide services to people who may not interface with greater behavioral health care systems, but can still benefit for its support. Over time, the program hopes to build trust with community members and to connect them to appropriate levels of care for ongoing services.

Box E: Program challenges of the past year and how did the agency mitigate challenges? Note: 1,000-character limit.

The program continues its efforts to recruit and train text line specific counselors. Our team of 30 text line counselors was smaller than last year's team of 40. To mitigate this, we scheduled paid shift supervisors on every shift. We hope to expand text line coverage to be 24hours/7 days per week by July 2022. The challenge will be to train enough volunteers to cover all the shifts. Working remotely can increase a counselor's sense of isolation and burnout. To mitigate this, the program utilizes text and video chat so that team members can stay connected, provide and receive support, and shift supervisors can provide coaching and feedback. The program also would like to serve community members who do not speak English. This year, we hired and trained a bilingual Spanish text line shift supervisor who will be able to respond to community members in Spanish during certain hours of the week. The part-time position is funded by a grant from Kaiser.

Box F: Program lessons learned of the past year? Note: 1,000-character limit.

Young people and their family/support systems continue to impress us with their remarkable resilience and adaptability to an uncertain world during a global pandemic. Although our Text Line serves clients with a variety of struggles, several common themes that our texters have recently approached us about include psychological trauma, interpersonal challenges, and anxiety/stress regarding school. This year was particularly a challenging year for several clients, too as many of them expressed feelings of isolation and anxiety due to the COVID-19 pandemic. Some youth texters also mentioned experiencing more family conflict das a result of the lockdown restrictions earlier in the year, along with difficulties focusing on online school.

Box G: For programs that refer individuals with severe mental illness, please provide information for the categories below:

G.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e. mental health treatment services):	8

G.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e. mental health treatment services):	n/a
G.3: Types of treatment individuals were referred to (list types) (500-character limit):	Crisis stabilization units including: Amber House, Sally's Place, Mobile Crisis Unit, Children's Hospital, Willow Rock
G.4: Unduplicated number of individuals who participated in referred program at least one time:	n/a
G.5: Average duration of untreated mental illness in weeks:	n/a
G.6: Average number of days between referral and first participation in referred treatment program:	n/a

Box H: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
H.1: Who is/are the underserved target population(s) your program is serving (e.g. TAY, Southeast Asian) (500 Characters):	TAY
H.2: Number of paper referrals to an ACBH PEI-funded program:	n/a
H.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	n/a
H.4: Average number of days between referral and first participation in referred PEI program:	n/a
H.5: Describe how your program encouraged access to services and follow through on above referrals (500 Characters):	Our program provides education about crisis resources available to community members. With client's consent, we warm handoff to clinics along the crisis continuum of care in Alameda County. For medium to high risk consumers, we offer follow up sessions to confirm referral completion.

Box I: For <u>Outreach, Suicide Prevention, and Stigma Reduction</u> programs, please provide information for unduplicated potential responders (i.e., those who are in a position to identify early signs of potentially severe mental illness provide support, and or refer individuals who need treatment) reached. ***(Note: For Prevention, Early Intervention, Access & Linkage programs, this section is optional.)***	
Number of Responders:	**30**
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):
Text Line Service	*28 text line counselors*
Text Line Service	*2 shift supervisors*

MHSA Program #: PEI 12

PROVIDER NAME: Crisis Support Services of Alameda County

PROGRAM NAME: Community Education Program

Program Outcomes & Impact: PEI Data Report FY 20/21

Program Name:	Community Education Program	
Organization:	Crisis Support Services of Alameda County	
PEI Program # and Name:	PEI 12 Suicide Prevention- Crisis Support Services Suicide Prevention/Community Education- Crisis Support Services of Alameda County	
Type of Report (Choose one):	Annual	
PEI Category (choose one):	Suicide Prevention	
Priority Area (place and X next to all that apply):		Childhood Trauma
		Early Psychosis
	X	Youth/TAY Outreach and Engagement
		Cultural and Linguistic
		Older Adults
	X	Early Identification of Mental Health Illness

Box A: Please provide a brief program description (character limit 1,000).

The goal of our Community Education Program is to raise awareness that suicide is a national public health issue and that our community is a natural safety net for those that are vulnerable to suicide risk. Providing education and training increases knowledge of suicide warning signs, risk and protective factors, and how to help. Another goal is to eliminate the stigma associated with suicide by talking about this openly and increasing the comfort level of our community to engage and provide support.

Box B: Number of individuals served this fiscal year through MHSA funding.

Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	12,917

Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	0
Number of unduplicated individual family members served indirectly by your program:	104
Grand total of unduplicated individuals served:	**13021**

Box C: Demographics of individuals served this fiscal year through MHSA funding.

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	9,879
Transition Age Youth (16-25 yrs.)	2
Adult (26-59 yrs.)	22
Older Adult (60+ yrs.)	4
Declined to answer	1
Unknown	3113
TOTAL	**13021**

SEXUAL ORIENTATION	
Gay/Lesbian	4
Heterosexual/Straight	19
Bisexual	
Questioning/Unsure	
Queer	
Declined to answer	5
Unknown	12992
Another group not listed	1
TOTAL	**13021**
If another group is counted, please specify:	

VETERAN STATUS	
Yes	
No	28
Declined to answer	1
Unknown	12992
TOTAL	**13021**

CURRENT GENDER IDENTITY	
Female	22
Male	55
Transgender	
Genderqueer	
Declined to answer	
Unknown	12992
Another identity not listed	
TOTAL	**13021**
If another identity is counted, please specify:	

PRIMARY LANGUAGE	
English	244
Spanish	
Cantonese	2
Chinese	
Farsi	
Arabic	
Tagalog	
Declined to answer	
Unknown	12924
Another language not listed	1
TOTAL	**13021**
If another language is counted, please specify:	

SEX ASSIGNED AT BIRTH	
Male	
Female	
Declined to answer	
Unknown	
TOTAL	

DISABILITY*** STATUS	
Communication Domain	
Vision	
Hearing/Speech	
Another type not listed	
Communication Domain Subtotal	**0**
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	1
Physical/mobility	1
Chronic health condition	
Disability Subtotal	**2**
None	24
Declined to answer	1
Unknown	12994
Another disability not listed	
TOTAL	**13021**
If another disability is counted, please specify:	

RACE	
American Indian or Alaska Native	1
Asian	6
Black or African American	5
Native Hawaiian or other Pacific Islander	
White	5
Other Race	6
Declined to answer	2
Unknown	12996
TOTAL	**13021**
If another race is counted, please specify: " More than one"	

Ethnicity/Cultural Heritage (Please choose only one per individual)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	
Mexican/Mexican American/Chicano	4
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	2
Total Hispanic or Latino	**6**
If Non-Hispanic or Non-Latino, please specify:	
African	2
African American	4
Asian Indian/South Asian	2
Cambodian	6
Chinese	2
Eastern European	1
European	2
Filipino	3
Japanese	3
Korean	
Middle Eastern	
Vietnamese	1
Other Non-Hispanic or Non-Latino ethnicity not listed	3
Total Non-Hispanic or Non-Latino	**20**
More than one ethnicity	7
Unknown Ethnicity	12985
Declined to answer	3
EHTNICITY TOTAL	**13021**
If another ethnicity is counted, please specify:	

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of. Note: 1,000-character limit.
Our online youth curriculum in a 20-min format met the needs that our schools were asking for: vital information provided to youth in a short amount of time allowed by the distance learning format. We received very positive feedback from our teachers on both the length and on the level of engagement that our TFL health educators were able to elicit from students. Another success is that we were able to connect with about the same number of youth as before the pandemic, along with creating relationships with new schools. Another new addition to our youth menu was developed by our Senior TFL Health Educator, Zoey Eberle. Zoey developed a Youth Peer Counseling workshop that was well received at the virtual Teens Tackle Tobacco Youth Conference. Another success was the creation of a new workshop added to our healthcare settings menu. Our Community Education Trainer, Jennifer Johal developed a workshop for health care workers to address burnout.

Box E: Program challenges of the past year and how did the agency mitigate challenges? Note: 1,000-character limit.
We were not able to gather enough significant quantitative data nor demographic data from our workshops this past year. We were not able to gather pre/post data as we were unable to access our audiences before training. Gathering data from youth was particularly challenging as each school/teacher had their own understandably strict permissions on their online platforms that did not always allow chat access to guests. Another issue was that online classrooms could be quite fluid where students would log off and on as a norm and we weren't confident that we would capture all the students that watched the presentation in full. Time was also a factor. Online classrooms varied from 30-45 minutes and we prioritized getting through content and Q&A before classes ended. The biggest challenge for our adult workshops is receiving responses. Though our adult survey and demographic link is being distributed, the response rate has been very low.

Box F: Program lessons learned of the past year? Note: 1,000-character limit.
Moving forward, we will elicit help from our teachers and organizations with regard to distribution of our survey links when providing our workshops virtually.

Box G: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
G.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e. mental health treatment services):	n/a

G.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e. mental health treatment services):	n/a
G.3: Types of treatment individuals were referred to (list types) (500-character limit):	Youth receive the # to our crisis line and our text line. Adults also receive a resource sheet that lists information on agency services, ACBH, and other local community resources.
G.4: Unduplicated number of individuals who participated in referred program at least one time:	n/a
G.5: Average duration of untreated mental illness in weeks:	n/a
G.6: Average number of days between referral and first participation in referred treatment program:	n/a

Box H: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
H.1: Who is/are the underserved target population(s) your program is serving (e.g. TAY, Southeast Asian) (500 Characters):	Youth, those who are incarcerated, and general community members served by local partners we work with.
H.2: Number of paper referrals to an ACBH PEI-funded program:	n/a
H.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	n/a
H.4: Average number of days between referral and first participation in referred PEI program:	n/a
H.5: Describe how your program encouraged access to services and follow through on above referrals (500 Characters):	n/a

Box I: For <u>Outreach, Suicide Prevention, and Stigma Reduction</u> programs, please provide information for unduplicated potential responders (i.e., those who are in a position to identify early signs of potentially severe mental illness provide support, and or refer individuals who need treatment) reached. ***(Note: For Prevention, Early Intervention, Access & Linkage programs, this section is optional.)***	
Number of Responders:	
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):
School classrooms	*9879*
School districts	*543 teachers, other school staff, school mental health counselors and parents*
Community organizations	*1219 adults*
Health Care settings	*269*
Correctional settings	*277 civilian staff*

MHSA Program #: PEI 12

PROVIDER NAME: Crisis Support Services of Alameda County

PROGRAM NAME: Clinical Program

Program Outcomes & Impact: PEI Data Report FY 20/21

Program Name:	Clinical Program	
Organization:	Crisis Support Services of Alameda County	
PEI Program # and Name:	PEI12 Suicide Prevention - Crisis Support Services Trauma Informed Counseling	
Type of Report (Choose one):	Annual	
PEI Category (choose one):	Suicide Prevention	
Priority Area (place and X next to all that apply):		Childhood Trauma
		Early Psychosis
		Youth/TAY Outreach and Engagement
		Cultural and Linguistic
	x	Older Adults
	X	Early Identification of Mental Health Illness

Box A: Please provide a brief program description (character limit 1,000).
Provide individual, family, and group therapy for school aged youth, community members of all ages experiencing grief, and seniors over age 55.

Box B: Number of individuals served during this fiscal year through MHSA funding.	
Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	163
Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	NA
Number of unduplicated individual family members served indirectly by your program:	NA

H.5: Describe how your program encouraged access to services and follow through on above referrals (500 Characters):	n/a

Box C: Demographics of individuals served during this fiscal year through MHSA funding.

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	45
Transition Age Youth (16-25 yrs.)	5
Adult (26-59 yrs.)	17
Older Adult (60+ yrs.)	96
Declined to answer	
Unknown	
TOTAL	**163**

SEXUAL ORIENTATION	
Gay/Lesbian	5
Heterosexual/Straight	90
Bisexual	8
Questioning/Unsure	1
Queer	2
Declined to answer	57
Unknown	
Another group not listed	
TOTAL	**163**
If another group is counted, please specify:	

VETERAN STATUS	
Yes	
No	
Declined to answer	
Unknown	163
TOTAL	**163**

CURRENT GENDER IDENTITY	
Female	90
Male	30
Transgender	12
Genderqueer	
Questioning/unsure of gender identity	1
Declined to answer	
Unknown	39
Another identity not listed	
TOTAL	**163**
If another identity is counted, please specify:	

PRIMARY LANGUAGE	
English	163
Spanish	
Cantonese	
Chinese	
Vietnamese	
Farsi	
Arabic	
Tagalog	
Declined to answer	
Unknown	
Another language not listed	
TOTAL	**163**
If another language is counted, please specify:	

SEX ASSIGNED AT BIRTH	
Male	
Female	
Declined to answer	
Unknown	163
TOTAL	**163**

DISABILITY*** STATUS	
Communication Domain	
Vision	
Hearing/Speech	
Another type not listed	
Communication Domain Subtotal	**0**
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	
Physical/mobility	
Chronic health condition	
Disability Subtotal	**0**
None	
Declined to answer	
Unknown	163
Another disability not listed	
TOTAL	**163**
If another disability is counted, please specify:	

RACE	
American Indian or Alaska Native	3
Asian	11
Black or African American	12
Native Hawaiian or other Pacific Islander	3
White	
Other Race	
Declined to answer	53
Unknown	84
TOTAL	**163**
If another race is counted, please specify:	

Ethnicity/Cultural Heritage (Please choose only one per individual)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	
Mexican/Mexican American/Chicano	
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	
Total Hispanic or Latino	**0**
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	
Total Non-Hispanic or Non-Latino	**0**
More than one ethnicity	
Unknown Ethnicity	163
Declined to answer	
EHTNICITY TOTAL	**163**
If another ethnicity is counted, please specify:	

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of. Note: 1,000-character limit.
Two clinical interns initiated the creation of the Asian American/Pacific Islander Support Group in response to the rise in stress following COVID-19 and increase in hate crimes against community members. This group was offered to current clients in addition to the larger community and is run as a drop-in group. Facilitators reported that attendees have appreciated a space that addresses the unique stressors related to the API community and that the group has been run in collaboration with attendees. Facilitators have described the experience as personally meaningful in that it allowed them to connect with the community and directly address many aspects of their cultural identity. Providing spaces like this is an important component of suicide prevention as communities who feel isolated can be at a higher risk for dying by suicide.

Box E: Program challenges of the past year and how did the agency mitigate challenges? Note: 1,000-character limit.
Due to the limitations presented by COVID-19, and the reduced amount of availability of our interns, we provided services to fewer total clients than in previous years. This was particularly noticeable in our school-based program where overall referrals were low and families proved difficult to engage. We were able to increase our engagements through groups, and provided an increasing number of groups as the year progressed.

Box F: Program lessons learned of the past year? Note: 1,000-character limit.
The program continued to develop its focus on increasing cultural humility practices, and made changes to the format of group supervision to encourage reflective practices. The program also supported the agency in its commitment to justice, equity, diversity, and inclusion (JEDI) by assisting with the creation and facilitation of affinity groups along with other work. Although this year has been uniquely challenging, we found some success in continuing to be creative with our clinical offerings. Clinical interns reported experiencing a sense of support and inclusion, and were able to provide high quality services. This year has been a significant learning experience and has helped provide a focus and direction for our next training year.

Box G: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
G.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e. mental health treatment services):	n/a

G.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e. mental health treatment services):	n/a
G.3: Types of treatment individuals were referred to (list types) (500-character limit):	n/a
G.4: Unduplicated number of individuals who participated in referred program at least one time:	n/a
G.5: Average duration of untreated mental illness in weeks:	n/a
G.6: Average number of days between referral and first participation in referred treatment program:	n/a

Box H: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
H.1: Who is/are the underserved target population(s) your program is serving (e.g. TAY, Southeast Asian) (500 Characters):	n/a
H.2: Number of paper referrals to an ACBH PEI-funded program:	n/a
H.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	n/a
H.4: Average number of days between referral and first participation in referred PEI program:	n/a
H.5: Describe how your program encouraged access to services and follow through on above referrals (500 Characters):	n/a

Box I: For <u>Outreach, Suicide Prevention, and Stigma Reduction</u> programs, please provide information for unduplicated potential responders (i.e., those who are in a position to identify early signs of potentially severe mental illness provide support, and or refer individuals who need treatment) reached. ***(Note: For Prevention, Early Intervention, Access & Linkage programs, this section is optional.)***	
Number of Responders:	
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):

MHSA Program #: PEI 13

PROVIDER NAME: Peers Envisioning and Engaging in Recovery Services (PEERS)

PROGRAM NAME: Wellness Recovery Action Plan (WRAP®)

Program Outcomes & Impact: PEI Data Report FY 20/21

Program Name:	Wellness Recovery Action Planning and Transition-Age Youth Wellness Program	
Organization:	Peers Envisioning and Engaging in Recovery Services (PEERS)	
PEI Program # and Name:	PEI 13 Wellness, Recovery & Resiliency Services-WRAP- Peers Envisioning and Engaging in Recovery Services	
Type of Report (Choose one):	Annual	
PEI Category (choose one):	Outreach	
Priority Area (place and X next to all that apply):	X	Childhood Trauma
		Early Psychosis
	X	Youth/TAY Outreach and Engagement
		Cultural and Linguistic
		Older Adults
		Early Identification of Mental Health Illness

Box A: Please provide a brief program description (character limit 1,000).

Wrap is an evidence-based practice through which peers share stories, ideas and insights and come up with a personal plan for getting well and staying well. The TAY Wellness Program offers ongoing wellness support and leadership development through bimonthly TAY Leadership Club meetings for one-time TAY wellness workshops for young people ages 18-25, all aligned with the TAYSOC 5 Pillars of Care.

Box B: Number of individuals served during this fiscal year through MHSA funding.

Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	378
Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	NA

Number of unduplicated individual family members served indirectly by your program:	NA
Grand total of unduplicated individuals served:	**378**

Box C: Demographics of individuals served during this fiscal year through MHSA funding.

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	3
Transition Age Youth (16-25 yrs.)	25
Adult (26-59 yrs.)	60
Older Adult (60+ yrs.)	23
Declined to answer	267
Unknown	
TOTAL	**378**

VETERAN STATUS	
Yes	3
No	103
Declined to answer	272
Unknown	
TOTAL	**378**

CURRENT GENDER IDENTITY	
Female	86
Male	39
Transgender	
Genderqueer	1
Questioning/unsure of gender identity	4
Declined to answer	248
Unknown	
Another identity not listed	
TOTAL	**378**
If another identity is counted, please specify:	

SEX ASSIGNED AT BIRTH	
Male	
Female	
Declined to answer	
Unknown	**378**
TOTAL	**378**

SEXUAL ORIENTATION	
Gay/Lesbian	9
Heterosexual/Straight	57
Bisexual	4
Questioning/Unsure	3
Queer	5
Declined to answer	289
Unknown	
Another group not listed	11
TOTAL	**378**
If another group is counted, please specify: Poly, Black woman, nonbinary	

PRIMARY LANGUAGE	
English	88
Spanish	9
Cantonese	
Chinese	
Vietnamese	
Farsi	
Arabic	
Tagalog	
Declined to answer	274
Another language not listed	6
TOTAL	**378**
If another language is counted, please specify: Bajan, Lithuanian, French, Urdu/Hindi, Visaya (Cobuano), Chemorro, Armenian, German	

DISABILITY*** STATUS	
Communication Domain	
Vision	1
Hearing/Speech	
Another type not listed	
Communication Domain Subtotal	**1**
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	1
Physical/mobility	2
Chronic health condition	
Disability Subtotal	**3**
None	54
Declined to answer	309
Unknown	
Another disability not listed	11
TOTAL	**378**
If another disability is counted, please specify: mental health, bipolar, anxiety	

RACE	
American Indian or Alaska Native	2
Asian	4
Black or African American	59
Native Hawaiian or other Pacific Islander	1
White	33
Other Race	254
Declined to answer	25
Unknown	
TOTAL	**378**
If another race is counted, please specify: More than one race, Latino	

Ethnicity/Cultural Heritage (Please choose only one per individual)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	2
Mexican/Mexican American/Chicano	1
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	2
Total Hispanic or Latino	**5**

If Non-Hispanic or Non-Latino, please specify:	
African	2
African American	12
Asian Indian/South Asian	1
Cambodian	
Chinese	
Eastern European	3
European	4
Filipino	2
Japanese	
Korean	
Middle Eastern	1
Vietnamese	6
Other Non-Hispanic or Non-Latino ethnicity not listed	14
Total Non-Hispanic or Non-Latino	**39**
More than one ethnicity	2
Unknown Ethnicity	
Declined to answer	332
EHTNICITY TOTAL	**378**
If another ethnicity is counted, please specify: Jamaican, Jewish, Indigenous, Bajan, Creole, Irish-American, Hawaiian	

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of. Note: 1,000-character limit.

The WRAP group in Spanish through La Familia, in particular, has been a crucial source of connection for participants, who primarily are elders and have been heavily isolated since March 2020. This group was able to support ACBH with the MHSA Plan Update by hosting a focus group in Spanish. Spanish-speaking consumers were under-represented in the community program planning process that informed development of the Three-Year MHSA Plan, so this was particularly important.

The following responses to the question, "What did you learn today?" gives a picture of how TAY Leadership Club participants themselves characterize what they are learning.
-Affirmation that I do not need to be/feel validated, and not to compare myself with others or have the need to be perfect!!

Box E: Program challenges of the past year and how did the agency mitigate challenges? Note: 1,000-character limit.

The primary challenge this year was that in-person programming was not safe, due to COVID-19. Our efforts to partners with another organization for a remote TAY WRAP group were successful. Despite our efforts to work with more than five potential partners, we were not able to set up a remote TAY WRAP group by the end of the fiscal year. We are committed to building at least one solid partnership for TAY WRAP early in FY 2021-22.

Box F: Program lessons learned of the past year? Note: 1,000-character limit.

To engage participants in WRAP and maintain participation in our groups, we had to experiment with new methods of outreach in the remote environment. Persistence and experimentation yielded the results we sought, and we were able to build and sustain participation even given the issues around the digital divide that all programs face.

To provide additional peer support during this time of increased isolation, we provided 150 one-to-one peer support calls to 28 unduplicated participants, averaging 15 minutes per call. These calls focused on wellness tools, personal connections, and referrals to related services. Participants talked about a wide range of concerns, with isolation and difficulties associated with poverty (e.g. income, housing) being the most prominent.

Box G: For programs that refer individuals with severe mental illness, please provide information for the categories below:

G.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e. mental health treatment services):	n/a

G.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e. mental health treatment services):	n/a
G.3: Types of treatment individuals were referred to (list types) (500-character limit):	n/a
G.4: Unduplicated number of individuals who participated in referred program at least one time:	n/a
G.5: Average duration of untreated mental illness in weeks:	n/a
G.6: Average number of days between referral and first participation in referred treatment program:	n/a

Box H: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
H.1: Who is/are the underserved target population(s) your program is serving (e.g. TAY, Southeast Asian) (500 Characters):	Mental health consumers, primarily people of color, including TAY and older adults.
H.2: Number of paper referrals to an ACBH PEI-funded program:	We made multiple referrals to other PEERS programs, BestNow! the Pool of Consumer Champions, and Bay Area Legal Aid, but not to PEI-funded programs.
H.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	n/a
H.4: Average number of days between referral and first participation in referred PEI program:	n/a
H.5: Describe how your program encouraged access to services and follow through on above referrals (500 Characters):	The TAY Leadership Club periodically invites guest presenters from community-based organizations that can serve as resources to TAY participants.

Box I: For <u>Outreach, Suicide Prevention, and Stigma Reduction</u> programs, please provide information for unduplicated potential responders (i.e., those who are in a position to identify early signs of potentially severe mental illness provide support, and or refer individuals who need treatment) reached. ***(Note: For Prevention, Early Intervention, Access & Linkage programs, this section is optional.)***	
Number of Responders:	
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):
Youth-oriented conference (virtual)	*104 youth and youth service providers*
Webinar	*712 youth and adult peer support service providers*
Community college	*10 students and student support staff*

MHSA Program #: PEI 17A

PROVIDER NAME: Youth Uprising

PROGRAM NAME: Early Intervention

Program Outcomes & Impact: PEI Data Report FY 20/21

Program Name:	Youth UpRising	
Organization:	Youth UpRising	
PEI Program # and Name:	PEI 17A Youth Uprising	
Type of Report (Choose one):	Annual	
PEI Category (choose one):	Early Intervention	
Priority Area (place and X next to all that apply):		Childhood Trauma
		Early Psychosis
	x	Youth/TAY Outreach and Engagement
		Cultural and Linguistic
		Older Adults
		Early Identification of Mental Health Illness

Box A: Please provide a brief program description (character limit 1,000).

Youth UpRising provides early intervention services for TAY who are not currently served by mental health services and are at-risk for developing symptoms of serious mental illness (SMI). YU helps TAY youth develop skills that instill independence, self-sufficiency and resilience.

Box B: Number of individuals served this fiscal year through MHSA funding.

Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	NA
Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	NA

Number of unduplicated individual family members served indirectly by your program:	NA
Grand total of unduplicated individuals served:	**37**

Box C: Demographics of individuals served this fiscal year through MHSA funding.

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	12
Transition Age Youth (16-25 yrs.)	25
Adult (26-59 yrs.)	
Older Adult (60+ yrs.)	
Declined to answer	
Unknown	
TOTAL	**37**

VETERAN STATUS	
Yes	
No	
Declined to answer	
Unknown	
TOTAL	

SEXUAL ORIENTATION	
Gay/Lesbian	2
Heterosexual/Straight	35
Bisexual	
Questioning/Unsure	
Queer	
Declined to answer	
Unknown	
Another group not listed	
TOTAL	**37**
If another group is counted, please specify:	

CURRENT GENDER IDENTITY	
Female	25
Male	12
Transgender	
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	
Another identity not listed	
TOTAL	**37**
If another identity is counted, please specify:	

PRIMARY LANGUAGE	
English	27
Spanish	10
Cantonese	
Chinese	
Vietnamese	
Farsi	
Arabic	
Tagalog	
Declined to answer	
Another language not listed	
TOTAL	**37**
If another language is counted, please specify:	

SEX ASSIGNED AT BIRTH	
Male	25
Female	12
Declined to answer	
Unknown	
TOTAL	**37**

DISABILITY*** STATUS	
Communication Domain	
Vision	
Hearing/Speech	
Another type not listed	
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	
Physical/mobility	
Chronic health condition	
Disability Subtotal	
None	
Declined to answer	
Unknown	37
Another disability not listed	
TOTAL	**37**
If another disability is counted, please specify:	

RACE	
American Indian or Alaska Native	
Asian	
Black or African American	22
Native Hawaiian or other Pacific Islander	
Other Race	
Declined to answer	
Unknown	15
TOTAL	**37**
If another race is counted, please specify:	

Ethnicity/Cultural Heritage (Please choose only one per individual)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	
Mexican/Mexican American/Chicano	15
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	
Total Hispanic or Latino	**15**
If Non-Hispanic or Non-Latino, please specify:	
African	
African American	22
Asian Indian/South Asian	
Cambodian	
Chinese	
Eastern European	
European	
Filipino	
Japanese	
Korean	
Middle Eastern	
Vietnamese	
Other Non-Hispanic or Non-Latino ethnicity not listed	
Total Non-Hispanic or Non-Latino	**22**
More than one ethnicity	
Unknown Ethnicity	
Declined to answer	
EHTNICITY TOTAL	**37**
If another ethnicity is counted, please specify:	

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of. Note: 1,000-character limit.
Youth UpRising was very happy about transitioning our telehealth mental wellness therapy sessions to in-person around April 2021. This in-person therapy was at the request of youth, primarily, and also given we had the appropriate COVID-19 measures in place. We also launched a group that focused on healthy boundaries, stress management, self-care and empowerment. Youth UpRising was very happy to continue serving youth with wellness services via telehealth at the height of the pandemic, around March/April 2020 and in the months to follow.

Box E: Program challenges of the past year and how did the agency mitigate challenges? Note: 1,000-character limit.
Our most significant challenge was engaging our young people while in quarantine. Our outreach included using social media to inform young people of the services we had available in hopes they would engage. From March 2020, until around summer, things were very slow and we believe it was due to youth processing what was happening in the world. When we did attempt to do telehealth with young people, some did not have adequate internet connectivity and others were not able to be at home in private spaces to have the conversations they needed to have with our therapists.

Box F: Program learned of the past year? Note: 1,000-character limit.
It will be important that we extend further opportunity for youth to let us know what programming they need. While we were able to determine the challenges that came up for them through our groups, counseling and therapy sessions, there is a great opportunity to further expand the programming based on their guidance. We are also increasing our peer-to-peer facilitation in our programming which we have seen is very helpful for youth development and building trust. Youth spend a lot of time with each other, much more than we are able to spend with them, and having that connection helps in the area of wellness and empowerment.

Box G: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
G.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e. mental health treatment services):	n/a
G.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e. mental health treatment services):	n/a
G.3: Types of treatment individuals were referred to (list types) (500-character limit):	n/a

G.4: Unduplicated number of individuals who participated in referred program at least one time:	n/a
G.5: Average duration of untreated mental illness in weeks:	n/a
G.6: Average number of days between referral and first participation in referred treatment program:	n/a

Box H: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
H.1: Who is/are the underserved target population(s) your program is serving (e.g. TAY, Southeast Asian) (500 Characters):	TAY
H.2: Number of paper referrals to an ACBH PEI-funded program:	n/a
H.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	n/a
H.4: Average number of days between referral and first participation in referred PEI program:	Less than two days once referred to YU.
H.5: Describe how your program encouraged access to services and follow through on above referrals (500 Characters):	As a result of the stigma around asking for help, our clinicians have general conversations that would result in finding out in a different way if a young person needed assistance that we knew could be provided through referrals.

Box I: For Outreach, Suicide Prevention, and Stigma Reduction programs, please provide information for unduplicated potential responders (i.e., those who are in a position to identify early signs of potentially severe mental illness provide support, and or refer individuals who need treatment) reached. ***(Note: For Prevention, Early Intervention, Access & Linkage programs, this section is optional.)***	
Number of Responders:	**NA**
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):

MHSA Program #: PEI 17B

PROVIDER NAME: REACH Ashland Youth Center

PROGRAM NAME: Early Intervention

Program Outcomes & Impact: PEI Data Report FY 20/21

Program Name:	REACH Ashland Youth Center	
Organization:	Alameda County- Center for Healthy Schools and Community	
PEI Program # and Name:	PEI 17B TAY Resource Center- REACH Ashland	
Type of Report (Choose one):	Annual	
PEI Category (choose one):	Early Intervention	
Priority Area (place and X next to all that apply):		Childhood Trauma
	X	Early Psychosis
	X	Youth/TAY Outreach and Engagement
		Cultural and Linguistic
		Older Adults
	X	Early Identification of Mental Health Illness

Box A: Please provide a brief program description (character limit 1,000).
REACH serves youth ages 11 through 24 who live throughout Alameda County with a focus on the Ashland and unincorporated areas, a community that is known for poverty, crime and chronic health conditions. 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.

Box B: Number of individuals served this fiscal year through MHSA funding.	
Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	117

Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	52
Number of unduplicated individual family members served indirectly by your program:	70
Grand total of unduplicated individuals served:	**239**

Box C: Demographics of individuals served this fiscal year through MHSA funding.

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	70
Transition Age Youth (16-25 yrs.)	49
Adult (26-59 yrs.)	
Older Adult (60+ yrs.)	
Declined to answer	
Unknown	50
TOTAL	**169**

SEXUAL ORIENTATION	
Gay/Lesbian	
Heterosexual/Straight	
Bisexual	
Questioning/Unsure	
Queer	
Declined to answer	
Unknown	169
Another group not listed	
TOTAL	**169**
If another group is counted, please specify:	

VETERAN STATUS	
Yes	
No	
Declined to answer	
Unknown	169
TOTAL	**169**

CURRENT GENDER IDENTITY	
Female	61
Male	56
Transgender	
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	51
Another identity not listed	1
TOTAL	**169**
If another identity is counted, please specify:	

PRIMARY LANGUAGE	
English	65
Spanish	22
Cantonese	
Chinese	
Vietnamese	
Farsi	
Arabic	
Tagalog	
Declined to answer	
Unknown	82
Another language not listed	
TOTAL	**169**

SEX ASSIGNED AT BIRTH	
Male	
Female	
Declined to answer	
Unknown	169
TOTAL	**169**

DISABILITY*** STATUS	
Communication Domain	
Vision	
Hearing/Speech	
Another type not listed	
Communication Domain Subtotal	**0**
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	
Physical/mobility	
Chronic health condition	
Disability Subtotal	**0**
None	
Declined to answer	
Unknown	169
Another disability not listed	
TOTAL	**169**
If another disability is counted, please specify:	

RACE	
American Indian or Alaska Native	
Asian	2
Black or African American	41
Native Hawaiian or other Pacific Islander	2
White	9
Other Race	56
Declined to answer	6
Unknown	53
TOTAL	**169**
If another race is counted, please specify: Youth who identified their race as Latinx (but not as White, multiracial, or another race) as well as youth who identified as multiracial/mixed race.	

Ethnicity/Cultural Heritage (Please choose only one per individual)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	1
Mexican/Mexican American/Chicano	45
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	6
Total Hispanic or Latino	**52**
If Non-Hispanic or Non-Latino, please specify:	
African	9
African American	31
Asian Indian/South Asian	
Cambodian	
Chinese	1
Eastern European	
European	6
Filipino	
Japanese	
Korean	
Middle Eastern	
Vietnamese	1
Other Non-Hispanic or Non-Latino ethnicity not listed	2
Total Non-Hispanic or Non-Latino	**50**
More than one ethnicity	8
Unknown Ethnicity	58
Declined to answer	1
EHTNICITY TOTAL	**169**
If another ethnicity is counted, please specify: Another Latino/Hispanic ethnicity, people who did not specify their ethnicity in more detail than Latinx	

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of. Note: 1,000-character limit.

FY 20/21 continued to present challenges due to COVID-19. Despite the challenges of the pandemic, we were able to have in-person stable groups at REACH. In consultation with public health, we developed a health screening process including temperature checks and complying with masking and social distancing protocols. We offered 5 different activity stable groups with 3 adult facilitators per group. Groups has 6-9 youth with space dictating the number that we could have in each group. Each stable group had scheduled breaks and mealtime to reduce the potential for group intermingling and exposure if there was a positive COVID case. Since June 2020, we have had 12 sessions of in-person learning and group activity. We are currently in our 2nd summer session. Furthermore, we have continued with our bi-monthly food distribution and recently hosted a vaccine pop-up event at the youth center.

Box E: Program challenges of the past year and how did the agency mitigate challenges? Note: 1,000-character limit.

The pandemic continues to challenge our service delivery model. We work closely with the public health department, school districts, and program partners to make sure that we are aligned with public health guidelines and recommendations. We hold daily debriefs at the end of the day to ensure that staff and partners are consistent with protocols and to address any breakdown in communication. We had 2 positive COVID cases last month and we were able to isolate the exposure and minimize the impact on programming. Although the positive cases were exposed outside of REACH, we took precautionary steps and asked the group that was exposed to quarantine for 10 days depending on their vaccination status. Regarding the health and wellness screener, it is currently being translated into Spanish to be more culturally responsive to our youth and families. Furthermore, we are currently working on our data tracking system to reflect accurate and comprehensive data.

Box F: Program lessons learned of the past year? Note: 1,000-character limit.

We need to continue to be judicious with health screening protocols and complying with public health guidance and best practices. We encourage youth and their families to get vaccinated if they are eligible and confront myths about the vaccine as well as educate staff on vaccine information. The pandemic placed additional technical challenges. It required most of us to learn different ways to navigate various virtual platforms, training of staff and upgrading computers and wi-fi capacity. Regarding data challenges, we realized that we will need to get staff trained on the data system and provide refreshers throughout the year so that all staff will be able to enter youth's information in a consistent and accurate manner.

Box G: **For programs that refer individuals with severe mental illness, please provide information for the categories below:**	
G.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e. mental health treatment services):	0
G.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e. mental health treatment services):	46
G.3: Types of treatment individuals were referred to (list types) (500-character limit):	In addition to being referred to resources to meet non-behavioral health needs, youth were referred to CCM's at REACH, YFSB, Fuente Health Center, Opportunity Academy, and Dreamcatchers. 1 youth already in therapy at Seneca Center
G.4: Unduplicated number of individuals who participated in referred program at least one time:	41
G.5: Average duration of untreated mental illness in weeks:	0.5
G.6: Average number of days between referral and first participation in referred treatment program:	3.6

Box H: **For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:**	
H.1: Who is/are the underserved target population(s) your program is serving (e.g. TAY, Southeast Asian) (500 Characters):	n/a
H.2: Number of paper referrals to an ACBH PEI-funded program:	n/a
H.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	n/a
H.4: Average number of days between referral and first participation in referred PEI program:	n/a
H.5: Describe how your program encouraged access to services and follow through on above referrals (500 Characters):	n/a

Box I: For <u>Outreach, Suicide Prevention, and Stigma Reduction</u> programs, please provide information for unduplicated potential responders (i.e., those who are in a position to identify early signs of potentially severe mental illness provide support, and or refer individuals who need treatment) reached. ***(Note: For Prevention, Early Intervention, Access & Linkage programs, this section is optional.)***	
Number of Responders:	**0**
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):

MHSA Program #: PEI 18

PROVIDER NAME: East Bay Agency for Children

PROGRAM NAME: Fremont Healthy Start Program

Program Outcomes & Impact: PEI Data Report FY 20/21

Program Name:	Fremont Healthy Start Program	
Organization:	East Bay Agency for Children	
PEI Program # and Name:	18388; Fremont Healthy Start	
Type of Report (Choose one):	Annual	
PEI Category (choose one):	Stigma and Discrimination Reduction	
Priority Area (place and X next to all that apply):		Childhood Trauma
		Early Psychosis
		Youth/TAY Outreach and Engagement
		Cultural and Linguistic
		Older Adults
	X	Early Identification of Mental Health Illness

Box A: Please provide a brief program description (character limit 1,000).
East Bay Agency for Children's (EBAC) 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.

Box B: Number of individuals served this fiscal year through MHSA funding.	
Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	442
Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	274
Number of unduplicated individual family members served indirectly by your program:	681
Grand total of unduplicated individuals served:	**1397**

Box C: Demographics of individuals served this fiscal year through MHSA funding.

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	1
Transition Age Youth (16-25 yrs.)	41
Adult (26-59 yrs.)	377
Older Adult (60+ yrs.)	297
Declined to answer	
Unknown	
TOTAL	**716**

SEXUAL ORIENTATION	
Gay/Lesbian	1
Heterosexual/Straight	210
Bisexual	1
Questioning/Unsure	
Queer	
Declined to answer	
Unknown	504
Another group not listed	
TOTAL	**716**
If another group is counted, please specify:	

VETERAN STATUS	
Yes	2
No	173
Declined to answer	
Unknown	541
TOTAL	**716**

CURRENT GENDER IDENTITY	
Female	86
Male	32
Transgender	
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	598
Another identity not listed	
TOTAL	**716**
If another identity is counted, please specify:	

PRIMARY LANGUAGE	
English	195
Spanish	164
Cantonese	19
Chinese	97
Vietnamese	6
Farsi	21
Arabic	6
Tagalog	
Declined to answer	
Unknown	208
Another language not listed	
TOTAL	**716**
If another language is counted, please specify: Other Chinese dialects. Koran, Cambodian, Turkish, Armenian, Other primary languages not listed	

SEX ASSIGNED AT BIRTH	
Male	498
Female	216
Declined to answer	2
Unknown	
TOTAL	**716**

DISABILITY STATUS	
Communication Domain	
Vision	
Hearing/Speech	4
Another type not listed	
Communication Domain Subtotal	4
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	19
Physical/mobility	48
Chronic health condition	40
Disability Subtotal	**107**
None	356
Declined to answer	
Unknown	275
Another disability not listed	
TOTAL	**742**
If another disability is counted, please specify:	

RACE	
American Indian or Alaska Native	
Asian	457
Black or African American	17
Native Hawaiian or other Pacific Islander	1
White	230
Declined to answer	
Another Race not listed (see below)	
Unknown	11
TOTAL	**716**
If another race is counted, please specify:	

Ethnicity/Cultural Heritage (Please choose only one per individual)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	27
Mexican/Mexican American/Chicano	128
Puerto Rican	2
South American	5
Another Hispanic/Latino ethnicity not listed	41
Total Hispanic or Latino	**203**
If Non-Hispanic or Non-Latino, please specify:	
African	2
African American	15
Asian Indian/South Asian	187
Cambodian	1
Chinese	130
Eastern European	
European	18
Filipino	33
Japanese	
Korean	80
Middle Eastern	8
Vietnamese	8
Other Non-Hispanic or Non-Latino ethnicity not listed	
Total Non-Hispanic or Non-Latino	**482**
More than one ethnicity	2
Unknown Ethnicity	29
Declined to answer	
EHTNICITY TOTAL	**716**
If another ethnicity is counted, please specify: unknown Hispanic/Latino	

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of. Note: 1,000-character limit.

Staff helped clients feeling stressed about socialization after COVID restrictions were lifted by offering coping strategies. Staff also shared up-to-date recommendations and news to ease family's concerns and address misinformation. Clients passed this on to their families and social networks – an invaluable asset, as hearing these messages from someone in their own circle is highly effective. Staff also used motivational interviewing to identify potential areas for further education and intervention.

Case study: Staff helped a mother whose abusive husband abandoned the family. The client lost her job due to a misunderstanding and had no other revenue. She was highly stressed and worried about paying rent. Our staff linked the client to legal resources, referred her to counseling and other services, and assisted her in applying for food stamps and health insurance. The client shared that the support she received helped her to become resourceful and strong for her children.

Box E: Program challenges of the past year and how did the agency mitigate challenges? Note: 1,000-character limit.

1)The lack of adequate and accessible mental health supports in certain languages is concerning, with the increased number of clients disclosing mental health issues and an anticipated wave of new clients seeking support. 2) Uncertainty regarding vaccines and mask wearing are making some clients stressed, 3) Financial and COVID-related stressors make it difficult for families to focus on anything other than their basic needs. 4) Families have increased concerns for their children's mental health and behavior challenges. 5) Clients experiencing loss are hesitant to discuss their grief. 6) Technology barriers impact client's access to mental health and other services and limit social connections. 7) With many county offices closed, many families have difficulty accessing services. Our staff also continue to work remotely, but we have made access easier by devoting time to assist clients in how to use technology. We also have a drop box where clients can delivery documents.

Box F: Program lessons learned of the past year. Note: 1000-character limit.

We learned much this year about implementing new data and service systems. There were changes made in our database that had unintended consequences in other areas and similarly with program services. Rolling out new systems takes time and patience as staff adjust to new procedures while simultaneously meeting clients' needs. Also, wellness checks, while important, are time consuming and draining for staff. It was their tendency to want to check in with everyone at once, but some structure was important for them to remain present with families, especially with emotions so high for all involved. We learned to give staff some structure about how to spend their time each day so that they could pace themselves. We also learned the importance of staff/client contact to reduce client isolation. Clients expressed gratitude that staff took time just to do the well checks, in their own language. Assisting clients with how to use technology is key to helping families feel connected and informed.

Box G: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
G.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e. mental health treatment services):	n/a
G.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e. mental health treatment services):	n/a
G.3: Types of treatment individuals were referred to (list types) (500-character limit):	n/a
G.4: Unduplicated number of individuals who participated in referred program at least one time:	n/a
G.5: Average duration of untreated mental illness in weeks:	n/a
G.6: Average number of days between referral and first participation in referred treatment program:	n/a

Box H: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
H.1: Who is/are the underserved target population(s) your program is serving (e.g. TAY, Southeast Asian) (500 Characters):	n/a
H.2: Number of paper referrals to an ACBH PEI-funded program:	n/a
H.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	n/a
H.4: Average number of days between referral and first participation in referred PEI program:	n/a
H.5: Describe how your program encouraged access to services and follow through on above referrals (500 Characters):	n/a

Box I: **For <u>Outreach, Suicide Prevention, and Stigma Reduction</u> programs, please provide information for unduplicated potential responders (i.e., those who are in a position to identify early signs of potentially severe mental illness provide support, and or refer individuals who need treatment) reached.** ***(Note: For Prevention, Early Intervention, Access & Linkage programs, this section is optional.)***

Number of Responders:	
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):
Fremont Healthy Start Program	*Parents, caregivers, general community members*
Fremont Healthy Start Program	*Parents, caregivers, general community members*
Schools	*School staff, teachers, parents, caregivers*
Client homes	*Parents, caregivers, general community members*

MHSA Program #: PEI 20A

PROVIDER NAME: Beats, Rhymes, and Life

PROGRAM NAME: Beats, Rhymes, and Life

Program Outcomes & Impact: PEI Data Report FY 20/21

Program Name:	Beats Rhymes and Life	
Organization:	BEATS RYHMES AND LIFE, INC.	
PEI Program # and Name:	PEI 20A culturally responsive PEI programs for African American Comm.-Beats, Rhymes and Life	
Type of Report (Choose one):	Annual	
PEI Category (choose one):	Prevention	
Priority Area (place and X next to all that apply):		Childhood Trauma
		Early Psychosis
	X	Youth/TAY Outreach and Engagement
	X	Cultural and Linguistic
		Older Adults
		Early Identification of Mental Health Illness

Box A: Please provide a brief program description (character limit 1,000).
Beats Rhymes and Life is a non-profit that serves primarily youth in the bay area. We promote the efficacy of youth in leading their own healing. We are a culturally congruent program that uses hip hop as the medium for our work with transitional aged youth with a focus on the African American community.

Box B: Number of individuals served this fiscal year through MHSA funding.	
Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	75
Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	NA
Number of unduplicated individual family members served indirectly by your program:	NA
Grand total of unduplicated individuals served:	75

Box C: Demographics of individuals served this fiscal year through MHSA funding.

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	6
Transition Age Youth (16-25 yrs.)	55
Adult (26-59 yrs.)	
Older Adult (60+ yrs.)	
Declined to answer	
Unknown	14
TOTAL	**75**

VETERAN STATUS	
Yes	
No	75
Declined to answer	
Unknown	
TOTAL	**75**

CURRENT GENDER IDENTITY	
Female	21
Male	26
Transgender	
Genderqueer	1
Questioning/unsure of gender identity	1
Declined to answer	26
Unknown	
Another identity not listed	
TOTAL	**75**
If another identity is counted, please specify:	

SEX ASSIGNED AT BIRTH	
Male	31
Female	31
Declined to answer	13
Unknown	
TOTAL	**75**

SEXUAL ORIENTATION	
Gay/Lesbian	
Heterosexual/Straight	31
Bisexual	6
Questioning/Unsure	4
Queer	1
Declined to answer	32
Unknown	
Another group not listed	1
TOTAL	**75**
If another group is counted, please specify:	

PRIMARY LANGUAGE	
English	60
Spanish	2
Cantonese	
Chinese	
Vietnamese	
Farsi	
Arabic	
Tagalog	
Declined to answer	13
Unknown	
Another language not listed	
TOTAL	**75**
If another language is counted, please specify:	

DISABILITY*** STATUS	
Communication Domain	
Vision	
Hearing/Speech	1
Another type not listed	56
Communication Domain Subtotal	**57**
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	3
Physical/mobility	1
Chronic health condition	
Disability Subtotal	**4**
None	
Declined to answer	14
Unknown	
Another disability not listed	
TOTAL	**75**
If another disability is counted, please specify:	

RACE	
American Indian or Alaska Native	
Asian	9
Black or African American	35
Native Hawaiian or other Pacific Islander	
White	2
Other Race	9
Declined to answer	20
Unknown	
TOTAL	**75**
If another race is counted, please specify:	

Ethnicity/Cultural Heritage (Please choose only one per individual)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	
Mexican/Mexican American/Chicano	6
Puerto Rican	
South American	1
Another Hispanic/Latino ethnicity not listed	
Total Hispanic or Latino	**7**
If Non-Hispanic or Non-Latino, please specify:	
African	1
African American	37
Asian Indian/South Asian	1
Cambodian	3
Chinese	1
Eastern European	
European	2
Filipino	
Japanese	
Korean	
Middle Eastern	
Vietnamese	3
Other Non-Hispanic or Non-Latino ethnicity not listed	
Total Non-Hispanic or Non-Latino	**48**
More than one ethnicity	7
Unknown Ethnicity	
Declined to answer	13
EHTNICITY TOTAL	**75**
If another ethnicity is counted, please specify:	

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of. Note: 1,000-character limit.
We are proudest of our ability to support our staff and adapt curriculum to Zoom throughout the pandemic. We created ways to record music through Zoom and added programming like our beat group that was a better fit for virtual tech-based programming. We were able to maintain the same level of rapport building and connection in our groups. We had a critical intervention when a student dropped out of our Zoom. Team members followed up to find that he got into a fight with his alcoholic mother. He talked of killing himself so we did a suicide assessment and reached out to his support services team through Seneca Services. The family was separated and he was able to gain other housing. With his stability solidified, he was able to perform months later in our showcase.

Box E: Program challenges of the past year and how did the agency mitigate challenges? Note: 1,000-character limit.
See above for details but the biggest challenges came as a result of the pandemic.

Box F: Program lessons learned of the past year? Note: 1,000-character limit.
We learned how important connection is to our youth, especially throughout the pandemic and that our democracy is not to be taken for granted. Interconnectedness was the key lesson that we walked away from this time with, and why it is so important to lean on and work with each other throughout crisis.

Box G: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
G.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e. mental health treatment services):	n/a
G.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e. mental health treatment services):	n/a
G.3: Types of treatment individuals were referred to (list types) (500-character limit):	n/a
G.4: Unduplicated number of individuals who participated in referred program at least one time:	n/a
G.5: Average duration of untreated mental illness in weeks:	n/a
G.6: Average number of days between referral and first participation in referred treatment program:	n/a

Box H: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
H.1: Who is/are the underserved target population(s) your program is serving (e.g. TAY, Southeast Asian) (500 Characters):	African American TAY
H.2: Number of paper referrals to an ACBH PEI-funded program:	n/a
H.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	n/a
H.4: Average number of days between referral and first participation in referred PEI program:	n/a
H.5: Describe how your program encouraged access to services and follow through on above referrals (500 Characters):	Our work is predicated on the specific niche of making music. If there is a red flag or an incident that unearths emergent needs, we support youth in the moment and facilitate reconnecting with existing support workers, or we will arrange support.

Box I: For Outreach, Suicide Prevention, and Stigma Reduction programs, please provide information for unduplicated potential responders (i.e., those who are in a position to identify early signs of potentially severe mental illness provide support, and or refer individuals who need treatment) reached. ***(Note: For Prevention, Early Intervention, Access & Linkage programs, this section is optional.)***	
Number of Responders:	**NA**
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):
Oakland High School	Teachers, students, COST collaborators
Castlemont High School	Teachers, students, COST collaborators
Cox Academy	Teachers, students, COST collaborators

MHSA Program #: PEI 20B

PROVIDER NAME: Black Men Speak

PROGRAM NAME: Culturally Responsive Programs for African Americans – Black Men Speak

Program Outcomes & Impact: PEI Data Report FY 20/21

Program Name:	PEI 20B Culturally Responsive Programs for African Americans	
Organization:	Black Men Speak	
PEI Program # and Name:	PEI 20B Culturally Responsive Programs for African Americans	
Type of Report (Choose one:)	Annual	
PEI Category (choose one):	Outreach	
Priority Area (place and X next to all that apply):		Childhood Trauma
		Early Psychosis
		Youth/TAY Outreach and Engagement
	X	Cultural and Linguistic
		Older Adults
		Early Identification of Mental Health Illness

Box A: Please provide a brief program description (character limit 1,000).
Black Men Speaks is a speaker's bureau that aims to reduce stigma and discrimination against people with mental health experiences by empowering African American Men and Women to share their personal stories of hope and recovery in our community.

Box B: Number of individuals served this fiscal year through MHSA funding.	
Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	2552
Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	NA
Number of unduplicated individual family members served indirectly by your program:	NA
Grand total of unduplicated individuals served:	**2552**

Box C: Demographics of individuals served this fiscal year through MHSA funding.

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	
Transition Age Youth (16-25 yrs.)	
Adult (26-59 yrs.)	
Older Adult (60+ yrs.)	
Declined to answer	
Unknown	2552
TOTAL	**2552**

VETERAN STATUS	
Yes	
No	
Declined to answer	
Unknown	2552
TOTAL	**2552**

CURRENT GENDER IDENTITY	
Female	
Male	
Transgender	
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	2552
Another identity not listed	
TOTAL	**2552**
If another identity is counted, please specify:	

SEX ASSIGNED AT BIRTH	
Male	
Female	
Declined to answer	
Unknown	2552
TOTAL	**2552**

SEXUAL ORIENTATION	
Gay/Lesbian	
Heterosexual/Straight	
Bisexual	
Questioning/Unsure	
Queer	
Declined to answer	
Unknown	2552
Another group not listed	
TOTAL	**2552**
If another group is counted, please specify:	

PRIMARY LANGUAGE	
English	
Spanish	
Cantonese	
Chinese	
Vietnamese	
Farsi	
Arabic	
Tagalog	
Declined to answer	
Unknown	2552
Another language not listed	
TOTAL	**2552**
If another language is counted, please specify:	

DISABILITY*** STATUS	
Communication Domain	
Vision	
Hearing/Speech	
Another type not listed	
Communication Domain Subtotal	
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	
Physical/mobility	
Chronic health condition	
Disability Subtotal	
None	
Declined to answer	
Unknown	2552
Another disability not listed	
TOTAL	**2552**
If another disability is counted, please specify:	

RACE	
American Indian or Alaska Native	
Asian	
Black or African American	
Native Hawaiian or other Pacific Islander	
White	
Other Race	
Declined to answer	
Unknown	2552
TOTAL	**2552**
If another race is counted, please specify:	

Ethnicity/Cultural Heritage (Please choose only one per individual)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	
Mexican/Mexican American/Chicano	
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	
Total Hispanic or Latino	
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	
Total Non-Hispanic or Non-Latino	
More than one ethnicity	
Unknown Ethnicity	2552
Declined to answer	
EHTNICITY TOTAL	**2552**
If another ethnicity is counted, please specify:	

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of. Note: 1,000-character limit.

We continued to meet most of our deliverables during the COVID 19 pandemic. We adapted to Zoom Video meetings for outreach and contacts. We adhered to all the guidelines for keeping everyone safe. We practice social distancing, wearing masks, and washing or cleansing hands often. We ordered masks and gloves to distribute to our members. One of our most noted successful outreach events was participation in the Rally Against Police Violence and Killing African American Men and Women at the state capitol in Sacramento, CA. We were able to pass out information about Black Men Speak and its goal to empower members. Other events included BMS' speaking event in Justice for Sean Monterrosa at San Francisco city hall, the CAMPRO Conference, the POCC Annual Conference 2021, and the REACH African American Trauma event via Zoom.

Box E: **Program challenges of the past year and how did the agency mitigate challenges? Note: 1,000-character limit.**

BMS (Black Men Speaks) would have completed all of our deliverables sooner, but with the COVID 19 crises and the shelter-in-place order, our plans were disrupted. We had four speaking engagements scheduled at various classrooms at UC Berkeley, another at a church in Oakland, and one with the POCC Steering Committee and Executive Committee. We also had planned engagements at Santa Rita and the Juvenile Justice Center but both were postponed. We will continue with those plans as things open again. Another challenge has been doing surveys. We were not able to get information on Zoom. Some of these challenges were met by conducting virtual meetings where speakers share their life experiences and stories of resilience, as well as short videos shared on social media.

Box F: Program lessons learned of the past year? Note: 1,000-character limit.

We adapted to a new way of doing our deliverables by using Zoom, and so our program can continue even in uncertain health and social situations by providing information and being available to our members and our community as a positive force. By continuing our relationships with organizations such as All of Us or None, BOP, REACH, and Boss, we have continued to increase visibility of BMS and empowerment in target populations in different ways. Through BMS presentations, we have seen much support of men released from incarceration including employment, housing, and self-sufficiency.

Box G: For programs that refer individuals with severe mental illness, please provide information for the categories below:

G.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e. mental health treatment services):	n/a

G.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e. mental health treatment services):	n/a
G.3: Types of treatment individuals were referred to (list types) (500-character limit):	n/a
G.4: Unduplicated number of individuals who participated in referred program at least one time:	n/a
G.5: Average duration of untreated mental illness in weeks:	n/a
G.6: Average number of days between referral and first participation in referred treatment program:	n/a

Box H: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
H.1: Who is/are the underserved target population(s) you program is serving (e.g. TAY, Southeast Asian) (500 Characters):	Our mission is to inform and enlighten mental health communities and the men and women of color about substance abuse
H.2: Number of paper referrals to an ACBH PEI-funded program:	n/a
H.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	n/a
H.4: Average number of days between referral and first participation in referred PEI program:	n/a
H.5: Describe how your program encouraged access to services and follow through on above referrals (500 Characters):	We encourage access to services by giving referrals for housing, employment, and mental health counseling with warm handoffs.

Box I: For <u>Outreach, Suicide Prevention, and Stigma Reduction</u> programs, please provide information for unduplicated potential responders (i.e., those who are in a position to identify early signs of potentially severe mental illness provide support, and or refer individuals who need treatment) reached. ***(Note: For Prevention, Early Intervention, Access & Linkage programs, this section is optional.)***	
Number of Responders:	**n/a**
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):

MHSA Program #: PEI 20C

PROVIDER NAME: MHAAC

PROGRAM NAME: Culturally Responsive Programs for African Americans – Family Outreach Program

Program Outcomes & Impact: PEI Data Report FY 20/21

Program Name:	African American Family Outreach Program	
Organization:	Mental Health Association of Alameda County (MHAAC)	
PEI Program # and Name:	PEI 20C Culturally Responsive PEI Programs for African American Community - Family Outreach	
Type of Report (Choose one):	Annual	
PEI Category (choose one):	Outreach	
Priority Area (place and X next to all that apply):		Childhood Trauma
		Early Psychosis
		Youth/TAY Outreach and Engagement
	X	Cultural and Linguistic
		Older Adults
		Early Identification of Mental Health Illness

Box A: Please provide a brief program description (character limit 1,000).

MHAAC provides five workshops for African American families. Workshops engage family members and provide professional and peer support to families helping their loved ones living with mental health conditions. Family members receive information about mental health/specific mental health disorders, information about services throughout alameda county for individuals with mental health and/or substance use disorder and are made aware of the importance of self-care as a means of stress reduction.

Box B: Number of individuals served this fiscal year through MHSA funding.

Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	NA

Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	NA
Number of unduplicated individual family members served indirectly by your program:	206
Grand total of unduplicated individuals served:	**206**

Box C: Demographics of individuals served this fiscal year through MHSA funding.

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	1
Transition Age Youth (16-25 yrs.)	2
Adult (26-59 yrs.)	51
Older Adult (60+ yrs.)	48
Declined to answer	4
Unknown	100
TOTAL	**206**

SEXUAL ORIENTATION	
Gay/Lesbian	
Heterosexual/Straight	
Bisexual	
Questioning/Unsure	
Queer	
Declined to answer	
Unknown	206
Another group not listed	
TOTAL	**206**
If another group is counted, please specify:	

VETERAN STATUS	
Yes	
No	
Declined to answer	
Unknown	206
TOTAL	**206**

CURRENT GENDER IDENTITY	
Female	90
Male	16
Transgender	
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	100
Another identity not listed	
TOTAL	**206**
If another identity is counted, please specify:	

PRIMARY LANGUAGE	
English	
Spanish	
Cantonese	
Chinese	
Vietnamese	
Farsi	
Arabic	
Tagalog	
Declined to answer	206
TOTAL	**206**
If another language is counted, please specify:	

SEX ASSIGNED AT BIRTH	
Male	
Female	
Declined to answer	
Unknown	206
TOTAL	**206**

DISABILITY*** STATUS	
Communication Domain	
Vision	
Hearing/Speech	
Another type not listed	
Communication Domain Subtotal	**0**
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	
Physical/mobility	
Chronic health condition	
Disability Subtotal	**0**
None	
Declined to answer	
Unknown	206
Another disability not listed	
TOTAL	**206**
If another disability is counted, please specify:	

RACE	
American Indian or Alaska Native	
Asian	
Black or African American	94
Native Hawaiian or other Pacific Islander	
White	2
Other Race	1
Declined to answer	
Unknown	109
TOTAL	**206**
If another race is counted, please specify:	

Ethnicity/Cultural Heritage (Please choose only one per individual)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	
Mexican/Mexican American/Chicano	3
Puerto Rican	
South American	2
Another Hispanic/Latino ethnicity not listed	9
Total Hispanic or Latino	**14**
If Non-Hispanic or Non-Latino, please specify:	
African	7
African American	33
Asian Indian/South Asian	2
Cambodian	
Chinese	1
Eastern European	
European	3
Filipino	
Japanese	
Korean	
Middle Eastern	
Vietnamese	
Other Non-Hispanic or Non-Latino ethnicity not listed	5
Total Non-Hispanic or Non-Latino	**51**
More than one ethnicity	
Unknown Ethnicity	89
Declined to answer	52
EHTNICITY TOTAL	**206**
If another ethnicity is counted, please specify:	

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of. Note: 1,000-character limit.

During FY 2020/21 MHAAC focused on developing culturally syntonic workshops for African American families to build community through cultural connection. Presenters were either African American or cross-cultural experts in services to the community. ACBH ally Dr. Aaron Chapman was a champion and of the remaining presenters, 83% were African American and 100% were POC. 98% of participants reported the presenters covered their topics well; 99% reported that their questions were answered well; 97% shared that the presentation was useful. Workshops were redesigned to draw from the African American experience by including cultural infusion through the use of music, spoken poetry, imagery and the stories of lived experience. Workshops promoted culturally syntonic self-care and self-care practices such as the FERC African American Support Group and the presentation of Dr. Theopia Jackson, President of the Association of Black Psychologists, who educated on the African American tradition of healing circles.

Box E: Program challenges of the past year and how did the agency mitigate challenges? Note: 1,000-character limit.

Our most significant challenge this year was evolving the program's outreach/engagement with no in-person contact. The program used an African American PR firm to promote through social media and to community leaders. African American radio station promotion and articles published in a local African American paper were implemented. With the addition of a part time outreach worker and coming under FERC administration, the program focused on increasing personal ties to organizations, however we found this difficult. The Steering Committee expanded their outreach to leverage relationships across the country resulting in 4 out-of-state participants. We had 435 Zoom registrants with 47% attending; average workshop attendance was 41. 80% of participants attended on computers and 20% attended via phone. 71% were from Alameda County (54% from Oakland); 23% from other Bay Area counties and 6% from outside the Bay Area. Despite engagement barriers, 90% of participants rated the workshops 8+ out of 10.

Box F: Program lessons learned of the past year? Note: 1,000-character limit.

The lesson learned this year was the importance of formative community feedback and transmission. We found that we needed more than an evaluation to garner floor needs and we learned that transmitting needs up is an important aspect of the work. We used an evaluation feedback loop in which participants response on workshop evaluations was used to shape program offerings. For example, we found that 52% of participant's loved ones live with MHI and SUD. We responded by providing presentations on SUD with MH. However, we found that an average of 54% of participants completed our evaluations. To address this, a standing discussion component was added to the workshops to garner live feedback on community needs and to inform the community of the program's transmission of their feedback to the ACBH system. For example, at the February workshop the community requested an African American Warmline, and this was brought to ACBH and is in discussion.

Box G: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
G.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e. mental health treatment services):	n/a
G.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e. mental health treatment services):	n/a
G.3: Types of treatment individuals were referred to (list types) (500-character limit):	n/a
G.4: Unduplicated number of individuals who participated in referred program at least one time:	n/a
G.5: Average duration of untreated mental illness in weeks:	n/a
G.6: Average number of days between referral and first participation in referred treatment program:	n/a
G.3: Types of treatment individuals were referred to (list types) (500-character limit):	n/a

Box H: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
H.1: Who is/are the underserved target population(s) your program is serving (e.g. TAY, Southeast Asian) (500 Characters):	n/a
H.2: Number of paper referrals to an ACBH PEI-funded program:	n/a
H.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	n/a
H.4: Average number of days between referral and first participation in referred PEI program:	n/a
H.5: Describe how your program encouraged access to services and follow through on above referrals (500 Characters):	n/a

Box I: For <u>Outreach, Suicide Prevention, and Stigma Reduction</u> programs, please provide information for unduplicated potential responders (i.e., those who are in a position to identify early signs of potentially severe mental illness provide support, and or refer individuals who need treatment) reached. ***(Note: For Prevention, Early Intervention, Access & Linkage programs, this section is optional.)***	
Number of Responders:	**15**
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):
Senior Center	*Administrative Manager, Executive Director, Lead PRA, FERC Program Supervisor, Presenters*
Recreation Center	*Administrative Manager, Executive Director, FERC Program Supervisor, Presenters*
Zoom	*Administrative Manager, Executive Director, FERC Program Supervisor, Presenters*

MHSA Program #: PEI 20D

PROVIDER NAME: RJOY

PROGRAM NAME: Culturally Responsive Programs for African Americans – Africentric Healing Circles

Program Outcomes & Impact: PEI Data Report FY 20/21

Program Name:	Africentric Healing Circles Program	
Organization:	Restorative Justice for Oakland Youth (RJOY)	
PEI Program # and Name:	African American Healing Circles	
Type of Report (Choose one):	Annual	
PEI Category (choose one):	Prevention	
Priority Area (place and X next to all that apply):		Childhood Trauma
		Early Psychosis
		Youth/TAY Outreach and Engagement
		Cultural and Linguistic
		Older Adults
	X	Early Identification of Mental Health Illness

Box A: Please provide a brief program description (character limit 1,000).

The RJOY African American Healing Circles program offers weekly restorative justice healing circles in open affinity group spaces with a focus on African American culture and Black mental health promotion and healing. Additionally, 3 large group events and 8 restorative justice training sessions are offered annually to advertise the array of Black mental health promotion activities offered and to prepare community members for co-facilitation of restorative justice groups.

Box B: Number of individuals served this fiscal year through MHSA funding.

Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	74

Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	15
Number of unduplicated individual family members served indirectly by your program:	1553
Grand total of unduplicated individuals served:	**1646**

Box C: Demographics of individuals served this fiscal year through MHSA funding.

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	6
Transition Age Youth (16-25 yrs.)	36
Adult (26-59 yrs.)	84
Older Adult (60+ yrs.)	25
Declined to answer	39
Unknown	1363
TOTAL	**1553**

SEXUAL ORIENTATION	
Gay/Lesbian	12
Heterosexual/Straight	1
Bisexual	8
Questioning/Unsure	
Queer	10
Declined to answer	119
Unknown	
Another group not listed	1363
TOTAL	**1553**
If another group is counted, please specify:	

VETERAN STATUS	
Yes	
No	
Declined to answer	
Unknown	1553
TOTAL	**1553**

CURRENT GENDER IDENTITY	
Female	96
Male	83
Transgender	
Genderqueer	8
Questioning/unsure of gender identity	
Declined to answer	56
Unknown	1310
Another identity not listed	
TOTAL	**1553**
If another identity is counted, please specify:	

PRIMARY LANGUAGE	
English	182
Spanish	4
Cantonese	
Chinese	
Vietnamese	
Farsi	1
Arabic	
Tagalog	
Declined to answer	
Unknown	1363
Another language not listed	3
TOTAL	**1553**
If another language is counted, please specify:	

SEX ASSIGNED AT BIRTH	
Male	96
Female	83
Declined to answer	8
Unknown	1366
TOTAL	**1553**

DISABILITY*** STATUS	
Communication Domain	
Vision	
Hearing/Speech	
Another type not listed	
Communication Domain Subtotal	**0**
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	
Physical/mobility	
Chronic health condition	
Disability Subtotal	**0**
None	
Declined to answer	
Unknown	1553
Another disability not listed	
TOTAL	**1553**
If another disability is counted, please specify:	

RACE	
American Indian or Alaska Native	3
Asian	22
Black or African American	1275
Native Hawaiian or other Pacific Islander	1
White	110
Other Race	
Declined to answer	2
Unknown	107
TOTAL	**1553**
If another race is counted, please specify: In RJOY's data collection efforts, some respondents have listed Latinx under race.	

Ethnicity/Cultural Heritage (Please choose only one per individual)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	1
Mexican/Mexican American/Chicano	1
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	105
Total Hispanic or Latino	**107**

If Non-Hispanic or Non-Latino, please specify:	
African	
African American	1275
Asian Indian/South Asian	
Cambodian	
Chinese	
Eastern European	
European	110
Filipino	1
Japanese	
Korean	
Middle Eastern	2
Vietnamese	
Other Non-Hispanic or Non-Latino ethnicity not listed	21
Total Non-Hispanic or Non-Latino	**1411**
More than one ethnicity	3
Unknown Ethnicity	30
Declined to answer	2
EHTNICITY TOTAL	**1553**

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of. Note: 1,000-character limit.
The program was successful meeting or exceeding all of its contract goals and objectives during FY 2021. Ten weekly healing circles were facilitated. At least 3 large group events were hosted and more than 8 trainings were delivered. A significant accomplishment was organizing and facilitating a Black Mental Health Conference that was attended by over 300 participants with 9 breakout sessions. Ten months ago, a former youth RJOY employee and circle participant was shot and killed. He was an engaged and expectant father of twins. He regularly attended Black Male Circle. He also supported the Youth Circle by accompanying young people from group homes and the community to the circle. We held several circles with his fiancée. The circles centered on healing and support. We held a virtual baby shower exploring needs.

Box E: Program challenges of the past year and how did the agency mitigate challenges? 1,000-character limit.
The primary challenge over the past year remained working in a virtual environment. We had relatively successful one-off events, such as talent shows, dance parties and the Reimagining Black Mental Health Conference, with significant numbers in attendance. But while initial participation in events and healing circles was strong, we experienced a mid-year drop in numbers for some circles that would seem to be attributable to "Zoom fatigue". Many participants in recent months have expressed eagerness to return to in-person meetings, something that we are beginning as vaccination rates rise and also as we have developed new protocols for in-person circles through community events we have held in the wake of incidents of violence in our community. We continued to follow up with participants, offering understanding while also trying to ensure that attendance remained high enough to engender trust and engagement among all participants in circles where attendance began to decrease.

Box F: Program lessons learned of the past year? Note: 1,000-character limit.
A key lesson learned this year is that there is a deep connection between isolation, stress, and violence: the slow emergence from out pandemic lockdown has been accompanied by a disturbing rise in violence in Oakland and around the country. The other side of this lesson is two-fold: first that the crisis we have endured is as much a mental health crisis as a public health crisis, and there is a need to provide strong interventions at the community and individual levels to help people address the impact of the past year in their lives. The second part is that connectedness and accountability to one another remain key means of interrupting patterns of violence in the community. RJOY was called upon to provide restorative justice circles for victims and witnesses of tragic incidents of violence this year, holding open meetings for example for members of a youth football team who witnessed the murder of a player's father in a dispute with another spectator.

Box G: **For programs that refer individuals with severe mental illness, please provide information for the categories below:**	
G.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e. mental health treatment services):	5
G.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e. mental health treatment services):	3
G.3: Types of treatment individuals were referred to (list types) (500-character limit):	Individual counseling, psychiatric medicine evaluation, individual psychotherapy, family therapy, group counseling, housing support, case management, housing, food and health care referrals
G.4: Unduplicated number of individuals who participated in referred program at least one time:	15
G.5: Average duration of untreated mental illness in weeks:	12
G.6: Average number of days between referral and first participation in referred treatment program:	10

Box H: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
H.1: Who is/are the underserved target population(s) your program is serving (e.g. TAY, Southeast Asian) (500 Characters):	n/a
H.2: Number of paper referrals to an ACBH PEI-funded program:	n/a
H.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	n/a
H.4: Average number of days between referral and first participation in referred PEI program:	n/a

H.5: Describe how your program encouraged access to services and follow through on above referrals (500 Characters):	n/a

Box I: For <u>Outreach, Suicide Prevention, and Stigma Reduction</u> programs, please provide information for unduplicated potential responders (i.e., those who are in a position to identify early signs of potentially severe mental illness provide support, and or refer individuals who need treatment) reached. ***(Note: For Prevention, Early Intervention, Access & Linkage programs, this section is optional.)***	
Number of Responders:	**NA**
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):

MHSA Program #: PEI 20E

PROVIDER NAME: Tri Cities Community Development Center

PROGRAM NAME: Culturally Responsive Programs for African Americans – Faith Based

Program Outcomes & Impact: PEI Data Report FY 20/21

Program Name:	Mental Health Friendly Communities	
Organization:	Tri Cities Community Development Center	
PEI Program # and Name:	PEI 20E - Culturally Responsive PEI Programs for African American Comm - Faith Based- Tri Cities Community Development Center	
Type of Report (Choose one):	Annual – Data Repot Not Submitted	
PEI Category (choose one):	Stigma and Discrimination Reduction	
Priority Area (place and X next to all that apply):		Childhood Trauma
		Early Psychosis
	X	Youth/TAY Outreach and Engagement
	X	Cultural and Linguistic
	X	Older Adults
	X	Early Identification of Mental Health Illness

Box A: Please provide a brief program description (character limit 1,000).

MHFC is a community best practice program that provides a bridge to connect the spiritual and clinical approach to mental health to eliminate stigma and discrimination and to improve outcomes for African American consumers and family members residing in Alameda County utilizing a faith-based strategy to harness the invaluable and historical role of faith in the African American Community. The Core principles of a Mental Health Friendly Communities Congregation is embodied in the Ten Commitments of a Mental Health Friendly Congregation. The MHFC Training Team works collaboratively the African American Faith leaders, their congregations/communities of faith and community stakeholders to dispel myths, build trust and relationships to provide culturally responsive services and partnerships to better serve African American consumers and family members.

Box B: Number of individuals served this fiscal year through MHSA funding.

Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	30
Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	50
Number of unduplicated individual family members served indirectly by your program:	220
Grand total of unduplicated individuals served:	**300**

Box C: Demographics of individuals served this fiscal year through MHSA funding.

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	10
Transition Age Youth (16-25 yrs.)	25
Adult (26-59 yrs.)	122
Older Adult (60+ yrs.)	113
Declined to answer	
Unknown	
TOTAL	**270**

VETERAN STATUS	
Yes	43
No	
Declined to answer	
Unknown	
TOTAL	**43**

SEXUAL ORIENTATION	
Gay/Lesbian	5
Heterosexual/Straight	220
Bisexual	
Questioning/Unsure	
Queer	
Declined to answer	48
Unknown	
Another group not listed	
TOTAL	**239**
If another group is counted, please specify:	

CURRENT GENDER IDENTITY	
Female	173
Male	90
Transgender	
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	
Another identity not listed	
TOTAL	**263**
If another identity is counted, please specify:	

PRIMARY LANGUAGE	
English	250
Spanish	
Cantonese	
Chinese	
Vietnamese	
Farsi	
Arabic	
Tagalog	
Declined to answer	
Unknown	
Another language not listed	
TOTAL	**250**
If another language is counted, please specify:	

SEX ASSIGNED AT BIRTH	
Male	173
Female	90
Declined to answer	
Unknown	
TOTAL	**263**

DISABILITY*** STATUS	
Communication Domain	
Vision	
Hearing/Speech	
Another type not listed	
Communication Domain Subtotal	**0**
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	
Physical/mobility	5
Chronic health condition	12
Disability Subtotal	**17**
None	
Declined to answer	
Unknown	
Another disability not listed	
TOTAL	**17**

RACE	
American Indian or Alaska Native	
Asian	
Black or African American	268
Native Hawaiian or other Pacific Islander	
White	3
Other Race	
Declined to answer	5
Unknown	
TOTAL	276
If another race is counted, please specify:	

Ethnicity/Cultural Heritage (Please choose only one per individual)	
If Hispanic or Latino, please specify:	
Caribbean	5
Central American	
Mexican/Mexican American/Chicano	3
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	
Total Hispanic or Latino	**8**
If Non-Hispanic or Non-Latino, please specify:	
African	15
African American	230
Asian Indian/South Asian	
Cambodian	
Chinese	
Eastern European	
European	
Filipino	
Japanese	
Korean	
Middle Eastern	
Vietnamese	
Other Non-Hispanic or Non-Latino ethnicity not listed	
Total Non-Hispanic or Non-Latino	**245**
More than one ethnicity	
Unknown Ethnicity	
Declined to answer	
EHTNICITY TOTAL	**253**
If another ethnicity is counted, please specify:	

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of. Note: 1,000-character limit.
One success story involved In His Hands Ministries of Fremont's Mental Wellness Seminar "Mind Management" in May. Women of all ages received specialized Mental Wellness training that focused on personal, relational, and spiritual tools to access and maintain/manage and develop mental wellness.

Box E: Program challenges of the past year and how did the agency mitigate challenges? Note: The box has a 1,000-character limit.
The primary challenge we experienced during the year involved adapting working with our mini-grant recipients to modify their original project plans to develop a hybrid virtual platform and process for accomplishing initial goals to impact their targeted community. Working with our grantees we developed a parallel in-person platform that will launch per county guidelines. We also experienced some challenges balancing the congregational trainings and community responses to the COVID-19 vaccine hesitancy within the African American community.

Box F: Program lessons learned of the past year? Note: 1,000-character limit.
Flexibility is essential to respond to the very fluid landscape caused by COVID-19 restrictions and guidelines. We have and are working very closely with each MHFC to implement strategies that are unique to their faith community and accessible to the larger MHFC. Each faith community's capacity to implement virtual platforms for their congregants and community varies. The smaller congregations are more limited than the larger congregations. We are working with each faith center to assure that each is able to maximize resources and access information to bridge the challenges of social distancing and shelter in place guidelines. Additionally, there was a growing need to address the mental health implications raised by social justice issues, policing in the Black community amidst the political landscape of a post-Trump America. Mental health ministries within our congregations are carrying a heavy load.

Box G: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
G.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e. mental health treatment services):	n/a
G.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e. mental health treatment services):	n/a

G.3: Types of treatment individuals were referred to (list types) (500-character limit):	n/a
G.4: Unduplicated number of individuals who participated in referred program at least one time:	n/a
G.5: Average duration of untreated mental illness in weeks:	n/a
G.6: Average number of days between referral and first participation in referred treatment program:	n/a

Box H: **For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:**	
H.1: Who is/are the underserved target population(s) your program is serving (e.g. TAY, Southeast Asian) (500 Characters):	n/a
H.2: Number of paper referrals to an ACBH PEI-funded program:	n/a
H.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	n/a
H.4: Average number of days between referral and first participation in referred PEI program:	n/a
H.5: Describe how your program encouraged access to services and follow through on above referrals (500 Characters):	n/a

Box I: For <u>Outreach, Suicide Prevention, and Stigma Reduction</u> programs, please provide information for unduplicated potential responders (i.e., those who are in a position to identify early signs of potentially severe mental illness provide support, and or refer individuals who need treatment) reached. ***(Note: For Prevention, Early Intervention, Access & Linkage programs, this section is optional.)***	
Number of Responders:	**130**
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):
Churches/faith communities	*23 pastors, 32 deacons, 30 ministers, 25 teachers and children, youth, TAY, and adult ministry leaders*
Congregational mental wellness teams	*20 mental health professionals who are members of each MHFC Congregations Mental Wellness Ministry*

MHSA Program #: PEI 20E

PROVIDER NAME: Peers Envisioning and Engaging in Recovery Services (PEERS)

PROGRAM NAME: Culturally Responsive Programs for African Americans – Hope & Faith

Program Outcomes & Impact: PEI Data Report FY 20/21

Program Name:	Hope & Faith (African American Mental Wellness and Spirituality Campaign)	
Organization:	Peers Envisioning and Engaging in Recovery Services (PEERS)	
PEI Program # and Name:	PEI 20E- Culturally Responsive PEI Programs for African American Comm - Faith Based - Peers Envisioning and Engaging in Recovery Services	
Type of Report (Choose one):	Annual	
PEI Category (choose one):	Stigma and Discrimination Reduction	
Priority Area (place and X next to all that apply):		Childhood Trauma
		Early Psychosis
	X	Youth/TAY Outreach and Engagement
	X	Cultural and Linguistic
	X	Older Adults
	X	Early Identification of Mental Health Illness

Box A: Please provide a brief program description (character limit 1,000).

The African American Mental Wellness and Spirituality Campaign, Hope & Faith, comprises three unique mini-campaigns hosted by three faith and spiritual/healing-based communities, each of which includes an educational presentation or orientation and a ten-week stigma reduction support group hosted by the faith community. The Campaign is informed by an advisory board that includes representatives from the three faith and spiritual/healing-based communities.

Box B: Number of individuals served this fiscal year through MHSA funding.

Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	825

Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	NA
Number of unduplicated individual family members served indirectly by your program:	NA
Grand total of unduplicated individuals served:	**825**

Box C: Demographics of individuals served this fiscal year through MHSA funding.

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	
Transition Age Youth (16-25 yrs.)	20
Adult (26-59 yrs.)	10
Older Adult (60+ yrs.)	11
Declined to answer	34
Unknown	750
TOTAL	**825**

SEXUAL ORIENTATION	
Gay/Lesbian	
Heterosexual/Straight	11
Bisexual	
Questioning/Unsure	1
Queer	
Declined to answer	42
Unknown	770
Another group not listed	1
TOTAL	**825**
If another group is counted, please specify: Black female	

VETERAN STATUS	
Yes	1
No	14
Declined to answer	40
Unknown	770
TOTAL	**825**

CURRENT GENDER IDENTITY	
Female	21
Male	2
Transgender	
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	32
Unknown	770
Another identity not listed	
TOTAL	**825**
If another identity is counted, please specify:	

PRIMARY LANGUAGE	
English	17
Spanish	
Cantonese	
Chinese	
Vietnamese	
Farsi	
Arabic	
Tagalog	
Declined to answer	38
TOTAL	**825**
If another language is counted, please specify: unknown 770	

SEX ASSIGNED AT BIRTH	
Male	
Female	
Declined to answer	
Unknown	825
TOTAL	**825**

DISABILITY*** STATUS	
Communication Domain	
Vision	
Hearing/Speech	
Another type not listed	
Communication Domain Subtotal	**0**
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	
Physical/mobility	
Chronic health condition	
Disability Subtotal	**0**
None	10
Declined to answer	41
Unknown	770
Another disability not listed	
TOTAL	**825**
If another disability is counted, please specify:	

RACE	
American Indian or Alaska Native	
Asian	
Black or African American	19
Native Hawaiian or other Pacific Islander	
White	1
Other Race	1
Declined to answer	34
Unknown	770
TOTAL	**825**
If another race is counted, please specify:	

Ethnicity/Cultural Heritage (Please choose only one per individual)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	
Mexican/Mexican American/Chicano	
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	
Total Hispanic or Latino	**0**
If Non-Hispanic or Non-Latino, please specify:	
African	1
African American	4
Asian Indian/South Asian	
Cambodian	
Chinese	
Eastern European	
European	
Filipino	
Japanese	
Korean	
Middle Eastern	
Vietnamese	
Other Non-Hispanic or Non-Latino ethnicity not listed	1
Total Non-Hispanic or Non-Latino	**6**
More than one ethnicity	1
Unknown Ethnicity	770
Declined to answer	48
EHTNICITY TOTAL	**825**
If another ethnicity is counted, please specify: Black/St. Thomas	

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of. Note: 1,000-character limit.
We are particularly proud of the extent to which each church has embraced offering peer-based mental health support to their faith community, making the mini-campaign their own. One example is that a faith leader at one church wove together her experience as a nurse with stories of people in the Bible with mental health challenges. Additionally, every church representative said they initially joined the Hope & Faith Campaign to support others in their community, but unexpectedly reaped deep benefits from the program themselves.

Box E: Program challenges of the past year and how did the agency mitigate challenges? Note: 1,000- character limit.
The biggest challenge during this time of operating remotely due to COVID-19 has been that participants are less likely to fill out our demographic and evaluation questionnaires online than they typically do when we meet in person. Some of this is due to technical challenges facing the church-based facilitators and participants. Nevertheless, through persistent outreach and technical assistance, we collected all of the data we needed.

Box F: Program lessons learned of the past year. Note: 1,000- character limit.
The clearest lesson that has emerged from the Hope & Faith Campaign is that African American faith communities – both clergy and members – are hungry for tools, language, and opportunities to address the links between mental health and spirituality. The process of reflecting on and adapting the anti-stigma support group curriculum to the needs of their church community deepened the sense of ownership over the Hope & Faith mini-campaign by each church. The most common comment on evaluation questionnaires was a version of "more" -- with participants asking for more information and peer support around mental health. This is a sharp contrast to the often-repeated stereotype that Black faith communities are not open to grappling with mental health.

Box G: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
G.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e. mental health treatment services):	n/a
G.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e. mental health treatment services):	n/a

G.3: Types of treatment individuals were referred to (list types) (500-character limit):	n/a
G.4: Unduplicated number of individuals who participated in referred program at least one time:	n/a
G.5: Average duration of untreated mental illness in weeks:	n/a
G.6: Average number of days between referral and first participation in referred treatment program:	n/a

Box H: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
H.1: Who is/are the underserved target population(s) your program is serving (e.g. TAY, Southeast Asian) (500 Characters):	African American members of faith and spiritual/healing communities.
H.2: Number of paper referrals to an ACBH PEI-funded program:	2
H.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	n/a
H.4: Average number of days between referral and first participation in referred PEI program:	n/a
H.5: Describe how your program encouraged access to services and follow through on above referrals (500 Characters):	We invest heavily in creating warm, open, supportive relationships with participants and our partners at each church, and use those relationships to facilitate referrals. Equipping the leaders at each church with access to local mental health resources is a key part of our strategy.

Box I: For <u>Outreach, Suicide Prevention, and Stigma Reduction</u> programs, please provide information for unduplicated potential responders (i.e., those who are in a position to identify early signs of potentially severe mental illness provide support, and or refer individuals who need treatment) reached. ***(Note: For Prevention, Early Intervention, Access & Linkage programs, this section is optional.)***	
Number of Responders:	**210**
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):
Churches	*210 members of African American faith communities*

MHSA Program #: PEI 22

PROVIDER NAME: Pacific Center for Human Growth

PROGRAM NAME: Older and Out

Program Outcomes & Impact: PEI Data Report FY 20/21

Program Name:	Older and Out	
Organization:	Pacific Center for Human Growth	
PEI Program # and Name:	PEI 22, Older and Out	
Type of Report (Choose one):	Annual	
PEI Category (choose one):		
Priority Area (place and X next to all that apply):		Childhood Trauma
		Early Psychosis
		Youth/TAY Outreach and Engagement
		Cultural and Linguistic
	X	Older Adults
		Early Identification of Mental Health Illness

Box A: Please provide a brief program description (character limit 1,000).

The Older & Out program offers free, drop-in therapy groups for LGBTQI2-S adults over the age of 60. Pacific Center partners with two senior centers in Alameda County, as well as the Oakland LGBTQ Center, to provide three Older & Out service locations when in-person. Groups are facilitated by 1-2 Pacific Center clinicians and trained peer specialists. Topics may include: loss of friends, aging, invisibility in the LGBTQIA+ community, loneliness, and resilience.

Box B: Number of individuals served this fiscal year through MHSA funding.

Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	22
Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	18

Number of unduplicated individual family members served indirectly by your program:	NA
Grand total of unduplicated individuals served:	**40**

Box C: Demographics of individuals served this fiscal year through MHSA funding.

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	
Transition Age Youth (16-25 yrs.)	
Adult (26-59 yrs.)	5
Older Adult (60+ yrs.)	35
Declined to answer	
Unknown	
TOTAL	**40**

VETERAN STATUS	
Yes	3
No	36
Declined to answer	1
Unknown	
TOTAL	**40**

SEXUAL ORIENTATION	
Gay/Lesbian	32
Heterosexual/Straight	
Bisexual	2
Questioning/Unsure	
Queer	2
Declined to answer	2
Unknown	
Another group not listed	2
TOTAL	**40**
If another group is counted, please specify: Fluid, Pansexual	

CURRENT GENDER IDENTITY	
Female	12
Male	19
Transgender	2
Genderqueer	4
Questioning/unsure of gender identity	
Declined to answer	2
Unknown	
Another identity not listed	1
TOTAL	**40**
If another identity is counted, please specify: Non-binary	

PRIMARY LANGUAGE	
English	37
Spanish	2
Cantonese	
Chinese	
Vietnamese	
Farsi	
Arabic	
Tagalog	
Declined to answer	1
Unknown	
Another language not listed	
TOTAL	**40**
If another language is counted, please specify:	

SEX ASSIGNED AT BIRTH	
Male	13
Female	27
Declined to answer	
Unknown	
TOTAL	**40**

DISABILITY*** STATUS	
Communication Domain	
Vision	1
Hearing/Speech	
Another type not listed	
Communication Domain Subtotal	**1**
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	1
Physical/mobility	4
Chronic health condition	3
Disability Subtotal	**8**
None	26
Declined to answer	5
Unknown	
Another disability not listed	
TOTAL	**40**
If another disability is counted, please specify:	

RACE	
American Indian or Alaska Native	1
Asian	1
Black or African American	6
Native Hawaiian or other Pacific Islander	
White	22
Other Race	5
Declined to answer	5
Unknown	
TOTAL	**40**
If another race is counted, please specify: More than one race	

Box C Continued: Please provide the numbers in the blue boxes for the demographic categories as listed below for individuals served to date July 1, 2019 through June 30, 2020 through MHSA funding.

Ethnicity/Cultural Heritage (Please choose only one per individual)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	
Mexican/Mexican American/Chicano	2
Puerto Rican	1
South American	
Another Hispanic/Latino ethnicity not listed	1
Total Hispanic or Latino	**4**
If Non-Hispanic or Non-Latino, please specify:	
African	
African American	11
Asian Indian/South Asian	
Cambodian	
Chinese	
Eastern European	1
European	1
Filipino	
Japanese	1
Korean	
Middle Eastern	
Vietnamese	
Other Non-Hispanic or Non-Latino ethnicity not listed	3
Total Non-Hispanic or Non-Latino	**17**
More than one ethnicity	4
Unknown Ethnicity	2
Declined to answer	48
EHTNICITY TOTAL	75
If another ethnicity is counted, please specify: 1st Nation: 1; 1st Nation/Chicano: 1; Jewish: 2	

Box D: In the boxes below please provide a brief response to the following question. 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. Note: The box has a 1,000-character limit.

After shelter-in-place (SIP), all 3 of the Older & Out groups moved online with fairly consistent attendance.

We are receiving reports that the virtual space has eased access for some group members, as one member had shared:

"[We need] easier access to support groups. The online group availability is helpful because due to health challenges I have been unable to regularly attend group [in-person]."

We have clear plans in development to reach more older adults through implementing virtual screenings to bring in more group members. Moreover, we are especially proud of the above: how we responded to shelter-in-place (SIP); how we shifted from in-person services to offering services in virtual spaces.

Box E: In the boxes below please provide a brief response to the following question. What were the challenges of the past year and how did your agency mitigate challenges? Note: The box has a 1,000- character limit.

Early on in SIP, we received feedback that the virtual space would be challenging to older adults. To mitigate this, we set up a system with our social work students, making weekly check-in calls and setting up 1:1 contacts to problem-solve.

After SIP, we became concerned about food insecurity so we reached out and, using our food budget, sent out 53 cards (to 35 unduplicated community members). A note we received: "Thank you for the card. There is no way that I can properly thank you enough. I want to volunteer to help you as a gift for all that you have done for LGBT senior citizens like me."

We've received complaints from BIPOC group members, that they've found it difficult to bring their full services to the group space, citing microaggressions. To mitigate this lack of safety, we held listening meetings and have plans for structural changes and training improvements.

Box F: In the boxes below please provide a brief response to the following question. What were the lessons learned of the past year? Note: The box has a 1,000-character limit.

The first lesson is how important it is to be ready to adapt to change in order to meet the needs of our clients. The second lesson is how vital it is to be ready to listen and respond to community members in order to better serve our BIPOC members. A third lesson is the necessity for us to have all the service providers steeped in Pacific Center culture, our mission and our vision, especially as we weave in our Diversity, Equity & Inclusion initiatives into all of our programming.

Box G: For programs that refer individuals with severe mental illness, please provide information for the categories below:

G.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e. mental health treatment services):	NA

Ethnicity/Cultural Heritage (Please choose only one per individual)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	
Mexican/Mexican American/Chicano	3
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	
Total Hispanic or Latino	**3**
If Non-Hispanic or Non-Latino, please specify:	
African	
African American	5
Asian Indian/South Asian	
Cambodian	
Chinese	1
Eastern European	1
European	4
Filipino	
Japanese	
Korean	
Middle Eastern	1
Vietnamese	
Other Non-Hispanic or Non-Latino ethnicity not listed	
Total Non-Hispanic or Non-Latino	**12**
More than one ethnicity	2
Unknown Ethnicity	
Declined to answer	23
EHTNICITY TOTAL	**40**
If another ethnicity is counted, please specify:	

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of. Note: 1,000-character limit.

All 3 of the Older & Out groups moved online with fairly consistent attendance for the majority of the year. The implementation of virtual screenings began in October 2020, and we have successfully completed 7. While the COVIC-19 pandemic has brought forth unprecedented, yet necessary social distancing practices, it has simultaneously increased loneliness and social isolation for many. We are delighted that Older and Out is a place for our older adults to remain connected, supported, and heard.

Box E: Program challenges of the past year and how did the agency mitigate challenges? Note: 1,000-character limit.
Throughout FY 20/21, food insecurity has been an ongoing concern for several of our older adult group and community members. To assist our group members, we used our food budget (split from two programs: Peer Groups and Older & Out) to provide 30 $100 Safeway gift cards (to 13 unduplicated people), a total of $2,000 in December 2020 and in May 2021. Despite our success in our O & O groups transitioning to Zoom, and the majority of our members continuing to connect through those spaces, some group members opted out, and/or became frustrated with the virtual platform. To mitigate this, we offered wellness check-in calls and emails, in which our BASW social worker intern provided to group members, dually serving as a "break" from Zoom, yet still providing connection, support, and linkages/referrals.

Box F: Program lessons learned of the past year? Note: 1,000-character limit.
We've learned that the LGBTQIA+ older adults are resilient, reaching out and seeking connection, even through the virtual platforms. Consequently, having grown closer through O & O, some members started their own peer support group. We are learning how to reach out to better serve BIPOC older adults. Additionally, we also learned that group members want more ways to connect and learn, thus we are planning diversity, equity, inclusion workshops in FY 21/22.

Box G: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
G.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e. mental health treatment services):	n/a
G.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e. mental health treatment services):	n/a
G.3: Types of treatment individuals were referred to (list types) (500-character limit):	n/a
G.4: Unduplicated number of individuals who participated in referred program at least one time:	n/a

G.5: Average duration of untreated mental illness in weeks:	n/a
G.6: Average number of days between referral and first participation in referred treatment program:	n/a

Box H: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
H.1: Who is/are the underserved target population(s) your program is serving (e.g. TAY, Southeast Asian) (500 Characters):	The underserved target population our program serves are LGBTQAI2-S Older Adults.
H.2: Number of paper referrals to an ACBH PEI-funded program:	n/a
H.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	n/a
H.4: Average number of days between referral and first participation in referred PEI program:	n/a
H.5: Describe how your program encouraged access to services and follow through on above referrals (500 Characters):	n/a

Number of Responders:	**6**
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):
Community mental health agency	Direct service staff, clinicians, administrators, program managers, volunteers, board members
Community senior centers	District service staff, administrators, volunteers, clinicians
Community family and youth services	Direct service staff, clinicians, administrators, program managers

MHSA Program #: PEI 22

PROVIDER NAME: Pacific Center for Human Growth

PROGRAM NAME: Peer Mentorship Project

Program Outcomes & Impact: PEI Data Report FY 20/21

Program Name:	Peer Mentorship Project	
Organization:	Pacific Center for Human Growth	
PEI Program # and Name:	PEI 22 LGBT Support Services	
Type of Report (Choose one):	Annual	
PEI Category (choose one):	Outreach	
Priority Area (place and X next to all that apply):		Childhood Trauma
		Early Psychosis
		Youth/TAY Outreach and Engagement
		Cultural and Linguistic
		Older Adults
	X	Early Identification of Mental Health Illness

Box A: Please provide a brief program description (character limit 1,000).

The Peer Mentorship Project is a program that offers ongoing, drop-in, peer-facilitated groups covering a range of topics and issues important to LGBTQIA+ communities. The topics for discussion derive from the group members at each session, which may include sharing of lived experiences, stigma, and isolation. These groups provide connection, emotional support, information, resource sharing and enjoyment. Peer groups meet weekly, bi-weekly, or monthly for up to two hours.

Box B: Number of individuals served this fiscal year through MHSA funding.

Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	34
Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	338

Number of unduplicated individual family members served indirectly by your program:	NA
Grand total of unduplicated individuals served:	**372**

Box C: Demographics of individuals served this fiscal year through MHSA funding.

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	
Transition Age Youth (16-25 yrs.)	62
Adult (26-59 yrs.)	239
Older Adult (60+ yrs.)	44
Declined to answer	27
Unknown	
TOTAL	**372**

VETERAN STATUS	
Yes	10
No	358
Declined to answer	4
Unknown	
TOTAL	**372**

SEXUAL ORIENTATION	
Gay/Lesbian	82
Heterosexual/Straight	22
Bisexual	74
Questioning/Unsure	26
Queer	89
Declined to answer	19
Unknown	
Another group not listed	60
TOTAL	**372**

If another group is counted, please specify: Asexual, Demisexual, Fluid, Pansexual

CURRENT GENDER IDENTITY	
Female	84
Male	35
Transgender	131
Genderqueer	48
Questioning/unsure of gender identity	15
Declined to answer	5
Unknown	
Another identity not listed	54
TOTAL	**372**

If another identity is counted, please specify: Agender, Non-binary, Genderfluid

PRIMARY LANGUAGE	
English	365
Spanish	
Cantonese	
Chinese	
Vietnamese	
Farsi	
Arabic	
Tagalog	
Declined to answer	
Unknown	
Another language not listed	
TOTAL	**372**

If another language is counted, please specify:

SEX ASSIGNED AT BIRTH	
Male	178
Female	103
Declined to answer	75
Unknown	16
TOTAL	**372**

Box C Continued: Demographics of individuals served this fiscal year through MHSA funding.

DISABILITY*** STATUS	
Communication Domain	
Vision	6
Hearing/Speech	8
Another type not listed	
Communication Domain Subtotal	**14**
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	31
Physical/mobility	17
Chronic health condition	13
Disability Subtotal	**61**
None	281
Declined to answer	7
Unknown	
Another disability not listed	9
TOTAL	**372**
If another disability is counted, please specify: Spinal stenosis, Complex PTSD, PTSD	

RACE	
American Indian or Alaska Native	10
Asian	40
Black or African American	29
Native Hawaiian or other Pacific Islander	4
White	236
Other Race	23
Declined to answer	28
Unknown	
TOTAL	**372**
If another race is counted, please specify: More than one race	

Ethnicity/Cultural Heritage (Please choose only one per individual)	
If Hispanic or Latino, please specify:	
Caribbean	7
Central American	6
Mexican/Mexican American/Chicano	16
Puerto Rican	5
South American	9
Another Hispanic/Latino ethnicity not listed	
Total Hispanic or Latino	**43**

If Non-Hispanic or Non-Latino, please specify:	
African	5
African American	13
Asian Indian/South Asian	10
Cambodian	
Chinese	16
Eastern European	33
European	109
Filipino	6
Japanese	4
Korean	3
Middle Eastern	6
Vietnamese	6
Other Non-Hispanic or Non-Latino ethnicity not listed	
Total Non-Hispanic or Non-Latino	211
More than one ethnicity	20
Unknown Ethnicity	
Declined to answer	98
EHTNICITY TOTAL	**372**
If another ethnicity is counted, please specify:	

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of. Note: 1,000-character limit.

FY 20/21 has further highlighted the deep commitment and passion for our facilitators as some groups have increased their meeting frequency from 1x/month to 2x, and from 2x/month to weekly gatherings. We are proud that the group MAPS (Metoidioplasty & Phalloplasty Support) started online. Their first meeting garnered 12 attendees, and since then have averaged 11! Additionally, four new groups are in development, showcasing the need and desire for support groups. They will begin in FY 21/22.

From July 2020 to December 2021, we increased the frequency of consultation meetings from 1x/month to 2x. We offered quarterly DEI trainings on the topics of micro-aggressions, disability, justice and accessibility, and intersectionality, in which facilitators provided positive feedback on what they learned.

Box E: Program challenges of the past year and how did the agency mitigate challenges? Note: 1,000-character limit.

We've received concerns over group members not following group guidelines causing feelings of lack of safety. To mitigate these challenges, our directors of community programs and diversity, equity and inclusion held listening sessions and had 1:1 meetings with involved parties. A complaint and feedback process with a restorative justice framework has been in development, and will be implemented in FY 21/22. Since we adopted our forms to be received digitally, individuals have had challenges completing and submitting our demographic forms. We are examining how we can ensure that our data is received in the upcoming FY.

Throughout this pandemic, food insecurity has been an ongoing concern for some of our facilitators and group members. To assist our community members, we applied our food budget (Peer Groups and Older & Out) to provide 20 $100 Safeway gift cards (to 13 unduplicated people), worth $2,000.

Box F: Program lessons learned of the past year? Note: 1,000-character limit.

How do we continue to serve our community and the most marginalized? This is the question we consistently asked ourselves this past year. The COVID-19 pandemic brought a myriad of change and challenges, and our agency, including our dedicated facilitators, responded with fervor and steadfast commitment to ensure that the needs of the community were met. We learned: 1) Flexibility and creativity is crucial to approaching and meeting community needs; 2) The resilience, devotion, and compassion of our facilitators allowed the program to flourish; and 3) That we may not reach some of our most vulnerable community members on virtual platforms, and for some group members there is no substitution for in-person services.

Box G: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
G.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e. mental health treatment services):	n/a
G.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e. mental health treatment services):	n/a
G.3: Types of treatment individuals were referred to (list types) (500-character limit):	n/a
G.4: Unduplicated number of individuals who participated in referred program at least one time:	n/a
G.5: Average duration of untreated mental illness in weeks:	n/a
G.6: Average number of days between referral and first participation in referred treatment program:	n/a

Box H: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
H.1: Who is/are the underserved target population(s) your program is serving (e.g. TAY, Southeast Asian) (500 Characters):	The underserved target population that our program serves are LGBTQI2-S identified people, transitional age youth, older adults, people of color, and people with disabilities.
H.2: Number of paper referrals to an ACBH PEI-funded program:	n/a
H.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	n/a
H.4: Average number of days between referral and first participation in referred PEI program:	n/a
H.5: Describe how your program encouraged access to services and follow through on above referrals (500 Characters):	n/a

Box I: For <u>Outreach, Suicide Prevention, and Stigma Reduction</u> programs, please provide information for unduplicated potential responders (i.e., those who are in a position to identify early signs of potentially severe mental illness provide support, and or refer individuals who need treatment) reached. ***(Note: For Prevention, Early Intervention, Access & Linkage programs, this section is optional.)***

Number of Responders:	**6**
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):
Community mental health agency	Direct service staff, clinicians, administrators, program managers, volunteers, board members
Community senior centers	Direct service staff, administrators, volunteers, clinicians
Community family and youth services	Direct service staff, clinicians, administrators, program managers

MHSA Program #: PEI 22

PROVIDER NAME: Pacific Center for Human Growth

PROGRAM NAME: Technical Assistance Program

Program Outcomes & Impact: PEI Data Report FY 20/21

Program Name:	Technical Assistance Program	
Organization:	Pacific Center for Human Growth	
PEI Program # and Name	PEI 22 Technical Assistance Program	
Type of Report (choose one)	Annual	
PEI Category (choose one)	Outreach	
Priority Area (place and X next to all that apply):		Childhood Trauma
		Early Psychosis
		Youth/TAY Outreach and Engagement
	X	Cultural and Linguistic
		Older Adults
		Early Identification of Mental Health Illness

Box A: Please provide a brief program description (character limit 1,000).

Technical Assistance Program at the Pacific Center for Human Growth provides cultural humility trainings to service providers in Alameda County. We provide both clinical and non-clinical trainings. Our trainings focus on how organizations can be more culturally responsive the LGBTQ+ community, both internally and externally.

Box B: Number of individuals served this fiscal year through MHSA funding.

Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	NA
Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	NA
Number of unduplicated individual family members served indirectly by your program:	NA

Grand total of unduplicated individuals served:	**0**

Box C: Demographics of individuals served this fiscal year through MHSA funding.

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	4
Transition Age Youth (16-25 yrs.)	20
Adult (26-59 yrs.)	96
Older Adult (60+ yrs.)	
Declined to answer	2
Unknown	10
TOTAL	**132**

VETERAN STATUS	
Yes	16
No	112
Declined to answer	
Unknown	4
TOTAL	**132**

CURRENT GENDER IDENTITY	
Female (Cis-Woman)	39
Male (Cis-Man)	28
Transgender ((Women & Men)	17
Genderqueer	11
Questioning/unsure of gender identity	
Declined to answer	
Unknown	17
Another identity not listed	20
TOTAL	**132**
If another identity is counted, please specify: ENBY and GNC	

SEXUAL ORIENTATION	
Gay/Lesbian	24
Heterosexual/Straight	23
Bisexual	3
Questioning/Unsure	
Queer	51
Declined to answer	2
Unknown	29
Another group not listed	
TOTAL	**132**
If another group is counted, please specify:	

PRIMARY LANGUAGE	
English	127
Spanish	
Cantonese	
Chinese	
Vietnamese	
Farsi	
Arabic	
Tagalog	
Declined to answer	3
Unknown	1
Another language not listed	1
TOTAL	**132**
If another language is counted, please specify:	

SEX ASSIGNED AT BIRTH	
Male (Cis-Woman)	34
Female (Cis-Man)	60
Declined to answer	31
Unknown	7
TOTAL	**132**

DISABILITY*** STATUS	
Communication Domain	
Vision	
Hearing/Speech	
Another type not listed	
Communication Domain Subtotal	**0**
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.) Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	19
Physical/mobility	2
Chronic health condition	13
Disability Subtotal	**34**
None	38
Declined to answer	23
Unknown	37
Another disability not listed	
TOTAL	**132**
If another disability is counted, please specify:	

RACE	
American Indian or Alaska Native	
Asian	9
Black or African American	7
Native Hawaiian or other Pacific Islander	2
White	71
Other Race	1
Declined to answer	14
Unknown	19
TOTAL	**132**
If another race is counted, please specify:	

Ethnicity/Cultural Heritage (Please choose only one per individual)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	
Mexican/Mexican American/Chicano	
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	24
Total Hispanic or Latino	**24**

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	
Total Non-Hispanic or Non-Latino	**0**
More than one ethnicity	
Unknown Ethnicity	106
Declined to answer	
EHTNICITY TOTAL	**132**
If another ethnicity is counted, please specify:	

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of. Note: 1,000-character limit.

There are training opportunities pending with multiple CBOs for FY 21/22. Qualitative feedback indicates that participants found the trainings and information shared to be relevant and helpful to their work during this unprecedented time. In FY 19/20, we were challenged by COVID-19/SIP to think of more creative ways to engage the wider community in culturally responsive trainings, so we invited community partners into internal clinical didactic trainings, broadening the scope of those trainings, drawing participants from other local academic institutions and clinical training programs.

Box E: Program challenges of the past year and how did the agency mitigate challenges? Note: 1,000-character limit.
Evaluations: In Q1 and Q2, we noted a significant lack of participation in course evaluations. In Q3 and Q4, PC explored more creative strategies for increased participation in evaluations, including presenting evaluations at the end of training modules, instead of as a follow up to training. PC delivered 17 unique and individual trainings – CBOs = 6 and didactics = 11, with a total of approximately 275-425 attendees (participants duplicated over multiple trainings, specifically didactics). At the end of each training, participants were asked to complete a course evaluation containing questions designed for content and structural feedback along with questions designed to collect demographic information. Of the 275-425 evaluations distributed, 132 of them received engagement. We noted that there were less attendees than in Q1 and Q2, but more responses to evaluations.

Box F: In the boxes below please provide a brief response to the following question. What were the lessons learned of the past year? Note: The box has a 1,000-character limit.
In FY 19/20, we began to recognize that 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. We have begun to develop more tiered and scaffolded training modules, and have taken a more active role in training our trainers to deliver the designated content. This model has received positive feedback.

Box G: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
G.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e. mental health treatment services):	n/a
G.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e. mental health treatment services):	n/a
G.3: Types of treatment individuals were referred to (list types) (500-character limit):	n/a
G.4: Unduplicated number of individuals who participated in referred program at least one time:	n/a
G.5: Average duration of untreated mental illness in weeks:	n/a
G.6: Average number of days between referral and first participation in referred treatment program:	n/a

Box H: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
H.1: Who is/are the underserved target population(s) your program is serving (e.g. TAY, Southeast Asian) (500 Characters):	The TA Program is designed to uplift and to support LGBTQIA+ populations via conducting culturally humility and cultural competency trainings for CBO's that operate in service to LGBTQIA+ populations.
H.2: Number of paper referrals to an ACBH PEI-funded program:	n/a
H.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	n/a
H.4: Average number of days between referral and first participation in referred PEI program:	n/a
H.5: Describe how your program encouraged access to services and follow through on above referrals (500 Characters):	n/a

Box I: For Outreach, Suicide Prevention, and Stigma Reduction programs, please provide information for unduplicated potential responders (i.e., those who are in a position to identify early signs of potentially severe mental illness provide support, and or refer individuals who need treatment) reached. ***(Note: For Prevention, Early Intervention, Access & Linkage programs, this section is optional.)***	
Number of Responders:	**6**
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):
Community Mental Health Agency	*Clinicians, direct staff, community members*
Community Mental Health Agency	*Clinicians, direct staff, community members*
Community Mental Health Agency	*Clinicians, direct staff, community members*
Volunteer Organization	*Program managers, staff, volunteers, board members, executives*

MHSA Program #: PEI 24

PROVIDER NAME: Roots Community Health Center

PROGRAM NAME: Sobrante Park

Program Outcomes & Impact: PEI Data Report FY 20/21

Program Name:	PEI 24 Sobrante Park Community Project-Roots Community Health Center	
Organization:	Roots Community Health Center	
PEI Program # and Name:	PEI 24 Sobrante Park Community Project-Roots Community Health Center	
Type of Report (Choose one):	Annual	
PEI Category (choose one):	Early Intervention	
Priority Area (place and X next to all that apply):		Childhood Trauma
		Early Psychosis
	X	Youth/TAY Outreach and Engagement
		Cultural and Linguistic
		Older Adults
	X	Early Identification of Mental Health Illness

Box A: Program description (character limit 500).

Roots Community Health Center seeks to address long-standing health inequities in the Sobrante Park community by partnering with the Sobrante Park Resident's Action Committee and Higher Ground to provide culturally responsive, comprehensive physical and mental health services, education, employment and training, and wraparound services that build self-sufficiency and promote community empowerment.

Box B: Number of individuals served this fiscal year through MHSA funding.

Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	10
Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	NA

Number of unduplicated individual family members served indirectly by your program:	36
Grand total of unduplicated individuals served:	46

Box C: Demographics of individuals served during this fiscal year through MHSA funding.

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	
Transition Age Youth (16-25 yrs.)	16
Adult (26-59 yrs.)	21
Older Adult (60+ yrs.)	9
Declined to answer	
Unknown	
TOTAL	**46**

SEXUAL ORIENTATION	
Gay/Lesbian	
Heterosexual/Straight	46
Bisexual	
Questioning/Unsure	
Queer	
Declined to answer	
Unknown	
Another group not listed	
TOTAL	**46**
If another group is counted, please specify:	

VETERAN STATUS	
Yes	
No	
Declined to answer	
Unknown	
TOTAL	

CURRENT GENDER IDENTITY	
Female	24
Male	22
Transgender	
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	
Another identity not listed	
TOTAL	**46**
If another identity is counted, please specify:	

PRIMARY LANGUAGE	
English	28
Spanish	18
Cantonese	
Chinese	
Vietnamese	
Farsi	
Arabic	
Tagalog	
Declined to answer	
TOTAL	**46**
If another language is counted, please specify:	

SEX ASSIGNED AT BIRTH	
Male	22
Female	24
Declined to answer	
Unknown	
TOTAL	**46**

DISABILITY*** STATUS	
Communication Domain	
Vision	3
Hearing/Speech	
Another type not listed	
Communication Domain Subtotal	**0**
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	
Physical/mobility	
Chronic health condition	
Disability Subtotal	
None	
Declined to answer	
Unknown	
Another disability not listed	
TOTAL	**0**

RACE	
American Indian or Alaska Native	
Asian	
Black or African American	28
Native Hawaiian or other Pacific Islander	
White	20
Other Race	2
Declined to answer	
Unknown	
TOTAL	**50**
If another race is counted, please specify:	

Ethnicity/Cultural Heritage (Please choose only one per individual)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	5
Mexican/Mexican American/Chicano	19
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	
Total Hispanic or Latino	**24**
If Non-Hispanic or Non-Latino, please specify:	
African	
African American	16
Asian Indian/South Asian	
Cambodian	
Chinese	
Eastern European	
European	
Filipino	
Japanese	
Korean	
Middle Eastern	
Vietnamese	
Other Non-Hispanic or Non-Latino ethnicity not listed	
Total Non-Hispanic or Non-Latino	**16**
More than one ethnicity	
Unknown Ethnicity	
Declined to answer	
EHTNICITY TOTAL	**40**
If another ethnicity is counted, please specify:	

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of. Note: 1,000-character limit.
Community-based gun violence and Covid-19 have been dual pandemics suffered by East Oakland residents over the past year. In addition to providing Covid testing and vaccination services, Roots has also played an active role in determining the root causes of the community-based violence in an effort to form strategies to address vicarious trauma. In June, this was personified when Madison Park Primary School staff reached out to Roots seeking counseling services for one of their Transition Kindergarten students who witnessed her father take his own life with a firearm. From the Roots Sobrante Park Coordinator to CEO/Founder Dr. Noha Aboleta, Roots responded immediately to provide a health navigator to the family to help connect the student to a pediatric mental health clinician and to help the family with any other services should they request them.

Box E: Program challenges of the past year and how did the agency mitigate challenges? Note: 1,000-character limit.
The Covid pandemic was the overarching challenge to providing services over the past year. It made it necessary to cut back on most in-person outreach efforts, which limited Root's ability to increase its visibility in the community and made consistent client engagement difficult. However, by moving community outreach and engagement efforts to virtual platforms, Roots was able to successfully remain immersed in the community, staying connected to the broader community and especially Root's clients by utilizing Zoom, Google Meets, phone calls, and texting. Roots also successfully transitioned touchless produce distributions to home delivery services for families that relied on this resource.

Box F: Program lessons learned in the past year? Note: 1,000-character limit.
Although Covid has been described as a once-in-a-lifetime pandemic, it has allowed the Roots organization the ability to create alternative methods of client and community engagement. By utilizing virtual platforms, Roots was able to stay connected to clients, community partners, and to engage in community outreach. However, recognizing that many community members lacked access to internet services and/or computers in the home, Roots developed "touchless" events that allowed for contact with small groups following CDC guidelines. The adverse challenges brought on by the pandemic made it necessary to create more frequent check-in meetings between Roots community partners as well as within the organization between departments. This ensured that the communicating of relevant information and data needed for reports, share outs, and event planning happened on a regular basis.

Box G: For programs that refer individuals with severe mental illness, information about those that referred:	
G.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e. mental health treatment services):	7
G.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e. mental health treatment services):	4

G.3: Types of treatment individuals were referred to (list types) (500-character limit):	Referred clients received weekly 1:1 sessions with a mental healthcare provider, or in some cases group therapy depending on the level and kind of treatment determined by clinician.
G.4: Unduplicated number of individuals who participated in referred program at least one time:	5
G.5: Average duration of untreated mental illness in weeks:	2 weeks – 1 month
G.6: Average number of days between referral and first participation in referred treatment program:	1 week depending on appointment availability

Box H: For programs that work to improve timely access to mental health services for underserved populations, information about those programs:	
H.1: Who is/are the underserved target population(s) your program is serving (e.g. TAY, Southeast Asian) (500 Characters):	Individuals and families of African-American and Latino/a/x descent who live, attend school, or work in Sobrante Park.
H.2: Number of paper referrals to an ACBH PEI-funded program:	7
H.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	0
H.4: Average number of days between referral and first participation in referred PEI program:	One week depending on whether the service requires an appointment.
H.5: Describe how your program encouraged access to services and follow through on above referrals (500 Characters):	Through the collaboration with our community partners, Sobrante Park Residents Action Council, Higher Ground, and Madison Park Academy Primary community members are referred to Roots for a variety of services. A Roots navigator will then work with that community member to help facilitate matching the appropriate service to meet the need of the client. The navigator also conducts regular check ins with the client to ensure the efficacy of the services.

Box I: For <u>Outreach, Suicide Prevention, and Stigma Reduction</u> programs, information for unduplicated potential responders (i.e., those who are in a position to identify early signs of potentially severe mental illness provide support, and or refer individuals who need treatment) reached. ***(Note: For Prevention, Early Intervention, Access & Linkage programs, this section is optional.)***	
Number of Responders:	
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Type of responders (e.g. 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police office at a school). (100 Characters)
Roots: 18 touchless produce distributions	*6 Roots staff*
Higher Ground: MLK Day of Service	*4 Roots staff; 4 Higher Ground staff; 18 other partner organization staff*
Higher Ground: Career Pathways and Readiness/Exploration Program	*24 Madison park Academy, Upper campus juniors and seniors*

MHSA Program #: PEI 26

PROVIDER NAME: Health and Human Resource Education Center

PROGRAM NAME: 10 X 10 Wellness Campaign

Program Outcomes & Impact: PEI Data Report FY 20/21

Program Name:	10x10 Wellness Program	
Organization:	Health and Human Resource Education Center	
PEI Program # and Name:	PEI 26 10 X 10 Wellness Center	
Type of Report (Choose one):	Annual	
PEI Category (choose one):	Prevention	
Priority Area (place and X next to all that apply):		Childhood Trauma
		Early Psychosis
		Youth/TAY Outreach and Engagement
		Cultural and Linguistic
	X	Older Adults
		Early Identification of Mental Health Illness

Box A: Please provide a brief program description (character limit 1,000).
Over the next 10 years, Alameda County's 10X10 Campaign will promote services, activities and policies, incorporating the 8 dimensions of wellness, that seek to increase the life expectancy of mental health consumers by 10 years. HHREC coordinates and implements this project for Alameda County Behavioral Health Care Services as part of their Mental Health Services Act funding.

Box B: Number of individuals served this fiscal year through MHSA funding.	
Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	8
Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	NA
Number of unduplicated individual family members served indirectly by your program:	NA

Grand total of unduplicated individuals served:	**8**

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	
Transition Age Youth (16-25 yrs.)	
Adult (26-59 yrs.)	6
Older Adult (60+ yrs.)	2
Declined to answer	
Unknown	
TOTAL	**8**

SEXUAL ORIENTATION	
Gay/Lesbian	
Heterosexual/Straight	8
Bisexual	
Questioning/Unsure	
Queer	
Declined to answer	
Unknown	
Another group not listed	
TOTAL	**8**
If another group is counted, please specify:	

VETERAN STATUS	
Yes	
No	
Declined to answer	
Unknown	8
TOTAL	**8**

CURRENT GENDER IDENTITY	
Female	8
Male	
Transgender	
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	
Another identity not listed	
TOTAL	**8**
If another identity is counted, please specify:	

PRIMARY LANGUAGE	
English	8
Spanish	
Cantonese	
Chinese	
Vietnamese	
Farsi	
Arabic	
Tagalog	
Declined to answer	
Unknown	
Another language not listed	
TOTAL	**8**
If another language is counted, please specify:	

SEX ASSIGNED AT BIRTH	
Male	
Female	8
Declined to answer	
Unknown	
TOTAL	**8**

DISABILITY*** STATUS	
Communication Domain	
Vision	
Hearing/Speech	
Another type not listed	
Communication Domain Subtotal	**0**
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	
Physical/mobility	
Chronic health condition	
Disability Subtotal	**0**
None	
Declined to answer	
Unknown	
Another disability not listed	
TOTAL	**0**
If another disability is counted, please specify:	

RACE	
American Indian or Alaska Native	
Asian	
Black or African American	6
Native Hawaiian or other Pacific Islander	
White	2
Other Race	
Declined to answer	
Unknown	
TOTAL	**8**
If another race is counted, please specify:	

Ethnicity/Cultural Heritage (Please choose only one per individual)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	
Mexican/Mexican American/Chicano	
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	
Total Hispanic or Latino	**0**

If Non-Hispanic or Non-Latino, please specify:	
African	
African American	6
Asian Indian/South Asian	
Cambodian	
Chinese	
Eastern European	
European	2
Filipino	
Japanese	
Korean	
Middle Eastern	
Vietnamese	
Other Non-Hispanic or Non-Latino ethnicity not listed	
Total Non-Hispanic or Non-Latino	**8**
More than one ethnicity	
Unknown Ethnicity	
Declined to answer	
EHTNICITY TOTAL	**8**
If another ethnicity is counted, please specify:	

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of. Note: 1,000-character limit.
The 10X10 Wellness Campaign maneuvered through personnel changes and the Covid-19 Pandemic. Program had to be altered and administered in an on-line format. However, through those changes, were able to 1. Hold one Get Fit class with a total of 11 consumers (Nov. 2 – Dec. 9); the 1st cohort received their certificates at time of graduation. 2. Work with the 10X10 CAB Committee to develop the #MentalHealthWellness365 T-shirt Campaign on Facebook and Instagram. The second cohort completed with 8 individuals obtaining certificates. Three participants continued to take the walking class well after the program ended. The Eight Dimensions of Wellness was stressed during this class and also included healthy food demonstrations and instructions. The We Move for Health event was another success for HHREC and CAB 10X10. CAB members also helped to plan the first-time virtual event with over 125 in attendance.

Box E: Program challenges the past year and how the agency mitigated the challenges? Note: 1,000-character limit.
NA

Box F: Program lessons learned of the past year? Note: 1,000-character limit.
Knowing the limitations of the new Go to Meeting platform, program managers were able to creatively take photos of the class during meetings to validate the class was given and there were participants in attendance. Each participant signed a media release granting HHREC the permission to take the photos and to store them in our confidential Google Drive for audit purposes.

Box G: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
G.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e. mental health treatment services):	n/a
G.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e. mental health treatment services):	n/a
G.3: Types of treatment individuals were referred to (list types) (500-character limit):	n/a
G.4: Unduplicated number of individuals who participated in referred program at least one time:	n/a

G.5: Average duration of untreated mental illness in weeks:	n/a
G.6: Average number of days between referral and first participation in referred treatment program:	n/a

Box H: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
H.1: Who is/are the underserved target population(s) your program is serving (e.g. TAY, Southeast Asian) (500 Characters):	n/a
H.2: Number of paper referrals to an ACBH PEI-funded program:	n/a
H.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	n/a
H.4: Average number of days between referral and first participation in referred PEI program:	n/a
H.5: Describe how your program encouraged access to services and follow through on above referrals (500 Characters):	n/a

Box I: For Outreach, Suicide Prevention, and Stigma Reduction programs, please provide information for unduplicated potential responders (i.e., those who are in a position to identify early signs of potentially severe mental illness provide support, and or refer individuals who need treatment) reached. ***(Note: For Prevention, Early Intervention, Access & Linkage programs, this section is optional.)***	
Number of Responders:	
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):
PEERS	
Telecare Corp./Villa Fairmont	
City of Berkeley Asian Health Services Specialty Mental Health	
Alameda County of Network of Mental Health Clients	
City of Berkeley Mental Health	
Downtown TAY	

NAMI Alameda County	
Bay Area Community Services (BACS)	
Pool of Consumer Champions	
Black Men Speaks	
Asian Health Services Specialty Mental Division Program (AHS SMH)	

MHSA Program #: PEI 27

PROVIDER NAME: Health and Human Resource Education Center

PROGRAM NAME: Health Through Art

Program Outcomes & Impact: PEI Data Report FY 20/21

Program Name:	Health Through Art	
Organization:	Health & Human Resource Education Center	
PEI Program # and Name:	PEI 27 Health Through Art	
Type of Report (Choose one):	Annual	
PEI Category (choose one):	Prevention	
Priority Area (place and X next to all that apply):	**X**	Childhood Trauma
	X	Early Psychosis
	X	Youth/TAY Outreach and Engagement
	X	Cultural and Linguistic
	X	Older Adults
	X	Early Identification of Mental Health Illness

Box A: Please provide a brief program description (character limit 1,000).

The Health Through Art program encourages the community to utilize art to express emotions, tell stories, and heal by hosting art workshops such as Yoga and Art Therapy. Also, HTA has hosted a biennial call for art for Alameda County residents to submit 2-D art illustrating what effects their mental health, including racism, discrimination, housing, socio-economic status, health disparities etc. 10 winning art pieces are selected for advertising campaigns displayed in Alameda County on billboards, bus shelters, and online platforms.

Box B: Number of individuals served this fiscal year through MHSA funding.

Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	234
Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	NA

Number of unduplicated individual family members served indirectly by your program:	NA
Grand total of unduplicated individuals served:	**234**

Box C: Demographics of individuals served this fiscal year through MHSA funding.

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	8
Transition Age Youth (16-25 yrs.)	212
Adult (26-59 yrs.)	4
Older Adult (60+ yrs.)	1
Declined to answer	
Unknown	9
TOTAL	**234**

SEXUAL ORIENTATION	
Gay/Lesbian	4
Heterosexual/Straight	22
Bisexual	8
Questioning/Unsure	
Queer	
Declined to answer	7
Unknown	193
Another group not listed	
TOTAL	**234**
If another group is counted, please specify:	

VETERAN STATUS	
Yes	
No	53
Declined to answer	1
Unknown	180
TOTAL	**234**

CURRENT GENDER IDENTITY	
Female	30
Male	12
Transgender	
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	190
Another identity not listed	2
TOTAL	**234**
If another identity is counted, please specify: non-binary	

PRIMARY LANGUAGE	
English	42
Spanish	
Cantonese	
Chinese	
Vietnamese	1
Farsi	1
Arabic	
Tagalog	
Declined to answer	
Unknown	189
Another language not listed	1
TOTAL	**234**
If another language is counted, please specify:	

SEX ASSIGNED AT BIRTH	
Male	30
Female	12
Declined to answer	
Unknown	192
TOTAL	**234**

DISABILITY*** STATUS	
Communication Domain	
Vision	
Hearing/Speech	
Another type not listed	
Communication Domain Subtotal	**0**
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	
Physical/mobility	
Chronic health condition	
Disability Subtotal	**0**
None	
Declined to answer	
Unknown	234
Another disability not listed	
TOTAL	**234**
If another disability is counted, please specify:	

RACE	
American Indian or Alaska Native	
Asian	13
Black or African American	6
Native Hawaiian or other Pacific Islander	3
White	3
Other Race	
Declined to answer	
Unknown	209
TOTAL	**234**
If another race is counted, please specify:	

Ethnicity/Cultural Heritage (Please choose only one per individual)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	1
Mexican/Mexican American/Chicano	3
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	3
Total Hispanic or Latino	**7**
If Non-Hispanic or Non-Latino, please specify:	
African	
African American	4
Asian Indian/South Asian	3
Cambodian	
Chinese	4
Eastern European	
European	
Filipino	
Japanese	
Korean	
Middle Eastern	1
Vietnamese	1
Other Non-Hispanic or Non-Latino ethnicity not listed	5
Total Non-Hispanic or Non-Latino	**20**
More than one ethnicity	9
Unknown Ethnicity	198
Declined to answer	
EHTNICITY TOTAL	**234**
If another ethnicity is counted, please specify: Taiwanese	

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of. Note: 1,000-character limit.

Despite setbacks that COVID-19 caused, the HTA program was determined to promote its work and to host free virtual art workshops to get community members through these tough times. We learned the TAY community was especially struggling with Zoom burnout since all of their classes were on Zoom. Our goal was to create fun and interactive workshops for them to participate in, especially since they knew how to use the technology. After successfully conducting outreach to over 180 students from James Logan HS, Fremont HS, and Castlemont HS, we were able to recruit students for 3 separate art therapy groups. In partnership with the licensed art therapist, we were able to create a safe place for the TAY to express their emotions and to assist with their mental health. One of the TAY was struggling with the death of her dog and the news that her grandmother was diagnosed with breast cancer. The therapy group was very helpful in getting her through this tough time.

Box E: Program challenges of the past year and how did the agency mitigate challenges? Note: 1,000-character limit.

During the 21/21 FY, HHREC was forced to reassess and redevelop many of its operational systems. For the first time ever, we were unable to conduct in-person programming and were required to shut down our office. Majority of the year the staff had to take time to research ways to provide programming virtually and how to cater that to our specific audiences. Another big component that affected our daily work was outreach. As all in-person outreach was halted, the program manager conducted outreach through phone calls, social media posts, email blasts, and countless follow ups. We are proud to say that through our innovative outreach efforts, we reached 180+ students/faculty during our online presentation to 5 high schools in alameda county. For the seniors, unfamiliarity with using technology was a challenge. Nevertheless, the program manager assisted participants over the phone and was able to successfully register them for workshops. In total, we successfully offered 9 art workshops.

Box F: Program lessons learned of the past year? Note: 1,000-character limit.

The ability to adapt to any condition is crucial and essential as a non-profit. In the past months, our community members not only had to battle the effects of a pandemic, but also make a life-changing decision on whether to get the COVID-19 vaccination or not. The decision was especially challenging for our community to make because of distrust with the U.S. government. Such events increased mental health illnesses dramatically. This is a testament to the growing need for wellness programs and therapy that HTA offers to the community. With an increase in volume, our financial resources need to increase. We need to purchase software like video conferencing tools and other technology that allows us to conduct our programs and reach our audiences virtually. We also need training for the staff to learn about the technology and pass on the knowledge to our participants. The harder the times get, the more vital programs like HTA are to rebuilding hope, resilience, and connection in our community.

Box G: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
G.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e. mental health treatment services):	n/a
G.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e. mental health treatment services):	n/a
G.3: Types of treatment individuals were referred to (list types) (500- character limit):	n/a
G.4: Unduplicated number of individuals who participated in referred program at least one time:	n/a
G.5: Average duration of untreated mental illness in weeks:	n/a
G.6: Average number of days between referral and first participation in referred treatment program:	n/a

Box H: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
H.1: Who is/are the underserved target population(s) your program is serving (e.g. TAY, Southeast Asian) (500 Characters):	TAY, Southeast Asian, Asian, low-income, seniors
H.2: Number of paper referrals to an ACBH PEI-funded program:	n/a
H.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	10
H.4: Average number of days between referral and first participation in referred PEI program:	10-15 days
H.5: Describe how your program encouraged access to services and follow through on above referrals (500 Characters):	During initial meetings with new participants, I learn about their demographics and interests and base referrals on that. I connect them with other HHREC programs and introduce them to the program manager of whichever program I am referring them to.

Box I: For <u>Outreach, Suicide Prevention, and Stigma Reduction</u> programs, please provide information for unduplicated potential responders (i.e., those who are in a position to identify early signs of potentially severe mental illness provide support, and or refer individuals who need treatment) reached. ***(Note: For Prevention, Early Intervention, Access & Linkage programs, this section is optional.)***	
Number of Responders:	**NA**
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):

MHSA Program #: PEI 28

PROVIDER NAME: Health and Human Resource Education Center

PROGRAM NAME: Downtown TAY

Program Outcomes & Impact: PEI Data Report FY 20/21

Program Name:	Downtown TAY	
Organization:	Health and Human Resource Education Center	
PEI Program # and Name:	Downtown TAY	
Type of Report (Choose one):	Annual	
PEI Category (choose one):	Prevention	
Priority Area (place and X next to all that apply):		Childhood Trauma
		Early Psychosis
	x	Youth/TAY Outreach and Engagement
		Cultural and Linguistic
		Older Adults
		Early Identification of Mental Health Illness

Box A: Please provide a brief program description (character limit 1,000).

Downtown TAY provides culturally responsive and trauma- informed programs, workshops, and outings to Transitional Age Youth of the African Diaspora in Alameda County between the ages of 18 – 24. Our mission is to empower our young adult community by connecting them to their culture, inspiring hope, promoting critical thinking and cultivating creativity while supporting their overall health and wellness.

Box B: Number of individuals served this fiscal year through MHSA funding.

Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	50
Number of unduplicated individuals your program served 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:	**50**

Box C: Demographics of individuals served this fiscal year through MHSA funding.

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	
Transition Age Youth (16-25 yrs.)	50
Adult (26-59 yrs.)	
Older Adult (60+ yrs.)	
Declined to answer	
Unknown	
TOTAL	**50**

VETERAN STATUS	
Yes	3
No	7
Declined to answer	
Unknown	
TOTAL	**50**

CURRENT GENDER IDENTITY	
Female	25
Male	25
Transgender	
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	
Another identity not listed	
TOTAL	**50**
If another identity is counted, specify	

SEX ASSIGNED AT BIRTH	
Male	25
Female	25
Declined to answer	
Unknown	5
TOTAL	**50**

SEXUAL ORIENTATION	
Gay/Lesbian	8
Heterosexual/Straight	38
Bisexual	2
Questioning/Unsure	
Queer	
Declined to answer	2
Unknown	
Another group not listed	
TOTAL	**50**
If another group is counted, please specify:	

PRIMARY LANGUAGE	
English	50
Spanish	
Cantonese	
Chinese	
Vietnamese	
Farsi	
Arabic	
Tagalog	
Declined to answer	
TOTAL	**50**
If another language is counted, please specify:	

DISABILITY STATUS	
Communication Domain	
Vision	
Hearing/Speech	
Another type not listed	
Communication Domain Subtotal	**0**
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	
Physical/mobility	
Chronic health condition	
Disability Subtotal	
None	50
Declined to answer	
Unknown	
Another disability not listed	
TOTAL	**50**
If another disability is counted, please specify:	

RACE	
American Indian or Alaska Native	
Asian	
Black or African American	30
Native Hawaiian or other Pacific Islander	1
White	
Other Race	
Declined to answer	
Unknown	
TOTAL	**31**
If another race is counted, please specify:	

Ethnicity/Cultural Heritage (Please choose only one per individual)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	
Mexican/Mexican American/Chicano	18
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	
Total Hispanic or Latino	**18**
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	
Total Non-Hispanic or Non-Latino	**0**
More than one ethnicity	
Unknown Ethnicity	
Declined to answer	
EHTNICITY TOTAL	**18**
If another ethnicity is counted, please specify:	

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of. Note: 1,000-character limit.
Recruited new staff, that included a new coordinator and two interns and facilitators for out Sista2Sista and Culture Broker Academy events. Assessed inventory and revamped supplies, developed new strategies for outreach that included scripts and flyers for marketing purposes. Created county-wide billboard campaigns that have successfully attracted new participants. Successfully created an outreach and tabling routine that effectively increased physical visibility and created a rapport among staff and the local community. Created a new fresh food program that delivers nutritious hot meals to youth and their families. Successfully hosted and participated in several Be Still Retreats.

Box E: Program challenges of the past year and how did the agency mitigate challenges? Note: 1,000-character limit.
Recruiting both staff and new participants took a lot of strategizing and trying out new approaches. Many schools were busy with transitioning back into the classroom setting, which hindered outreach opportunities to a degree. Covid remained a barrier for reaching high school populations, as well as it prevented many people from wanting to travel for services. Many youth were interested in attending programming but were conflicted due to potentially finding jobs. We remedied these issues by travelling to various cities and delivering necessities to youth, either by tabling or by Covid-protocol approved presentations. We began creating new and diverse events to attract new participants with varied scheduled events to accommodate the time conflicts that occurred. A lot of new programs and initiatives were created, with some including incentives, in attempts to bring in new youth. We were continuously providing virtual services and training throughout the entire time period.

Box F: Program lessons learned of the past year? Note: 1,000-character limit.
Throughout the course of this time period, we have learned that innovation and creativity are our best approaches when it comes to attracting new participants. We have noticed that our most out-of-the-box ideas seem to have really stood out with our students. Events such as Free Friday Movies, a segment in which we display new movies that are specifically chosen for our demographic, have been really popular with the new recruits as well as with follow resource providers who have become accustomed to sharing our events with their participants. Our participants seem to really enjoy the variety of programming and opportunities that our program provides. We have learned that we have a very diverse group of individuals who all have multiple layers of needs that can be tended to simultaneously. Our efforts to have a broad range of resources and outreach tactics have resulted in participants receiving aid in multiple areas of life and participating in more than one initiative.

Box G: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
G.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e. mental health treatment services):	n/a
G.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e. mental health treatment services):	n/a
G.3: Types of treatment individuals were referred to (list types) (500-character limit):	n/a
G.4: Unduplicated number of individuals who participated in referred program at least one time:	n/a
G.5: Average duration of untreated mental illness in weeks:	n/a
G.6: Average number of days between referral and first participation in referred treatment program:	n/a

Box H: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
H.1: Who is/are the underserved target population(s) your program is serving (e.g. TAY, Southeast Asian) (500 Characters):	TAY, African American, LGBTQA+, Latinx, Asian, young parents, family and support systems of TAY
H.2: Number of paper referrals to an ACBH PEI-funded program:	4
H.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	50
H.4: Average number of days between referral and first participation in referred PEI program:	1
H.5: Describe how your program encouraged access to services and follow through on above referrals (500 Characters):	During our intake process, we assess the needs of each new participant and determine what services they need. From there we are able to make the appropriate recommendation to our partner programs.

Box I: For <u>Outreach, Suicide Prevention, and Stigma Reduction</u> programs, please provide information for unduplicated potential responders (i.e., those who are in a position to identify early signs of potentially severe mental illness provide support, and or refer individuals who need treatment) reached. ***(Note: For Prevention, Early Intervention, Access & Linkage programs, this section is optional.)***	
Number of Responders:	**NA**
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):

MHSA Program #: PEI 28

PROVIDER NAME: Health and Human Resource Education Center

PROGRAM NAME: Black Women's Media and Wellness Project

Program Outcomes & Impact: PEI Data Report FY 20/21

Program Name:	Black Women's Media and Wellness Project	
Organization:	Health and Human Resource Education Center	
PEI Program # and Name:	PEI 28 Black Women's Media and Wellness Project	
Type of Report (Choose one):	Annual	
PEI Category (choose one):	Outreach	
Priority Area (place and X next to all that apply):		Childhood Trauma
		Early Psychosis
	x	Youth/TAY Outreach and Engagement
		Cultural and Linguistic
	x	Older Adults
		Early Identification of Mental Health Illness

Box A: Please provide a brief program description (character limit 1,000).

The BWMWP increases awareness among African American women and their families and older African American adults about mental health issues, wellness and co-occurring conditions. BWMWP promotes mental health education and resources; and develops and promotes recovery and wellness through relevant culturally appropriate messages about self-care, family involvement and culturally responsive community activities.

Box B: Number of individuals served this fiscal year through MHSA funding.

Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	378
Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	NA

Number of unduplicated individual family members served indirectly by your program:	NA
Grand total of unduplicated individuals served:	**378**

Box C: Demographics of individuals served this fiscal year through MHSA funding.

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	4
Transition Age Youth (16-25 yrs.)	1
Adult (26-59 yrs.)	24
Older Adult (60+ yrs.)	34
Declined to answer	
Unknown	315
TOTAL	**378**

SEXUAL ORIENTATION	
Gay/Lesbian	
Heterosexual/Straight	
Bisexual	
Questioning/Unsure	
Queer	
Declined to answer	
Unknown	378
Another group not listed	
TOTAL	**378**
If another group is counted, please specify:	

VETERAN STATUS	
Yes	
No	
Declined to answer	
Unknown	378
TOTAL	**378**

CURRENT GENDER IDENTITY	
Female	105
Male	31
Transgender	
Genderqueer	
Questioning/unsure of gender identity	2
Declined to answer	
Unknown	240
Another identity not listed	
TOTAL	**378**
If another identity is counted, please specify:	

PRIMARY LANGUAGE	
English	378
Spanish	
Cantonese	
Chinese	
Vietnamese	
Farsi	
Arabic	
Tagalog	
Declined to answer	
TOTAL	**378**
If another language is counted, please specify:	

SEX ASSIGNED AT BIRTH	
Male	31
Female	105
Declined to answer	
Unknown	242
TOTAL	**378**

DISABILITY*** STATUS	
Communication Domain	
Vision	
Hearing/Speech	
Another type not listed	
Communication Domain Subtotal	**0**
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	
Physical/mobility	
Chronic health condition	
Disability Subtotal	**0**
None	
Declined to answer	
Unknown	378
Another disability not listed	
TOTAL	**378**
If another disability is counted, please specify:	

RACE	
American Indian or Alaska Native	1
Asian	1
Black or African American	227
Native Hawaiian or other Pacific Islander	
White	3
Other Race	3
Declined to answer	
Unknown	143
TOTAL	**378**
If another race is counted, please specify:	

Ethnicity/Cultural Heritage (Please choose only one per individual)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	
Mexican/Mexican American/Chicano	3
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	
Total Hispanic or Latino	**3**
If Non-Hispanic or Non-Latino, please specify:	
African	
African American	227
Asian Indian/South Asian	
Cambodian	
Chinese	
Eastern European	
European	
Filipino	
Japanese	
Korean	
Middle Eastern	
Vietnamese	
Other Non-Hispanic or Non-Latino ethnicity not listed	
Total Non-Hispanic or Non-Latino	**227**
More than one ethnicity	
Unknown Ethnicity	148
Declined to answer	
EHTNICITY TOTAL	**378**
If another ethnicity is counted, please specify:	

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of. Note: 1,000-character limit.
We are excited for this past year. Not only did we anticipate meeting the deliverables, but we exceeded the deliverables. The response was positive and we have been able to serve 378 community members in total with an average of 40 participants at each event. This exceeds our contracted number of participants by 60%. We are continuing a great work with the Be Still community and book clubs. The highlight of our successes this year include: encouraging intergenerational participation by providing 4 scholarships for young African American girls to attend a Spring Break Empowerment Camp; putting more effort into reaching the family members of our participants. Many of our new participants have reported that they've been invited by current Be Still community members.

Box E: Program challenges of the past year and how did the agency mitigate challenges? Note: 1,000-character limit.
As programming for BWMWP has shifted online, challenges remain in the area of keeping participants interested in online events; PEI data collection, and having an adequate budget to providing incentives for greater participation. In order to keep participants interested, we had to create dynamic programming and think outside the box. Participants were heavily encouraged to share their ideas about program topics and guests. We were able to present different topics that were not overlapping and they received positive feedback. With social distancing and shelter-in-place regulations, there was little to no interaction with participants. Now, that regulations are lifting, there have been opportunities to provide community members with materials to promote mental health. Survey Monkey is now being used as a tool to collect data from participants and we expect greater participation.

Box F: Program lessons learned of the past year? Note: 1,000-character limit.
The biggest lesson learned this year is the necessity to modify internal practices to expand outreach. With many agencies and community centers unable to operate fully, the focus was shifted to social media and word of mouth to drum up participation. Along with expanding outreach, adjusting technology to meet the needs of running virtual events was a must. HHREC provided training with Kim Coulthurst of Pathways Consultants to develop an outreach strategy plan to insure impactful programming

Box G: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
G.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e. mental health treatment services):	n/a

G.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e. mental health treatment services):	n/a
G.3: Types of treatment individuals were referred to (list types) (500-character limit):	n/a
G.4: Unduplicated number of individuals who participated in referred program at least one time:	n/a
G.5: Average duration of untreated mental illness in weeks:	n/a
G.6: Average number of days between referral and first participation in referred treatment program:	n/a

Box H: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
H.1: Who is/are the underserved target population(s) your program is serving (e.g. TAY, Southeast Asian) (500 Characters):	African American women of all ages living in Alameda County
H.2: Number of paper referrals to an ACBH PEI-funded program:	n/a
H.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	n/a
H.4: Average number of days between referral and first participation in referred PEI program:	n/a
H.5: Describe how your program encouraged access to services and follow through on above referrals (500 Characters):	Online magazine is available to program participants that encourages mental health awareness and resources for treatment.

Box I: For <u>Outreach, Suicide Prevention, and Stigma Reduction</u> programs, please provide information for unduplicated potential responders (i.e., those who are in a position to identify early signs of potentially severe mental illness provide support, and or refer individuals who need treatment) reached. ***(Note: For Prevention, Early Intervention, Access & Linkage programs, this section is optional.)***	
Number of Responders:	
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):
Community college	*2 instructors and 1 academic counselor*
Churches	*3 ministers at churches who lead women's groups*
Medical facilities	*1 director of family care services, 1 medical doctor, 1 holistic doctor*
Community centers	*20 parents of minority youth*


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 Innovation Project may introduce a novel, and/or ingenious approach to a variety of mental health practices. Innovation 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	2022-2023	$2,134,597
Mobile Technology App Project	2022-2023	$178,602
Land Trust	2022-2023	$1,218,131
INN CPPP Project	2022-2023	$150,000

INN Project Goals

Community Assessment Treatment Team (CATT): San Leandro, Hayward and Oakland currently have CATT teams to be pilot tested.

Pilot Project Community	*Achieved Services/year 1 July 21,2020 – July20, 2021*	*Projected Services/year 2*	*Projected Services/year 3*
San Leandro, Oakland, and Hayward are overwhelming majority of call response locations	1,185 calls; 758 clients served	840 contacts	840 contacts
	64% of persons served who did 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: Housing for individuals with serious mental illness (SMI):

Community	*Achieved Goals for FY21-22*	*Goals for FY22-23*	*Goals for FY23-24*
SMI individuals whose income is 200% below federal poverty level ($27,450 annually or less)	Founding board of directors elected by Advisory Committee; Articles of Incorporation and bylaws achieved; executive director identified.	Complete federal tax exemption applications; Initial property to be purchased; initial consumers identified and housed.	Additional consumers to be housed; Financing models for sustainability identified.

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:

The CATT program is using a mobile crisis transport staffing model that accesses technological support to enable the CATT program to connect clients to a wider and more appropriate array of services. The CATT team consists of:

- A licensed mental health clinician who is teamed up with an Emergency Medical Technician (EMT) in an unmarked vehicle specially designed for the CATT team. Together, this team can provide mental and physical assessment to individuals in crisis and transport them to appropriate services required in the moment; and
- Technology supports, ReddiNet, are used to identify current availability of beds and Community Health Records to provide the most accurate information about the client's physical and mental health history.

By bringing together the right staffing and the right technology, this innovative crisis response teams' goals are to *reduce unnecessary 5150 holds, transportation to medical facilities for medical clearance, and the many hours of waiting for clients and first responders.* In addition, the goal to increase access to appropriate services by connecting and transporting clients whether or not they are on a 5150 hold.

In the first year of the CATT program, July 20, 2020 and July 20, 2021, there were 1,185 requests for a CATT team response. A CATT team provided services to 758 clients (64% of all calls). Of the 758, 465 (62%) resulted in a client transport. Approximately 40 CATT responses per month avoid what would likely have been an unnecessary hospital transportation 5150 involuntary hold.

The first-year evaluation final report has been completed by the CATT project evaluator, Public Consulting Group (PCG). A report brief was created by PCG and can be found in the appendix. The brief contains highlights and summary of the CATT program background and overview; process evaluation findings; outcome evaluation findings; response, transport, and involuntary hold dispositions; and program recidivism.

CATT Summary of Challenges and Resolutions

In the MHSA Update FY21/22, a number of challenges were identified and that additional funding was going to be required to uplift the project for continued success. MHSA requested from the Mental Health Services Oversight and Accountability Services (OAC) the additional funding it has identified. ACBH staff and representatives from the CATT project presented to the OAC on November 18, 2021. The total amount requested, $4,759,312, was approved by the OAC.

The following is a summary of the reasons for the additional funding request and the amounts for each fiscal year:

1. Assist in paying for salaries of the emergency medical technicians due to a low original salary projection;
2. Additional mobile crisis teams are needed to be up and running sooner than anticipated due to the pandemic; and
3. Assist in paying for the emergency medical services project coordinator whose role was not well thought out in the original proposal.

Fiscal Year 20/21	$1,216,862
Fiscal Year 21/22	$1,745,181
Fiscal Year 22/23	$1,797,269
Total	$4,759,312

This additional funding brings CATT overall approved funding to a total of $14,637,394.

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.

This two and half years (2.5) project is 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 is offering new opportunities for outreach, and engagement, and support to the communities listed below by testing a technology-based delivery system for mental health solutions.

There are five (5) grantees who have created mental health mobile apps for four (4) identified populations. Of the five (5) grantees, two (2) of them are doing a single identified population while the remaining three (3) are doing multiple populations. The identified populations and the awarded grantees, Diversity in Health Training Institute (DHTI); Korean Community Center of the East Bay (KCCEB); Mental Health Association for Chinese Communities (MHACC); NAMI; and Niroga Institute, are listed below with their respective targeted population:

Targeted Populations	Name of Grantee	Name of Grantee
1) Caregivers of family members who suffer from a Serious Mental Illness (SMI) or a Serious Emotional Disturbance (SED)	KCCEB	MHACC
2) Youth/Transition Age Youth (TAY) who are victims of trauma induced by violence, particularly gun violence	DHTI	Niroga Institute
3) Attempted Suicide Survivors	MHACC	NAMI
4) Immigrants, Asylees, and Refugees	DHTI	KCCEB

Most of the grantees have websites and presentation videos posted on YouTube. The following table also broadly shows the status of the grantee projects:

Grantee	Targeted Population	Status
DHTI	TAY (Youth/Transition Age Group)	The evaluation period continues for TAY usage.
	Immigrants, Asylees, and Refugees	A website has been set up for focus groups to review and gather input: https://allynetwork.org/ . Providers are being uploaded as well.
KCCEB	Caregivers of Individuals with SMI or SED	There was difficulty finding volunteers because this app is created specifically for Chinese speaking caregivers. A presentation for the app can be found here (turn on closed caption for English as it is in Chinese): https://www.youtube.com/watch?v=FzvqQDum6-M&t=1s
	Immigrants, Asylees, and Refugees	Population requested tangible solutions in addition to and before addressing mental health. This app was created specifically for Korean business owner who experienced trauma due to racism and violence. The app is available in the Korean language. https://www.youtube.com/watch?v=iSiFgYQQKV8
MHACC	Caregivers of Individuals with SMI or SED	New clickable demo with new home page layout which provides connections to mental health providers. A presentation of MHACC's app can be found here: https://youtu.be/WNgEKyjPMm0
	Attempted Suicide Survivors	App design is in its third design after receiving input from their beta testers. A presentation of MHACC's app can be found here: https://youtu.be/e7oDJqdNgLQ
NAMI	Attempted Suicide Survivors	Their app website has been setup: https://www.dinobi.org/. There is an early access list for initial users on the website.
Niroga Institute	TAY (Youth/Transition Age Group)	Incorporating input from focus groups; creating options that support youth with special needs; and seeking language options. A presentation of Niroga's app can be found here: https://www.youtube.com/watch?v=fxXmDX7WEgk

There was an innovation conference for the MH Tech apps in November, 2021 where all grantees were given an opportunity to present their apps in a public forum hosted by the county. Almost a hundred people were in attendance for the day long remote event.

MH Tech 2.0 Summary of Challenges and Resolutions

MHSA division is looking to ACBH's executive team to review all the apps created in hopes that some, if not all of them can be folded into appropriate systems of care. If additional funding is approved from another funding stream, then the county will support the apps during the Fiscal Year 2022-2023. Currently, ACBH has put in notification to MHSOAC that the county will be extending the project (no cost extension) for another seven (7) months until June 30, 2022.

PROJECT NAME: Supportive Housing Community Land Alliance (CLA)

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: The Community Land Alliance (CLA), is based on a community land trust model, is a nonprofit, community-based organization designed to ensure community stewardship of land. Community land trusts are often associated with conservation efforts. However, the significant effort to ensure affordable long-term housing through this form of ownership is the CLA's mission. The alliance will acquire land and maintain ownership of it permanently. The CLA will enter into long-term, renewable leases with residents. If the resident leaves, the resident earns 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 is promoting interagency collaboration in order for the **Alameda County Supportive Housing Community Land Alliance to develop and maintain supportive housing units.** ACBH will be partnering 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 CLA is looking to begin its partnership with the housing division in spring of 2022. This timing will parallel the exit of the project's grantee, Northern California Land Trust (NCLT). The subject matter expert, Burlington Associates, will continue its work with the project until December 2022.

CLA Summary of Challenges and Resolution

The Supportive Housing Land Alliance team has been working since October, 2020. Currently the CLA has been incorporated and is finalizing its Form 1023, Application for Recognition of Exemption Under Section 501(c)(3) of the Internal Revenue Code. The 1023 is used for the Internal Revenue Service to issue a determination letter or ruling letter that recognizes an organization's exemption from federal income tax. This is a final step for the CLA to become a full-fledged non-profit entity.

Due to the pandemic, a fellowship was appropriated to support the deployed project managers and staff who were unable to reasonably fulfill duties while performing COVID response team duties. The county's collaboration with the national nonprofit FUSE Corps created an executive fellowship. The FUSE fellowship enabled ACBH to have extra support in regard to project management. The FUSE

fellowship ended in October, 2021. However, the fellow has transitioned to working for the project as a consultant. Currently, the former fellow is assisting in transferring project management to the identified executive director.

As a consultant, the former FUSE fellow continues to work closely with NCLT's project manager; ACBH Subject Matter Consultant, Burlington Associates (BA); and ACBH staff to keep the CLA project on track. The former FUSE fellow's broad deliverables that were completed included:

	Deliverable	Results
1)	Review current affordable housing efforts and engage with stakeholders	• Introduced County Supervisors, City Councilmembers, State Housing & Community Development staff to CLA • Connected with supportive services and affordable housing organizations to learn about best practices and assess organizations for future contracts • Enlisted CLA in joining 2 Adult Residential Facilities advocacy and learning groups • Established connections within Alameda County Community Care Licensing to facilitate acquisition of ARFs that are closing/for sale.
2)	Develop a comprehensive strategic plan to establish and sustain CLA	• Assisted in establishing a mission and vision statement • Stewarded development of Equity Principles and statement for CLA • Facilitated the launch of an Advisory Committee • Drafted a short-term strategic plan for CLA • Assisted with content and design of CLA website with support of NCLT, and BA
3)	Ensure incorporation of CLA	• Facilitated election of founding board of directors • Assisted in drafting and approving organization's bylaws • Provided orientation and training for founding board members
4)	Support long-term implementation	• Created draft program manuals for Acquisitions, Property Management, and Supportive services • Developed initial messaging and presentations • Created a funding/financing sources database

The project's next steps include a proforma; budgets for adult residential care facilities (ARF) and single-family home purchases; complete program manuals for property management and supportive services; and building sustainable financial model(s). Additionally, plans on strategic partnership to acquire properties with nonprofits that are buying property, serving clients with SMI and delivering supportive services. There is continued pursuit to make request for information from organization to facilitate various models of partnership with existing organization for the SHCLA's prototype.

Currently, MHSA is working on procurement of a project evaluator. The evaluator's contract will run concurrently with the remaining two and half years (2.5) of the project beginning in July, 2022.

Future INN Prospects

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.

There are three innovation ideas currently being developed to bring to the MHSOAC for approval within the next twelve (12) months. All three of these projects involve peer contribution and involvement for success:

New INN Programs under Development for Possible Future Procurement (see *Appendix B-5 for future proposals)*

INN IDEAS	Population	Problem Trying to Solve	Strategies
1. Peer-Based Strategies, Consumer Empowerment using DBT	Peers and Consumers	How to engage more of our ACBH clients in using DBT therapeutic supports	Web-based DBT skills trainings developed for peer to facilitate online and in person DBT skills practice groups
2. Peer- Led Continuum of Forensic Services	Peer focused; Mental health consumers at risk of or are justice involved	Many ACBH clients discharged from Santa Rita have few resources and supports, leading to potentially high recidivism rates	Peer Respite for at risk or Justice Involved Individuals
3. Alternatives to Confinement Continuum of Forensic Services	Clinical focused for mental health consumers at risk of or are justice involved	Prevention of incarceration and divert individuals from criminal justice system into mental health services	Provide alternative treatment setting for people who do not require services in a locked environment to stabilize

1. Consumer Empowerment Using DBT (Dialectical Behavioral Therapy) Summary

The DBT proposal came out of the County's Community Program Planning Process (CPPP) meetings during February – May 2020. During a larger webinar focus group, DBT online training was presented as an idea for uplifting peers. The webinar included stakeholders, and the County's Peers Organizing Community Change (POCC and formerly known as Pool of Consumer Champions) agreed that this would be a good pilot project to support.

The DBT project will develop an online Dialectical Behavioral Therapy (DBT) Peer to Peer training program to train peers with the skills of DBT. This program is to provide new skills as peers enhance their hire ability and increase their skills as peers when practicing within peer to peer groups. ACBH wishes to provide a learning environment that is removed from restrictive time and space. An online training program is able to provide an avenue that is self-paced, recovery-oriented mode of learning for peers to cultivate relationships with others committed to learning, practicing, educating others about, and building mastery of the 4 DBT skill sets: core mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness.

There are several DBT techniques that coincide with the recovery philosophy that make it an excellent fit with peers:

- Validation is the non-judgment belief that consumers 'experiences are understandable and important. The peer practices validation by respecting the program participants self-knowledge;
- Radical genuineness is a validation strategy that believes in the client's strengths and capacity for change; and
- Collaboration which in DBT is viewed as a strategy that strengthens the working relationship[2] and coincides with peer process "to arrive at a mutually acceptable plan for moving forward in the treatment process."[3]

It is these parallels in philosophy that makes DBT training to peers very appealing to refresh and broaden the skills of peer support specialists. A proposal summary is listed in the Appendix.

Forensic Services Summary

Alameda County faces the issue of people with serious mental illness (SMI) experiencing incarceration as one of the most prominent challenges facing the behavioral health and cranial justice communities. It is more likely that an individual will be booked into jail than be engaged in treatment thus creating jails as large mental health institutions.

The two forensic proposals were born out of Alameda County Behavioral Health Services and Forensic System Redesign Plan Update, May, 2021[4]. The two innovation plans, *Peer-led Continuum of Forensic Services* and *Alternative to Confinement Continuum of Services,* arose out of the county's efforts to divert individuals with mental health challenges from the justice system into mental health services. Both of these innovation plans were developed for and by community stakeholders, including the County's Justice Involved Mental Health Task Force.

2. Peer-led Continuum of Forensic Services

The Peer-led Continuum of Forensic Services is a collection of four (4) components: Reentry Coaches, WRAP for Reentry, Forensic Peer Respite, and Family Navigation and Support. Three are peer-led and one is family focused. The project specifically seeks to:

- Support mental health consumers who are justice involved by helping them transition back into the community following an arrest or incarceration;
- Identify and address the issues that led up to their arrest and/or incarceration, and connect with mental health and other services to support them in their recovery and reentry journey; and

[2] Ibid.
[3] Deegan, P. E., & Drake, R. E. (2006). Shared decision making and medication management in the recovery process. Psychiatric Services, 57(11), 1636-1639.
[4] http://www.acgov.org/board/bos_calendar/documents/DocsAgendaReg_5_10_21/HEALTH%20CARE%20SERVICES/Regular%20Calendar/Item__1_ACBH_Services_Forensic_sys_5_10_21.pdf

- Seeks to build the capacity of family members to advocate on behalf of their loved one with a serious mental illness who has become justice involved.

As a result of the continuum of services, we expect that individuals will experience fewer episodes of arrest and/or incarceration and will have increased participation in ongoing mental health and other services.

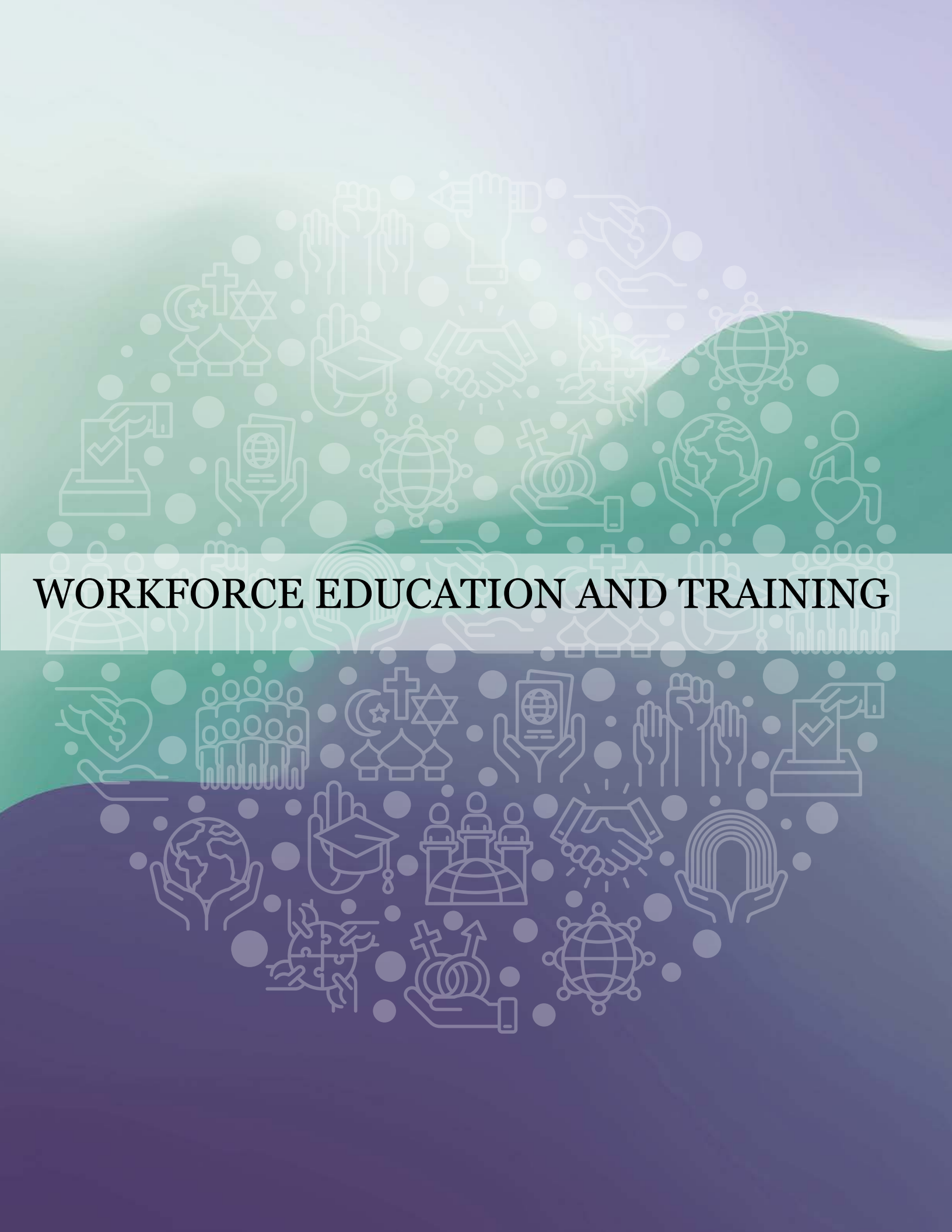
3. Alternatives to Confinement Continuum of Forensic Services

The Alternatives to Incarceration Continuum of Forensic Services is a collection of three (3) services that work together and are intended to prevent incarceration and divert individuals from criminal justice system into mental health services. These services are Forensic Crisis Residential Treatment, Arrest Diversion/Triage Center, and Reducing Probation/Parole Violations. This continuum of care specifically seeks to divert individual from incarceration when:

- A mental health consumer who is forensically involved begins to exhibit early warning signs of a crisis with behaviors that may lead to police contact;
- At the moment of police contact that may result in arrest, and
- The person has fallen out of compliance with their probation or parole and is subject to re-arrest.

Using models from mental health and other disciplines, these three interventions collectively provide an opportunity to divert forensic mental health consumers from police contact that may result in being detained, from being arrested or booked into the jail if detained, and from being re-arrested if unable to comply with the terms and conditions of their release. These priorities for diversion arose out of the sequential intercept mapping process with Alameda County's Justice Involved Mental Health Task Force and focus on preventing entry into the criminal justice system as well as promoting exit from the criminal justice system.

A proposal summary for the Peer-led and the Alternative to Confinement forensic continuums of care is listed in the Appendix.



WORKFORCE EDUCATION AND 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 1 (Success Story)

Lieng Dao: Ohlone College Mental Health Advocacy Program

I attended Ohlone Community College as a Biology major. However, I often have doubted this hardcore science major was a good fit for me. When the pandemic hit, I had Covid anxiety. For a while, I suffered from loneliness as I was isolating myself and had no human interaction other than my family. My mental health declined, and I realized there were many people who were also silently suffering alone. Hence, I wanted to learn more about mental health and lend a helping hand to those in need. Therefore, I decided to join the Mental Health Advocacy Program at Ohlone College and became heavily involved with other programs such as Mental Health Equity Scholar and CA Community College Smoke Free Campus Research study. I found these programs do meaningful work, are the most rewarding, and are great ways to give back to the community as we helped students who mentally struggled during a pandemic. I finally learned that my passion is in the public health field and decided to change my major. I have since transferred to San Jose State University, looking back, I would not be where I'm at without Ohlone StepUp, a program that promotes student mental health, reduces stigma, and makes students feel supported, valued, and socially connected.

One of the modules that stood out to me the most from the Mental Health Advocacy Program is self-care. We often overload ourselves and try to be productive all the time, but it is easy to overlook that selfcare is a form of productivity and it is incredibly important to take care of ourselves during this great pandemic. For my service-learning project, a component of the program, I held a workshop via Zoom for Ohlone Extended Opportunity Programs and Services (EOPS) students who were burned out by online learning. Lockdown had taken a toll on students, so my workshop was a small gathering for everybody to share their thoughts, concerns, and express their hopes for the future. Through this valuable experience with Ohlone, I discovered that I enjoy serving others, giving back to the community, and ultimately solidified my major choice. Despite the challenges of the COVID-19 pandemic, I was able to overcome and thrive when devoting my effort to serving others.

Making the switch from biology to public health was not all smooth sailing since there was a lot of pressure from my family who believed that I wasted time taking a lot of biology major classes that are not needed for public health. But I was determined, and I felt happier learning about public health as it satisfied my intellectual curiosity, and the desire to serve the community motivated me to work hard.

An American entrepreneur Biggs Burke once said, “Don’t be afraid to start all over again. This time, you’re not starting from scratch, you’re starting from experience.” I want to send a message to my fellow college students to tell them that there are always more options for you to choose if you’re willing to work hard for it. If you don’t like where you’re at, change your path, starting with skills and experiences in your field of interest, and you will become successful.

Client Vignette 2 (Success Story)

Marisol: FACES for the Future – Bright Young Minds Conference

“The last two years were really hard,” says Marisol T.*, a 17-year-old FACES for the Future Student in South Alameda County. Marisol lives in unincorporated Ashland with her mother and younger brother, who is 10 years old. She says, “My mom has really bad anxiety and depression and it was worse when she didn’t take her medication. It was hard going home from school and not knowing what was going to happen. School was like, my place to take a break from that.” When the COVID-19 pandemic shut down schools in March, 2020, Marisol and her brother began participating in distance learning from home, and things became even more difficult. She helped her brother navigate his online classes while trying to manage her own high school workload. She tried her best to maintain stability in her household and support her mother. Marisol says it was these lived experiences that inspired her to pursue a career in mental health. “Ever since I was little, I wanted to help people, like, as a nurse or something. But helping my mom with her mental illness made me realize that mental health is really important, and maybe I can make a difference as a psychiatric nurse practitioner one day.” Marisol credits FACES for the Future and the Bright Young Minds Conference for showing her that a career in mental health is possible. She says, “My FACES Program Coordinator believes in me and is always there to support me. I could talk to him when I was stressed or if I had a question. And at the Bright Young Minds Conference, I got to see a lot of different kinds of professionals, even some who had been through some of the same things I’ve been through. We also learned about grief and how to manage stress. It made me feel like I can do it, so that’s a good feeling.”

*Please note that at the student’s request, some personal details have been altered to protect their privacy.

Client Vignette 3 (Success Story)

Ahlam Mohammed: FACES for the Future Alumni

FACES Program: St. Rose Hospital graduated from San Lorenzo HS, 2016
Education: currently enrolled in the Master's Program of Social Work, CSUEB
Current Profession: Behavioral Health Tech, providing services to children with Autism
Goal: Earn an LCSW, support and provide resources to troubled youth

Ahlam Mohammed is a first-generation student who participated in the FACES for the Future St. Rose Hospital program. Ahlam graduated from the FACES program and San Lorenzo high school in 2016 and participated in the Summer Behavioral Health Undergraduate Summit. She earned a bachelor's degree in Sociology and a minor in Human Development at Cal State University East Bay (CSUEB) and recently entered the Master's in Social Work program at Cal State University East Bay.

Through participation in the FACES program at St. Rose hospital, Ahlam was exposed to several FACES internship rotations where she learned about the healthcare system, patient care, and behavioral health. The internship program allowed Ahlam to connect with mentors who shared their pathways into the health professions. Ahlam was inspired to continue a path to grow as an individual and pursue higher education in a field where she can create meaningful change. Ahlam shared, "FACES helped me identify my passion and opened doors for me to overcome cultural challenges ".

As a Muslim Yemeni woman, Ahlam expressed that she is motivated and dedicated to break barriers and open doors for women within her community. While also pursuing a career in social work to support and provide resources to troubled youth. Ahlam mentions how being a youth in modern-day America is challenging due to societal stigmas and how they have altered our idea of mental, physical, and emotional health and became driven to pursue a behavioral health career.

Ahlam has been an inspiration within her family and her community. She hopes to positively impact and model for her younger siblings and community that they can also pursue their dreams and goals. Even if that does require having to find a balance between cultural expectations and her own aspirations. She recognizes that many young people face different challenges whether it's cultural, financial, environmental, etc. in life that can greatly impact their future. Ahlam shares, "With every hardship comes ease, we are tested and run into obstacles to discover our strengths."

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
2. Training/Technical Assistance
3. Mental Health Career Pathways
4. Residency/Internship
5. Financial Incentive

1. Workforce Staffing

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 20/21 Outcomes, Impact, and Challenges:

- Workforce Education and Training (WET) has been transferred from the Mental Health Service Act (MHSA) division to the Office of the Alameda County Behavioral Health (ACBH) Director effective October, 2021. This transformation highlights an opportunity to further support WET, both externally and within the community, through a broader departmental perspective. ACBH is in the process of increasing WET infrastructure to support department wide trainings to ACBH staff and contracted community-based providers.

- As part of organizational structural changes within ACBH, in October the WET team transitioned to be under the leadership of the Office of the Behavioral Health Director. The director's vision is to have a more coordinated effort for trainings across the department and to develop a departmental training plan.

- WET being under the leadership of the Office of the Behavioral Health Director, it's anticipated that there will be more coordination of trainings being offered by the various ACBH units and programs and there will also be department-wide trainings.

- ACBH WET Training Officer retired from the County in January 2022. Following the Training Officer's departure, the WET manager is in the process of beginning the hiring process.

- ACBH is committed to continue WET activities. WET is currently funded through the MHSA Community Support Services (CSS) component and 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. In September 2020, ACBH WET participated in the workforce development needs assessment survey and stakeholder engagement process funded, and coordinated by the Greater Bay Area (GBA) Regional Workforce Education and Training. The purpose of the survey was to gather information from mental and behavioral health workforce development stakeholders across the region and inform future WET Plan programs and strategies, funding, and training opportunities. A total of 76 respondents completed the survey, with representation from all 13 counties and cities in the Greater Bay Area Region. Alameda County made up 51% of the respondents for the GBA needs assessment survey. The results and data from the survey also informs our system on further developing our workforce and training programs.

FY 21/22 Progress Report:

- Alameda County Workforce Education and Training (WET) local Loan Repayment Program (ACLRP) is in the process of transitioning into the State-funded Regional Workforce Education and Training (WET) Partnership Program (RP).

FY 21/22 Progress Report (cont'd):

- On March 24, 2020, Alameda County and California Mental Health Services Authority (CalMHSA) executed a participation agreement (PA) to implement the Alameda County Loan Repayment Program with ACBH WET. This agreement allocated a maximum of $500,000.00 of funding, and spanned a program term of April 1, 2020 through May 31, 2022. On October 8, 2020, the Parties amended the ACLRP agreement by which CalMHSA agreed to continue to act as administrative and fiscal intermediary in the implementation of a second cycle of the ACLRP. This agreement allocated a maximum of and additional $500,000.00, for a total of $1,000,000, and extended the program term to February 28, 2023.

- Alameda County Behavioral Health (ACBH) WET, in collaboration with CalMHSA, launched its first cycle of the local ACLRP in July 2020, and began a second cycle in July 2021. Of note, Alameda County is one of the only Greater Bay Area Region (GBA) counties that has completed a round of loan repayment and is moving into round two, using State funds. effective from July 1, 2020 through June 30, 2025.

- Currently, CalMHSA in contract with HCAI, is serving as the administrative and fiscal agent for the WET RP and coordinating with the GBA Counties to establish partnership agreements. Alameda County is working with CalMHSA on transitioning the ACLRP cycle 2 applicants into the WET RP in order to take advantage of the existing State WET RP funding. CalMHSA is amending the current ACBH Participation Agreement (PA) and morphing it into a PA that works for the WET regional partnership (RP) activities.

- Every five years, OSHPD develops a WET plan to address specific workforce needs. The State allocates funding to the five Regional Partnerships across California, including the Greater Bay Area Region based on the MHSA funding formula. The 2020-2025 State Workforce Education and Training (WET) program aims to address the shortage of mental health practitioners in the public mental health systems (PMHS) through a framework that engages Regional Partnerships and supports individuals through five categories including: Pipeline Development, Loan Repayment Program, Undergraduate College and University Scholarships, Clinical Master and Doctoral Graduate education stipends, and Retention Activities.

- Based on local Alameda County WET programming and previous Mental Health Service Act Community Program Planning Process (CPPP) information, Alameda County WET opted to implement the Loan Repayment, the Community College Behavioral Health Career Pipeline and the Scholarship and Mentoring Programs for undergraduate students following OSHPD's framework.

- The total OSHPD grant allocation for Alameda County is $2,102,701.02 from July 1, 2020 through June 30, 2025. There is a matching amount required for all GBA participating counties and Alameda's total County Match Fund requirement under the 2020-2025 WET RP is $521,722.91. Upon signed agreement, CalMHSA will collect all local matching funds. Alameda County intends to reallocate funds previously allocated to the ACLRP toward the OSHPD WET RP for the purpose of fulfilling its County Match Fund requirement. Alameda County will use the existing ACLRP contract funds (2nd cycle, FY21-22) with CalMHSA towards Alameda's match amount of $521,722.91.

2. Training/Technical Assistance

Program Description: Provides a coordinated, consistent approach to training and staff development. Develops, researches and provides a broad array of training related to mental health practice; wellness, recovery and resiliency; peer employment and supports and management development.

ACBH Training Unit

FY20/21 Outcomes, Impact and Challenges:

- From the period of July 1, 2020 – June 30 2021, the Training Unit provided or collaborated on a total of 73 training activities, thereby training 1,926 ACBH and contracted provider (CBO) staff. Provided/offered 451 continuing education (CE) hours to LCSWs, LMFTs, LPCCs, LEPs, Addiction Professionals, and RNs and 186 CE hours to psychologists.

- Training topics covered a variety of issues including, but not limited to, Mental Health First Aide; Adult and Youth Suicide Assessment & Intervention; Preventing, De-Escalating, and Managing Aggressive Behavior in Behavioral Health Settings; Tobacco Cessation Interventions; Legal and Ethical issues; and trainings related to Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS).

- Provided Trauma Informed Systems (TIS) overview presentation for NAMI East Bay Speakers' meeting and for the African American Family Outreach Project members. Beginning in February 2021, the training officer has worked with East Bay Agency for Children, Trauma Transformed (T^2), on a TIS curriculum revision project that will be completed by the end of December 2021. The intent of the revision is to create curriculum that is more relevant and responsive to current issues. Persons involved in the curriculum revision project include the T^2 TIS Implementation & Evaluation Coordinator, the ACBH training officer, ACBH TIS coordinator, ACBH TIS trainers, and peers and family members of ACBH services. The peers and family members are paid a stipend for their work on the project. TIS 101 training provides foundational knowledge of TIS principles and helps participants understand how trauma and stress impact developing bodies and brains, communities, organizations, and systems.

- Provided trainings related to trauma informed care including “Surviving Compassion Fatigue a.k.a Secondary and Vicarious Trauma”; “Understanding Nervous System Regulation and Culturally Sensitive Restorative Practices for Providers and Clients in Times of Crisis.” The training “Trauma Informed Standards, Practices, and Strategies for Healthcare Organizations: Safety Talk in the Context of CLAS and Cultural Competency” was provided by the Office of Ethnic Services and supported by the training institute.

- Fourteen (14) of the trainings were hosted by the Office of Ethnic Services of which twelve related to one or more of the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS). Some examples include “Recovery Process of African Americans: Seeking Wellness during COVID-19 Re-opening Phases”; “Working with Interpreters/Language Lines for Behavioral Health Professionals”; “People Power Equals Change: Lessons from a Hyperlocal Community Assessment of Opioid Use and Community Well-Being”; “What is Wellness: An Indigenous Perspective on Healing and Connection”; “The Crooked Room: Racism, Adversity, and African American Health”; “Trauma Informed Standards, Practices, and Strategies for Healthcare Organizations: Safety Talk in the Context of CLAS and Cultural Competency.“

- Provided five (5) trainings in Adult Mental Health First Aid (MHFA) and two (2) Youth MHFA trainings thereby certifying 75 ACBH and provider staff. An additional six (6) MHFA trainings were provided to the community including two (2) that were provided to 23 staff of the Fremont, Union City, and Albany City Library branches.

- Provide continuing education credits for the California State University East Bay two-year post graduate Infant and Early Childhood Mental Health certificate program in which 15 students are enrolled.

- Hosted the April 2021, Greater Bay Area Mental Health and Education Workforce Collaborative funded Virtual Mental Health First Aid (MHFA) instructor's training and sponsored eight (8) attendees. The eight attendees included two (2) ACBH staff, four (4) staff from MHSA funded contracted agencies with programs for the Underserved Ethnic Language Population (UELP), and two (2) persons from the National Alliance on Mental Illness (NAMI) Tri-Valley. All eight instructors are now certified to teach Adult MHFA virtually.

- 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). They also evaluate the training content, instructor, technology, accessibility, and program administration. At the end of every training, participants are encouraged to complete an evaluation and if they want continuing education credit, it is required. For all trainings, evaluation data results indicate all outcome measures are being met on an average of at least a 4 or 5 of the Likert scale, with 5 being "strongly agree."

Challenges:

- Due to the majority of staff working remotely, both county and contracted provider, all trainings have been provided virtually which presents technical challenges for both the presenter and participants. Although the evaluation results regarding technical aspects are positive overall we know that some participants were not able to either log in or stay for an entire training due to connectivity problems.

- For the Mental Health First Aid (MHFA) trainings, the transition from in person trainings to the online platform presents a challenge and limitation because participants need to complete 2-hours of pre-work prior to the instructor-led online training. For all scheduled trainings an average of 2-4 out of 20 registrants did not complete the prework. There are always a number of no shows for in person trainings as people's schedules and circumstances change, but the requirement of prework plus the ability to use an online platform presents additional hurdles for persons who want to get certified in MHFA.

- With trainings moving to online platforms we were faced with the challenge of needing to have shorter trainings, which means there are less continuing education hours available. For trainings that required 6-hours of instruction, we addressed this by offering the trainings in two days, but that is also challenging for some staff schedule-wise.

- There continues to be challenges related to the Learning Management System (LMS), SumTotal, that was purchased in 2019. Although there was a plan to "go-live" with the new system in May 2020, because of system glitches and challenges with getting user accounts for the 4,000+ contracted provider staff, as of November 2021, the system is still not fully functional for Behavioral Health. We have used the system in a limited capacity for all ACBH staff to complete HIPAA compliance trainings which is a success, but hope to be able to use the system fully by January 2022.

FY21/22 Progress Report*:*

- For FY 2021/22, beginning July 1, 2021: As of February 9, 2022, the Training Unit provided or collaborated on a total of 32 training activities, thereby training 959 ACBH and contracted provider staff. Provided/offered 130 continuing education (CE) hours to LCSWs, LMFTs, LPCCs, LEPs, Addiction Professionals, and RNs and 97 CE hours to psychologists.

- Training topics were provided on a variety of issues including adult and youth suicide assessment & intervention, mental health first aid, de-escalating and managing aggressive behavior, tobacco cessation interventions, and trainings related to trauma, responding to crisis, and using a telehealth platform.

- By the end of the 21/22 fiscal year, eight (8) Mental Health First Aid (MHFA) trainings will have been provided virtually for 140 – 160 county and contracted provider staff. Five (5) of the trainings are Adult MHFA and three (3) are Youth MHFA.

- Continue the collaboration with California State University East Bay, providing continuing education credit for their two-year (January 2021-December 2022) post graduate Infant and Early Childhood Mental Health certificate program.

- An overview of Trauma Informed Systems (TIS) will be included in the new ACBH employee onboarding training. All newly hired ACBH staff will attend the onboarding and in addition to receiving the TIS overview they will be encouraged to attend other trainings, such as Mental Health First Aid, the 3.5-hour TIS training, and CLAS trainings.

- Continue to maintain provider accreditation and offer required continuing education (CE) credit for Licensed Clinical Social Workers, Licensed Marriage and Family Therapists, Licensed Professional Clinical Counselors, Licensed Educational Psychologists, Licensed Clinical Psychologists, Registered Nurses, and certified Addiction Professionals.

- The current Training Officer has been in the position since July 2017 and will be retiring from the County in January 2022. Following her departure, the WET manager will begin the hiring process and it is expected that the position will be filled by March of 2022.

- As part of organizational structural changes within ACBH, in October the Workforce Education and Training (WET) team transitioned to be under the leadership of the Office of the Behavioral Health Director. The director's vision is to have a more coordinated effort for trainings across the department and to develop a departmental training plan.

FY22/23 Anticipated Changes:

- Under the direction of the ACBH director, the training unit will be actively involved in onboarding over 100 new staff that will be hired to fill positions in the Forensic, Diversion and Re-Entry System of Care.

- In the transition from AC Care Connect to CalAIM additional training needs are anticipated for county and contracted provider staff. This would include training on Enhanced Care Management and how to effectively serve the populations of people experiencing homelessness, justice involved individuals, and those who use multiple systems of care.

- With Workforce Education and Training (WET) being under the leadership of the Office of the Behavioral Health Director, it's anticipated that there will be more coordination of trainings being offered by the various ACBH units and programs. There will also be department-wide trainings, such as monthly Specialty Toolkit trainings which will be brown bag lunch trainings on specific topics and procedures.

- Once the new Learning Management System (LMS) is functioning we are excited about the features available to ACBH and contracted provider staff. 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 also provide an opportunity to compile and analyze evaluation data and measure outcomes more efficiently.

- In response to the shelter-in-place order all trainings moved to an online platform. Although the transition took time to develop and time for staff to adjust, it will be beneficial to continue to offer online trainings in addition to in person trainings. It has been a goal of ACBH to offer online trainings to reduce staff travel time needed and allow for more accessibility. Additionally, the new LMS system provides a platform allowing the ability to launch and learn on mobile devices. We are excited about the opportunity to utilize this function to be able to provide online learning content including, but not limited to, courses, videos, Training materials, etc.

- The curriculum revision of the 3.5-hour Trauma Informed Systems training will be complete by 2022. With the support of the ACBH Director and the Health Equity Officer, we anticipate that all ACBH staff will be highly encouraged to complete the training.

ACBH Office of the Medical Director - Workforce Development and Training Activities

- Alameda County Office of the Medical Director's (OMD) Workforce Development Programs and Services aimed at building the skill set of the behavioral health and primary care workforce in Alameda County to deliver high quality culturally responsive care management services to complex and high need behavioral health clients. The following types of "on-site" workforce development trainings and mentoring opportunities for primary care and behavioral health Safety Net providers illustrates the continuous commitment of ACBH to providing quality care services to its underserved and low-income residents:

- The continuous funding of a yearlong on-site clinical Fellowship experience for one (1) selected UCSF School of Psychiatry student at the Health Care Services Agency, Healthcare for the Homeless Services, TRUST Primary Care Clinic.

- The embedding of ACBH, Primary Care Psychiatric Consultation Program (PCPCP) in eight Alameda County FQHCs to help primary care providers and behavioral health clinicians improve their skills in treating and diagnosing psychiatric conditions that are often presented in the primary care setting. With the Consultant Psychiatrists having access to and understanding of the County's specialty behavioral healthcare system, they continue to be a bridge for care coordination for Alameda County's primary care Safety Net System. The program continues to help improve service capacity in the primary care clinics by helping their medical and behavioral health providers improve skills and comfort level when diagnosing and treating primary care patients with complex behavioral health conditions.

- During the last six months of PYS, the Primary Care Psychiatric Consultation Program (PCPCP) staff were able to provide 2,683 consultations services and 37 training presentations to primary care providers and behavioral health clinicians in nine Alameda County Community Health Centers;

- After the completion of the Sixth Cohort of primary care providers attending the UC Davis, School of Psychiatry, Primary Care Psychiatry Fellowship Program in December, 2020, the eight Alameda County FQHCs and the Alameda Health Consortium decided that a better utilization of the County's Primary care Integration funds would be to have the ACBH Office of the Medical Director's Primary Care Psychiatric Consultants to provide their primary care providers and behavioral health clinicians on-site trainings and individual consultation services as needed.

- During 20/21, the Primary Care Psychiatric Consultation staff were able to provide 2,683 consultations services and 37 training presentations to primary care providers and behavioral health clinicians in eight Alameda County Community Health Centers and one HIV Specialty Care Health Center. With the Primary Care Psychiatric Consultants being ACBH staff, they have also helped to improve care coordination by assisting Safety Net primary care providers and behavioral health clinicians learn how to properly complete the required screening documents for the ACBH, ACCESS Office that will facilitate a high need patient's approved admission into the County's Specialty Mental Health or SUD Systems of Care.

- ACBH has continued to fund 12 Integrated Behavioral Health Care Coordinators (IBHCCs) positions in eight FQHCs. The IBHCCs have received continuous training opportunities in how to use the Alameda Care Connect, Community Health Record (CHR) to monitor care coordination referrals to health and social community resources (housing assistance, food banks, social services, emergency rooms, etc.) as well as gain valuable work experience with primary care and behavioral health providers. During the past year, the IBHCCs provided care coordination services to 2,053 Alameda Care Connect eligible clients.

FY 21/22 Progress Report (cont'd):

Pediatric Care Coordinator Pilot

- In January, 2021, ACBH approved Alameda Health Consortium's request to fund a new pilot Workforce Development Project to support one new Pediatric Care Coordinator position for eight community health centers. The Pediatric Care Coordinator are to be responsible for linking pediatric clients to medical, behavioral, and social services in a preventative and comprehensive manner. This position will act as the liaison between the client and the community, and will serve to dissolve the silos between the medical and BH departments within the eight health centers. This role will also work to support young clients with the basic health and social needs to minimize their risks for entering the criminal justice system as adults. As of September 2021, all 8 health centers had hired and onboarded their Pediatric Care Coordinators (PCCs), and provided over 1900 care coordination services to pediatric patients and their families.

3. Mental Health Career 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.

FY20/21 Outcomes, Impact and Challenges:

- MHSA WET provided funding to FACES for the Future, Ohlone Community College, Center for Empowering Refugees and Immigrants (CERI), Beats Rhymes and Life and California State University East Bay (CSUEB) to develop Mental Health Career Pathways. ACBH WET has partnered with the contracted organizations and programs and implemented the following activities:

- 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.

- FACES for the Future team hosted the Bright Young Minds virtual conference in partnership with ACBH WET and Eden Area Regional Occupational Programming (ROP). Serving students from across Southern Alameda County, the event was held April 27 and April 28, 2021.

- Provided workshops on trauma informed practice, wellness and grief recovery. 150 students from Hayward, San Leandro, San Lorenzo, and Castro Valley participated in the two-day virtual event.

- 90 high school seniors were certified in Mental Health First Aid to support advancement in their professional and college pathway. Highlights from the post survey of the attendees include:

- All students that completed the survey reported that they learned something new during the conference

- 91% of students that completed the survey believe there are accessible service in their community
- 56.4% of students that completed the survey stated that someone they know or they have encountered barriers accessing behavioral health services.
- 59.1% of students that completed the survey said their interest changed to a behavioral health field because of this conference

- Ohlone College remains committed to continuing the Mental Health Advocacy Program as a strategy to support workforce development efforts and in providing more opportunities for students to connect with each other and contribute to advancing student mental health.

FY21/22 Progress Report:

- Ohlone College completed its fourth cohort of the Mental Health Advocacy Program which trains students on a wide range of mental health topics and support their planning and delivery of service learning projects to promote mental health to their affinity groups. This semester, student participants came from three affinity groups that are underserved or experience disproportionate rates of mental health challenges: EOPS (Extended Opportunity Programs and Services), Umoja Scholars Program (a learning community for students of African descent), and Puente (a Latinx student learning community).
- This fourth cohort of the Mental Health Advocacy Program was a success by far the most stellar and engaging group Ohlone have had. Being in person, which has not been the norm in the past twenty months, made a significant difference in the delivery of content, group discussion, and students' reception to the material, each other, and the program's objectives. Students provided constructive feedback on how to improve future training modules and program components, particularly service learning projects.
- To address sustainability of this program - a noncredit program proposal has been completed and uploaded into the college's Curricunet system; we are waiting for the proposal to be added to an upcoming Curriculum Committee agenda for review and subsequent vote.
- The Alameda County College Mental Health Student Navigator Program has completed its first full semester of the second pilot year-long workforce development training pilot program where students learn about the community mental health system to provide "case management" support for their peers to transition from campus-based care to community-based care. The cohort is diverse, and students are committed to the work and feel they are helping their peers get connected to services.
- Funded by Alameda County Behavioral Health (ACBH) Workforce Education and Training (WET), the Navigators program was able to recruit a strong and diverse cohort of ten students representing three schools: Berkeley City College, Chabot College, and Ohlone College.
- In an effort to integrate student engagement programs at Ohlone, mental health navigators were invited to produce a special 'Navigator Take Over' podcast series as part of Ohlone's 'Note to Self' podcast program. The student leaders worked together well in planning their selected topics and organized each episode in an outline to increase the quality of each recording session. Students enjoyed their experience and appreciated the opportunity to elevate the navigator program on the podcast airwaves.

FY 21/22 Progress Report (cont'd):

- Mental Health Navigator Manuscript - during the summer months of 2021, the project director, along with a Laney College navigator from the first cohort, collaborated on drafting a manuscript highlighting the navigator program's pilot year experience. The manuscript, written as a 'brief note,' was submitted to the Health Promotion Practice journal titled, "Community College Mental Health Navigators: A Pilot Program to Improve Access to Care" in mid-September. The reviewers recommended publication, but also suggest some minor revisions to the manuscript. Revisions were made within a few days and the manuscript was submitted within the week of notification.

- The StepUp Mental Health Program at Ohlone College is exploring the curriculum approval process with the College Curriculum Committee Chair in response to the WET manager proposing institutionalizing of the Wellness, Recovery and Resiliency curriculum.

- In October 2021, Ohlone Community College in collaboration with ACBH WET hosted an online behavioral health career panel and mentoring event to bring awareness of the wide variety of behavioral health careers to students already serving in their school as mental health navigators and advocates. The larger goal was to foster and grow students into a career pipeline with interactive experiences in order to attract an emerging, diverse workforce to the behavioral health care field.

- ACBH WET funded Wellness in Action (WiA), a workforce development program, at the Center for Empowering Refugees and Immigrants (CERI). WiA develops career pathways in the mental health field and improve mental health access for underserved refugees and immigrants. WiA works with *community leaders* from indigenous, refugee, and immigrant communities interested in promoting mental health and wellness. WiA offered eleven mini-grant awards to support grassroots community leaders and provided technical and clinical consultation and skill building trainings for careers in community mental health.

Beats Rhymes and Life

- Beats Rhymes and Life (BRL) is a newly funded MHSA WET Program to increase educational pathways and training for Transition Age Youth (TAY) to enter the human services professions such as social work, psychology, nursing, education, and our Hip-Hop Therapy model. BRL supports TAY in their educational and vocational development. Participants learn skills in how to work with youth as peer monitors and artistic instructors. The 1st 12 weeks of instruction focus on facilitation skills, group work and artistry skills while the second half gives participants the opportunity to engage BRL's community of care through direct practice (mental health awareness presentations, one-time workshops, etc.).

- Target Population: Alameda youth 18-24, who have graduated from High School, earned a GED or are interested in earning their GED. BRL prioritizes African American or those of diverse African ancestry but serve anyone who met the other above-mentioned general stipulations.

FY20/21 Outcomes, Impacts, and Challenges:

- **Staffing:** By this point, BRL has hired nine of the eleven open staff positions for the WET PPP program.

- **Client Enrollment:** The program goal is to engage 20 TAY youth during the course of the 21/22 fiscal year. BRL used a rolling admission model. Six participants, or Fellows, launched and have completed the 12 weeks of classes and readying for direct practice and there is a second cohort of six in the pipeline completing

intake and assessment and about to start their cycle of classes. BRL is recruiting for the final 8 to be enrolled and engaged before the end of the fiscal year.

- **Training**: The program will provide 36 hours of training on work readiness, social skills, trust, safety, emotional regulation, self-efficacy, self-regard, accountability, facilitation, group, peer mentorship and the use of artistry for rapport building and healing. Most of the cohort are ready and moving into direct practice for the spring semester all are continuing with case management and or therapeutic supports.

- **Field Exposure:** All Fellows shadow or make site visits with professionals in the social services field. Each Fellow will receive six shadowing or guest lecture opportunities overall over the course of their year in the program. Two of the six or 33% of the guest lecture presentations have been completed. Four Fellows are transitioning into direct practice in January for the first time as planned. One other will begin in February. Two Fellows will not complete coursework until later in the spring but still should by the time they graduate from the Academy.

- **Case Management:** All six Fellows from the first cohort first went through a MAPS assessment, BRL's own internal assessment tool. This assessment covers mental health, academic, physical, and other areas where urgent needs can be highlighted for case managers. Fellows completed 34 sessions of case management and or therapy support overall. Fellows received an average of six sessions each of case management and/or individual therapy support. Categories of support have included grant applications, stability supports, mental/emotional care, college applications, job readiness and goal setting.

Challenges:

- The first challenge would be the Covid-19 epidemic. This has had far reaching impacts to all in terms of how staff and youth interact as well as how services can be delivered. BRL's initial semester was through telehealth primarily and is transitioning to a hybrid model. TAY are eager to engage in person but not all TAY desire to or have received vaccination.

- Telehealth has performed extremely well, but nothing beats the in-person engagement. As the program moves into the spring, BRL is looking for the program pieces best suited for in-person engagement while still vigilant in terms of staff and participant safety. The program started looking at the case management and music production program components as spaces that could be more in person and the classes to continue via telehealth, all while new variants and safety protocols evolve.

- This program was funded as of July 1, 2021, therefore BRL needed to launch the program while still working on startup objectives such as recruitment of staff and curriculum development.
  As a result, the program had to push back intended August start to September. The current staff have worked above and beyond to fill all the vacant roles and responsibilities. BRL anticipates the program in the spring to run more at capacity due to fuller staffing and having more of the programming already in place.

- Recruitment, or to be more specific, finding precise recruitment partners for long term collaboration toward building sustainable pipelines for TAY, is an ongoing process. Some of the most interesting things that came up were participants' need for stability and mental/emotional supports while very much needing to activate as gainfully employed adults. Whereas the program is built for youth who actively seek to be in human services, for some of the participants, this is the first time they are being introduced to human services as a field. They are often getting started on their learning journey of professional fields or professionalism. The program is also seeing that more high schools offer experiential/internship models earlier. BRL program is designed developmentally for young adults but the captive audience seems to present earlier in these alternative model High Schools. BRL is continuing to look at ways to build into

these schools through corresponding Hip Hop Therapy prevention programs and build the pipelines from three to five high schools and colleges.

Client Impact:

- Client E joined our 1st cohort in September through referral from a non-profit that supports youth and TAY from the foster care system. He completed their cycle of services with the agency before joining ours. They were consistent with the classes and skeptical and slightly defensive in regards to the case management and individualized therapy support. As the program approached the end of the 12 weeks of classes, E shared with the lead clinician that they didn't think they could continue with the program. They were dealing with circumstances that were contributing to extreme feelings of overwhelm and depression. Struggling with the violent loss of a close friend, abrupt termination from their other job, toxic family members with substance struggles, abusive romantic interactions, plus trying to stay on top of her own struggles with alcohol use came to a head when she shared with our clinician thoughts of suicidal ideation. With all this going on, they were going to exit the BRL program because they didn't feel like they were able to show up in a way that would have us disappointed with them. This would not be the first time a youth would choose to disengage because of misplaced feelings of shame, not realizing that the BRL program is built to support during turbulent times. Program case management team including clinical supervisors collaborated on a treatment plan to address their ideation, dangerous triggers, and logistical support with the approaching holiday season and holiday break from services. BRL case manager and clinician met with E and together crafted a plan outlining triggers, supports, and check ins during the break with the Lead Clinician and Academy Dean during the two-week holiday from before Christmas Eve and after New Year's. He struggled somewhat with the intensity of the support but verbally expressed their love of the program and the supports that they received. He shared that they wanted to commend us on not giving up on them and encouraged us especially when working with foster youth to continue to be persistent because you never know when that support will land with the youth at the exact time it's needed.

FY21/22 Progress Report:

- BRL anticipates engagement of twelve participants in the spring and continuing outreach and recruitment of the remaining eight fellows before the end of the fiscal year. BRL anticipates filling any vacant staff positions and solidifying curriculum by the end of the fiscal year as well.

FY2022/23 Program or Service Changes:

- No major changes are anticipated in regards to recruitment, just more articulation and confirmation of directed site collaborators for High Schools, Colleges, and Community Based Organizations. So far, confirmed collaborations with assigned site partners will be Met West High School, Oakland School of the Arts, Oakland High School, First Place for Youth, and Expressions Technical School. BRL will continue to work with the Peralta Community College school system. The Pathway Program is one third of the work that BRL provides. The other two programs are care provider trainings for others organizations as well as direct work with community youth. BRL hopes to solidify the bridge between the direct practice and the Pathway to Work programming.

- BRL also have decided to raise the case management minimum interactions to two times a month as well as scheduling spaces within their committed work times on Tuesdays and Thursdays to engage in case management and/or individualized therapy. BRL is launching the case management before the start of classes so that participants can become accustomed to their full schedule as soon as possible

Early Childhood Mental Health Postgraduate Certificate Program

FY 20/21 Outcomes, Impacts, and Challenges:

- MHSA WET provided funding in FY18/19 to launch a two-year pilot Early Childhood Mental Health Post Graduate Continuing Education 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.
- In FY 2018/19 Alameda County Behavioral Health (ACBH) and California State University East Bay (CSUEB) launched the pilot *Early Childhood Mental Health Post Graduate Continuing Education Certificate Program* which focused on the developmental foundations of infant and early childhood mental health. The program's content examined the developmental foundations of relationship-based clinical work between infants, young children, families, and caregivers, and combined theory and practice. The curriculum places a strong emphasis on working with families from diverse cultural, racial, and ethnic backgrounds, which is especially important given Alameda County's socioeconomic, racial, cultural, ethnic, and immigrant diversity.
- The program began with a cohort of fifteen (15) students, fourteen (14) of whom were subsidized by Mental Health Services Act Workforce, Education & Training (MHSA WET) funds and one (1) paid out of pocket. Of the fifteen (15) students, eleven (11) were clinicians of color, ten (10) spoke one of the identified threshold languages, and all fifteen (15) worked in Alameda County early childhood community-based organizations (CBOs).
- In year two (FY 19/20), Cohort 1 saw the fifteen (15) members of the original cohort return intending to complete the second year of the program. However, one (1) student dropped in Fall 2019 and fourteen (14) of the fifteen (15) students completed the program in December 2020.
- Year two (2020) presented new challenges resulting from COVID-19. COVID-19 required the development of new teaching methods to address safety concerns. In response, class instruction was moved online (i.e., TEAMS) which ensured ongoing instruction. For administrative coordination, ACBH staff helped to strengthen the reporting systems used by creating a TEAMS administrative page to track requisite student information (i.e., attendance, class participation, grades). This tracking form was also used for grading.
- In year two, ACBH had a leadership transition from retiring Margie Padilla, Director of Early Childhood Program, who helped develop the program, to Dr. Clyde Lewis, EPSTD Coordinator. Dr. Lewis was selected to provide on-going program management.
- ACBH worked with CSUEB to develop a plan for student recruitment. These efforts were successful in providing information about the program and the application pool increased considerably from the first cohort recruiting efforts. The second cohort had a competitive application process and will also have fifteen (15) students. The range of interest from CBO employees increased and as such, there is a wider range of organizations represented.

- In year three (FY 20/21), a new second cohort of 16 students was recruited (22 applicants and 16 accepted into the program). The recruitment process started in Spring of 2020. In the spirit of collaboration, meetings were conducted with CYASOC Leadership Team and the CSUEB Cohort Instructor to review the recruitment and selection criteria, the steps and resources needed and the timeline. A rubric was developed to assess students that meet criteria. The planning team also discussed lessons learned from the last cohort cycle to apply best and improving practices for the new cohort.

- Cohort announcements focused on individuals who focus on early childhood skill development as well as exhibit cultural competencies that can meet the unique needs of the diverse Alameda County. child and family populations. Announcements were distributed to the Alameda County network of service provider agencies, to networks of CSUEB staff, and to employees and interns at current clinic and outpatient service sites.

Program Evaluation:

- The program was evaluated by a tool developed by UCSF Benioff Children's Hospital Oakland in the first year of the pilot. In the second year of the cohort, the corresponding evaluation survey was administered by the CSUEB Faculty Member and Instructor. The evaluation focused on methodological approaches used for student training. To this end, the evaluation provides ongoing feedback for managers to ensure continuous quality improvement.

- To see the full report and evaluation see: *Appendix D-3 MHSA WET: CSU East Bay Early Childhood Program Annual Report*

FY 22/23 Anticipated Changes:

- This program has been approved through the end of the second cohort in which participants will graduate in December 2022. The future direction of the program will be discussed in the coming months towards the goal of sustaining the program beyond this pilot. WET funds have supported these efforts as well as the complimentary evaluation services.

4. Residency/Internship

Program Description: Coordinates academic internship programs across the ACBH workforce. Outreaches to educational institutions to publicize internship opportunities.

UCSF Public Psychiatry Fellowship Program

FY20-21 Outcomes, Impact and Challenges:

- In FY 2020-21, UCSF was unable to recruit anyone to place in the BHCS clinical education and training program, therefore, we did not host any fellow.

FY21-22 Progress Report:

- 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.

- Currently one selected UCSF School of Psychiatry fellow is participating in a yearlong on-site clinical Fellowship experience at the Health Care Services Agency, Healthcare for the Homeless Services, Trust Primary Care Clinic.

FY22-23 Anticipated Changes:

- In FY 2022-23, ACBH will not be able to host a fellow as UCSF was unable to recruit a participant for the Program.

- ACBH Office of the Medical Director (OMD) and WET have been exploring with Stanford School of Psychiatry to develop a Public Psychiatry Rotation Program beginning FY22-23.

ACBH Graduate Internship Program

- Manage and facilitate the onboarding process for Children Young Adult System of Care (CYASOC), Adult and Older Adult System of Care (AOASOC), Adult Forensic Behavioral Health and Vocational Rehabilitation, Nursing, and other programs/units within the ACBH department.
- Due to the COVID 19 pandemic there was a need to pivot all internship program operations to electronic and virtual platforms. The shift to a mostly virtual internship program was swift and necessary.
- Provide updates and revise documents to the "Onboarding Resource Manual" which was created to provide guidance, structure, and compliance for the internship program.
- Develop necessary forms and/or documents as needed to address new program policies, procedures and applicable laws, regulations, and ethical standards of practice.

- Development of an all-electronic intern orientation welcome packet was formatted due to the pandemic, to include important ACBH documents and other useful information to support interns during the pandemic.

- Effectively manage and facilitate the amendments to five (5) practicum agreements for schools in collaboration with county counsel.

- Twenty (20) students were onboarded and placed within ACBH programs and units. The number of interns was slightly lower than the previous year, more than likely due to the pandemic. Six (6) interns with the Children's and Young Adults System of Care, Eleven (11) Adult & Older Adult System of Care, Nine (9) of those Nursing students, Three (3) with CONREP.

- The mission and goal of the internship program is to provide training that optimizes student learning, leadership, and overall support and development. Ongoing relationship building efforts between the internship coordinator, HR, Finance, clinical coordinator, and clinical intern supervisors positively *impacts* efficiency and value to the Internship Program. The competing priorities of multiple internal and external stakeholders requires a higher level of coordination and standardization.

2020-21 ACBH Interns – Ethnicity (Number of interns= 20)

African American	6 – 30%
Asian	5 – 25%
Caucasian	4 – 20%
Hispanic/Latino	4 – 20%
No response	1 – 5%

2020-21 ACBH Interns – Language (Number of interns= 20)

English	11 – 55%
Cantonese	0
Mandarin	0
Spanish	5 – 25%
Tagalog	1 – 5%
Vietnamese	0
Other	2 – 10%
No response	1 - 5%

Six (6) interns were exposed to a total of ten (10) virtual trainings, including:

- Working with Schools and Special Education, CBT/DBT; Expressive Arts, Documentation Training; HANDLE (Holistic Approach to Neuro Development and Learning Efficiency); Strengthening Relationships Through Partnerships; Pediatric Psychopharmacology and Suicide Assessment and Intervention.

- All in-service trainings were virtual through ZOOM due to the pandemic.

- In-service training evaluations indicates a positive *impact*. In-service trainings and trainers were extremely beneficial and well received by the interns

Coordinate and facilitate annual internship fairs and internship orientations.

- Representing ACBH at local internship fairs for bay area colleges and universities virtually to give potential student 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. All internship fairs were conducted virtually this year due to the pandemic.
- ACBH Internship Program Representative for (3) virtual internship fairs (approximately 20 students) from Cal State East Bay, USF and SJSU.

- The ACBH Intern Orientation is a full two (2) day collaborative effort with clinical supervisors and clinical director to provide a positive and successful start to the internship assignment. Students are provided with presentations, tours, and group interaction. ACBH Intern Orientation was conducted virtually this year due to the pandemic.

FY21-22 Progress Report:

- Developing improved system to collect and manage training and program evaluation results to inform program planning, intern recruitment, placement and follow up.

- Continuing to collect and manage training and program evaluation results to inform program planning, intern recruitment, placement and follow up.

- Facilitation of the post-internship program evaluation forms for data preservation. This effort seeks to gather information from the intern perspective for continuous enhancement of internship program.

- Improvement of onboarding efforts, in conjunction with system leaders, to create standard guidelines, practice, and protocol for onboarding interns for all systems of care.

Challenges:

- Having the ability to pivot during high stress times of the pandemic was imperative

- Working with county counsel to find creative ways to communicate new COVID-19 guidelines for amendments to practicum agreements with schools
- 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 has been a *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.

FY22-23 Anticipated Changes:

- Social media presence is imperative for the internship program to better communicate and promote program.
- Developing an online protocol for the Internship Program and onboarding process.
- In the process of creating a more formal and inclusive intern recruitment strategy under the guidance of the ACBH Director's office.
- Update and enhance internship website to reflect most current intern assignments available to support students in their program search.

Korean Community Center of the East Bay – Graduate Internship Program

FY20/21 outcomes, impacts, and challenges:

- Korean Community Center of the East Bay (KCCEB), Graduate Internship Program is funded by MHSA WET. The internship program trained 6 MSW students for MHAP's first cohort (3 first-year and 3 second-year). Interns came from UC Berkeley, CSU East Bay and University of Southern California. For two-thirds of the students, KCCEB was their first experience in a primarily Asian-serving organization. In addition to English, interns offered services in Cantonese, Mandarin, Khmer, Korean and Tagalog.

- Interns were involved in various KCCEB programs including Senior Case Management, Social Services, and Prevention/Early Intervention (UELP) Programs. Students were placed on-site at KCCEB as well as two school-based sites (Alameda Science and Technology and San Leandro High School). They learned about the broader system of care and mental health coordination through referrals with local partners (e.g., IWAY, Peralta Community Colleges, Family Bridges, Kent Gardens Senior Community, and Alzheimer's Association).

- Interns provided mental health outreach and engagement, senior wellness checks (100 Korean seniors and 50 Chinese seniors), helped to develop mental health innovation (mobile app project for Chinese caregivers and Community Thrive Korean small business relief) and had one-on-one case management and PEI clients (total of 70 clients). First-year students held a case load of 8-12 clients and second-year students held caseloads of 10-15 clients. Finally, our interns had a unique opportunity to be actively involved in advocacy efforts including the Behavioral Health Equity Coalition, Senior Prevention Injury Partnership, East Bay Immigrant and Refugee Forum, API Coalition, State Oral Health Alliance, Health Justice Network, and California Pan-Ethnic Health Network. Interns' support was especially critical during the pandemic and anti-Asian violence to ensure that our seniors' needs were being met and that they did not fall through service cracks. Interns were also actively involved in ensuring more visibility and representation for behavioral health services were allocated to Asian and Pacific Islanders.

- KCCEB developed a curriculum including video trainings, individual and group learning components and handouts with 6 components: 1) Core Competency for Mental Health Practitioner (Social Work 9 Competencies); 2) Foundations for the Organization and Program 1 (Social Services, Case Management, AB74, UELP/PEI, MAA + Progress Notes, Clinician's Gateway); 3) Supervision and Training (Individual, Group, Training topics: Anxiety, Depression, Trauma-informed Care, Self-Harm, Suicide Assessment, Culturally responsive counseling and interpretation) + Outside trainings; 4) Advocacy; 5) Direct Service (Roles, Settings, Client Assessments, UELP Reporting Requirements); 6) Evaluation.

Challenges:

- COVID: Most interns saw their clients virtually or through the phone. Only in exceptional cases were clients allowed to meet in person at the KCCEB office. On the positive side, KCCEB was able to have interns from Southern California because in-person contact was not offered due to the pandemic. KCCEB also had our online call platform with Salesforce that made reaching out to clients more seamless. The challenge of COVID was especially felt among working with youth for whom virtual sessions were less than ideal. Students were not always available during intern availability, had limited privacy in their homes for therapeutic sessions and faced school stress with virtual classes. As such, interns spent a lot of time following-up and chasing down clients which took away from available time in direct clinical settings.
- KCCEB anticipated 10-12 hours of supervision and training time for the MHAP program based on prior experience in training programs. In reality, the MHAP training program took 20-25 hours per week. Students seemed to need more time learning foundational skills, wanted more shadowing time for assessments, care plan development, counseling and/or collaborative/advocacy or community-based multidisciplinary team meetings. Finally, there was a lot of clinical documentation and paperwork needed for different programs and three different school sites.

FY21/22 Progress Report:

- KCCEB is hosting 5 students this year from CSU East Bay, Dominican University, and Palo Alto University. Three interns are focusing on school-based services at Alameda Science and Technology and San Leandro High School, API community children, families, and adults and two interns are supporting Korean seniors.
- KCCEB is operating a hybrid-model so that some interns are seeing clients in-person. One of the challenges we are seeing this year is an increase in mental health service needs both from youth and from the Korean community. The pandemic has impacted peoples' mental health and we are seeing more complex cases.
- Compared to last year, we are seeing an increase in referrals. In just the first half of our contract year, case numbers surpassed last FY (35 so far, last year was 22). In the school site settings, we are seeing students experiencing anxiety, depression, and other traumas in returning to school or being in public settings, grief and loss of people who have passed away or transitions with people leaving home, family arguments and stress, etc. One thing we notice about our Asian students is that they are more likely to be reluctant to share with their parents that they need mental health support. As we have a UELP contract, we are able to take students who are not asked to obtain parental consent.
- This is the first year we have received self-referrals from KCCEB for mental health counseling among LEP Korean clients including three seniors and one youth. In the past, community referrals have been through proxy or indirect methods (i.e. friends or family calling on behalf of other individuals) due to stigma. Community members self–referring is an indicator that there is a dire need in the community, to the level that individuals cannot wait on seeking help.
- Our long-term goal is to develop a pipeline where we increase the number of API mental health professionals serving the LEP and immigrant community. We are delighted that our former and current interns are pursuing their careers in community mental health, joining non-profit organizations that focus on serving marginalized communities to continue their career path. Among our second-year graduates, two have gone into community-based organizations (Family Justice Center in Contra Costa Co and a senior center in LA). We also have a Korean-speaking intern who initially started volunteering with KCCEB to help with

senior wellness assessments during COVID-19, then joined as a graduate student intern to build her clinical skills, and will continue her mental health practice as a staff member of KCCEB upon graduation.

FY22/23 Anticipated changes:

- Currently, the MHAP Program falls under the direct responsibility of the Program Director. We learned that in order to run a robust program, individual and group supervision takes twice as long as anticipated as interns require more clinical support and oversight in areas of their direct work, learning and developing their clinical intervention skills, and practicing their clinical documentation skills. In response, this year we will have two supervisors (including a part-time consultant). One supervisor is providing individual supervision, including coordination of services, providing clinical training and overall oversight of the interns, while the second supervisor is providing group supervision. This gives students different clinical perspectives and also reduces the burden for supervision especially during this time when there are increasing crises and complex cases. We have also diversified our supervisors so that one is an LCSW and the other LMFT in Art Therapy. This allows KCCEB to be more versatile in training and supporting mental health trainees across different backgrounds (social work, psychology) and also gain specialized skills (e.g., art therapy).

- KCCEP is also working to build up our reputation not only as a Korean-serving organization but as an API-wide serving organization. Because of the perception that the program only serves Koreans, we generally have a lower pool of MSW intern applicants. As School Internship Site Coordinators see our work with the broader Asian American community and in the schools, we hope to increase our applicant pool.

Consumer and Family Member Training, Education and Employment

FY20/21 Outcomes, Impact and Challenges:

- BestNow is funded by MHSA WET to provide training, education and employment services to Peers.

- BestNow focused on recruitment and preparation for the Peer Support Specialist class and successfully recruited 20 Peer Support Specialist Training participants even with the ongoing public health crisis.

- Provided a total of 15 Pre-Employment Workshops that were open to consumers, with each workshop serving at least five consumers who are contemplating employment for the first time or who are re-entering the job market.

- Workshops focused on interviewing skills, cover letter/resume building, financial literacy, overcoming stress, benefits of returning to work, and emotional skillfulness.

- Focused heavily on outreach to consumers and collaborated with ACBH and other agencies within the mental health and substance use disorder systems of care, to support student access to Peer Support specialist training.

- Conducted two orientation sessions for three months for a total of 30 individuals showing to get their questions answered by BestNow.

- Adapted trainee selection process to be held remotely online, using BestNow graduates as panel interviewers and holding the interviews on Zoom.
- Restructured training program, including editing down curriculum materials while taking the opportunity to update materials.
- Added curriculum sections on Trauma and Cultural Humility in an effort to keep training up to date and address the SAMHSA Core Competencies for Peer Workers.
- Held support groups to assist training graduates on Zoom on a biweekly basis. These groups were well attended with an average of 15-20 individuals attending. The participants expressed how supportive those groups were during such a challenging time.
- 11 agencies represented at the internship fair, showing the dedication of our partner programs to the internship program and the value that our interns have brought to these agencies over the years. The agencies represented included Alameda County Network of Mental Health Clients, Berkeley Mental Health, Bonita House, Telecare (several program sites), BACS, PEERS, POCC, ACBH Consumer Empowerment Department, and Options Recovery.

Challenges:

- Several orientation sessions had a much lower number of participants show up than the number of people who registered using the Zoom link provided on our outreach materials. This could be due to technology-related challenges from participants or individuals registering too far in advance.
- A major challenge we experienced during this fiscal year was also restructuring the Peer Support Specialist Training to adapt to the restrictions resulting from the COVID-19 crisis while meeting our contract deliverables.
- BestNow made the decision to shorten the length of each training session because of trainee and facilitator limits on how long they could stay engaged in each Zoom session. We also decided to meet 3 times per week instead of 4. To make up for this, we added a Friday Practice Sessions which were optional and required less planning and coordination. We also added biweekly one-on-one check-ins with our participants to make up for the classroom time lost.
- Another challenge was technology-related skill gaps for many of our trainees. While most trainees had devices, they could use to attend class sessions, we did have to arrange to lend a BestNow laptop to one person who otherwise would not have been able to participate.
- In general, some participants struggled with skills such as sending email attachments, navigating the Zoom platform, and even saving and downloading documents.
- BestNow attempted to address these challenges in various ways. We held a “How to Use Zoom workshop,” before the training started to support the participation of people who were new to using Zoom. We have also done a lot of one-on-one support talking with participants through commonly used skills such as saving documents to their devices and attaching documents (such as assignments) to emails.
- Additionally, because of the continued challenges posed by the COVID-19 pandemic and Alameda County shelter-in-place order, many agencies which previously hosted BestNow interns declined to do so. This made

it very challenging to find appropriate internship opportunities for all of our trainees. With the reduced number of internship options available, many trainees have also declined to intern at agencies that would require them to have direct contact with participants due to the COVID-19 safety concerns. Trainees may have started the program with the assumption that the situation would be safer once the internship portion of the training began; however, the numbers in Alameda County continued to rise. Furthermore, a continued challenge for our trainees is related to criminal justice records.

- We continue to have highly qualified trainees rejected from internships/employment opportunities because they have convictions on their record, without regard to the time that has passed since their convictions or the nature of their convictions.

- We maintain that Peer Support Specialists who have personal lived experience with incarceration and the criminal legal system have valuable insights to share from their experiences and should be given equal opportunities for internships/employment opportunities as those trainees without these experiences.

FY21/22 Progress Report:

- In the Fiscal year of 2021-2022, there were some big changes to our contract and the structure of the Peer Support specialist training. Originally our training was 7-weeks of classroom time with a required 6-month part-time internship at an Alameda County mental health and/or substance use recovery program. The dual in-class and workplace experience was a system designed to ready folks with little work experience, or folks returning to work after a long absence, to feel confident to find sustainable employment after the training.

- BestNow condensed the training down to 4 weeks of classroom time, with limited internship opportunities (with priority to participants with the least employment experience).

- Restructures the curriculum and took out some components in order to shorten the training.

- 20 individuals graduated from their Peer Support Specialist training program and connect 4 individuals to internships and 2 individuals to full-time job opportunities for the 2021 year.

- Additionally, BestNow ran cycles with a very diverse demographic group. In FY2021-2022, we had 30.6% of our participants identified as African American, 16.3% as European American, 8.2% as Latino, 6.1% as Asian American, 4.1% as middle eastern, 4.1% as Native American, and 2% identified as Pacific Islander.

- Hired a new program manager, program curriculum coordinator, and program trainer. With the new team, BestNow is in the process of revamping their social media accounts in order to stay more connected with agencies and prospective participants. We also successfully hosted our first alumni event after COVID-19 began, which had over 35 alumni attend.

- BestNow is expecting to go into 2022 with having our first internship fair after the pandemic and also offering our 101-documentation training in-house with the help of the new program manager. We also plan on having refresher course training for any previous graduate who may feel they need it in preparation for when the state certification exam gets released.

FY22/23 Anticipated changes:

- BestNow is anticipating many changes for the 2022-2023 fiscal year such as restructuring the trainings.
- BestNow is considering having 3 different training courses. Two of those will be 80-hour training specifically for individuals already working in behavioral health care services. This type of training could also be used as refresher training for BestNow alumni who might have graduated many years ago. The third type of training we would offer would be between 120-180 hours (TBD) and it would be for Peers who want to work in behavioral health care services. This training would be more in-depth and would consist of presenters coming to teach certain portions of the curriculum as well as teaching the participants about community building and networking.
- Establishing a mandatory internship period.
- Remove the two "Refresher" 10-hour courses, that were meant to prepare BestNow! alumni for Peer Specialist Certification. It has been challenging to understand what to include in the refresher courses, as SB803 is still in the process of being implemented and we are not sure what format the test will look like. To meet this challenge, we developed a curriculum for a "Refresher" that targets each core competency, but even covers just those concepts would still be fit in a sort 10-hour course. We believe that encouraging individuals who have previously taken the 120-hour training, who would like to "Refresh" PSST information before certification, to take the 80-hour training instead. We believe that 80 hours is still very quick, and is best suited for Peers already working in behavioral health care services who would like to become certified.

5. Financial Incentive

Program Description: Offer financial incentives as workforce recruitment and retention strategies, and to increase workforce diversity. Financial Incentives are offered to eligible clinical staff employed in ACBH and to graduate interns placed in ACBH and contracted community-based organizations, and who are linguistically and or culturally able to serve the underserved and unserved populations of the County.

Behavioral Health Loan Repayment Program for eligible clinical staff who complete a service obligation in public behavioral health in Alameda County.

ACBH Graduate Intern Stipend Program

FY20/21 Outcomes, Impact and Challenges:

- Executed and administered the 9th cycle of the Graduate Intern Stipend Program in August 2020.
- Awarded 20 stipends in the amount of $6,000 each for 720 internship hours. Of the 20 awardees, 95% represent the diverse communities of Alameda County.

2020-21 Graduate Intern Stipend Awardees – Ethnicity (Number of awardees =20)

African American	3 – 15%
Asian	7 – 35%

Caucasian	1 – 5%
Hispanic/Latino	8 – 40%
Other	1 – 5%

2020-21 Graduate Intern Stipend Awardees – Language (Number of applicants=20)

English	5 – 25%
Cantonese	1 - 5%
Mandarin	0
Spanish	9 – 45%
Tagalog	2 - 10%
Vietnamese	0
Other	3 - 15%

Challenges:

- Having the ability to pivot during high stress times of the pandemic was imperative
- Reverting all GISP communications to an electronic process.
- Work in collaboration with finance team to process all GISP invoices and distribution of stipend payments through finance for the past year due to new COVID 19 guidelines

FY21-22 Progress Report:

- Launched 10th cycle of Graduate Intern Stipend Program in August 2021 with a focus on interns across system, including behavioral health interns in primary care settings and increasing interns who speak one or more threshold languages: Spanish, Cantonese, Mandarin, Vietnamese, and Tagalog.

FY22-23 Anticipated Changes:

- Use of more modern technology and social media presence to effectively communicate to wider student audience.

ACBH Loan Repayment Program

FY20/21 Outcomes, Impact and Challenges:

- On March 24, 2020, Alameda County and California Mental Health Services Authority (CalMHSA) executed a participation agreement (PA) to implement the Alameda County Loan Repayment Program with ACBH WET. The purpose of ACLRP is to provide financial incentive to retain qualified, eligible employees in hard-to-fill/retain positions in the Alameda County Behavioral Health Care system, including employees of community-based organizations.

- ACBH WET, in collaboration with CalMHSA, launched its first cycle of the local ACLRP in July 2020, and began a second cycle in July 2021.

- 35 individuals who represent the diverse communities of Alameda County applied and 21 clinicians from County and contract Community Based Organization (CBO) settings received up to $10,000 towards their

outstanding student loans.

FY21/22 Progress Report:

- Alameda County Workforce Education and Training (WET) local Loan Repayment Program (ACLRP) is in the process of transitioning into the State-funded Regional Workforce Education and Training (WET) Partnership Program (RP).

- Alameda County is working with CalMHSA on transitioning the ACLRP cycle 2 applicants into the WET RP in order to take advantage of the existing State WET RP funding. CalMHSA is amending the current ACBH Participation Agreement (PA) and morphing it into a PA that works for the WET regional partnership (RP) activities. Of note, Alameda County is one of the only Greater Bay Area Region (GBA) counties that has completed a round of loan repayment and is moving into round two, using State funds. effective from July 1, 2020 through June 30, 2025.

FY22/23 Anticipated Changes:

- Based on local Alameda County WET programming and previous Mental Health Service Act Community Program Planning Process (CPPP) information, Alameda County WET will implement a Community College Behavioral Health Career Pipeline Scholarship and Mentoring Program for undergraduate students funded by the WET Regional Partnership.

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, ACBH continues to transfer CSS funds to the CFTN component for various programs and projects. 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 21/22-22/23

Medical Respite Expansion projects (CF2): In FY 19/20 ACBH allocated $3M in MHSA CFTN funding for Medical Respite bed expansion projects in Alameda County.

The Health Care for the Homeless (HCH) unit under the Alameda County Health Care Services Agency (HCSA) is developing a new medical respite project called Oak Days utilizing these funds.

Oak Days is currently running as a non-congregate emergency shelter with 40 beds set aside for very medically fragile clients who have complex physical and mental health care needs.

To be eligible for one of the 40 beds at Oak Days clients must meet ALL THREE of the following criteria:

1. Functionally compromised (which includes both physical and mental health issues)
2. Complex chronic condition (including mental health)
3. 8 or more ED visits, or 2 or more inpatient in last year (psych ED visits and inpatient psych admissions are included in the count)

These beds were created to meet a need that doesn't exist. The majority of start-up costs have been provided through Alameda County's Whole Person Care Program, but there is currently a need for the provider to purchase a Home Health Agency License. This is a one-time expense that will allow the agency to pay for caregivers with Medicaid funding and will open up other medical respite opportunities for Alameda County.

Ongoing Projects

During FY 22/23 the following CFTN projects were in process. These projects were listed as new programs/projects in previous Plan Updates (FY 18/19 and 19/20) and/or the current MHSA Three Year Plan FY 20/21-22/23. Updates on progression of these programs and projects were provided in last year's MHSA Plan Update FY 21/22 under the ongoing section of the Plan. Several of these projects will be completed this fiscal year (FY 22/23) and others will be continued and completed in FY 23/24 and beyond.

CFTN Program Summaries:

PROJECT NAME: CF2 Respite Bed Expansion

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 run by LifeLong Medical Care, a Federally Qualified Health Center and a partner to ACBH on multiple programs, opened in September 2019. The program is designed as a 27-bed medical respite (3 first floor ADA accessible beds and 24 beds on a second floor with no elevator). The Adeline Street Recuperative Care program is a medical respite program that provides a safe place to recuperate, medical services, and behavioral health support. Clients receive medical care and case management services, meals, behavioral health services, and connection to cash and food benefits, primary care providers, mental health services, and follow-up appointments. The site has staff on-site 24 hours a day, 7 days a week. Staffing includes case managers and nursing. During COVID, the capacity has been reduced to 15 beds in order to accommodate social distancing and quarantine needs.

FY 21/22 Progress: The program started ramping up in September 2019 and reached close to full capacity by the end of January 2020. Referrals for the program come from Alameda Health System and Street Health teams. From program start (7/1/19) through 12/15/21, 227 clients were admitted. Approximately 30-40 unduplicated clients are served per quarter.

Starting in March 2020 the capacity of the program was reduced in order to meet COVID safety guidelines; however, capacity was increased again to full capacity in July 2021. In FY 20-21, 117 unduplicated clients were served.

PROJECT NAME: CF3 County Facility Renovation

Project Description: This is a one-time project for capital costs of adding the 3 new suites at the ACBH administrative offices at 2000 Embarcadero Cove in Oakland. The suites are for growth in the Quality Management unit, the Utilization Review unit and the Information Systems (IS) unit.

FY 21/22 Progress: This project remains on hold due to COVID-19 as the County, including ACBH, has many remote workers and full determination of the department's space needs looking forward is currently a separate project by a GSA Consultant that will commence in first quarter of 2022.

More information will be included in the MHSA Three-year Plan (FY 23/24-25/26) as is available.

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 Wellness Center (AWC) to help alleviate the homelessness crisis and address adverse health outcomes among vulnerable populations in Alameda County. APC Wellness Center will include approximately 90 beds of Permanent Supportive Housing for seniors, a 50-bed medical respite, a primary care center, and a resource center for persons experiencing homelessness. See the FY 18/19 MHSA Plan Update for a more detailed project description at www.ACMHSA.org

FY 21/22 Progress: In 2020 the architectural design and design development phases were completed. Renderings were completed and received support from the neighbors at a community meeting. APC is working with Mercy Housing to develop the permanent supportive housing community for unhoused seniors and collaborating closely with LifeLong Medical Care (services and health partner) to shape the AWC integrative service model.

Beginning in 2021 County support of the project transitioned from Health Care Services Agency to Housing and Community Development, as APC continues their work on capital development. Construction on the first phase of the project is set to start in July 2022.

PROJECT NAME: CF5: African American Wellness Hub Complex

Project Description: The African American Wellness Hub Complex began development in FY 20/21 and will be developed over the next three years (FY 20/21-22/23). This Hub Complex 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.

FY 21/22 Progress: ACBH, in partnership with the Alameda County General Services Agency (GSA) department, continues to work on the development of the African American Wellness Hub Complex (HUB). In FY 21/22 ACBH Leadership identified an additional $8.8M (non-MHSA funds) to enhance the current $6M (MHSA CFTN funds) budget for a total development budget of $14.8M.

The ACBH Office of Ethnic Services, in partnership with the ACBH Building Facility Manager and GSA identified an outside architecutural team who completed their final Space Needs Assessment report for the African American Wellness HUB. The report presented three viable options and limitations for the procurement of the HUB. The partnership continues by explorating and examining the inventory of County owned facilites for the HUB and other potential suitable sites.

More information will be available on the progress of either a land purchase or building purchase/renovation as it becomes available and will be posted on the MHSA website and in the next MHSA Three Year Plan (FY 23/24-25/26)

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 21/22 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.

As of FY 21/22 the project is moving forward and an Architect/ Engineer (A&E) is updating the scope to maximize the parking potential and compliance with ADA. Additionally, the parking area will be fully lighted and a secure recycling area will be included to meet city of Hayward and County regulations. Considerations for drainage and curb access into the building will be a component. The A&E are scheduled to finish their work by April 2022 when ACBH will then address the soil removal and move forward with the construction. 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 (EHR), to include: billing, managed care, e-prescribing functions, data interoperability and functions as needed to support clinical and fiscal operations of ACBH. 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 21/22 Progress: ACBH has utilized CFTN funds to develop and release a request for proposal (RFP) for the *billing section* of the EHR. This project was awarded in January 2021. The contract with the vendor began in April 2021 for the pre-implementation planning phase. The Implementation planning phase began in July 2021 (FY 21/22).

As of April 2021, ACBH is now partnering with the vendor Streamline Healthcare Solutions, LLC, to formally initiate the effort to provide a fully integrated billing system on the SmartCare Platform to replace *INSYST* (the department's current registration and billing platform). The Implementation planning phase began in July 2021 and will continue through FY 21/22.

Streamline and the integrated SmartCare Platform will incorporate all of the functionality necessary to ensure staff and contracted providers work together within and across organizational boundaries. This platform will help to advance the effective delivery of behavioral health care for our clients and the communities we serve. SmartCare will also provide our system with options to resolve system challenges and facilitate enhanced flexibility for data sharing.

More information will be available on the progress of this project as it becomes available and will be posted in the next MHSA Three Year Plan (FY 23/24-25/26)

Additionally, under the CFTN Component 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 (CG) Interface and Consulting Services for CG
- CFTN Administration

PERFORMANCE MANAGEMENT INITIATIVES

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. A summary of RBA examples for MHSA are included in *Appendix C-1.*

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 hired and/or is recruiting 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)

[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.

- 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.

- Compliance and Privacy Officer: Support the MHSA program to adhere with federal, state and local guidelines.

*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

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 uses a web-based data and outcome reporting system called YellowFin. MHSA staff partnered with System of Care staff and the ACBH Data Services team to update the FSP outcomes dashboard to include the Service Teams. The Service Team impact metrics are used for the FY 20/21 Report and to make decisions on transforming the teams. The reporting dashboard covers hospitalizations, incarcerations, primary care linkage, and system costs. The Service Teams were added because of the success of the FSP dashboard.

The Underserved Ethnic Language Programs (UELPs), Evaluation Workgroup has finished it's first round of changes to the yearly UELP evaluation. The workgroup redesigned the logic model and worked with a graphic designer to create a graphical version of it and re-worded and updated both the Pre/Post Health Assessment and Participant Satisfaction Surveys. Both of these have been implemented during FY 21/22 using Survey Monkey and the results will be used during the evaluation.

During the FY 18/19 In Home Outreach Teams (IHOT) evaluation, the need for a dashboard in Yellowfin was identified to track client's discharge outcomes, how long the client works with the IHOT, and pre-IHOT and post-IHOT hospitalizations, incarcerations, crisis and subacute admissions. The IHOT Program Specialists is now using the dashboard to track the clients in the program and their outcomes.

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 Care Services Department Mental Health Services Act Division would like to acknowledge the contributions of departmental staff, affiliates, consultants, and community partners, including, but not limited to:

Alameda County Behavioral Health Care Services Department

Amymade Graphic Design

Alameda County Board of Supervisors, District 4

Bryan Kring Design

Financial & Contracts Division

City of Fremont Human Services Department

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 Board

MHSA Stakeholder Group

MHSA Community Program Planning Process Steering Committee

NAMI East Bay

NAMI Chnese

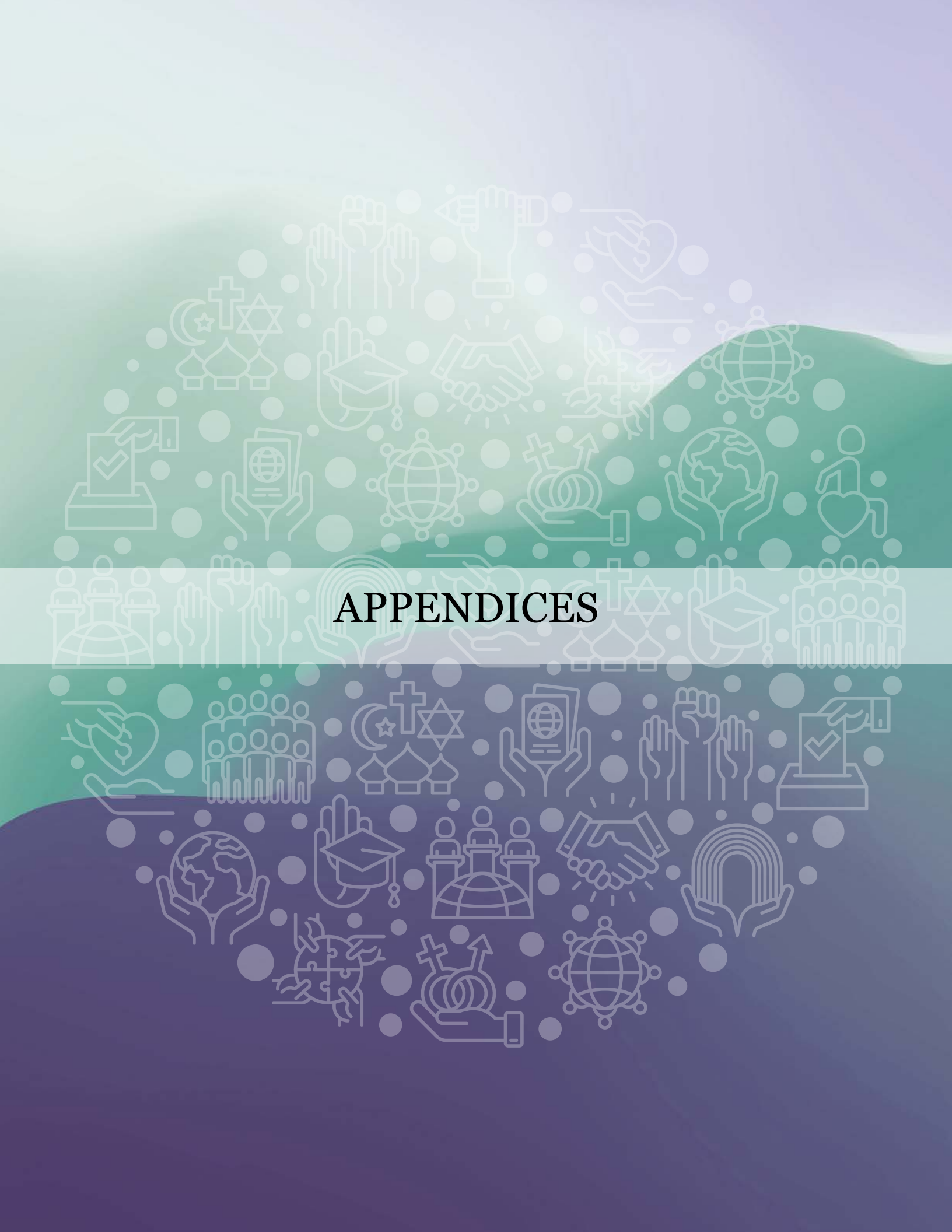
Office of Ethnic Services

Peers Envisioning & Engaging in Recovery Services (PEERS

Peers Organizing Community Change (POCC)

Public Health Department, Community, Assessment, Planning, and Evaluation (CAPE)

Swords to Plowshares



APPENDICES

Appendix A: MHSA-SG Meeting Calendar

alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

MENTAL HEALTH SERVICES ACT (MHSA)

STAKEHOLDER GROUP MEETING CALENDAR, 2022 rv3

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

DATE	TIME	LOCATION	MEETING THEMES
January 28, 2022	2:00-4:00pm	Go To Meeting	• Program Spotlight: Mental Health Peer Coach • Annual Plan Update • MHSA Community Planning Meetings (CPM) Outreach & Focus Group
February 25, 2021	2:00-4:00pm	Go To Meeting	• MHSA Goal Setting/Finding A Common Link • Program Spotlight: STRIDES • Review Operating Guidelines
March 25, 2022	2:00-4:00pm	GoToMeeting	• Presentation: ACT Fidelity
April 22, 2022	2:00-4:00pm	Go To Meeting	• CPPP/INN recommendations • Program Spotlight: INN Proposals (Project Indigo)
May 27, 2022	2:00-4:00pm	GoToMeeting	• MHSA Plan Public Comment/Public Hearing • Quarterly Program Data Review • Program Spotlight: OESD 33/Deaf Community
June 24, 2022	2:00-4:00pm	Go To Meeting	• Compliance- HIPAA for family members
July 22, 2022	2:00-4:00pm	Go To Meeting	• Leg Review: AB2022
August 26, 2022			• Program Spotlight: Deaf & Hard of Hearing
September 23, 2022	2:00-4:00pm	Go To Meeting	• Program Spotlight: Annual Plan Review & CPPP Data
October 28, 2022	2:00-4:00pm	Go To Meeting	• Leg Information: LPS/Conservatorship
November 18, 2022**	2:00-4:00pm	Go To Meeting	• Presentation: Supportive Housing
December 16, 2022**			• Program Spotlight/Presentation: • MHSA Policy & Legislation Review • End of Year Celebration/Retreat
			• Interview Qs

MHSA STAKEHOLDER MEETING CALENDAR
Mariana Real, MPH, MCHES
Revision Date: 3/22/2022

alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

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 • Sent to HCSA: 5/2020 • 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 • # meetings held		• Convened 10 meetings (initiated 2/19/20 – 6/3/20) • 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 2. Embed on the MHSA webpage 3. Embed link on flyer 4. Track response rates weekly	• # unduplicated survey completion/each language		Finalized 4/23/20 Live on 4/27/20 • # surveys: 627 which is a 14% increase from previous 3-year efforts ○ English: 587 ○ Chinese: 31 ○ 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 2. Secure approval 3. Post to MHSA website	• Approved MHSA 3-Year Plan • # residents reached • # website hits/pageviews/downloads		• MHSA Plan approval date projected to 10/1/20, FY18/19 annual update approved 5/2020 • Website hit: (4/27/20 – 5/31/20): 2,145 users

alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

MHSA CPPP, 2020
Outreach & Marketing Plan
(Updated: July 23, 2020)

					(2,089 new users) and 10,594-page views • # residents reached via surveys: 627 • # 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 • # completed Innovations Idea forms		• New Community Input page, INN idea form, and Pop up message live 4/27/20 • # HHREC/POCC hotline calls: 177 • # 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. 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* • # PSAs completed by ACBH staff: *Tri Valley*	• Facebook Ad (5/5/20: $490/ 2wks • Post News Groups: $1840/1wk • East Bay Times: $695/1/4pg/2wks • Tri City Voice: $500 per 1/3pg/2wks • Alameda-Contra Costa Medical Assoc: $500/2wks	• Start date: 4/27/20 (total 35 days outreach) • # Media Outlets Contacted: 9 • # PSAs: 1 (tri-Valley) • # Interviews Completed: *0*

MHSA CPPP, 2020
Outreach & Marketing Plan
(Updated: July 23, 2020)

			• **# interviews completed by ACBH staff:** *0*	• Bay Area Reporter: $604/ 1/5pg/wk. • 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** **○ LaNiece Jones Media PR firm sends E-Blasts** **2. HHREC pay for Facebook advertisements and paid aids in online newspapers (e.g. Oakland Post)** **3. Utilize YouTube as a platform**	• **# Facebook social media hits:** *1,066 clicks/2 weeks* • **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** • **# 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** **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)* **3. Post content through Alameda County CAO**	• **Complete register of distribution lists:** • **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** ○ **Webmaster sent 4/28/20**

alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

MHSA CPPP, 2020
Outreach & Marketing Plan
(Updated: July 23, 2020)

		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

Convene Focus Groups	**Identify, recruit, host 10 community focus groups by May 30, 2020.**	**1. Develop Focus Group materials** **2. Coordinate focus Group Facilitator Training** **3. Develop Focus group tip sheet and Questionnaire** **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** • **# and name of participating agencies** • **# focus groups** • **# participants per agency** • **# consents received** • **# completed (paper only):** ○ *MHSA/MHAB: 1* ○ *POCC Volunteers* ○ *HHREC* ○ *BOS 4*		• **Focus Group Toolkit posted: 5/2020** • **# Trainings: 6** ○ MHSA (5/11/20): 3 ○ SM meeting (5/20/20): 14 ○ PEERS (5/12/20): 2 ○ All MHAB (5/16/20): XX ○ MHAB Children (5/XX/20): 2 ○ POCC (5/26/20): 7 • **# Focus Groups/ attendees: 12 / 186** ○ *ACBH Operations (4/6/20): 44* ○ *MHSA-SG (4/24/20): 11* ○ *PEERS/AA-FAITH (5/12/20):7* ○ *La Clinica CyB (5/13/20); 9* ○ *MHAB General (5/18/20): 19* ○ *UELP (5/22/20): 13*

alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

MHSA CPPP, 2020
Outreach & Marketing Plan
(Updated: July 23, 2020)

					○ *MHAB Children's Committee/TAY (5/22/20): 34* ○ *MHAB Adult (5/5/20): 5* ○ *POCC/Camphor (5/27/20): 28* ○ *LGBTQIA+ HHREC/Office of Ethnic Services (5/27/20): 6 (20 preregistered)* ○ *MHAB Criminal Justice (5/27/20): 10* ○ *Family Dialogue Group (7/23/20): 12* • **# consents:** ALL (verbally read) • **# 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** **2. Participate in ALCO system of care meeting to include:** *POCC, FSP,*	• **# attendees** (roster) • **# meetings presented** • **# clinicians (55,817)**		

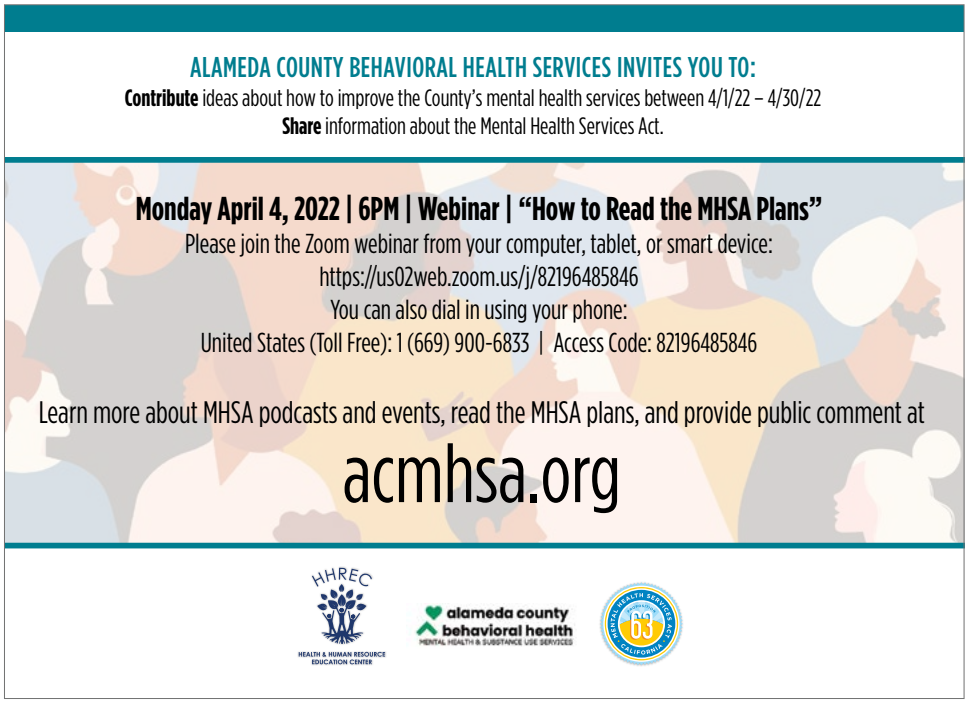
		Adult, and Children SoC, Crisis Providers, PEI 3. **Augment electronic health records and proprietary case management systems/software** *(e.g. EPIC, CalWIN, ETO, Persimmony)* **to provide information/proctor surveys** 4. **Contact CA Dept. of Consumer Affairs, procure Provider List & send CPPP flyer via PS Print:** ○ *Behavioral Science: 6,890* ○ *Psychology: 1,641* ○ *RNs: 26,734* ○ *LVN Psytech: 13,868* ○ *MedBoard:6,684* 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** • **# surveys completed with consent/assent forms**		

alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

MHSA CPPP, 2020
Outreach & Marketing Plan
(Updated: July 23, 2020)

		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 • # complete surveys • #/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 • # attendees at event • # surveys completed (paper-based) • CPM Satisfaction rate • #/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 • # materials distributed at CPMs (# FG participants)		○ See # FG participants ○ # INN forms: 29 web forms submitted)

Appendix B-2 CPPP E-Flyer




WE WANT TO HEAR FROM YOU!
Help shape and impact Alameda County's mental health system!
COMMUNITY PROGRAM PLANNING PROCESS & 30-DAY PUBLIC COMMENT NOTICE
for the Alameda County Mental Health Services Act Annual Update FY22/23
HHREC
MHSA PODCAST
alameda county
behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES
HHREC
HEALTH & HUMAN RESOURCE
EDUCATION CENTER
MHSA is funded by a 1% tax on individual incomes over $1 million.


ALAMEDA COUNTY BEHAVIORAL HEALTH SERVICES INVITES YOU TO:
Contribute ideas about how to improve the County's mental health services between 10/1/21 – 1/31/22
Share information about the Mental Health Services Act.
Learn more about MHSA podcasts and events,
read the MHSA plans, and provide public comment at
acmhsa.org
HHREC
HEALTH & HUMAN RESOURCE
EDUCATION CENTER
alameda county
behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

Mental Health Services Act Community Education & Input

MHSA Plan Update FY 22/23

Presented by: Mariana Real, MPH
MHSA Sr. Planner, Alameda County Behavioral Health Care Services

Mental Health Services Act

The Mental Health Services Act (MHSA) emphasizes Transformation of the Mental Health System and Improving the Quality Of Life for people living with mental illness and those at-risk for mental illness and/or mental health challenges.

- In 2004, California voters passed Proposition 63, know as the Mental Health Services Act.
- Funded by 1% tax on individual incomes over $1 million.
- Services must be voluntary.
- Non-supplantation: MHSA may not replace existing program funding or be used for non-mental health programs.

2

MHSA 101: 5 MHSA Components

#	Component	Abbreviation	% of Funding	Sub-component
1.	Community Services and Supports	CSS	76%	Full Service Partnership Outreach & Engagement, Systems Development (OESD)
2.	Prevention and Early Intervention	PEI	19%	Prevention, Early Intervention, Recognition of Signs of Mental Illness, Access and Linkage to Treatment, Stigma and Discrimination Reduction, Suicide Prevention & Promotion
3.	Innovation	INN	5%	None
4.	Workforce, Education and Training	WET	Funding from CSS	None
5.	Capital Facilities and Technological Needs	CFTN	Funding from CSS	None

3

MHSA CORE PRINCIPLES

- Community Collaboration
- Cultural Competence
- Wellness Focus: Recovery and Resilience
- Client and Family Driven Mental Health Services
- Integrated Service Experience

4

MHSA 101: 5 MHSA Components

1. Community Services and Supports (CSS):

Provides direct treatment and recovery services to individuals of all ages living with serious mental illness (SMI) or serious emotional disturbance (SED):

- **Full Service Partnership (FSP)** plans for and provides the full spectrum of services, mental health and non-mental health services and supports to advance client's goals and support their recovery, wellness and resilience using a **"What ever it takes"** approach.
- **General Systems Development (GSD)** improves the mental health service delivery system.
- **Outreach and Engagement (O&E)** is to reach, identify, and engage unserved individuals and communities in the mental health system and reduce disparities.

Source: www.steinberginstitute.org/wp-content/uploads/2017/10/MHSA-101-1

5

MHSA 101: 5 MHSA Components

2. Prevention and Early Intervention (PEI):

Funds may be used for programs that **identify early mental illness**, **improve** *timely* **access** to services for **underserved** populations, and **reduce negative outcomes** from untreated mental illness including:

1. Suicide
2. Incarcerations
3. School failure or dropout
4. Unemployment
5. Prolonged suffering
6. Homelessness
7. Removal of children from their homes

6

MHSA 101: 5 MHSA Components

3. *Innovation (INN):*

5% of funds received for CSS and PEI may be used for innovative programs that develop, **test** and **implement promising practices** that have not yet demonstrated their effectiveness. Needs approval from Mental Health Services Oversight & Accountability Commission.

Current ACBH Innovation projects include the:

- Community Assessment and Treatment Team (CATT)
- Land Trust
- MH Applications

- **Two INN projects in development** focusing on justice involved individuals who have a severe mental illness (SMI).

7

MHSA 101: 5 MHSA Components

4. *Workforce Education and Training (WET):*

This component aims to **train** more people to **remedy the shortage** of qualified **individuals who provide services** to address severe mental illness. Counties may use funds to **promote employment** of mental health **clients** and their **family members in the mental health system** and **increase the cultural competency** of staff and workforce development programs. Funding source is CSS.

5. *Capital Facilities and Technological Needs (CFTN)*

This component finances capital and infrastructure to support implementation of other MHSA programs. It includes **funding to improve or replace technology** systems and other **capital projects**. Funding source is CSS.

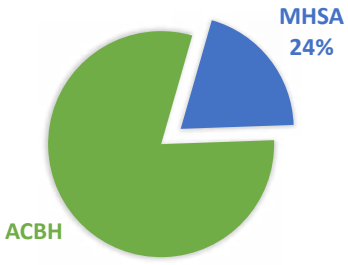
****Counties may transfer up to 20% of their previous CSS 5-year allocation average to CFTN, WET or the Prudent Reserve:**

8

MHSA: What is the Current Budget?

ACBH FY 21/22 Total Approved Budget of $569.7M

- 706 County Civil Service positions
- 3,000+ positions with community-based providers



MHSA Annual Budget is $140.6.1M (approximately 24% of the overall ACBH Budget)

- *172 County Civil Service positions (25%)*
- *16,000+ individuals served in MHSA funded treatment programs*
- *9,000+ individuals served in MHSA PEI funded programs*

9

MHSA: Five Plan Components

FY 21/22 budget estimates in millions

Community Services & Supports	Prevention & Early Intervention	Workforce, Education & Training	Capital Facilities & Technological Needs	Innovative Programs
43 ongoing work plans	24 ongoing workplans	10 programs and strategies	8 projects	4 approved projects 2 pending project
$99.71M annually	$16.21M annually	$3.42 M annually	$12.26 M	$8.99M
13%+	7%+	3.6%+	9.8%-	42.6%+

10

MHSA Financial Terms

•***Reversion Period:*** Counties must expend the revenue received for each core component within a specific timeframe, starting with the year the revenue is received, or must return it to the State Mental Health Fund.

- *CSS and PEI funds have a 3 year reversion period.*
- *INN has up to 5 years and must be connected to an approved INN project.*
- *WET and CFTN have a 10 year reversion period.*

•***Prudent Reserve (PR):*** Counties are required to establish and maintain a PR for revenue decreases.

- *Counties may fund to a level determined appropriate and that does not exceed 33% of the counties' largest annual distribution (Info Notice 18-033)*
- *The restricted account that MHSA monies can be placed in that is not subject to reversion to the State and can be used in times of reduced MHSA funding associated with an economic decline.*
- *Requires approval from the Department of Health Care Services before it can be utilized at the local level.*
- *If utilized, the year it's utilized, MHSA funds cannot be transferred to WET or CFTN.*

11

MHSA Financial Terms, cont.

•***Annual Adjustment:*** A lump sum, usually positive, that is known two fiscal years after the revenue was earned.

Annual Adjustments are incredibly volatile:

•Two-year lag

•Known by March 15th

•Deposited on July 1st

•Called the "True Up"

	FY 17/18	FY 18/19	FY 19/20	FY 20/21
Actual Allocation (SCO Funding)	71,629,573	72,099,545	65,694,634	96,158,248
Estimated Allocation	68,856,043	68,334,729	80,415,461	79,688,108
Over/(under)	2,773,530	3,764,816	(14,720,828)	16,470,140*

* Includes deferred revenue from FY 19/20

12

Community Program Planning Process (CPPP):
Title 9 CCR Section 3300

- The County shall provide for a CPPP as the basis for developing the Three-Year Program and Expenditure Plans and Annual Updates.
  - To ensure that the CPPP is adequately staffed, the County shall designate positions and/or units responsible for:
    - The overall CPPP, ensuring that stakeholders have the opportunity to participate in the CPPP and training stakeholders
  - Stakeholder participation shall include representatives of unserved and/or underserved populations and family members of unserved/underserved populations.

13

The stakeholder groups that are to be included in the Community Program Planning Process are to reflect the diversity of the demographics of the county, including, but not limited to, geographic location, age, gender, and race/ethnicity and ….

- Clients and Peers
- Families of children, adults and seniors clients/consumers
- Providers of social services
- Providers of mental health and substance use treatment services
- Education field
- Persons with disabilities, including providers
- Health care
- Veterans and/or representatives form veterans organizations
- Law enforcement
- Other interests (faith-based, aging and adult services, youth advocates, etc.)
- College-age youth
- Individuals from diverse cultural and ethnic groups

14

Oversight of Counties

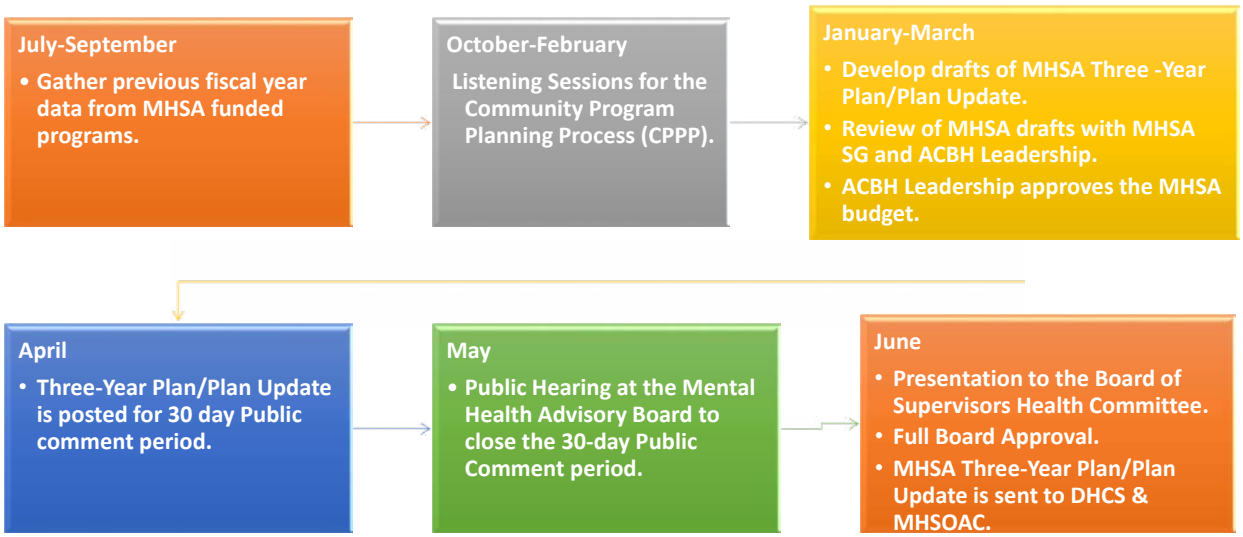
•To ensure that counties are implementing the MHSA correctly, there are two state entities that provide guidance, support, monitoring and oversight:

•**DHCS:** Department of Health Care Services
- Monitors the performance contract between the state and the county
- Provides Information Notices that clarify regulations
- Conducts program reviews
- Provides technical assistance

•**MHSOAC: Mental Health Services Oversight & Accountability Commission**
- Oversees and approves Innovation Projects
- Develops multi-county Innovation Projects
- Research and Evaluation

15

MHSA Three-Year Plan/Plan Update Cycle



16

Thank You

For more information email us at MHSA@acgov.org or visit us at www.ACMHSA.org

17

ALAMEDA COUNTY BEHAVIORAL HEALTH

Mental Health Services Act (MHSA) Annual Update, FY 22/23

Community Program Planning Process (CPPP)

LISTENING SESSION - INPUT QUESTIONS & ANSWERS

Focus Group: Veterans Collaborative Court |Date: 10/29/21| Attendees: 9

1. What are the top or most pressing mental health issues right now in your community?
   - **Mental struggles** in the psyche. Fear & mental fragility, bot physical
   - **Basic access** to MH services. These services don't feel available to vets.
   - **Boredom**, which can lead to depression. Being alone/**isolated**, lacking community, no one to talk to, nothing on weekends.
   - **Easy access to alcohol**, it's all around
   - There are 3 VA's in the Bay Area and each of them is different in terms of quality. Many reported the **Oakland VA's quality is not great**. Palo Alto is much better.

2. Are there **individuals, groups** and/or **cultural communities** who you believe are **not being adequately served?**
   - Homeless Veterans

3. What do you see as **barriers** for people to get help?
   - **Lack of services** on the **weekends** and **after hours**
   - **Lack of familiarity and knowledge** about what is out there **for services and supports**, Vets just don't know. Without familiarity there is hesitancy.
   - There's a lack of knowledge/awareness and **lack of assistance/navigation** on how to access services
   - Disconnection between VA and County MH system
   - **Wait times** can be weeks. Which doesn't help in a crisis
   - Lack of access to **technology** (computer, phone) and **transportation** (car)

4. What are your ideas on how to **better serve** our communities?
   - **More communication with the courts** about who is eligible for the Veterans Collaborative Court, more information for attorneys.
   - **More training** at VA's
   - Services and support on **weekends and evenings**
   - **Outreach and better information about the VA's**
   - Information on **housing** and housing supports
   - Information on how to get started and **navigate with the VA**
   - **Setting up a "game plan"** once your service is complete, so that you have activities and supports.
   - **Holding Veteran's community forums** where people can share out and information is provided.
   - More local resources listed on CalVet website

alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

ALAMEDA COUNTY BEHAVIORAL HEALTH
Mental Health Services Act (MHSA) Annual Update, FY 22/23

Community Program Planning Process (CPPP)

LISTENING SESSION - INPUT QUESTIONS & ANSWERS

- Information on resources included in an individual's military discharge packet.

5. What MHSA-funded services are you aware of, either as services you or someone you know has taken advantage of or as services you would feel comfortable recommending to others?
   - Swords to Plowshare
   - Operation Dignity Berkeley Free Housing

ALAMEDA COUNTY BEHAVIORAL HEALTH

Mental Health Services Act (MHSA) Annual Update, FY 22/23

Community Program Planning Process (CPPP)

LISTENING SESSION - INPUT QUESTIONS & ANSWERS

Focus Group: ACBH contracted CBOs |Date: 12/3/21| Attendees: 23

Note: Workforce was an overall theme throughout the listening session:

- ✓ How to build peer and para professional pipelines.
- ✓ More workforce incentives for undergraduates and individuals at community colleges.
- ✓ More culturally congruent services with a workforce that looks and speaks the languages or clients.
- ✓ Making sure the workforce is properly trained.
- ✓ Use of WET funds to develop apprenticeship partnerships with local community colleges.

1. What are the top or most pressing mental health issues right now in your community?
   - **Crisis Services for Kids:** Lack of enough Crisis Residential Services for kids; Kids getting stuck in the ER, no aftercare planning

2. Are there **individuals, groups** and/or **cultural communities** who you believe are **not being**
   - Residents in East County, where there are few services
   - Individuals where English isn't their first language, not having bi-lingual staff is a barrier to future services.
   - Transgender and Gender fluid community
   - Individuals with sex addictions
   - SUD issues, especially with crystal meth
   - Youth/young adults that can "age out" of the children's system, but due to factors like trauma and relapse, they need more time with the types of services provided in the children's system. This was titled "more grace group"
     - Similar comment: The gap for **foster youth** (and others) that lose EPSDT eligibility at 21, are still in need of services, and don't necessarily qualify for Adult SMHS

3. What do you see as **barriers** for people to get help?
   - When clients have to move from provider to provider, clients feel tossed around
   - Medi-cal billing
   - Not enough coordination/collaboration between CBO's education system and the home
   - Timing of when services/supports/activities are available: Need services/supports/activities in the evening and weekends.
   - Severe lack of bilingual clinicians to work with the client and family members
   - many school-based mental health services are only available to youth who have Medi-Cal.

4. What are your ideas on how to **better serve** our communities?
   - More **culturally congruent services with a workforce that looks and speaks** the languages or clients
   - Services/supports/activities on the weekends after hours
   - **More mobile crisis services**, especially in the evening weekend and early morning that also don't include law enforcement (aka like CATT). Crisis Support said the need to have a mobile team go out to see a person who has called the crisis line is ballooning. Multiple people echoed this comment.

ALAMEDA COUNTY BEHAVIORAL HEALTH
Mental Health Services Act (MHSA) Annual Update, FY 22/23

Community Program Planning Process (CPPP)

FOCUS GROUP - INPUT QUESTIONS & ANSWERS

- It would be great to see ACBH pursue the BHCIP funding opportunity to develop crisis care mobile units, and leverage MHSA to provide services.
- More focus on **community mental health using more primary prevention strategies**. Focusing on the community as compared to the individual.
- **Wholistic programming** where there is a staff/provider that follows a client, even if they switch programs or providers so that the person doesn't fall through the system and has a constant connection to help them navigate and adjust to the BH system.
- True MH and primary care integration
- **Using MHSA to fund coordination of services**. A lot of new funding is coming to counties and MHSA could be used to assist in the coordination of all of the funds and services.
- **More ethnic and linguistic focused services, like the UELP** programs (MHSA PEI programming) Here's an excerpt from the chat:
  Our PEI funded UELP program is doing a lot of community-based work engaging monolingual Spanish speaking residents who won't necessarily identify with the traditional behavioral health care delivery, they create community, in addition to culturally responsive group and individual counseling. I am calling this out as a successful, cost effective model flexible enough to tailor to the unique cultural needs of diverse communities.
- More **early childhood** intervention services
- More **training for caregivers.**
- **Expand children's services** by leveraging MHSA as the non-federal share of cost (done in other counties).
  Use of **technology funds** to support implementation of forthcoming **CalAIM.**
- Use of **technology funds** to help CBOs with **implementation of EHRs**
- Funding

5. What **MHSA-funded services** are you aware of, either as services you or someone you know has taken advantage of or as services you would feel comfortable recommending to others?
   - Crisis Support Services of Alameda County
   - Family Education Resource Center (FERC)/Mental Health Association of Alameda County (MHAAC)
   - Full Service Partnerships (FSP's)
   - Felton Institute, First Break program

ALAMEDA COUNTY BEHAVIORAL HEALTH

Mental Health Services Act (MHSA) Annual Update, FY 22/23

Community Program Planning Process (CPPP)

FOCUS GROUP - INPUT QUESTIONS & ANSWERS

Focus Group: Reentry Collaborative Court |Date: 11/16/21| Attendees: 6

1. What are the top or most pressing mental health issues right now in your community?
   - Coming home is stressful—especially when you start off homeless. Seeking help with mental health issues can be overwhelming, but things become more bearable when you get treatment
   - Being able to find people you trust that want to help you
   - Finding new ways to cope

2. Are there **individuals, groups** and/or **cultural communities** who you believe are **not being**
   - Homeless and trying to survive after getting out
   - Dealings with race and substance use issues
   - African American and Latino populations have nowhere to get help with the traumas from being back in jail- trauma, grief, losses, depression. We may not be educated, we've adapted to jail life and life outside is hard. We have to ask where do you live? Who cares about me? Who do I reach out to?
   - Drugs led me to criminal activity, and criminal activity took me to jail. When we're inside, we're not rehabilitated. We still have the same problem so when we get out and we have a habit, we get into trouble again. We need to be honest with ourselves and others to get the help we need
   - I made myself a target—I chose and got addicted to the lifestyle. I have PTD from what I experienced in that lifestyle
   - I can't help anyone until I help myself. I chose to get this help and I am happy

3. What do you see as **barriers** for people to get help?
   - Wanting to visit your old atmosphere. You get lost and feel like you've got to catch up. You end up crashing- you can't go back, you've' got to cut all ties. If you wan to live a new life, you've got to leave the old life alone
   - I came "home" homeless. I had no way to cope with my grief and loses. I was in for son long, I didn't recognize this life
   - My situation was different, it was my attitude. I sought help, I didn't have room to breathe. Each person's journey is unique. You're a newborn coming back to society, some people don't have a choice to not return to the same atmosphere. I've learned how to breathe, you've got to get help and connect with like-minded people. I'm starting to heal. I had to become vulnerable to get what I need.
   - I had to come out of my comfort zone- had to do things differently. Prison became a comfort, so I had to break the cycle of seeking comfort in the streets and in prison, I had to change my thinking, start doing things that were productive and now I can be proud of myself. I had to seek therapy, I had to change my whole life.

alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

ALAMEDA COUNTY BEHAVIORAL HEALTH
Mental Health Services Act (MHSA) Annual Update, FY 22/23
Community Program Planning Process (CPPP)
FOCUS GROUP - INPUT QUESTIONS & ANSWERS

- Being honest with yourself- it's hard. You've got to stay positive. You've got to know who is good for you or not, have self-respect and have boundaries
- Breaking out of the mental prison
- Need to want to seek a better life for myself

4. What are your ideas on how to better serve our communities?
   - Peer counselors who understand this experience in the institutions and in outreach programs and even those like you who are doing listening sessions
   - Intervention in pre-release. Help those about to exit understand what PTSD is, educate them on mental health issues that commonly effect the re-entry population and educated them on how and where to get services to help
   - Tell us what we need to hear, not what we want to hear
   - Build trust with us to let us know that you truly want to help us
   - Build a real "Dream Team" support system to keep you uplifted and accountable. (People who believe in you, people who will give it to you straight, people who you don't want to let down, and people who have more time clean and sober for you to call)
   - Keep your circle small
   - Homeless services
   - Know how to approach the younger generation- a lot of them aren't using low-level drugs, they're going straight to the hard stuff. Their parents are acting and dressing too young, bad examples to the kids. Not involved in raising them, letting electronics raise them. They're not communicating, there's no respect for their parents
   - Coming up, I always understood everyone else, but I never had anyone to talk to

ALAMEDA COUNTY BEHAVIORAL HEALTH

Mental Health Services Act (MHSA) Annual Update, FY 22/23

Community Program Planning Process (CPPP)

FOCUS GROUP - INPUT QUESTIONS & ANSWERS

Focus Group: PEERS Life Every Voice & Speak (LEVS) |Date: 11/17/21| Attendees: 19

1. What are the top or most pressing mental health issues right now in your community?
   - Homelessness
   - Racism
   - Isolation
   - Re-Gentrification
   - Drugs
   - Housing conditions for people who live in board in-care (nutrition, communication, admin)
   - Worry about an attempt to expand forced treatment series
   - Mental health challenges
   - Undiagnosed - Not enough access to cultured and colored therapists
   - Fear of not being able to be understood during crisis intervention
   - Lack of quality MH services, i.e. therapy and peer support
   - Trying to receive services from people who aren't native
   - Affordable housing and housing services for communal natives
   - Police-Training for people of color
   - Lack of opportunity/lack of jobs
   - Emphasizing more state services
   - Training and practical application of Peer Support & MH Consumer
   - Movement Values & Principals for Peer Support Specialist Managers
   - More education around healthy lifestyle/healthy living
   - Lack of neighborhood support groups/peer support house
   - Making sure that we try to help our unhoused folks without taking the funds and services away from existing MH programs and services

2. Are there **individuals, groups** and/or **cultural communities** who you believe are **not being**
   - African American Community, poverty
   - Elderly, Seniors Community
   - Seniors with mental health challenges
   - People in the autism spectrum (i.e. Less services for adults and children)
   - Veterans
   - Incarcerated / Re-Entry
   - Youth, TAY Community / Rebellion
   - Immigrants, undocumented
   - Lack of knowing how to get services, assistance with documents
   - Unhoused, displacement
   - Access to SOAR specialists to help with benefits and appeals

3. What do you see as **barriers** for people to get help?
   - Seniors live with roommates not of their choosing and food not of their choosing because they do not have enough income to live with choices and options

alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

ALAMEDA COUNTY BEHAVIORAL HEALTH
Mental Health Services Act (MHSA) Annual Update, FY 22/23
Community Program Planning Process (CPPP)
FOCUS GROUP - INPUT QUESTIONS & ANSWERS

- access to tech and knowledge to interface in order to access/apply for services
- Illiteracy, lack of education
- Lack of advocates
- Fear of asking for help (looking stupid)
- Being mis-understood
- Outreach in multiple languages, assistance for people where they are (remote tech access)
- Some folks don't access services for fear of being mistreated or being forced into services or forced to take medications.
- Frustration with constantly making calls related to services and not receiving an immediate response
- The experience of forced treatment and resultant trauma and stigma.
- More anti-stigma campaigns and education to lower/remove barriers to accessing care
- Release of independence/ fear of not being understood
- really lengthy applications for services
- Some have experience of being disrespected or not being heard or being provided services that weren't helpful to them.
- mobile services (I know there are examples of this)
- Hard to try and get ahold of services while trying to stay compliant around covid standard
- Stigma, being afraid of being labeled "mentally ill" and how this can affect person's ability to qualify for future employment. - Stigma of being labelled "addict"
- Fear of organization's being pushed for covid vaccinations and or being fired for not being vaccinated

4. What are your ideas on how to **better serve** our communities?
   - More SOAR specialists, more resources to go to
   - Fund more quality peer support services.
   - Peer support positions are very underfunded and peer support persons are
   - Underpaid
   - Warming centers/respite/community center with resources, SOAR/eligibility specialists, technology mentoring/assistance/access
   - we need more mental health services for people on the Autism Spectrum
   - I think that pop up clinics in traditionally underserved areas would be helpful. I think that going to tent cities and homeless encampments to let them know about the services that are available would be good as well
   - Ditto
   - Training on best practices, trauma-informed care, employment services
   - Having the right peer support with lived in experiences - more peers with lived experience on boards
   - Ditto on increased services for those on autism spectrum; all neuro-divergent
   - Create space for open dialogue between peer and all other services providers to help reduce stigma of people with lived experience working in behavioral health system
   - All voices at the table! Benefit of education, experience, lived experience, strategies, etc.
   - Socialization of seniors, wanting to be with others

alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

ALAMEDA COUNTY BEHAVIORAL HEALTH
Mental Health Services Act (MHSA) Annual Update, FY 22/23

Community Program Planning Process (CPPP)

FOCUS GROUP - INPUT QUESTIONS & ANSWERS

- Improve career pathways for peer support specialists and provide them with living wage.
- Make sure they feel respected and valued in the workplace. - diversity of peers within the mental health system
- A good resource person on staff in senior centers to accommodate seniors on their challenges
- Provide more opportunities for all of us in the community to connect, spend time together and support each other. This will help reduce isolation.
- More collaborations with service providers and all different walks of life
- Continue improving Mobil Crisis Response
- More community opportunities, village type of vibe
- Fund VOLUNTARY services and stop expansion of involuntary services that are
- NOT helpful and create more trauma
- More support for LGBTQ

5. What MHSA-funded services are you aware of, either as services you or someone you know has taken advantage of or as services you would feel comfortable recommending to others?
   - PEERS
   - CRISIS SUPPORT SERVICES
   - Lift Every Voice and Speak
   - Wellness House
   - BACS: Be a little more supportive in coordination of care
   - Benita House: Their staff and experience was nice
   - Jay Mahler Center
   - HHREC
   - Sally's Place

ALAMEDA COUNTY BEHAVIORAL HEALTH

Mental Health Services Act (MHSA) Annual Update, FY 22/23

Community Program Planning Process (CPPP)

FOCUS GROUP - INPUT QUESTIONS & ANSWERS

Focus Group: PEI Providers |Date: 11/18/21| Attendees: 28

1. What are the top or most pressing mental health issues right now in your community?
   - Homelessness
   - Community Violence
   - Disconnection, Loneliness
   - Grief/Loss (connected to community violence
   - Need for expanded CATT services and another crisis response team supports like MET
   - Complex Trauma
   - Financial
   - Increased Food Prices
   - Non-police responses to mental health crises
   - Unaccompanied youth trauma
   - Suicide
   - Mental Health
   - Need for residential treatment beds; out of homecare for loved ones when released from 5150 and related hospitalization
   - Teen stressed with impacts of school and work expectations
   - Reduced income/joblessness
   - Hopelessness and helplessness resulting from isolation during the covid 19 pandemic
   - Heightening of range of issues in schools have always been there – for staff and students and families – depression/suicidality – crisis support, disconnection, general overwhelm, anxiety, basic needs
   - Need to focus on healing spaces, lack of providers and staff (teachers, counselors, etc.)
   - Parent / Child Conflict
   - Loved ones being unhoused
   - Challenges with technology and lack of access to technology
   - Heightened use of substances exacerbating mental health
   - Financial hardship in older individuals without tech devices
   - Covid shame
   - Isolation of the LGBTQIA+ folks who live solo w/o children, w/o tech
   - Loss of miles stones and adjusting to our new normal
   - Covid has magnetized equity issues

2. Are there **individuals, groups** and/or **cultural communities** who you believe are **not being adequately served?**
   - Hmong Communities – in particular school systems
   - Capacity to support and serve afghan refugee community
   - Older adults in the African community
   - Older adults need tech devices, Wi-Fi connection and training / coaching to use tech
   - Spanish speaking families we serve do not have enough MH resources and supports in Spanish
   - Kids with low-income insurance
   - Language capacity barriers
   - Access to primary and preventative care
   - More culturally syntonic MH support services for our Punjabi speaking community in south county
   - API community experiencing increased amount of violence and hate crimes
   - Lots of waitlists and the need to be innovative with service delivery

alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

ALAMEDA COUNTY BEHAVIORAL HEALTH
Mental Health Services Act (MHSA) Annual Update, FY 22/23
Community Program Planning Process (CPPP)
FOCUS GROUP - INPUT QUESTIONS & ANSWERS

- The need for practitioner and mental health workers' self-care

3. What do you see as **barriers** for people to get help?
   - Funding for healing circles would be incredible
   - Language barriers
   - County outlines on forced treatment / leaves consumer with additional trauma
   - Cultural barriers
   - Transportation
   - Fear, not feeling safe to bring their full selves to the providers, language, providers not understanding
   - Criminal justice system not set up to meet mental health needs. Clients don't get services they need when incarcerated and transition out
   - Loss of trust in mental health system due to past experiences requires us to invest in
   - relationship building in the impacted communities before expecting folks to participate in services
   - Hard to hire folks because of community based work is underpaid, shortage of folks entering the mental health field
   - The lack of culturally responsive providers /responsive services
   - Families left out due to HIPAA

4. What are your ideas on how to **better serve** our communities?
   - Lifting mental health services in schools
   - Making sure your providers are taking care of themselves in order to take care of the community they serve
   - A peer provider MH warmline for African American Families
   - Financially supporting QTBIPOC folks who are training to become therapists
   - Mutual Aid / Respite Care for people / families in MH crises
   - Build up community ambassadors that can be liaisons onto the community
   - Increased PEI funding for healing circles
   - More Mental health expressive arts programs, workshops, etc. for all ages, and cultures
   - Tier 1 practices of creating a sense of belonging (in a classroom, etc.)
   - Mental Health & Wellness programs in faith communities (across all faiths)
   - Resource sharing forum to encourage more collabs/partnerships between communities
   - resources to better support community members as a whole person)

5. What **MHSA-funded services** are you aware of, either as services you or someone you know has taken advantage of or as services you would feel comfortable recommending to others?
   - PEERS
   - HHREC: Get Fit, TAY, Health Through Art

ALAMEDA COUNTY BEHAVIORAL HEALTH

Mental Health Services Act (MHSA) Annual Update, FY 22/23

Community Program Planning Process (CPPP)

FOCUS GROUP - INPUT QUESTIONS & ANSWERS

Focus Group: MHSA Stakeholder Group |Date: 11/19/21| Attendees: 11

1. What are the top or most pressing mental health issues right now in your community?
   - Housing and housing being labeled as available for people with mental health issues—there's hardly anything in housing available for those leaving locked facilities and Sally's Place only has 8 beds—it's abysmal. What's available and how do they get there?
   - Supportive housing is a huge need. We need to offer something that leads to independent living
   - More sub-acute and acute beds and catastrophic episodes needing more than 36 hours—more beds are needed
   - Pre and Post Crisis services with hospitalizations
   - Not having connection—even on hotlines or Zoom—not everyone has access
   - Distance groups don't work for everyone, people feel alone
   - More early treatment at first episode
   - COVID anxiety, Zoom fatigue and social disconnection
   - Technological issues within the SMI community are worse-- some people don't know how to use the technology or they don't trust it
   - Lack of crisis facilities and re-entry facilities in south county
   - Not everyone has access to computers, phones and Internet
   - Not enough transportation available for mental health crisis
   - Providers expand criteria to get funding then lower their criteria or capacity due to lack of staffing
   - With COVID demand for mental health services has gone up, but the funding has not
   - We need more—not to move money around (Peter to pay Paul) but we need more money for more services

2. Are there individuals, groups and/or cultural communities who you believe are not being
   - People with developmental disabilities and mental health issues—it's more complex to treat medically and psychologically so that population falls through the cracks or don't meet criteria
   - Accessibility and cost—especially for students
   - Immigrants—access difficulty and financial hardships
   - Asian community—stigma and cultural resistance to having to ask for help
   - Not enough definition expansion on criteria—there are people who don't match the specifics
   - Veterans (as a whole) but especially those who aren't eligible for VA benefits—not everyone know that not every Veteran gets VA benefits
   - Those who have more mild mental illness—it might hinder function but not as much help is offered as it in with SMI
   - New influx of Afghani community—not enough providers are equipped to serve

ALAMEDA COUNTY BEHAVIORAL HEALTH
Mental Health Services Act (MHSA) Annual Update, FY 22/23

Community Program Planning Process (CPPP)

FOCUS GROUP - INPUT QUESTIONS & ANSWERS

3. What do you see as **barriers** for people to get help?
   - Communication silos—our systems don't communicate, people are hitting roadblocks without knowing there's help along the way and they don't know where to get it
   - Need more workforce
   - Mild or moderate mental illness—they're not seen as urgent needs
   - Difficulty in communicating needs—especially in the black community
   - Need more black practitioners
   - Lack of qualified providers
   - Lack of providers who can connect culturally and linguistically
   - Cost of living—effects ability to keep providers working here
   - Workforce pay is low, high turnover, low recruitment
   - People passing the buck—leads to dead ends for people who need help
   - Even those who get connected to services don't always continue
   - Clinicians don't often follow up with those who don't continue because they think they "don't want the service"
   - Hearing "I don't believe you" from people who are supposed to help them
   - Own-ness on the client
   - Not enough qualified and available providers, but we all still need to challenge our views, points of privilege, biases, etc.
   - Specifically, people who don't want to return due to a negative cultural encounter

4. What are your ideas on how to **better serve** our communities?
   - Combat to community training for agencies providing services to Veterans
   - Outreach to high schoolers and college students to prepare and encourage them to pursue this field as their career path
   - More peer support specialist—to help others navigate the systems
   - Changing language around mental illness—mental illness doesn't hold the same validity in the general population as physical health, switch focus to wellness concept
   - Stress the continuum of variations of severity in mental health—chronic, severe, moderate, mild
   - More public education on mental health

5. What **MHSA-funded services** are you aware of, either as services you or someone you know has taken advantage of or as services you would feel comfortable recommending to others?
   - FERC
   - Innovation grant winners
   - PEI Providers
   - PEERS
   - So many things! Hard to say something specific

ALAMEDA COUNTY BEHAVIORAL HEALTH

Mental Health Services Act (MHSA) Annual Update, FY 22/23

Community Program Planning Process (CPPP)

FOCUS GROUP - INPUT QUESTIONS & ANSWERS

Focus Group: City of Fremont Mobile Evaluation Team (MET) |Date: 12/2/21| Attendees: 8

1. What are the top or most pressing mental health issues right now in your community?
   - Lack of crisis stabilization services, residential facilities - if people need to be placed they have to go North. Law enforcement has to transport out of the area. Big hole in the service delivery system here.
   - Delusion disorder, Schizophrenia. Crisis stabilization services are only for two weeks. Not enough supportive housing. Need residential / closed facility - Villa Fairmont.
   - Co-occurring disorders - substance use/meth/alcohol in conjunction with severe mental illness along with trauma.
   - For school/students - so far for the academic year we have had 15 students go through 5150 evaluation; Students from affluent parts of the community;
   - Walk in to emergency rooms include both adults and adults;
   - Need more drop-in facilities for unsheltered communities Anxiety, depression, adjustment disorders since COVID;
   - Homeless are more A.A./ PI men; veterans; adults/seniors
   - Some have private ins/lack of services;
   - People not comfortable with P.D /we don't have clin who are auth to do 5150s

2. Are there **individuals, groups** and/or **cultural communities** who you believe are **not being**
   - Insurance
   - culturally appropriate services
   - stigma among some cultures
   - medical issues
   - family supports
   - accessibility to walk-in services
   - have to call ACCESS which has a procedure that is difficult for homeless clients
   - technology gaps
   - programs not welcoming
   - lack of stable housing
   - isolation
   - services aren't available when the client needs them
   - post-hospital placement not meeting criteria for skilled nursing board
   - conservatorship for homeless
   - youth need more crisis stabilization programs
   - IHOT caseloads too high
   - lack of crisis stabilization programs in south county
   - lack of staffing
   - lack of SUD services
   - Privacy barriers related to HIPAA/Privacy regulations

3. What do you see as **barriers** for people to get help?
   - Crisis stabilization services;
   - Funding to expand MET team
   - Long term funding for SUD/MH recovery programs
   - More youth services
   - Paramedic type clinicians - different way to configure response teams

alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

ALAMEDA COUNTY BEHAVIORAL HEALTH
Mental Health Services Act (MHSA) Annual Update, FY 22/23

Community Program Planning Process (CPPP)

FOCUS GROUP - INPUT QUESTIONS & ANSWERS

- Multi-disciplinary teams that are authorized to coordinated;
- Outreach specialists that community members trust - "SOAR - Services, Outreach, Accessibility & Recovery"
- Law enforcement provided appropriate training for 5150 eval
- Affordable housing
- Peer specialists
- expertise in working with developmentally disable
- Jail diversion programs for mentally ill and homeless
- More medication management needed

4. What are your ideas on how to **better serve** our communities?
   - Mobile mental health services offered by City of Fremont Human Services which is MHSA
   - Senior peer counseling program for older
   - Prevention
   - MET team expansion
   - Education, support and engagement with youth and parents to increase access and utilization of services
   - Anti-stigma campaigns addressing parent/child died
   - Expansion of LGBTQI+ services and gender identify issues for both youth and adults

5. What **MHSA-funded services** are you aware of, either as services you or someone you know has taken advantage of or as services you would feel comfortable recommending to others?
   - Alternatives to 5150 - "Living room" model; safe places to go that are not necessarily hospital admission;
   - Could County have more long-term treatment options;
   - Need more peer/lived-experience staff

ALAMEDA COUNTY BEHAVIORAL HEALTH

Mental Health Services Act (MHSA) Annual Update, FY 22/23

Community Program Planning Process (CPPP)

FOCUS GROUP - INPUT QUESTIONS & ANSWERS

Focus Group: NAMI East Bay |Date: 12/8/21| Attendees: 20

1. What are the top or most pressing mental health issues right now in your community?
   - Supportive housing, with resources and vocational component
   - No follow-up from institutions, no continuum of care established—no place to stay when leaving John George or jail—need case management for those being released from those institutions
   - Hearing Voices— if medication and hospitals didn't work, having more Hearing Voices groups with others and with peers with lived experience—especially in underserved communities
   - Lack of stabilization before release—neglected, no step-down services or locked care after release without being stabilized
   - Substandard facilities
   - Make families a part of the services and care teams—find a way to collaborate and work around HIPAA
   - Lack of follow-up and case management—some people are good at "gaming the system" to get out without treatment
   - Many people end up on the street over and over again
   - Addressing the website—where to go for resources, and what about those with private insurance? They don't know where to go
   - Advocates neede3d to help set up health care and supplemental services
   - Failure to serve the needs of those unable to engage in voluntary treatment—some people don't know or don't think they need help
   - Need a more robust AOT program
   - More dialogue groups
   - Working on better use of money with recovery proof and recovery focused campaign/outreach
   - There's a disconnect of Mental Health and Mental Illness—what does painting a mural have to do with Mental Illness?

2. Are there individuals, groups and/or cultural communities who you believe are not being
   - SMI population being discharged
   - People of color—many are afraid of phoning the police, fearful of shooting incidents and wrongful incarceration
   - People of color who are incarcerated—anywhere to go that can connect them with help after release?
   - Cantonese speaking population, Spanish speaking population and the LGBTQ population—especially needing the Hearing Voices groups, they build community and support others with lived experience
   - High utilizers—repeated visits to John George and to jail. Obviously, their need isn't being met AT ALL!

alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

ALAMEDA COUNTY BEHAVIORAL HEALTH
Mental Health Services Act (MHSA) Annual Update, FY 22/23

Community Program Planning Process (CPPP)

FOCUS GROUP - INPUT QUESTIONS & ANSWERS

- The families of the folds who have no support
- Stabilizing people of color in the hospitals—not sending them to jail

3. What do you see as **barriers** for people to get help?

- Normalizing mental health language
- Mental illness blame issue
- Definition of a 5150 is a problem—some are volatile but not yet a "danger"
- Issues of independence in voluntary vs. involuntary services—some people refuse
- Lack of adequate shelter and housing
- No answers, no call backs, all the recordings with no live people for people trying to get services—dead end phone numbers, if I was in crisis I would have given up
- 51510 with police—people want help but not cops
- Sometimes people can "pull it together" when cops are there or when they want to get out of going to John George – many cops don't know how to access they history of hospitalizations before arriving on scene—there's a law AB (something)
- Stigma and fear, fear of hospitalization. Normalizing and education with voices and other extreme experiences
- Lack of beds
- The Medicaid Institution for Mental Diseases (IMD) exclusion at facilities and beds
- Undiagnosed—especially those with substance use disorders, they may not receive proper or any mental health diagnosis
- Record keeping needs improvement—sharing information is necessary and it's too siloed

4. What are your ideas on how to **better serve** our communities?
   - Money! We need more! Need more facilities and more staff, better pay for the staff, especially because the burn out is a major factor
   - FSPs—we need more, they're very helpful
   - Any in-between services available? Something between self-identified services and FSPs?
   - Centralized place for links to find services and resources, for every city in the county—with updates quarterly. They need people to update and check links and accuracy regularly so people aren't receiving outdated information
   - Enter into partnerships with other community clinics—train them to run groups, (i.e. Hearing Voices group) and peer to peer training
   - Political voice needed—someone to push for our needs
   - FASMI has a good presence to push for mental health issues
   - Specialized care unto for mental health, take them to respite, 24-hour site to decompress (diversion services)

alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

ALAMEDA COUNTY BEHAVIORAL HEALTH
Mental Health Services Act (MHSA) Annual Update, FY 22/23
Community Program Planning Process (CPPP)
FOCUS GROUP - INPUT QUESTIONS & ANSWERS

- Services without treatment, resources, case management and follow-up
- Board and Cares needed
- Need services for those with private insurance (like Kaiser) to participate with these special services
- Kaiser waiting rooms are not safe

5. What MHSA-funded services are you aware of, either as services you or someone you know has taken advantage of or as services you would feel comfortable recommending to others?
   - Land trust would have a great impact on housing
   - Hearing Voices groups
   - FERC, Mobile Crisis services (but need weekend and evening services)

ALAMEDA COUNTY BEHAVIORAL HEALTH

Mental Health Services Act (MHSA) Annual Update, FY 22/23

Community Program Planning Process (CPPP)

FOCUS GROUP - INPUT QUESTIONS & ANSWERS

Focus Group: Veterans-Swords to Plowshare| Date: 12/10/21| Attendees: 7

1. What are the top or most pressing mental health issues right now in your community?
   - PTSD is a big problem
   - PTSD in addition to lack of sleep, nightmares and flashbacks
   - Exacerbated issues due to COVID—food insecurities, jobs, housing issues and being unsure of the future
   - Being terrified of failure—people end up in limbo instead of trying
   - Afraid of change and adapting
   - For Student population of Vets, remote learning leads to isolation and depression
   - Not knowing all the options for services—in alternative (not Vet focused) settings

2. What do you see as **barriers** for people to get help?
   - Affordable housing for Vets
   - Needing services on site where Vets are living
   - Finding one's own benefits—finding the proper information (not all Vets are eligible for VA benefits)
   - How counties interpret/understand Vets needs and benefits, and not knowing how to help them navigate
   - Needing more education on benefits and who gets them
   - Some Vets don't want to go to the VA
   - Visibility of resources—where and how?
   - Associations with bad experiences
   - Not feeling safe in the spaces with other Vets—some people didn't have the best experience with the military and don't want to be associated with them
   - Provide funding for more holistic and alternative therapies—outdoors activities, art, and services that lead to organic conversations
   - Offer services for meditation for stress management

3. What are your ideas on how to **better serve** our communities?
   - Decreasing isolation Safe space for seniors to not be "scoffed at" but welcomed to participate
   - Designated housing for Vets—supportive housing
   - Training for providers on inclusiveness and cultural competency
   - Make spaces more welcoming for women and LGBTQ population of Vets
   - Improving employment opportunities—translating military jargon to fit civilian job descriptions
   - Create a space for mild to moderate mental health issues
   - Provide services for Vets around parenting and spousal relationships for family stabilization
   - Provide Combat to Community training for providers
   - More visibility of services

alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

ALAMEDA COUNTY BEHAVIORAL HEALTH
Mental Health Services Act (MHSA) Annual Update, FY 22/23
Community Program Planning Process (CPPP)
FOCUS GROUP - INPUT QUESTIONS & ANSWERS

- When exiting Military service, provide service members a packet of resources in the area and how to find them
- Provide a liaison from military to civilian life—a warm hand off
- More work in cannabis and psychedelic drug options as alternative to VA prescribed drugs for mental health management

4. What MHSA-funded services are you aware of, either as services you or someone you know has taken advantage of or as services you would feel comfortable recommending to others?
   - HHREC
   - Oakland VA
   - Castro Valley area—library and other places for Vets to plug in
   - Eden House
   - Swords to Plowshares

ALAMEDA COUNTY BEHAVIORAL HEALTH

Mental Health Services Act (MHSA) Annual Update, FY 22/23

Community Program Planning Process (CPPP)

FOCUS GROUP - INPUT QUESTIONS & ANSWERS

Focus Group: PRIDE Coalition |Date: 1/5/22| Attendees: 16

1. What are the top or most pressing mental health issues right now in your community?
   - Clients calling in reporting isolation, substance use (stigma, pandemic).
   - Community violence- recent cases of trans people killed.
   - complicated relationships in bio family made worse due to the pandemic. especially youth who may have been at school and now have to be home.
   - i second the isolation comment. much more substance use. difficulty getting sensitive medical care.
   - Homelessness, discomfort entering facilitity like Cherry Hill for detox (maybe frontline, first person the level of competence of working with population is missing), isolation, lack of resources
   - Issues around grief and loss from the pandemic.
   - Availability of more organizations that provide gender affirming medical and mental health care throughout the county
   - Homelessness – residential living of care is lacking (not enough beds), Resources not always LGBTQ+ friendly; SUD residential services/adult residential / crisis residential services.
   - access to services in unincorporated and East County.
   - These groups need extensive services, like wrap around services. MHSA funding never went to CSS. WE have dedicated agencis that serve NA/Latinx/Asian folks but not for these communities. We've done prevention & early intervention & one-time INN services, but we've neglected these folks. Folks don't feel safe going to a lot of programs. They may call out for crisis but dont beyond that. They recyle in and out of the jail. We need extensive wrap around dedicated services. MHSA was designed to meet the *unmet* needs and unserved folks

2. Are there **individuals, groups** and/or **cultural communities** who you believe are **not being**
   - A lot of our services aren't outwardly LGBTQ friendly which discourages many queer/trans individuals from pursuing help
   - Services not covered by insurance
   - Learning how to navigate the ACCESS for services in a timely manner. I've waited 1-1 ½ weeks to receive a response. Client was discouraged because of issues with culture and language which prompted [me] to go through a provider to help this individual.
   - Navigating the 1-800 number and coaching people who need to learn how to navigate support such as John George. Why aren't there billboards or signs on the bus, such as " If you need help blah blah blah, call Alameda County"
   - Disconnect. Breakdown in county from orgs funded to provide mental health. There is a breakdown in care. Left hand doesn't know what the right hand is doing. There is funding, a lot goes to orgs that have been around a long time but not those doing the work
   - Services for the older/aging population

3. What do you see as **barriers** for people to get help?
   - Capacity building & other Funding for new organizations doing the work.

alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

ALAMEDA COUNTY BEHAVIORAL HEALTH

Mental Health Services Act (MHSA) Annual Update, FY 22/23

Community Program Planning Process (CPPP)

FOCUS GROUP - INPUT QUESTIONS & ANSWERS

- Creating physical, inclusive spaces would serve the population better
- Advertisements & visuals (radio stations, television advertisement, audio and visuals) using mobile technology when they log onto the internet with an advertisement bar
- We have models for cultural competencies that are doing this (such as access lines for the Asian community). We need these models for the LGBTQ community as a cultural group.
- Add policy and inclusion initiative sin our RFP/FOA. We can ask them to include integrate questions addressing how they'll serve LGBTQ folks, training,
- Local data – missing tangible information on the actual/accurate rate of suicide deaths among LGBTQ folks. We know rates of attempts and through anecdotal information. There was a CA bill approved in 2021 regards to death certs having non-binary identification. We can do better at a local level.
- require our providers to enter the SOGIE data that they already collect at assessment. InSyst now can accept this data, but ACBH is not yet requiring it be entered as they do for the other data.

4. What are your ideas on how to **better serve** our communities?
   - Trans people of color
   - Individuals with substance use
   - Our LGBTQ+ youth, particularly our Transgender and Non-binary youth. The CHKS reports from our schools in Alameda Co confirm this.
   - People of color, certainly trans
   - Developmentally delayed
   - Newcomer youth who identify as LGBTQ
   - The undocumented
   - New immigrants/asylum seekers
   - The homeless
   - Our aging folks compounded with isolation
   - seniors-absolutely, especially those in nursing homes. Many have to go back into the closet and even de-transition when in the SNF's to be safe.
   - Trans community of color

5. What **MHSA-funded services** are you aware of, either as services you or someone you know has taken advantage of or as services you would feel comfortable recommending to others?
   - Pacific Center
   - I don't know, I have no idea what services are funded by MHSA

6. Other comments/suggestions
   - ACBH should collect data and look at how they serve/dont serve unserved/underserved groups
   - It would be great if these questions could be brought to focus groups which comprise these individuals: LGBTQ+ youth, seniors, non-binary from both MH and SUD clients.
   - I am very happy to see so many people attend this. Yay!

ALAMEDA COUNTY BEHAVIORAL HEALTH

Mental Health Services Act (MHSA) Annual Update, FY 22/23

Community Program Planning Process (CPPP)

FOCUS GROUP - INPUT QUESTIONS & ANSWERS

- Oakland has had one of the largest lesbian community and receive da center. We need to recruit culturally competent mental health providers. I don't want to compare it to a language differential for pay, thinking about creatively dinding a way to get providers who would be able to provide these services- it's one of a missing link and id like to be a part of that project.
- We desperately need CBO's who are funded to provide LGBTQ+ specific services. CBO's are funded for wrap around and case mgt services on a cost basis vs. a small amount for a specific FFS.

ALAMEDA COUNTY BEHAVIORAL HEALTH

Mental Health Services Act (MHSA) Annual Update, FY 22/23

Community Program Planning Process (CPPP)

FOCUS GROUP - INPUT QUESTIONS & ANSWERS

Focus Group: Peers Organization Community Change #1 & #2 |Date: 1/5-6/22| Attendees: 29 + 32

1. What are the top or most pressing mental health issues right now in your community?
   - Homelessness
   - Housing (stress of getting and keeping it) -also can cause drug use
   - Depression/isolation
   - Living in poverty creates stress (food is up, medication is up, gas went up, etc.)
   - Trauma

2. Are there individuals, groups and/or cultural communities who you believe are not being
   - Native American Community
   - Youth
   - People who identify as co-occurring
   - LGBTQ+ and LGBTQ Youth in particular
   - Victims of trauma, they get overlooked because of their behavior.
   - People who hear voices (special messages)

3. What do you see as barriers for people to get help?
   - Transportation
   - Technology (can't get on a listening session, telemedicine, etc.)
   - Language
   - Trauma and Historical Trauma
   - Not enough funding, we fight for crumbs
   - Lack of education around mental health
   - Lack of family and community support
   - Accessibility around and throughout the Bay Area
   - Stigma
   - Past negative experiences with "the systems"
   - Not enough support/navigation
   - Poverty
   - Fear of people with mental health issues, especially fear of those who hear voices (special messages)
   - Workforce: Providers that don't look like clients or speak their language ("if I don't see anyone that I can identify with then I don't speak up").

4. What are your ideas on how to better serve our communities?
5. What MHSA-funded services are you aware of, either as services you or someone you know has taken advantage of or as services you would feel comfortable recommending to others?
   - More peer respite programs (for seniors, veterans, re-entry/forensic)
   - Peer support specialists on the County crisis teams
   - POCC would like its own facility (multiple comments on this)
   - For people to keep their own provider and not get moved around

- Older Adult services
- More peer support specialists

- More advertisement for mental health services in largely Asian community areas would bring more awareness and de-stigmatization to AAPI's and their families around mental health.
- Trauma education
- Allocate funds to train ALL POLICE OFFICERS to successfully respond in crisis situations. If there's only a few then qualified officers might not respond in a crisis, therefore the situations often get out of hand and sometimes there are fatalities that can be avoided.
- Supported housing for emancipated youth
- Older Adult housing

- Better support for the family,
- Adding funds in ACBH contracts to trainings for Peer Support Specialist
- Services on the weekends and after 5.
- Connect peer support specialists with clinicians as a team
- More peer support services and activities
- Workforce:
    - Providers that look like the community and/or speak their language (if you don't see anyone that you can identify with then you don't speak up).
    - Funding or stipends for interested folks willing to go to school for necessary credentials or certifications to assist in mental health services and with regards to mental health issues
- Older Adults (hotline or warm line for Older Adults) could be run by peer specialists
- Housing supports

6. Oher comments/suggestions?

- POCC needs their own facility.
- I think that the LGBTQ+ community gets forgotten about except for one month out of the year when, as a population, they are dealing with things all year long, not just in June...especially LGBTQ+ Youth who may end up in the streets because their families have ostracized them/kicked them out after they have come out
- I think that, especially if there are folks struggling with mental health issues or receiving messages and on the street, there are people afraid to approach them or reach to them so that they can get/know about services that could help them. I'm not sure how to reach those who are special message receivers but they are not just people to be scared of, but people who need support and services like everyone else

ALAMEDA COUNTY BEHAVIORAL HEALTH

Mental Health Services Act (MHSA) Annual Update, FY 22/23

Community Program Planning Process (CPPP)

FOCUS GROUP - INPUT QUESTIONS & ANSWERS

Focus Group: Cultural Responsiveness Committee |Date: 1/12/22| Attendees: 25

1. What are the top or most pressing mental health issues right now in your community?

- Mental health stigma
- suicide among children and youth
- isolation with Older Adults, especially those with language needs
- Suicide and homelessness
- Stigma
- Homelessness/houselessness
- Community violence & stigma
- Linkage and navigating a complex network and system of care
- Homelessness & mental health
- Access to income and benefits
- Substance Abuse, Stigma around MH, Isolation, Housing is a major issue overall.
- racism, both interpersonally and structurally which leads to health and mental health disparities.
- Increased trauma of pandemic on top of generational trauma and systemic racism. Deep uncertainty, anxiety and stress about survival needs such as housing and health needs
- COVID blame/targeted attack towards Asian American community members/staff.
- Fear: violence against API, increased symptoms of depression, anxiety, exacerbate symptoms of PTSD
- I would agree that linkage to services and figuring out how to access services is challenging for people who would like help.
- Criminalization of persons living with mental illness and co-occurring substance use disorders.
- Agreed with chats and sharing re: Complex Trauma and violence upon API communities
- LGBTIQ2S community and lack of support services throughout the county.
- Family Member and Consumer: Counseling services in jails or for those who are incarcerated should be made more readily available so they have access to those services at no cost. This way when they are ready for release they will been mentally on a better path to recovery- and address issues with trauma.
- Suicide rates have decreased nationally but Black/AA (40-45%) and Asian American (30-35%) had a significant increase (possibly 30-35%) for suicide rates possibly exacerbated due to isolation and hate crimes.

- Workforce issues are going to get more impacted. There is a higher need for MH support but so many of our providers are struggling with finding people to hire.
- POCC has hear a lot about incarceration of black/brown communities of color as well as homelessness.
- I'm hearing people experienced homelessness due to employment loss, COVID, but not necessarily due to age old beliefs such as drug use or making bad decisions. We need messaging in the community to restructure the mindset around homelessness today

alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

ALAMEDA COUNTY BEHAVIORAL HEALTH
Mental Health Services Act (MHSA) Annual Update, FY 22/23
Community Program Planning Process (CPPP)
FOCUS GROUP - INPUT QUESTIONS & ANSWERS

- LGBTIQ2S communities youth are have increasingly difficulty finding needed support in dealing with stigma, discrimination, and hate crimes. The Trans community also.

    - Access to technology, both devices and wifi access is huge for treatment and support as well as social and academic opportunities. Families are sharing one device for everything from medical appointments to virtual classrooms.
    - increase in late autism diagnosis of those in the adult CJ system. not sure if we are seeing the same here in Alameda County.

2. Are there **individuals, groups** and/or **cultural communities** who you believe are **not being**
    - Monolingual seniors living alone do not have adequate access to technology (or know how to use technology) during this time; thus, unable to access services including mental health services;
    - language proficient outreach services
    - ACCESS – what to ask for and how to get a referral for what they need. The help isn't available or the wait is extremely long or they don't meet criteria for what they need. The system is hard to maneuver through this one front door.
    - People calling ACCESS are in vulnerable places and need help maneuvering. We need the decision makers to act as "secret shoppers," try calling themselves so they can see where it is broken
    - We only offer 1 kind of mental health treatment. We are myopic in how we approach giving support.
    - Language and lack of cultural sensitivity
    - Race
    - knowing where to get the information and having it on hand, knowing what they have available thru their plans
    - Immigration status- undocumented, fear form public charge
    - Location and trust concerns
    - Barriers include lack of non-police first responders
    - Lack of genuine trauma informed and culturally affirming approach in our work. Often staff on the ground don't have the support to engage effectively
    - lack of bilingual/bicultural workforce...use of language line is often not ideal.
    - Racism, anti-Blackness. All forms of racism. Technology not available for the singular ways we could support people. Lack of culturally appropriate and culturally developed within the community treatment/support services.
    - Transportation
    - Communication/education to address how to access services
    - Language-assumption that African American/black don't require services because they speak English
    - Many people are retraumatized in our locked facilities. If people seek help, we are still over medicating people and restraining them, especially the Black and Brown communities.
    - offering people a list of providers to call is just plain neglect!

alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

ALAMEDA COUNTY BEHAVIORAL HEALTH

Mental Health Services Act (MHSA) Annual Update, FY 22/23

Community Program Planning Process (CPPP)

FOCUS GROUP - INPUT QUESTIONS & ANSWERS

- Digital divide as we enter into the telehealth world.
- Automated system is a huge barrier
- It would be good "training" to have all Executive and Decision Makers to spend a Friday night during a full moon at PES, and then at SRJ. The people making the decisions are so far removed from the reality of the trauma that our residents experience trying to reach help. Again, the fail first, be very symptomatic to receive any types of services.
- Stigma
- many clients are torn between going to work and making money to provide for themselves or their families versus attending a counseling session.
- Administrative barriers (payment system), the billing system is archaic as are the productivity requirements that go against wellness of any type
- Concerns around Peer Support Specialist work moving forward. Family members/Consumer peers will be trained in the same pathology driven and racist practices and billing, documenting and productivity issues that licensed clinicians are struggling with. The mere supplying of bodies isn't going to solve this if we are all working within the boundaries of this unhealthy system
- High stress and low pay for MH workers

3. What do you see as **barriers** for people to get help?
   - In home consultations with preschool aged children – high school and junior college working with the institutions to address the issues of suicide.
   - More support for API behavioral health workers who are traumatized and community members as well. We have a workforce issues and can't lose people who have the experience, knowledge, expertise to work with this community. (additional support systems for BH employees)
   - Media/messaging around homelessness to perceive peoples' negative assumptions around those who are unhoused.
   - Use MHSA to improve reentry programs
   - Cultural sensitivity in response to who we are serving. Respect community cultural beliefs re: services such as involving their family members in the process
   - Black and Latinx therapists and at the leadership level.
   - WE need to allow funding to cover non-traditional approaches to treatment, non-western approaches. Many groups are not interested in the kind of treatment being offered and we don't offer them what they are likely to respond to.
   - How can the training that clinicians receive be analyzed and transformed to not be perpetuating the Systemic White Pathology driven process of DSM and controlling of non-white bodies?
   - we need more peer and treatment providers from the afghan community - that can work in the community not at a clinic
   - Localized, community location for direct services.
   - Invite populations we target to the table to help decided/design hat interventions work for them. Not a listening session or focus group.

- Listen to our communities and follow the leads that they give us. We are still doing a patronizing and White supremacy mindset to the services we are supposed to be providing. Community members know what they need, we need to listen
- We need more open minded and lived experience leadership influence on what is needed to better serve our communities
- African American community: a health center that focused on specific needs of AA and mirrors other centers that are available for other communities.
- Tokenism method of populating boards and advisory committees doesn't work, its window dressing. One consumer, one family member, one or non-white person is a joke and insulting
- Payment system needs an overall requires providers to fit their services in a box. We need to focus on overhauling the system
- Advocacy work to change messaging and highlight peer navigators/peer workers as a health care job for those linguistic/ethnic populations that don't gravitate to this type of work.
- Consider intersections of populations such as having BIPOC AA meetings.
- Coaching is important- from the receptionist to the Eds

4. What are your ideas on how to **better serve** our communities?
   - People in the deaf community
   - Incarcerated population
   - API population including pregnant women and incarcerated
   - "API" includes over 50 ethnic groups and over 50 languages - not including ethnically and linguistically blended families.
   - Black and Brown women, LGBTQI2S people, Incarcerated people/including juvenile "justice", people with physical disabilities, people without SMI/SED levels of symptomology - the fail first method makes for higher levels of trauma for Peers and Family Members.
   - Asian American and Pacific Islanders, in particular the limited English proficient population
   - Limited and/or Lack of outreach to home bound community members and newly arrived refugees/immigrants
   - All people who don't speak English as a first language, but also the "belief" that Black American's don't need their own services because they speak English and the various cultural differences are not considered significant enough to have specialized services.
   - Low penetration rate continues to be low for the Khmer community (Cambodian)
   - Seniors (ignored in our system, vulnerable to homelessness, subject to violence, often experiencing crises earlier in life)
   - When our Seniors get hospitalized it can be a very negative turning point in their lives. Their discharge plans overwhelmingly focus on taking away their independence and placing them in nursing homes and long-term locked environments.
   - Limited English proficient communities run across various racial/ethnic group. We have to go beyond that and look at the trends in smaller, immigrant and/or refugee communities that are left out. services cannot just be for 'threshold' languages/communities.
   - Mam community from Guatemala. Our AC3 consumer engagement team has been doing outreach and to increase health linkage

ALAMEDA COUNTY BEHAVIORAL HEALTH
Mental Health Services Act (MHSA) Annual Update, FY 22/23
Community Program Planning Process (CPPP)
FOCUS GROUP - INPUT QUESTIONS & ANSWERS

- African American Youth (10-15)- need easy access to counseling and other MH services available- without parent consent so they can have services in privacy and get the help they need. For sexuality, home/school life, COVID and transiting to puberty or other milestones of development.
- Trans and queer population especially nonbinary
- Given the pandemic, we need to consider frontline and essential workers as a group that needs mental health support.
- Afghan community members, sex workers, and other marginalized people should be in this conversation and in the planning. They are not being served well if at all.

5. What MHSA-funded services are you aware of, either as services you or someone you know has taken advantage of or as services you would feel comfortable recommending to others?
   - Wellness centers
   - Sally place peer respite
   - Our FSPs
   - TAY early psychosis program
   - TAY adult triage programs
   - MHSA housing program and CLAs FSPs
   - CATT team
   - FSPs
   - PEIs
   - Housing Dept
   - UELP programs
   - POCC
   - PEERS WRAP Groups
   - Social inclusión campaign
   - ACBH eating disorder consultant
   - FERC
   - ACNMHC- Berkeley drop-in center
   - Best now
   - Reaching across
   - Family support
   - Co learning
   - Coaching
   - Parents café
   - FERC

ALAMEDA COUNTY BEHAVIORAL HEALTH

Mental Health Services Act (MHSA) Annual Update, FY 22/23

Community Program Planning Process (CPPP)

FOCUS GROUP - INPUT QUESTIONS & ANSWERS

Focus Group: African American Communities |Date: 1/13/22| Attendees: 29

1. What are the top or most pressing mental health issues right now in your community?
    - Homelessness
    - Mental Health implications due to COVID-19, COVID variants, and its impact on our seniors, parents, and children. We're 2-3 years out from having a semblance of normalcy. We need dollars to project into the future.
    - Substance abuse
    - Substance abuse creates psychosis and mental illness which is compounded with homelessness, unemployment, access to medical, and COVID
    - Mental illness and suicide
    - Health inequity and access to quality care – we need trauma informed care throughout this system
    - Foster care system: children have unaddressed trauma. The system impacts the family dealing with substance abuse, physical, and sexual abuse. The parent is overwhelmed and has issues with anxiety and the children are then abused.
    - Self-sufficiency amongst consumers
    - Lack black behavioral health professionals
    - Affordable housing
    - Safe employment opportunities. "At - Will" employment is also an issue.
    - For the youth - COVID has impacted community activities and results in substance abuse by parents & children. We need preventive measure before children reach juvenile hall or the hospital
    - Access to communication. Many are unable to access Zoom without money to get a proper phone or leverage Wi-Fi-- especially the older generation
    - The toxic impact of institutional, organizational and individual "White Supremacy" that infects all psychiatric assessment and treatment; masks itself as regulatory procedures and one-size-fits-all programs and procedures -all of which is acidic psychic terrorism
    - Lack black mental health individuals and resources to conduct adequate outreach. We need to get services to the people who need it.
    - Address the racism and hobbling of people of color (POC) internally within Alameda County Behavioral Health

2. Are there **individuals, groups** and/or **cultural communities** who you believe are **not being**
    - Lack integrated care facilities, for example, Asian Americans have 3 facilities where mental health and primary health care services are integrated in one location making it easier for people to get there and access services. Resources are strategically placed in these ethnic communities whom outlive African Americans by 5 years (Native American community), 11 years (Asian American), and 8 years (Latinx community). We have the most health disparities and lowest life expectancy and we have no integrated care. We have to fight for a wellness hub which isn't equitable.

- Failure to recognize and utilize the wisdom of African American culture and traditions seems to be discriminative.
- White/BIPOC providers receiving innovation funding failed to integrate services for African Americans with no consequences or accountability 10 years ago.
- Climate of CBO and governmental organizations that won't let you mention African American, healing, and the legacy of slavery- this is why nothing has happened for us
- Finance and insurance
- Lack trust in the system
- Inappropriate outreach to African Americans
- Lack results- a lot of talk and no action
- Bad policy and procedure-makers
- Disrespect towards African American providers and consumers.
- Identify cultural brokers in the African American community and develop a pool of brokers to serve as a liaison to the County, providers, and communities
- Absence of black leaders
- Stigma that you don't have it together if you require mental health services
- Others want to keep African Americans oppressed so they don't look bad
- White supremacy
- Structural impediments to "on the ground" folks earning contracts to provide the work
- Every identifiable barrier related to the "Dis-at-ease" disease of white supremacy
- Inability of County to factor in WS as a treatment related issue with many outcomes
- Black people are often misdiagnosed

3. What do you see as barriers for people to get help?
    - Building the capacity of African American CBOs
    - Require funding for the Wellness Hub be implemented into every MHSA plan that's being developed. Set aside $9M from CSS, $7.5 from PEI, and $2M from WET programs. These programs should be implemented through the African American Holistic Wellness Hub and the Bay Area Chapter of the Association of Black Psychologists should be awarded the grant /contract by the County to implement these services. All our programs are Black-centered, our association has many national and international chapters.
    - Leadership academy to address the absence of black leaders
    - We need more Black providers in mental health
    - Increased collaborations with the resources that we have
    - African American Wellness Hub approach that' s not Eurocentric and segmented. It should be funded as stated and appropriately
    - County should emphasize the need for diversity in their funding stream and expand funding for organizations and not place so much emphasis on evidence-based practices, because they do not work for all population and/or weren't created with African Americans in mind, unlike others.
    - Need an educational component to announce new treatment modalities for African American

alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

ALAMEDA COUNTY BEHAVIORAL HEALTH
Mental Health Services Act (MHSA) Annual Update, FY 22/23
Community Program Planning Process (CPPP)
FOCUS GROUP - INPUT QUESTIONS & ANSWERS

- An African American hub

4. What are your ideas on how to **better serve** our communities?
   - African immigrant community needs more outreach
   - African American community as a whole is unserved/underserved, not represented, or are unable to access services. It's hard to find a program that identifies as African American. I hear it exists but am unable to access it. Other groups have dedicated community centers that are not available to African Americans
   - Formerly incarcerated
   - Family members lack a dedicated place where they can go to receive vital information and resources to house and empower family members living with mental health challenges.
   - Black transgender community
   - The failure to use the science of Black psychology and the application of African American culture and wisdom traditions makes all current services inadequate for all African American persons, families and community
   - Youth as suicide numbers grow
   - Black perinatal (pregnant & parenting) population given African Americans have the poorest perinatal outcomes, birth trauma, and the highest maternal, fetal and infant mortality rates
   - Youth with substance abuse issues
   - The whole Black community is not being adequately served. As a result of being inadequately served we are inappropriately served in behavioral systems.
   - African-centered implies a holistic approach, including African spiritual wisdom and culture

5. What African American Wellness Hub: Is this the solution, what are barriers, what are elements/recommendations to develop a sound hub? (Note: Co-host replaced LS question with a new one: **What MHSA-funded services are you aware of, either as services you or someone you know has taken advantage of or as services you would feel comfortable recommending to others**?)
   - This is not ONE or THE solution but a part of improvements. A solution fits into the Eurocentric logical system. The African American system is not individualistic but is about collectivity. This hub is a part of a broader solution.

6. **Other comments/suggestions:**
   - These are the same questions asked in previous MHSA plans, the responses are the same. We (Bay Area chapter of the Association of Black Psychologists) provided a white paper on recommendations. The County cannot compartmentalize mental health illness into different groups without addressing it holistically. A 2011 Utilization Report said African Americans were underserved/unserved, and in 2022 it's the same issue. Here is the link to African American Utilization Report: https://acmhsa.org/innovation-communitypbased-learning/innovation-grants-round-2

alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

ALAMEDA COUNTY BEHAVIORAL HEALTH

Mental Health Services Act (MHSA) Annual Update, FY 22/23

Community Program Planning Process (CPPP)

FOCUS GROUP - INPUT QUESTIONS & ANSWERS

- [For the African American community] You should: (1) Post listening questions on an annual basis through town hall meetings and have focus groups concentrate on each question to develop a comprehensive response to the County regarding the MHSA Plan, and (2) the county should be a partner in this process and build into the process accountability not just form the County perspective but to providers targeting the African American community. The pattern we are currently following doesn't work for the African American community- we like to come together and bridge the divide which takes time for us.

ALAMEDA COUNTY BEHAVIORAL HEALTH

Mental Health Services Act (MHSA) Annual Update, FY 22/23

Community Program Planning Process (CPPP)

FOCUS GROUP - INPUT QUESTIONS & ANSWERS

Focus Group: City of Fremont-Older Adults |Date: 1/18/22| Attendees: 8

1. What are the top or most pressing mental health issues right now in your community?
   - Logistics
   - Bureaucracy, so complex, challenging to figure out how to access services Eligibility requirements are often so different and not clearly defined, especially during the pandemic.
   - Not enough staffing
   - Limiting resources
   - Navigation of services as a lot of services require technology
   - Transportation
   - Homelessness
   - Cost of living: Not adequate/sustainable housing.
   - Inconsistency and unreliability of programs - they "come and go."
   - Staff/counselors are not consistent if they can't keep their job.
   - Homelessness is impacting senior people - they may be "couch surfing" - if they are mentally challenged they may lose their housing situation.
   - Loneliness and isolation.
   - Telehealth has been a big transition for seniors and the pandemic caused a hardship for seniors.
   - Increase of suicidality, anxiety - feelings of constant worry.
   - Safety - crime against seniors (theft, hate crimes).
   - Failure to enforce laws.
   - Strongly related to anxiety.

2. Are there **individuals, groups** and/or **cultural communities** who you believe are **not being**
   - Blind people also neglected.
   - Medicare population is having access issues.
   - Lack of coordination procedures in conflict with one another.
   - Cultural groups who have stigma against mental health. Groups that lack language services.

3. What do you see as **barriers** for people to get help?
   - Technology focus on access
   - Other options need to be maintained
   - older adults without family support
   - IHSS is often inconsistent, or clients rely on an allotted number of hours set by the county which may not be enough; and they do not offer overnight hours; but the client does not meet requirements for a nursing facility
   - Some groups delay getting services due to stigma - services need to be "wrapped" in something else like an activity.
   - Income - way it is assessed. You may have net worth but not cashflow to get services
   - Lack of awareness of services

alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

ALAMEDA COUNTY BEHAVIORAL HEALTH

Mental Health Services Act (MHSA) Annual Update, FY 22/23

Community Program Planning Process (CPPP)

FOCUS GROUP - INPUT QUESTIONS & ANSWERS

4. What are your ideas on how to **better serve** our communities?
   - More of umbrella type of environment - helping to direct people to the service they need.
   - Going door-to-door instead of sitting in an office somewhere and requiring older people to find help. Whose job is it to do that outreach?
   - Is it possible to set up new 111 line as a single source that will help route seniors to the right service?
   - Wrapping/bundling services into an activity program.
   - Provide training to law enforcement/fire department so they have the knowledge to refer people to services as seniors may go to them when in crisis.
   - Written materials/online/short seminars to educate and refreshers for first responders.
   - Use other community services (doctors) to help distribute information.
   - Reaching out to broadcast networks/media?
   - Need more services that have language and cultural capacity.
   - Ihande' s programs are well regarded - she has developed a lot of programs that help meet some of these challenges.

5. What **MHSA-funded services** are you aware of, either as services you or someone you know has taken advantage of or as services you would feel comfortable recommending to others?
   - Senior Peer Counseling Program;
   - Senior Mobile Mental Health;
   - Food Banks
   - Age Well (Senior) Centers

6. Other Comments/Suggestions
   - Older people get forgotten.
   - Every agency and healthcare facility serving them should have one or two seniors being served included on their boards and committees.
   - Create an organization that would address these challenges and come up with the solutions.
   - "Complex Care" (Stanford Healthcare) people that help people navigate and access services.

ALAMEDA COUNTY BEHAVIORAL HEALTH

Mental Health Services Act (MHSA) Annual Update, FY 22/23

Community Program Planning Process (CPPP)

FOCUS GROUP - INPUT QUESTIONS & ANSWERS

Focus Group: Family Members |Date: 1/19/22| Attendees: 9

1. What are the top or most pressing mental health issues right now in your community?
   - Homelessness
   - Find and Access treatment- family knowledge (knowing about different programs)
   - Not knowing there is a problem
   - Anger directed towards parents
   - Lack of compliance- revolving door. There isnt a step down. Youre either in John George or out and if lucky into Villa Fairmont. I dont know anyone using amber house or J Mueller or Sallys place – i dont know how functional they are and i should. Supportive housing is needed
   - No follow-up or follow through. People seriously ill need wrap around Support services. It's hard to stay housed without these supports. Housing is a revolving door and then things fall a part without supports and they're back on the streets.
   - Navigating the system is getting harder and harder and finding something thats not paid for with MHSA or Medi-Cal. Someone put on FSP after Villa Fairmont discharge never received those services which they're entitled to. We need a lot more Access when people request them.
   - IHOT provided a lot of Support but not STRIDES and now my child is homeless again. I had to pay for hotels. STRIDES helped her become her own payee so she really doesnt have any money now. WE had to work with SSI to have another payee for her. Now she spends her money and has n place to go and it's a continuation issue. The ball drops and it starts over again.
   - Increase in suicidality and suicides
   - Homelessness is prevalent, egregious, and like everyone says there's no support if someone gets housing/services and no support for continuation of it. Wrap would be helpful
   - We need appropriate non violence crisis response systems. We have things going on in the county but Its a huge need.
   - We need Spanish speaking services. Families carrying for loved ones across the age spectrum are suffering from lack of spanish services.
   - Fmailies caring for children are having issues in the pandemic. A 9YO son said he lost his childhood in the pandemic.
   - Step down Support is a need
- Understanding conservatorship- it's complicated for family members. We need support around making that system more accesible for people.
- We need more culturally syntonic services and Support helping families know how to talk to providers so they can get their needs across cultural barriers

2. Are there **individuals, groups** and/or **cultural communities** who you believe are **not being**
   - Revisiting the waiver concept once they're discharged
   - I hear families thankful to hear other families. We need a network of support groups around the county- somehow this information should get out maybe during discharge

alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

ALAMEDA COUNTY BEHAVIORAL HEALTH
Mental Health Services Act (MHSA) Annual Update, FY 22/23
Community Program Planning Process (CPPP)
FOCUS GROUP - INPUT QUESTIONS & ANSWERS

- I agree- we need a family support facilitator. The perfect model for me happened when we participated in the IHOT program. It was a joint effort with everyone working together. We need that model in all levels of care unlike my experience with STRIDE where they treated me like I was the enemy. I liked that they encouraged family members to participate.
- Revisit the whole HIPAA issue. It was a way to protect digital privacy of health information and wasn't meant to place a wall between people with psychosis and their families. Amongst some caregivers, there's a fanatical adherence to HIPAA> do people ever actually get sued for talking to people. Its sometimes used as an excuse to not be bothered by families I had some practitioners ignore it for my child's best interpret. Nothing bad happened, only good things because of it. Can someone look at the law and reinterpret its applicability to his situation. My child was missing, and a county called me up, I provide the history, they told me my son gave them verbal permission to contact me but they really wanted his SSI to see if he had coverage. They didn't care that much. They just wanted to get paid. If they can find ways to bypass it in certain situations why not find other ways.
- HIPPA and confidentiality training for providers is critical.
- It sounds as if a lot of comments around support for families have to deal with access. Access to information, access and support in terms of more regular contact with peers.

3. What do you see as **barriers** for people to get help?

- Lack of culturally sensitive outreach & information
- It still feels as if it's a disjointed and silo'd process. We had to take charge and make sure everyone communicates together for our son.
- Ease of use
- There is no help or follow up at John George. Even if you get into a FSP- it's hard to get them to do what they should do. No accountability.
- My problem has been, I've been able to navigate and find things/resources. My problem is getting the system to talk to me. I can navigate and get help with the help of FERC, but some agencies quote HIPAA and I can't get past that and my child wouldn't survive unless I was there
- Id like all mental health services to have a mission statement that recognizes the family and client. This should be an official stance to get everyone thinking that way. The families are doing the heavily lifting. If you don't recognize or address that you lack the whole circle. It wont work without the family
- The biggest barriers I family member access to support their loved ones. When I think of MHSA dollars, I think of training that should happen across the board in all systems about the family member role.
- HIPAA ruins a lot of this. We need to maintain different ways to keep the connection going post discharge. When do we discuss Issues of waiver to contact family.
- The system is set up to damage to family relationship the way its set up everytime you call 5150 to pick up a child. Everytime you tell families don't let them back home or get a restraining order and tats the only way they'll get conserved. The children get home and are angry feeling betrayed. There is a lack of trust and anger that grows because

alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

ALAMEDA COUNTY BEHAVIORAL HEALTH
Mental Health Services Act (MHSA) Annual Update, FY 22/23
Community Program Planning Process (CPPP)
FOCUS GROUP - INPUT QUESTIONS & ANSWERS

everything about the system creates an adversarial relationship and perception family is against them

4. What are your ideas on how to **better serve** our communities?
    - Spanish-speaking families
    - trans
    - Dhari speaking afghan community
    - I read in the Chronicle that 5% of the SF population is the Black population and they make up 35% of the homeless and the majority of homeless are people living with serious mental illness. I'd think if im trying to solve the probelm lets look at the community most impacted since forever using stsatistics. While that is a SF statistic, here in the east bay it's worse. We need to go where the need is most urgent. Wouldnt it be nice to finally solve that
    - Each cultural groups handles the idea of mental illness in a different way. A South Asian family was introduced to a world they know nothing of. The culturally ethnic groups need more than "here is a service." We know where the hotspots are, so, let's target them as a beginning would be a Good thing
    - The african american has been inappropriately served especially in the jail
    - The LGBTQIA hasn't been counted statistically by alameda county system of care so we dont know what theyre receiving. Its not accounted for and you can't provide statistics when you can't count them.
    - The system is based on White supremacy model controlling black, Brown and other bodies not fitting that model. We need to thoroughly examine our system from the top down including who people are trained and our caregivers. We need to analyze this information or we won't be able to truly serve the various cultures in our community
    - It strikes me that numbers are helpful. Looking at population demographics may be helpful. We need a statistician to xompare the numbers to service information t osee if they reflect trends.
    - We are all get because things aren't that tangible
    - IHOT should be expanded
    - CATT/moble response crisis services need to be expanded

5. What **MHSA-funded services** are you aware of, either as services you or someone you know has taken advantage of or as services you would feel comfortable recommending to others?
    - I heard IHOT fundigb was being reduced
    - What is being done/set aside to Foster , create Support for more workers in the pipeline
    - FERC- i refer people here
    - Mobile crisis teams- i dont draw out that it's MHSA funded but its helpful to know this being on the MHSA Stakeholder Group Committee
    - IHOT is one of the best services we've had and helped my daughter after working in the mentalhealth system for a combined 50 years.
    - FERC

ALAMEDA COUNTY BEHAVIORAL HEALTH

Mental Health Services Act (MHSA) Annual Update, FY 22/23

Community Program Planning Process (CPPP)

FOCUS GROUP - INPUT QUESTIONS & ANSWERS

- Mobile crisis
- Some FSPs
- IHOT was an amazing program
- I had a Good experience with FERC
- IHOT should be expanded

alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

ALAMEDA COUNTY BEHAVIORAL HEALTH

Mental Health Services Act (MHSA) Annual Update, FY 22/23

Community Program Planning Process (CPPP)

FOCUS GROUP - INPUT QUESTIONS & ANSWERS

Focus Group: NAMI Chinese |Date: 1/14/22| Attendees: 22

Summary of key points of the session:

- ✓ Language barrier. Parents often do not have enough English proficiency to secure help for their ailing children, who command good English.
- ✓ Police are not as anxious to help as they used to be. They sometimes even turn around and ask helpless parents for advice.
- ✓ Dire shortage of funding from the county/state greatly hampers community services for the mentally ill and their family.
- ✓ County/state must step in to help cope with rampant societal discrimination against the mentally ill.
- ✓ The squeaky wheel gets the grease: The Chinese community must be more active in advocating for public help and support for the mentally ill.
- ✓ There is a severe shortage of psychiatrists. Scholarships to encourage young people to pursue career in psychiatry and mental health.
- ✓ Need to heighten community awareness of mental health issues as a preventive measure. Again County/state has to step in, providing much needed funding to help.
- ✓ Need outpatient clinics and long-term care facilities in Chinatown.

1. What are the top or most pressing mental health issues right now in your community?
   - I would like to take this time to have the attention of you and the public be alerted that there are so many families that need help out there. Anorexia is a serious illness. Staff not related to this area may not know about it.
   - There's no way to send people to the mental hospital. It's so difficult. If County can build a middle man or something. Take those people to evaluate them. If they can actually figure out how to send them to the hospital. Too many hospitals that even can't take those people. I found that is very difficult right now.
   - Police are not coming anymore. Say like 5150, police ~~will~~ used to take them to the hospital. They don't do that anymore. The police will stay outside. Even you have violence at home, they will ask you, "are you willing to go to the hospital?" Of course, the patient will say no. Then the police will tell you, "I cannot" and he walks away. "There are too many cases." They will walk away. Even you trick the patient to the hospital, the hospital is full right now. I don't think they can find any. They will ask the patient, "are you okay?" The patient says, "yes, I'm." "So, you have to go, I'm sorry." It's very frustrating to the family. I don't think that's the problem of language. Of course, if there's an interpreter, that will make life easier for people who don't speak well in English. Yeah, hospitalization is the very big problem now
   - If I look up information online, I'm not sure I can find any information that is helpful related to mental health. It is very difficult for elderly to search things on the internet.
   - The warm line has overloaded. Cases have tripled. Is this situation resulting from home staying during the Covid? Does it increase the psychotic episode or elevated the symptoms? As Carole mentioned, there's not enough hospital rooms to take in mental

patients, and this situation seems to have been aggravated by language barrier. Some patients need to stay in the hospital but cannot because of the parents' language barrier.

- When the police came in 5150 calling, the child, I mean the patient, speaks fluent English and said, "I'm fine, I don't have a problem." But the parents know that their child break the window, hitting things here and there due to insomnia every night. However, the parents cannot speak fluent English and are unable to send their child to the hospital. The most important thing to know now is that cases are escalating. Many families with mental patients are hard hit in the pandemic.
- There is a language barrier in 5150 call cases. Patients speak fluent English but not the parents. They are not speaking fluently enough to send their kids to get help. That is actually one of the problems caused by Covid.
- I agree with that kids speak English better than their parents. That is a very difficult situation to deal with. Especially in terms of appearance, Kids speak fluent English and they act normally when calling the police. Even though the police know that they might suspect the kids do have some problem, they cannot do anything because of the normal appearance and conversation. This is one reason they delay sending their ailing kids to hospital.
- This is a tough situation whenever we call 911, the kids act normally, even after the police come, the child will answer questions and speak fluently. Parents are limited in English. So, this is probably the cost of the delay in service.
- I think besides calling 911, English is also vital when we need to go to the hospital or report to our jobs. Otherwise there will be a big breakdown. Things happened to us yesterday, we called the police, we tell them about our situation. They asked my daughter but she refused to answer. If the police team asked her that way, of course she would not answer anything. There is inadequacy in services.

2. Are there **individuals, groups** and/or **cultural communities** who you believe are **not being**
   - I hope more helping hands can be extended to families ~~with~~ struggling like mine. We have been living like hell for the past two years. My elder daughter had no schooling except online due to the pandemic. She developed an eating disorder and has been in and out of the hospital for almost twenty times. But we received very inadequate help. There was no proper response to our request, every time we made one. I hope Alameda County can treat eating disorders as a life- threatening illness and provide adequate services. You can't sustain two days without eating. Can you imagine my elder daughter having not eaten for five to six days consecutive! She was on the verge of dying! Yet the County provided no meaningful help. Does the County take life seriously? The service is so bad and inadequate. I hope through this platform to call attention to the seriousness of eating disorder, to address it as ~~is~~ a life-threatening illness. Normal human heart rate is 60 per minute, my daughter's was 39, she could die at any moment. We rushed her to the UCSF hospital in SF. But once until her vitals were stable, they discharged her, without any follow-up services by a specialist. My daughter felt helpless. We were totally lost as to where to look for help. After the discharge,

alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

ALAMEDA COUNTY BEHAVIORAL HEALTH
Mental Health Services Act (MHSA) Annual Update, FY 22/23
Community Program Planning Process (CPPP)
FOCUS GROUP - INPUT QUESTIONS & ANSWERS

we managed to have a meeting with the Alameda County, but they told us there was no resources for us. How can you save lives if you are not given necessary resources?

- Peers need help finding jobs
- The pandemic had a great impact on senior people. They could not go out to use facilities, especially for those who have mental illness. As far as I know there were three who committed suicide. That is a big ratio in the Chinese community.

3. What do you see as barriers for people to get help?

- I think language barrier and the need for translation is still the issue. Besides the 911 service, there are many other services that we need, such as help with finding a job. To be able to communicate in English is necessary. Once communication failed due to lack of English proficiency, it affects everything down the road. It is a big problem.
- This is not a problem of language barrier. Now, it's about the hospital refusing to accept patients unless they are dying. My daughter's heart rate and blood pressure had reached a very low level. But they would not take her in because she was not in immediate danger of dying. This is a big problem.
- They told us that my daughter's situation needed a long-term care.
  Anorexia needs more than just one day of treatment to recover. The County only provided 7 weeks of treatment. According to an anorexia specialist we had talked to, my daughter needed consecutive treatment up to 5 to 6 months. She cannot to be discharged in 7 weeks. That is not enough. The County promised and signed a treatment for 5 months. But later in the second meeting, they revoked that and changed it to 6 to 8 weeks. The hope I had after the first meeting was suddenly dashed! How disappointing!
- At the end of last year, my daughter and I tried to look for an alternative doctor, psychiatrist, for her mental illness. We had a great deal of difficulty as far as availability goes. I had a list of, I think 85 or 86 doctors, I must have gone through at least 40 to 50 doctors and none of them were available. That really created a lot of anxiety for my daughter alone. The unavailability for any alternative doctor when she was having problems with her current one.
- Another one is the Institute course she has been going to, which is in Union City. She has been going there for her drug management. Since the end of 2017 or beginning of 2018, they have constantly, maybe every other month, changed their personnel. So, there was no so-called routine to follow up. The staff were poorly trained.
- Difficult for peers to find jobs
- Asian hate around the county. They do not feel safe living, it's a very big issues in our community.
- The Chinese community suffers most because of language barrier.
- Another problem with us, as many people in the group have already mentioned, t is the follow up services. Without follow-up services, one single treatment is totally useless.
- stigma and the discrimination
- I think the stigma is more-pronounced in the traditional Chinese culture, in the traditional Chinese community. For the younger people, especially those who are educated and grew up here in the US, the issue of stigma is less serious

alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

ALAMEDA COUNTY BEHAVIORAL HEALTH

Mental Health Services Act (MHSA) Annual Update, FY 22/23

Community Program Planning Process (CPPP)

FOCUS GROUP - INPUT QUESTIONS & ANSWERS

- I would like to call our attention to an important problem we have, that really don't have enough psychiatrists or mental health doctors. I think our medical schools are not pumping out as many regular doctors as psychiatrists. At Kaiser, for example, they have very limited resources for mental health.

4. What are your ideas on how to **better serve** our communities?
   - A senior told me all she wanted is to have somebody to chat with her. Someone to visit her.
   - Peers need help finding jobs. Although there are stable enough to work, they are often afraid of people round them. Is there any way to help? I applied for BOA but there was no Chinese speaking staff when I went to the building.
   - We need funds for our peer counselors, peer counselors, being able to go out of the field because we have lots of volunteers, but the volunteers will get very tired and it's difficult. If we have enough counselors, a lot of resources can be translated into Chinese. We can directly help people out there as an organization
   - I want a place in Chinatown to answer your questions in person
   - We can get lots of information from the WeChat group. My mother-in-law does not know how to search ~~on~~ the website, or go online.
   - Mental health is a chronic illness. Treatment in an outpatient clinic is important. But follow-up services, long-term caring services, are equally important. ? If the State give equal attention to both clinical treatment and long-term care services, a lot of problems can be avoided.
   - I think prevention has a lot of room for improvement. All of the people that are sitting here are not doctors, not trained therapists, but many of us are trained support group facilitators. We have gone through different training. Some by NAMI, some by ourselves, and some are hard learned life experiences. Such training and experiences can play a very important role in spotting serious problems before they actually take place
   - Implement more public education on mental health.

5. What **MHSA-funded services** are you aware of, either as services you or someone you know has taken advantage of or as services you would feel comfortable recommending to others?
   - NAMI
   - MHACC

ALAMEDA COUNTY BEHAVIORAL HEALTH

Mental Health Services Act (MHSA) Annual Update, FY 22/23

Community Program Planning Process (CPPP)

FOCUS GROUP - INPUT QUESTIONS & ANSWERS

Focus Group: TAY Forum |Date: 2/8/22| Attendees: 6

1. What are the top or most pressing mental health issues right now in your community?
   - Housing
   - Finding a job
   - Stress in general
   - Work life balance and this area being super expensive
   - Stress, depression, anxiety
   - Work stress
   - Family issues
   - Not understanding what resources, are around you
   - Mental health is the backseat driver
   - Suicide
   - A lot of stigmas around mental health
   - In the Asian community it looked down upon
   - Super underrepresented having to cover basic needs
   - More financial need for our queer youth and young adults
   - Learning how to become and find the path that is chosen

2. Are there **individuals, groups** and/or **cultural communities** who you believe are **not being adequately served?**
   - International students
   - Minors in high school
   - Confidential care for minors
   - Latino Community
   - African American Community
   - Women of color (being a women)

3. What do you see as **barriers** for people to get help?
   - Insurance
   - Language barriers
   - Community Based Orgs are underfunded
   - Transportation
   - Accessibility
   - Finding people in these orgs that will answer
   - Doesn't have adequate help (shunned or pushed away)
   - Lack of awareness
   - Lack of understanding where your resources are
   - Limitation of resources
   - Also note at Ohlone there's only one full time counselor, the rest are interns so that's temporary and always changing
   - CAL Berkeley Services are limited to basic needs
   - Limited mental health resources are scarce in Alameda County
   - Mental health is looked down upon
   - Not enough awareness
   - People don't know about resources or where they are
   - Cultural Sensitivity

4. What are your ideas on how to **better serve** our communities?
   - Funding
   - Getting more people who understand the system
   - Getting more people to help the process to finding resources
   - Having that bridge that connects you to resources

alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

ALAMEDA COUNTY BEHAVIORAL HEALTH

Mental Health Services Act (MHSA) Annual Update, FY 22/23

Community Program Planning Process (CPPP)

FOCUS GROUP - INPUT QUESTIONS & ANSWERS

- Main hubs in central locations
- Social Media needs to be re-vamped and used stronger
- same with insurance! a lot of people don't understand how to seek therapists based on their needs and their ability to pay!
- Having more of those resources available
- Having a wider diversity of staff
- Understanding therapists who understand family values
- Physical health is at the forefront/Mental health needs to be talked about more in the household

5. What MHSA-funded services are you aware of, either as services you or someone you know has taken advantage of or as services you would feel comfortable recommending to others?
   - HHREC
   - Boys & Girls Club
   - YMCA
   - I ain't never heard of this
   - More mental health resources on student ID's (high school, College)
   - Making one social media for the county and more outreach for MHSA Programs (using communities to outreach specifically schools)
   - Mental Health Presentations through schools (middle, high, and College)

alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

Peer-Led Continuum
Forensic and Reentry Services
MHSA Innovation Project

Amount Requested: $8,615,531

Project Duration: 5 Years

Submitted by:
Alameda County Behavioral Health Care Services

Prepared by:
Roberta Chambers, PsyD
The Indigo Project

Date:
03/18/2022

alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

Section 1: Innovations Regulations Requirement Categories

General Requirement

An Innovative Project must be defined by one of the following general criteria. The proposed project:

- ☐ Introduces a new practice or approach to the overall mental health system, including, but not limited to, prevention and early intervention
- X Makes a change to an existing practice in the field of mental health, including but not limited to, application to a different population
- ☐ Applies a promising community driven practice or approach that has been successful in a non-mental health context or setting to the mental health system
- ☐ Supports participation in a housing program designed to stabilize a person's living situation while also providing supportive services onsite

Primary Purpose

An Innovative Project must have a primary purpose that is developed and evaluated in relation to the chosen general requirement. The proposed project:

- X Increases access to mental health services to underserved groups
- X Increases the quality of mental health services, including measured outcomes
- ☐ Promotes interagency and community collaboration related to Mental Health Services or supports or outcomes
- ☐ Increases access to mental health services, including but not limited to, services provided through permanent supportive housing

alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

Section 2: Project Overview

Primary Problem

The issue of people with serious mental illness (SMI) and/or substance use disorders (SUD) experiencing incarceration is one of the most prominent challenges facing the behavioral health and criminal justice communities. In many jurisdictions, individuals with mental illness are more likely to be booked into jail than engaged in treatment, and jails have become the largest mental health institutions. **This issue is exacerbated because the legal threshold to arrest and incarcerate someone is lower thanis the legal threshold to engage that same individual in treatment if they are unwilling or unable to participate on a voluntary basis.** Because the legal standard for incarceration is much lower than the threshold for involuntary treatment and jail beds are more readily available than treatment beds, either voluntary or involuntary, it has become increasingly common to incarcerate individuals in need of mental health services.[1] Despite intentional efforts to make the mental health system as accessible and recovery-oriented as possible, there remains a group of individuals who will not engage in voluntary services and are more likely to be incarcerated than treated by the community behavioral health system. **Once a person with SMI and/or SUD becomes justice-involved, they are more likely to remain involved and penetrate the justice system further[2], [3].** These individuals typically have minimal financial resources and are more likely to be held in jail awaiting trial or placement for treatment, including competency restoration. They may experience difficulty complying with the terms and conditions of probation or release, and they may be charged with a new criminal offense while confined in jail.

Within California and across the Nation, there is a concerted effort to identify diversion opportunities and to ensure a continuum of services for individuals with mental health issues who are involved with the criminal justice system. Alameda County, along with its partners and community of stakeholders, has invested substantial time and resources on a number of efforts that aim to strengthen forensic and reentry mental health services for people with mental health needs and/or substance use disorders by:

---

[1] National Sheriff's Association and Treatment Advocacy Center. *The Treatment of Persons with Mental Illness in Prisons and Jails: A State Survey.* Retrieved from: https://www.treatmentadvocacycenter.org/storage/documents/treatment-behind-bars/treatment-behind-bars.pdf.

[2] Fellner J: (2006), A corrections quandary: mental illness and prison rules. Harv CR-CL L Rev 41:391–412,

[3] Abramsky & Fellner, supra note 3, at 59 (citing Letter from Keith R. Curry, Ph.D., to Donna Brorby, Atty. in the Ruiz v. Johnson litigation (Mar. 19, 2002)

alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

Safely diverting people from the justice system into treatment,	Stabilizing and connecting individuals in custody to community behavioral health services, and	Promoting service participation that reduces recidivism.

The department unveiled a Forensic and Reentry Services Plan[4] in May of 2021 and has been systematically working through the short, mid, and long terms actions set forth in the plan. Alameda County was interested in how Innovation funds could assist in addressing the forensic and reentry mental health needs in the County. This Innovation plan arose out of these concerted efforts to divert individuals with mental health challenges from the justice system into mental health services and was developed for and by community stakeholders, including the County's Justice Involved Mental Health Task Force.

Proposed Project

Project Description

The *Peer Led Continuum of Forensic Mental Health Services* is a collection of four (4) continuum of services, of which three are peer led and one is family focused. The continuum of services specifically seeks to:

1. Support mental health consumers who are justice involved by helping them transition back into the community following an arrest or incarceration,
2. Identify and address the issues that led up to their arrest and/or incarceration
3. Connect with mental health and other services to support them in their recovery and reentry journey, and
4. Build the capacity of family members to advocate on behalf of their loved one with a serious mental illness who has become justice involved.

As a result of the continuum of services, we expect that individuals will experience fewer episodes of arrest and/or incarceration and will have increased participation in ongoing mental health and other services. The included services are described below.

4 http://www.acgov.org/board/bos_calendar/documents/DocsAgendaReg_5_10_21/HEALTH%20CARE%20SERVICES/Regular%20Calendar/Item__1_ACBH_Services_Forensic_sys_5_10_21.pdf

alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

Reentry Coaches. In Alameda and across the state, there have been strong outcomes associated with using people with lived experience to support individuals following a crisis or hospitalization to connect to follow-up mental health services. These individuals are sometimes referred to as peer mentors and have shown strong outcomes in increasing service linkage and reducing crisis and hospitalization in Alameda, Orange, and other counties. This project aims to employ forensic peer specialists who can serve as reentry coaches for individuals with serious mental illness to help them transition back into the community. Their role is to help the person with whatever they need, including tangible resources such as linkages for food and shelter or transportation to appointments, as well as encouragement and consciousness raising to actively participate in their own recovery and reentry journey. Referrals into the program may come from service providers supporting reentry planning at the Santa Rita jail, and ideally the reentry coach would be able to make contact with the individual before they are released from jail. However, their first contact may be upon release at the Safe Landing program, which is a drop in center on site at the jail that provides information and referrals to individuals leaving the jail, or at another community location. The reentry coach will work with the individual to develop a personalized reentry plan that addressed the needs and issues that the person feels are most pressing, and the coach can stay involved for up to 90 days providing direct peer support as well as support to engage with other services.

WRAP for Reentry. The Centers for Human Development have a number of curricula based on Wellness Recovery Action Planning (WRAP) for specialty populations, including individuals with mental health challenges who are involved with the criminal justice system. Existing WRAP facilitators as well as identified Forensic Peer Specialists will receive training in WRAP for Reentry. The WRAP for Reentry groups will be available at existing peer led programs as well as offered at the peer respite, Forensic CRT (included as a part of the Alternatives to Confinement continuum of services), and potentially at Santa Rita, if permitted.

Forensic Peer Respite. The Forensic Peer Respite will be available to adult mental health consumers who are justice involved who would benefit from a brief moment of pause to reflect on their recovery and reentry journey, address whatever issues are coming up for them, and receive peer support to connect them with whatever services may be most helpful to support their continued recovery and reentry. This program will provide 24/7 peer support services that address mental health, substance use, and criminogenic needs in an unlocked, peer-led environment. The average length of stay based on other peer respites will span 5-14 days with the opportunity to extend up to 30 days with ACBH approval, and the total capacity will be 6. The Forensic Peer Respite would be available to consumers who are beginning to experience early warning signs of a crisis or other behaviors that place them at high likelihood of police contact.

The program will accept consumers ages 18-59 with mental health and criminal justice involvement who can be safely served in this environment. This program is intended to be a step up from the community as well as step down from the jail, and referrals may come from community mental health providers who are serving justice-involved mental health consumers as well as providers from jail mental health, psychiatric hospitals, psychiatric emergency services, local emergency departments, crisis stabilization units, sobering centers and detoxification units, and the reentry coaching program described above. It is also possible that the program will also accept consumers from the Forensic CRT if there is an individual that would be better served in a peer-led environment.

Family Navigation and Support. Family members of adult children with mental health issues are a critical component of supporting an individual to participate in mental health treatment and exit the justice system. However, family members have to quickly become experts in the justice system and relevant mental health law in order to understand and work within the justice system and process in support of their loved one. The family navigation and support service would develop and disseminate informational materials about the forensic mental health process. This program would collaborate and train existing warmlines, staffed by family partners, to educate and coach families on how to best advocate for their loved ones and would collaborate with ACBH to ensure information materials are translated and accessible for all Alameda County residents. The program would also provide individual and group consultation to families in order to increase knowledge of the justice mental health system and the legal process; the types of specific hearings, legal mechanisms, and appeals for individuals with mental health issues; how competency is determined, what incompetent to stand trial means, and what services may be available; how to provide medical and mental health information to the jail and other legal entities; and how to advocate on behalf of a loved one who has become involved with the criminal justice system.

Project General Requirements

The Peer Led Continuum of Forensic Mental Health Services both adapts an existing mental health practice for the forensic mental health population as well as adapts practices from other disciplines.

The Forensic Peer Respite, Reentry Coaches, and WRAP for Reentry take existing mental health practices and seeks to apply them to adult mental health consumers who are involved with the criminal justice system. Specifically, this continuum of services is inspired by the Peer Respite model which exists in other jurisdictions and in Alameda County, the WRAP curriculum which has a strong evidence base and has been implemented for decades in Alameda County, and peer mentoring programs who support individuals post crisis or hospitalization that are available across the state. In each of

these instances, they have been modified for a justice involved mental health population and seek to promote similar outcomes including reduced arrest and incarceration rather than crisis and hospitalization as well as increased service connectedness.

The Family Navigation and Support component is modeled after other disciplines, specifically the resources and consultation available through advokids[5] for the foster care system or Regional Centers for families with intellectual and/or developmental disabilities. These programs offer a combination of written resources, consultation, education, and support to educate families about the intricacies of the system and equip them to advocate on behalf of their family member.

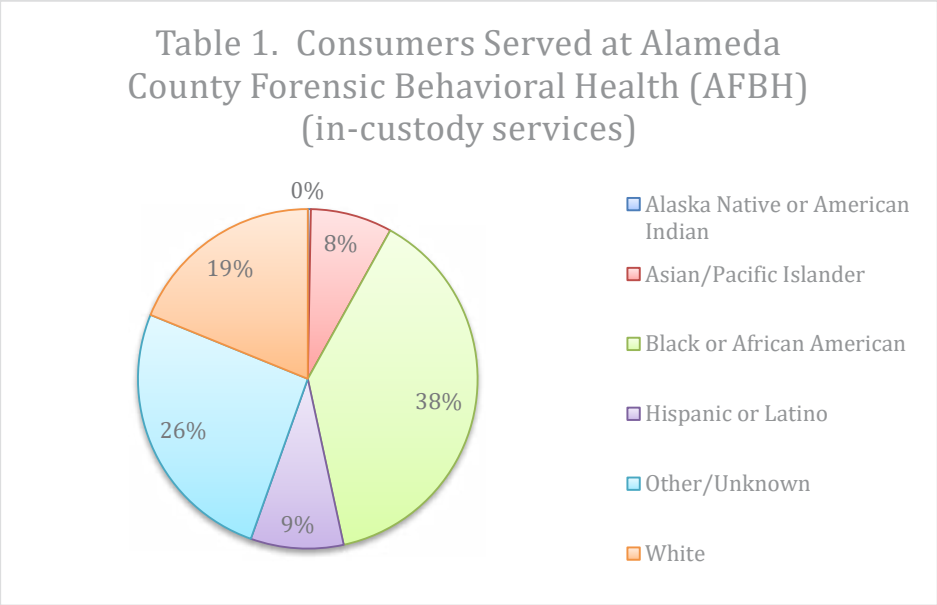
Individuals to be Served

Overall, the Peer Led Continuum of Forensic Mental Health Services project will serve 2,279 individuals per year. We anticipate that the Reentry Coaches will serve approximately 480 individuals per year, which is 15 consumers per coach with an average engagement of 90 days and 8.0 FTE. The WRAP for Reentry program will serve approximately 960 individuals, or 20 unduplicated individuals per month per facilitator, of which there will be 4 facilitators. We expect to serve approximately 122 individuals in the Forensic Peer Respite per year. This assumes that the 6 bed Forensic Peer Respite will operate at 85% capacity with an average length of stay of two weeks. We also expect to reach about 800 families with the written resources through the Family Navigation and Support program, with about 25%, or 200 families, reaching out for consultation or other support. However, we anticipate that there is significant overlap between the programs.

This continuum of services will serve transition age youth ages 18-25 and adults ages 26 and up who have significant mental health issues and are involved with the criminal justice system; they may also have co-occurring substance use issues. They may be of any gender or gender identity as well as sexual orientation. We anticipate that consumers will be predominantly Black or African American with smaller percentages of people who are white, Latinx, or Asian, Pacific Islander, and American Indian. This is based on demographic data of consumers receiving services at Adult Forensic Behavioral Health, which is the outpatient clinic located inside the County jail, as demonstrated in Table 1. We also anticipate that a proportion of individuals will speak Spanish and other languages and will ensure language access is available. Additionally, the Family Navigation and

[5] Advokids is a legal advocacy organization committed to protecting foster children across California and provides a variety of educational materials to support children and families who are navigating the dependency court process.

Support project will work with culturally specific organizations to ensure that they have the capacity to support individuals to advocate on behalf of their family members.



Research on INN Project

The issue of individuals with serious mental illness who are involved with the justice system has become one of the largest problems facing communities across the nation, and the rate of individuals with serious mental illness is two to six times higher among incarcerated populations than it is in the general population.[6] Research clearly demonstrates that outcomes for people with mental illness who become justice involved have better outcomes when diverted into services than when in custody. Peer support has a strong evidence base for supporting individuals to reduce crisis and/or hospitalization as well as engage in mental health and other recovery based services.

[6] Cloud, David, and Chelsea Davis. Treatment Alternatives to Incarceration for People with Mental Health Needs in the Criminal Justice System: The Cost-Savings Implications. Vera Institute, 2013. Retrieved from: https://www.vera.org/downloads/Publications/treatment-alternatives-to-incarceration-for-people-with-mental-health-needs-in-the-criminal-justice-system-the-cost-savings-implications/legacy_downloads/treatment-alternatives-to-incarceration.pdf.

The Peer Led Continuum of Forensic Mental Health Services provides three peer-led and one family-focused services that are intended to support individuals to transition from incarceration to the community and use peer support to address whatever issues may contribute to police contact, arrest, and/or incarceration. Using models from mental health and other disciplines, these four programs collectively provide an opportunity to support individuals to reenter the community and engage in services that reduce the likelihood of future arrests and/or incarceration.

These priorities for diversion arose out of the sequential intercept mapping process with Alameda County's Justice Involved Mental Health Task Force and focus on supporting reentry as well as promoting exit from the criminal justice system. They are based on the principles of peer support provided at opportunities identified through Alameda County's Sequential Intercept Mapping process.

At this time, no other jurisdiction has developed a singularly focused Forensic Peer Respite or applied a peer mentor approach to people with serious mental illness reentering from jail. While WRAP for Reentry is implemented in other jurisdictions, it does not yet have an evidence base supporting its use. People with forensic mental health needs may be served in Peer Respite, peer mentor, or WRAP programs, but none specialize in the intersection between behavioral health and justice system involvement and specifically target behavioral health and criminal justice involvement. While there are myriad versions of parental support, none are solely focused on supporting family members whose loved ones with serious mental illness have become justice involved. To this end, this project aims to explore the extent to which these programs are able to reduce criminal justice system involvement for people with serious mental illness (e.g., reduced jail bookings and jail days, increased service participation, increased exit from the criminal justice system).

Learning Goals/Project Aims

In Alameda County, 25% of ACBH consumers receive mental health services in the jail, and 10% of consumers only receive mental health services in the jail.[7] This highlights the need to address the over-incarceration of people with mental health issues and support them outside of a jail environment as a key County priority. This project, along with the other Innovation Plan entitled *Alternatives to Confinement,* is one element of a larger Forensic Mental Health and Reentry Plan and represents the service offerings that are relevant to and meet criteria for Innovation projects.

---

[7] http://www.acgov.org/board/bos_calendar/documents/DocsAgendaReg_5_10_21/HEALTH%20CARE%20SERVICES/Regular%20Calendar/Item__1_ACBH_Services_Forensic_sys_5_10_21.pdf

With this project, Alameda County Behavioral Health seeks to pilot these four services within a continuum of care to understand the extent to which these programs, separately and together, increase access to and participation in mental health services for adults with mental health and criminal justice involvement and improve outcomes, including reduced jail bookings, jail days, and exit from the criminal justice system.

Evaluation or Learning Plan

This Peer Led Continuum of Forensic Mental Health Services project evaluation will explore process and outcome measures related to the four included services. The overarching evaluation questions include:

1. What resources are being invested, by whom, and how much?
2. Who is being served, at what dosage, and in what ways, including participation in more than one INN-funded service?
3. To what extent do people who participate in INN-funded services experience reduced jail bookings, jail days, and are able to exit the criminal justice system?
4. To what extent do people who participate in INN-funded services experience increased service engagement and participation?
5. How does family education and consultation support individuals to move through the justice system?

The evaluation will explore the following types of quantitative data:

- Socio-demographics of individuals served, including race/ethnicity, age, gender identity, sexual orientation, zip code, income type and amount, housing status, level of education, and veteran status.
- Clinical and justice involved profile of individuals served, including mental health diagnoses and previous service participation; previous arrest, charge, and booking information; substance use and misuse; known trauma history; other clinically relevant information.
- Current program and service participation, including program, service type, procedure code, provider type, dates of service, length of encounter, length of episode, disposition. This includes for INN-funded programs as well as all other Mental Health Plan (MHP)-funded services, such as crisis and hospitalization as well as other residential and outpatient services.
- Current justice system interactions, including jail bookings and discharge dates, charges filed, court dispositions. If feasible, police contact and arrest data that did not result in a jail booking may also be included.

- Referrals, including referrals sources into the INN-funded programs as well as referrals and linkages provided from the INN-funded programs into other mental health services.
- Experience of services from consumers, family, behavioral health providers, and justice professionals.
- Perception of knowledge, understanding, and collaboration between behavioral health providers and justice professionals.

Quantitative data will be collected directly from the County's data services in collaboration with the Sheriff's Office via existing Memorandum of Understanding, the Community Health Record funded through the Whole Person Care Initiative, and via data request to the courts. Experience of services and perception of knowledge, understanding, and collaboration will be collected via interviews and focus groups; there may also be a brief survey developed for service recipients and their families or involved professionals.

Data will be collected on an ongoing basis and reported annually to providers and partners in order to support communications and continuous quality improvement as well as to the Mental Health Services Oversight and Accountability Commission (MHSOAC) in order to meet INN reporting requirements.

Section 3: Additional Information for Regulatory Requirements

Contracting

The County expects to contract out all of the services included in this proposal. Additionally, the County intends to contract for an external evaluator for this project to work with our internal data support team in exploring the learning goals and evaluation questions listed above as well as complete required reporting for the project. The County will appoint a contract monitor for each of these contracts to ensure contract compliance as well as a portion of the County project/program manager to supervise the quality of work performed.

Community Project Planning

These projects arose out of a longer-term planning and system improvement process dedicated to improving services for justice involved mental health consumers. The Justice Involved Mental Health (JIMH) Task Force included representatives from the Health Care Services Agency, Alameda County Behavioral Health, Public Defender, District Attorney, provider and advocacy organizations, consumer and family

representatives, faith based and other community leaders. After a more than year long process, the JIMH Task Force published a report in September 2020 with multiple stakeholder recommendations, including a focus on supporting reentry. Concurrently, ACBH published a Forensic Mental Health and Reentry Plan in October 2020 that was informed by JIMH and included additional actions informed by evidence-based practice and ACBH's strategic direction.

During 2021, ACBH systematically went through the Forensic Mental Health and Reentry Plan and identified aspects of the plan that either warranted further development and/or consideration or may meet criteria for INN funds. As a part of this process, ACBH contracted with the Indigo Project to engage in INN Project planning. The Indigo Project met with a number of internal and external stakeholders to gather information and workshop the ideas and concepts as they evolved, including:

- Consumer representatives and members of the Pool of Consumer Champions
- Family representatives and individuals from NAMI
- Providers who represent communities who are underrepresented because of cultural affiliation and language access
- Members of the African American subcommittee
- Members of the MHSA Stakeholder group
- Healthcare for the homeless providers
- System of Care Directors for Adult, Crisis, and Forensic Mental Health Services
- Consumer and Family Empowerment Managers

With each discussion, the concepts evolved and were further developed and clarified. These projects will be included in the MHSA Annual Update Community Program Planning (CPP) process in 2022 with the hopes of beginning implementation in FY2022.

MHSA General Standards

This project arose out of a community effort to address the needs of mental health consumers who are forensically involved. It was developed by consumers, family, and communities to support wellness and recovery and avoid incarceration. Community collaboration is exemplified in not only how this project was developed but also in how the project itself works to support individuals to return to and remain in their communities rather than in a jail environment. Cultural Competency is included as a foundational component in that this project seeks to address the overincarceration of people with mental illness, the majority of whom are BIPOC individuals, by supporting individuals to reenter their communities and successfully exit the justice system. Additionally, the services themselves will be informed by and primarily staffed by individuals who represent

our County's diverse populations. Services will be client and family driven in that services aim to preserve a person's freedom, independence, and ability to consent to their own services by using person centered planning with family member input that respects an individual's needs and preferences and works in partnership with each individual and their family to discover how they understand the issues that they're facing and helps them develop a plan that they are willing to do to address what is most important to them. The services are wellness, recovery, and resiliency focused in that they are built upon the belief that participation in mental health services and supports are more productive and meaningful than incarceration and that services that respect an individual's ability to invest in their own recovery journey are more likely to result in sustained freedom than "rehabilitation" provided by the jails. Finally, services are intended to be integrated in that these programs seek to strengthen each person's ability to renter the community and successfully navigate the service system with peer support.

Cultural Competence and Stakeholder Participation in Evaluation

On a quarterly basis, ACBH will convene a stakeholder meeting with individuals who are invested in both forensic mental health INN projects, which include this project and the *Alternatives to Confinement* continuum of services. This meeting will serve dual purposes to gather information from stakeholders and partners about their perspectives on the project and its implementation as well as to provide data from the evaluation to support a CQI process. As a part of this project, we will explore the extent to which the project is reaching its intended target population and that people receiving services are reflective of the jail population (i.e., the population receiving services is comparable to the Santa Rita population in terms of race/ethnicity and age). This will be one component of what is discussed in the quarterly meetings as well as overall feedback and evaluation data described in the preceding section.

Innovation Project Sustainability and Continuity of Care

This project with its continuum of services will primarily serve individuals with serious mental illness. If this project accomplishes its intended objectives of 1) reducing jail bookings and jail days and 2) increasing participation in ongoing mental health services, the County will continue to fund the project using a combination of MHSA Community Services and Supports funding and Federal Financial Participation (FFP). Most of the services described in this plan should be eligible for Medi-Cal reimbursement following completion of the INN project, assuming peer certification and billing for peer support continue implementation during this INN project.

alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

Communication and Dissemination Plan

If this continuum of services is successful at 1) reducing jail bookings and jail days and 2) increasing participation in ongoing mental health services, ACBH will apply to present learnings at California-specific conferences, including the forensic mental health association, California Institute of Behavioral Health Services, and California Association of Counties (CSAC) conferences. Additionally, ACBH will request that the contracted evaluator prepare a white paper that can be distributed through the California Behavioral Health Directors Association, California Probation Officers Association, and the MHSOAC listserv.

Keywords include:

1. Mental health reentry
2. Forensic Peer Respite
3. WRAP for Reentry
4. Reentry Peer Support
5. Reentry Family Support

Timeline

ACBH proposes a 5 year Innovation project in which the first two years of the project allow for program start-up. While services may be able to be implemented more quickly, we believe that it is important to have all elements available at the same time, particularly with a service model that requires significant coordination with partner agencies. To that end, ACBH will begin the site identification and procurement process upon MHSOAC approval. This may take up to nine months to facilitate a competitive bid process and then enter into contracts. The second year will focus on preparing the programs for opening, developing written materials, and outreaching and coordinating with our justice partners. Concurrently, the evaluators will be working with the department and stakeholders to develop the evaluation approach. Years 3-5 will focus on service provision as well as data collection and analysis to support learning. In the final year, ACBH will also develop an ongoing funding strategy using MHSA, realignment, and FFP dollars. In year 5, the evaluators will also draft the summative evaluation report and a white paper detailing project implementation, outcomes, and lessons learned.

Year 1	Project Start-up - County Procurement • Procure mental health provider and evaluator services • Execute INN service provider and evaluator contracts
Year 2	Project Start-up - Program Development Preparation • Site Identification • Written Materials Development • Staff Hiring and Training • Outreach to partner agencies Project Start-up - Project Evaluation • Evaluation planning, including stakeholder input Milestone: Services Commence Milestone: Evaluation Plan Complete
Year 3	Ongoing: Service provision Ongoing: Data collection Quarterly: Stakeholder convening to support CQI Annual: INN reporting
Year 4	Ongoing: Service provision Ongoing: Data collection Quarterly: Stakeholder convening to support CQI Annual: INN reporting
Year 5	Ongoing: Service provision Ongoing: Data collection Quarterly: Stakeholder convening to support CQI End of Project: Sustainability Plan End of Project: Summative INN report

Section 4: INN Project Budget and Source of Expenditures

INN Project Budget and Source of Expenditures

The next three sections identify how the MHSA funds are being utilized:

alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

A) BUDGET NARRATIVE (Specifics about how money is being spent for the development of this project)
B) BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY (Identification of expenses of the project by funding category and fiscal year)
C) BUDGET CONTEXT (if MHSA funds are being leveraged with other funding sources)

Budget Narrative

Provide a brief budget narrative to explain how the total budget is appropriate for the described INN project. The goal of the narrative should be to provide the interested reader with both an overview of the total project and enough detail to understand the proposed project structure. Ideally, the narrative would include an explanation of amounts budgeted to ensure/support stakeholder involvement (For example, "$5000 for annual involvement stipends for stakeholder representatives, for 3 years: Total $15,000") and identify the key personnel and contracted roles and responsibilities that will be involved in the project (For example, "Project coordinator, full-time; Statistical consultant, part-time; 2 Research assistants, part-time…"). Please include a discussion of administration expenses (direct and indirect) and evaluation expenses associated with this project. Please consider amounts associated with developing, refining, piloting and evaluating the proposed project and the dissemination of the Innovative project results

A slower start-up will be implemented due to overstaffing and expenditure concerns expressed by the systems of care managers. Managers agreed that expanding staffing as the project progresses will be more efficient and beneficial as appropriate adjustments are identified. The following budget outlines the start-up and projected annual expenditures:

alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

Staffing				
Position	**Quantity**	**Salary**	**Start-up**	**Annual Cost**
Program Director/	1	$ 95,000	$ 71,250	$ 95,000
RC Reentry Coach	5	$ 72,000	$ 90,000	$ 360,000
WRAP Facilitator	3	$ 74,000	$ 55,500	$ 222,000
FPR Program Manager	1	$ 85,000	$ 42,500	$ 85,000
FPR Forensic Peer Specialist	10	$ 72,000	$ 180,000	$ 720,000
FNS Navigators	3	$ 74,000	$ 55,500	$ 222,000
Total Salaries			$ 494,750	$ 1,704,000
CBO Benefits @ 33%			$ 168,215	$ 579,360
Total Staffing	**26**		**$ 662,965**	**$ 2,283,360**
Operations				
Contractors and Other Staffing Needs				
FPR Relief Staff	3000 hours	$25/hour	$ -	$ 75,000
Consultant - Legal System			$ 40,000	$ 20,000
Consultant - Materials Dev't			$ 18,000	$ 8,000
Recruitment			$ 12,000	$ 4,000
Pre-employment Expenses			$ 7,500	$ 3,750
Training			$ 30,000	$ 18,000
Supplies				
Food			$ 8,000	$ 62,400
Household Supplies			$ 4,000	$ 4,800
Personal Hygeine Items			$ 6,000	$ 9,600
Medical and First Aid			$ 2,000	$ 3,000
Office Supplies			$ 48,000	$ 4,800
Program Supplies			$ 22,000	$ 7,200
Facilities/Utilities				
Lease Payment		$ 12,000		$ 144,000
Gas and Electric		$ 800	$ 4,800	$ 9,600
Water		$ 990	$ 5,940	$ 11,880
Garbage		$ 600	$ 3,600	$ 7,200
Comcast/Xfinity		$ 1,200	$ 7,200	$ 14,400
Maintenance (Furniture and Equipment)			$ 32,000	$ 12,000
Maintenance (Property)				$ 24,000
Housekeeping		$ 1,500	$ 9,000	$ 18,000
Laundy		$ 1,800	$ 10,800	$ 21,600
Landscaping		$ 1,000	$ 6,000	$ 12,000
Communications				
Telephone		$ 600	$ 3,600	$ 7,200
Cell Phones		$ 600	$ 1,500	$ 6,000
Microsoft 365		$ 2,376	$ 1,188	$ 2,376
Transportation				
Vehicle Lease and Fees		$ 800	$ 2,400	$ 16,800
Vehicle Maintenance (incl gas, oil, etc)			$ -	$ 4,000
Mileage			$ -	$ 2,800
Transportation Assistance			$ -	$ 4,160
Other Services				
Insurance			$ 2,250	$ 9,000
Total Operations			**$ 287,778**	**$ 547,566**
Total Staffing			$ 662,965	$ 2,283,360
Total Operations			$ 287,778	$ 547,566
Total Direct Costs (Staffing + Operations)			$ 950,743	$ 2,830,926
Total Indirect (15%)			$ 142,611	$ 424,639
Total Costs			**$ 1,093,354**	**$ 3,255,565**
Potential Medicaid Revenue				$ 1,106,892
Total INN Funds Needed			**$ 1,093,354**	**$ 2,148,673**

alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

Alternatives to Confinement

MHSA Innovation Project

Amount Requested: $13,432,653

Project Duration: 5 Years

Submitted by:
Alameda County Behavioral Health Care Services

Prepared by:
Roberta Chambers, PsyD
The Indigo Project

Date:
03/18/2022

alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

Section 1: Innovations Regulations Requirement Categories

General Requirement

An Innovative Project must be defined by one of the following general criteria. The proposed project:

- ☐ Introduces a new practice or approach to the overall mental health system, including, but not limited to, prevention and early intervention
- X Makes a change to an existing practice in the field of mental health, including but not limited to, application to a different population
- X Applies a promising community driven practice or approach that has been successful in a non-mental health context or setting to the mental health system
- ☐ Supports participation in a housing program designed to stabilize a person's living situation while also providing supportive services onsite

Primary Purpose

An Innovative Project must have a primary purpose that is developed and evaluated in relation to the chosen general requirement. The proposed project:

- X Increases access to mental health services to underserved groups
- X Increases the quality of mental health services, including measured outcomes
- X Promotes interagency and community collaboration related to Mental Health Services or supports or outcomes
- ☐ Increases access to mental health services, including but not limited to, services provided through permanent supportive housing

Indigo Project

alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

Section 2: Project Overview

Primary Problem

The issue of people with serious mental illness (SMI) and/or substance use disorders (SUD) experiencing incarceration is one of the most prominent challenges facing the behavioral health and criminal justice communities. In many jurisdictions, individuals with mental illness are more likely to be booked into jail than engaged in treatment, and jails have become the largest mental health institutions. **This issue is exacerbated because the legal threshold to arrest and incarcerate someone is lower than is the legal threshold to engage that same individual in treatment if they are unwilling or unable to participate on a voluntary basis.** Because the legal standard for incarceration is much lower than the threshold for involuntary treatment and jail beds are more readily available than treatment beds, either voluntary or involuntary, it has become increasingly common to incarcerate individuals in need of mental health services.[1] Despite intentional efforts to make the mental health system as accessible and recovery-oriented as possible, there remains a group of individuals who will not engage in voluntary services and are more likely to be incarcerated than treated by the community behavioral health system. **Once a person with SMI and/or SUD becomes justice-involved, they are more likely to remain involved and penetrate the justice system further[2], [3].** These individuals typically have minimal financial resources and are more likely to be held in jail awaiting trial or placement for treatment, including competency restoration. They may experience difficulty complying with the terms and conditions of probation or release, and they may be charged with a new criminal offense while confined in jail.

Within California and across the Nation, there is a concerted effort to identify diversion opportunities and to ensure a continuum of services for individuals with mental health issues who are involved with the criminal justice system. Alameda County, along with its partners and community of stakeholders, has invested substantial time and resources on a number of efforts that aim to strengthen forensic and reentry mental health services for people with mental health needs and/or substance use disorders by:

---

[1] National Sheriff's Association and Treatment Advocacy Center. *The Treatment of Persons with Mental Illness in Prisons and Jails: A State Survey.* Retrieved from: https://www.treatmentadvocacycenter.org/storage/documents/treatment-behind-bars/treatment-behind-bars.pdf.
[2] Fellner J: (2006), A corrections quandary: mental illness and prison rules. Harv CR-CL L Rev 41:391–412,
[3] Abramsky & Fellner, supra note 3, at 59 (citing Letter from Keith R. Curry, Ph.D., to Donna Brorby, Atty. in the Ruiz v. Johnson litigation (Mar. 19, 2002)

alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

Safely diverting people from the justice system into treatment,	Stabilizing and connecting individuals in custody to community behavioral health services, and	Promoting service participation that reduces recidivism.

The department unveiled a Forensic and Reentry Services Plan[4] in May of 2021 and has been systematically working through the short, mid, and long terms actions set forth in the plan. Alameda County was interested in how Innovation funds could assist in addressing the forensic and reentry mental health needs in the County. This Innovation plan arose out of these concerted efforts to divert individuals with mental health challenges from the justice system into mental health services and was developed for and by community stakeholders, including the County's Justice Involved Mental Health Task Force.

Proposed Project

Project Description

The *Alternatives to Incarceration* continuum of services is a collection of three co-located services that are working together intended to prevent incarceration and divert individuals from the criminal justice system into the mental health services. This continuum of services specifically seeks to divert individuals from incarceration in three primary ways:

1. When a mental health consumer who is forensically involved begins to exhibit early warning signs of a crisis with behaviors that may lead to police contact,
2. At the moment of police contact that may result in arrest, and
3. When the person has fallen out of compliance with their probation or parole and is subject to re-arrest.

This continuum of services seeks to provide services that prevent individuals with mental health and criminal justice involvement from being booked into the jail. Services include the following three programs.

Forensic Crisis Residential Treatment (CRT). The Forensic CRT will provide a voluntary, unlocked alternative to hospitalization and/or incarceration for individuals with

[4] http://www.acgov.org/board/bos_calendar/documents/DocsAgendaReg_5_10_21/HEALTH%20CARE%20SERVICES/Regular%20Calendar/Item__1_ACBH_Services_Forensic_sys_5_10_21.pdf

alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

mental health and criminal justice involvement who require services to re-stabilize and address the issues that place them at higher risk for police contact and/or an involuntary hold or arrest. While this may seem similar to the Muriel Wright Center in neighboring Santa Clara County, Muriel Wright is intended to provide crisis residential services for individuals who receive services through their criminal justice mental health program while Alameda County's proposed CRT is intended to divert individuals with mental health issues from the criminal justice system, regardless of whether or not they are already enrolled in forensic mental health services. While they are both forensic CRTs, Alameda County's proposed program serves to test a different function within the system for individuals who may or may not already be enrolled in public mental health services.

This program will provide 24/7 mental health services and supports that address mental health, substance use, and criminogenic needs in an unlocked environment. The average length of stay will span 5-14 days with the opportunity to extend up to 30 days with Mental Health Plan approval, and the total capacity will be 16. The Forensic CRT will be licensed by Community Care Licensing as a Short Term Social Rehabilitation Facility and certified by Medi-Cal. The Forensic CRT would be available to consumers who are beginning to experience early warning signs of a crisis or other behaviors that place them at high likelihood of police contact. At the Forensic CRT, individuals would be able to stabilize from the crisis and address the issues that were increasing the likelihood of police contact.

The facility will accept consumers ages 18-59 with mental health and criminal justice involvement who meet medical necessity criteria for crisis residential services and do not require services in a locked setting. This program is intended to be a step up from the community as well as step down from a locked environment, and referrals may come from community mental health providers who are serving justice-involved mental health consumers as well as providers from jail mental health, psychiatric hospitals, psychiatric emergency services, local emergency departments, crisis stabilization units, sobering centers and detoxification units, and the arrest diversion program described below. It is also possible that the Forensic CRT will also accept transfers from the existing CRTs if there is an individual with criminogenic needs that would be better served in a forensic environment.

Arrest Diversion/Triage Center. The arrest diversion/triage center is a centrally located program where law enforcement officers can bring someone with a serious mental illness who would otherwise be arrested in order to avoid the jail booking and engage the person in other services. This program is unlocked and is not intended to accept individuals who require services in a locked environment. The arrest diversion center is open 24/7 and staffed with a clinical program supervisor, case managers, and certified forensic peer specialists. When a person is brought to the arrest diversion center, they are welcomed

Indigo Project

and offered a snack or other supports to help them feel comfortable and address any imminent basic needs. Once they have settled, the case manager meets with the individual to understand the person's situation and what short term interventions may be most successful in helping the person address whatever issues contributed to law enforcement contact. They may also identify longer term supports that may be useful. Based on this assessment and the person's preferences and willingness to participate, the case manager will make arrangements with and for the person to obtain the agreed upon short term services. They may also complete referrals for the longer term supports, if it makes sense to do so. While there are other programs that provide diversion from the criminal justice system into treatment, the programs are 1) either led by the justice system or 2) if they are led my mental health staff, they are placed in a crisis or emergency setting. Alameda County's proposed arrest diversion/triage center differs from other models in that it is not a crisis or hospital setting, and mental health staff will provide assessment, brief intervention, and service coordination to engage the person in services that help them address the issues that led to the police contact and promote their mental health.

The County, through its stakeholder-led Justice Involved Mental Health Taskforce and Sequential Intercept Mapping Process, has prioritized the need to divert arrest for individuals with mental health challenges in Alameda County. One of the identified barriers to pre-arrest diversion is a location where law enforcement officers can take someone to obtain services that will reduce the likelihood of subsequent police contact. This service provides that alternative drop off location and realigns the need for assessment and case planning back to mental health staff who can determine what a person's needs and preferences are and link them to the appropriate programs and interventions.

Reducing Probation/Parole Violations (RP/PV). People with significant mental health challenges often struggle to comply with the terms and conditions of release and may be more likely to be re-incarcerated as a result of a parole or probation violation. Additionally, providers appear hesitant to interact with the justice system on behalf of their consumers for fear of triggering additional legal challenges for the people they serve. This program provides educational materials and training for mental health providers who work with mental health consumers who are involved with the justice system in order to build their capacity to support the people they work with. Specifically, providers will learn how to support consumers they're working with to comply with the terms and conditions of their release and build the skills and knowledge to help consumers negotiate with their parole or probation officers on how to come into compliance with the terms and conditions of their release without being reincarcerated.

alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

In the training, mental health providers will learn how work with consumers to understand their forensic history, what terms and conditions they have failed to comply with, how they understand why they have failed to comply, what services they have been participating in to address their mental health and criminogenic risk and needs, and what services they are willing to participate in. Staff will also learn how to develop a plan for reaching out to the parole or probation officer with the goal or coming into compliance with the terms and conditions of release without "being violated" or having to be booked into the jail. Staff will also learn how to negotiate directly with the probation or parole officer on behalf of or in partnership with the consumer. Additionally, this program will also support providers to increase knowledge of and comfort in working with legal entities to resolve parole and probation violations.

Project General Requirements

The Alternatives to Confinement continuum of services both adapts an existing mental health practice for the forensic mental health population as well as adapts practices from other disciplines.

The Forensic CRT borrows the CRT model, which provides an alternative treatment setting for people who do not require services in a locked environment to stabilize from a crisis and return to their community. While there is a strong evidence base for reducing avoidable hospitalization for people experiencing mental health crisis, the CRT model has not been piloted for people experiencing crisis who are at risk of arrest or incarceration as a result of their mental health and criminogenic needs. This continuum of services seeks to test whether or not a forensic-focused CRT would reduce incarceration for people experiencing mental health issues that place them at high likelihood of police contact. The continuum of services would also measure the extent to the extent to which the program can connect people to ongoing mental health services, thereby decreasing the likelihood of future justice involvement. Currently, Alameda County has three CRTs for individuals with mental health issues that are experiencing crisis but do not require services in a locked environment. These programs have been successful in preventing avoidable hospitalization and connecting individuals to longer term mental health services and supports. The proposed Forensic CRT would provide the same level of mental health supervision but integrate services that address substance use and other criminogenic risk and need to support mental health consumers who are justice involved.

The Arrest Diversion Center is inspired by triage models from other disciplines. For example, the triage model is used across emergency and jail environments to quickly determine level of need and obtain that level of care. San Francisco used this type of model specifically in their juvenile justice system to avoid booking youth into their juvenile hall. The Centralized Assessment and Referral Center (CARC) operated by Huckleberry

Youth Programs accepted juveniles from police officers and would meet with them and their families to assess their needs and connect them to ongoing services and supports. Contra Costa County used a similar model for individuals experiencing homelessness out of their multi-service drop-in centers (MSCs) where police could transport an individual to a service center rather than book them into the jail. Once at the MSCs, homeless individuals could access a variety of tangible supports (e.g., laundry, shower, food) as well as obtain an assessment and service linkages and referrals. However, these types of programs are rarely led by the mental health system, and when they are mental health led, they are typically set up as an urgent care center or crisis stabilization unit, are subject to rules and regulations for those environments, and do not have or are unable to maintain a specific forensic focus. This program intends to maintain a low barrier for police drop off and service provision with the singular focus to quickly connect mental health consumers with services that will reduce the likelihood of police contact or re-arrest, which may include partnering or negotiating with their family and other natural supports to develop a plan.

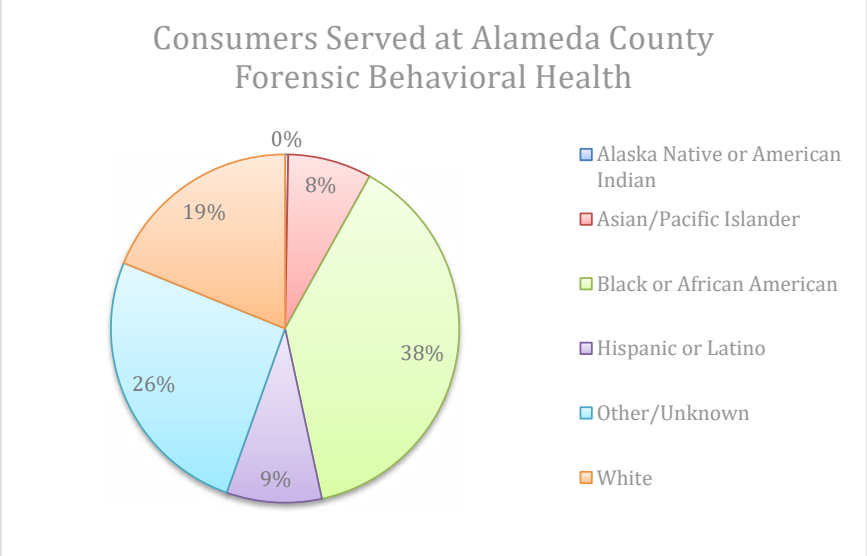
The RP/PV program also takes an existing type of program used across the justice system and applies it specifically to mental health consumers. Santa Cruz has a large and highly successful Reducing Revocations program for individuals on community supervision, and San Joaquin County has significantly reduced their incidence of probation violations resulting in re-arrest as a result of this type of intervention. This program will specifically apply that successful intervention to mental health consumers to determine if the RP/PV training can reduce re-arrest for individuals on community supervision as well as increase the rates of successful probation/parole completion for mental health consumers.

Individuals to be Served

Overall, the Alternatives to Confinement continuum of services will serve 2,279 individuals per year. The arrest diversion center will serve approximately 1,825 individuals per year. This assumes that there will be about 5 individuals per day who are diverted from arrest and jail booking to the center. We expect to serve approximately 700 individuals in the Forensic CRT per year. This assumes that the 16 bed Forensic CRT will operate at 85% capacity with an average length of stay of one week. We also expect to serve about 40 providers in the RP/PV program. However, we anticipate that there is significant overlap between the programs.

This continuum of services will serve transition age youth ages 18-25 and adults ages 26 and up who have significant mental health issues and are involved with the criminal justice system; they may also have co-occurring substance use issues. They may be of any gender or gender identity as well as sexual orientation. We anticipate that consumers will

be predominantly Black or African American with smaller percentages of people who are white, Latinx, or Asian, Pacific Islander, and American Indian. This is based on demographic data of consumers receiving services at Adult Forensic Behavioral Health, which is the outpatient clinic located inside the County jail, as demonstrated in Table 1. We also anticipate that a proportion of individuals will speak Spanish and other languages and will ensure language access is available.



Research on INN Project

The issue of individuals with serious mental illness who are involved with the justice system has become one of the largest problems facing communities across the nation, and the rate of individuals with serious mental illness is two to six times higher among incarcerated populations than it is in the general population.[5] Research clearly demonstrates that outcomes for people with mental illness who become justice involved are better when diverted into treatment than when in custody. The Sequential Intercept Model (SIM)[6] is a conceptual framework that defines a series of opportunities to divert individuals who have contact with or are involved with the criminal justice system into

[5] Cloud, David, and Chelsea Davis. Treatment Alternatives to Incarceration for People with Mental Health Needs in the Criminal Justice System: The Cost-Savings Implications. Vera Institute, 2013. Retrieved from: https://www.vera.org/downloads/Publications/treatment-alternatives-to-incarceration-for-people-with-mental-health-needs-in-the-criminal-justice-system-the-cost-savings-implications/legacy_downloads/treatment-alternatives-to-incarceration.pdf.

[6] https://www.samhsa.gov/criminal-juvenile-justice/sim-overview

treatment. The SIM framework provides a system-wide way in which to organize interventions and resources in order to maximize diversion into treatment at each intercept. Risk Needs Responsivity (RNR)[7] represents an approach to effective interventions within the justice system that allows for a wide variety of programs, services, and interventions to be used. The *risk principle* states that services should be targeted to the assessed risk of reoffending. The *needs principle* states that treatment should target assessed criminogenic needs. The *responsivity principle* states that treatment should be tailored to meet the specific learning style, motivation, abilities, and strengths of the individual. Essentially, RNR states that treatment and supervision decisions should be based on assessed risk and need.

The Alternatives to Incarceration continuum of services co-locates three services that are intended to divert individuals from being arrested and/or booked into the jail in order to divert them into treatment. Using models from mental health and other disciplines, these three interventions collectively provide an opportunity to divert forensic mental health consumers from police contact that may result in being detained, from being arrested or booked into the jail if detained, and from being re-arrested if unable to comply with the terms and conditions of their release. These priorities for diversion arose out of the sequential intercept mapping process with Alameda County's Justice Involved Mental Health Task Force and focus on preventing entry into the criminal justice system as well as promoting exit from the criminal justice system. They are based on the RNR principles in that they do not prescribe a single approach but instead provide opportunities to assess both behavioral health and RNR principles and develop service plans that connect individuals with services that are likely to address behavioral health and criminogenic risk and need as well as reduce the likelihood of sustained or future criminal justice involvement.

At this time, no other jurisdiction has developed a singularly focused Forensic CRT or applied a reducing revocations approach to people with serious mental illness. People with forensic mental health needs may be served in CRT models or general reducing revocation programs, but none specialize in the intersection between behavioral health and justice system involvement and specifically target behavioral health and criminogenic risk and need. While there are myriad versions of a triage center across the nation, none are led by the mental health system, and none are exclusively focused on arrest diversion for people with serious mental illness. To this end, this continuum of services aims to explore the extent to which these programs are able to reduce criminal justice system

[7] Andrews, D., Bonta, J., & Hoge, R. (1990). Classification for effective rehabilitation. *Criminal Justice and Behavior*, *17*, 19–52. https://doi.org/10.1177/0093854890017001004

involvement for people with serious mental illness (e.g., reduced jail bookings, reduced revocations, increased exit from community supervision).

Learning Goals/Project Aims

In Alameda County, 25% of ACBH consumers receive mental health services in the jail, and 10% of consumers only receive mental health services in the jail.[8] This highlights the need to address the over-incarceration of people with mental health issues and support them outside of a jail environment as a key County priority. This continuum of services, along with the other Innovation Plan entitled *Peer Led Continuum of Forensic Mental Health Services,* is one element of a larger Forensic Mental Health and Reentry Plan and represents the service offerings that are relevant to and meet criteria for Innovation projects.

With this continuum of services, Alameda County Behavioral Health seeks to pilot these three co-located services to understand the extent to which these programs, separately and together, increase access to and participation in mental health services for adults with mental health and criminal justice involvement; improve outcomes, including reduced jail bookings, jail days, and probation/parole violations; and increase knowledge and collaboration between mental health and criminal justice providers and agencies.

For the Forensic CRT, we hope to learn the extent to which the Forensic CRT is able to prevent avoidable jail bookings and jail bed days at the moment of intervention as well as following CRT participation. We also hope to learn the extent to which individuals engage in ongoing mental health services following CRT discharge. These are similar to the expected outcomes of a non-forensic CRT except they substitute jail bookings and bed days for crisis and hospitalization.

Similarly, we hope to learn the extent to which law enforcement officers are willing to divert individuals to the arrest diversion center in lieu of booking them into the jail therefore resulting in reduced jail bookings. We also hope to explore if and how individuals participate in ongoing mental health services following participation at the arrest diversion center and whether or not they remain in the community or are re-arrested. We also hope to learn more about their assessed level of need and referred level of care to better share system capacity needs for ongoing program planning.

Finally, we hope to learn whether or not a concerted effort to reduce parole and probation violations for people with serious mental illness reduces booking individuals into the jail as a result of parole or probation violation. We also hope to learn the extent to which the program results in increased knowledge, understanding, and collaboration amongst probation and parole

---

[8] http://www.acgov.org/board/bos_calendar/documents/DocsAgendaReg_5_10_21/HEALTH%20CARE%20SERVICES/Regular%20Calendar/Item__1_ACBH_Services_Forensic_sys_5_10_21.pdf

Evaluation or Learning Plan

This Alternatives to Confinement continuum of services evaluation will explore process and outcome measures related to the three co-located services. The overarching evaluation questions include:

1. What resources are being invested, by whom, and how much?
2. Who is being served, at what dosage, and in what ways, including participation in more than one INN-funded service?
3. To what extent do people who participate in INN-funded services experience reduced jail bookings, jail days, and parole/probation revocations?
4. To what extent to people who participate in INN-funded services experience increased service engagement and participation?
5. How does knowledge, understanding, and collaboration between mental health and criminal justice agencies change over the course of the project? What activities and experiences promote or detract from the working relationship?

The evaluation will explore the following types of quantitative data:

- Socio-demographics of individuals served, including race/ethnicity, age, gender identity, sexual orientation, zip code, income type and amount, housing status, level of education, and veteran status.
- Clinical and justice involved profile of individuals served, including mental health diagnoses and previous service participation; previous arrest, charge, and booking information; substance use and misuse; known trauma history; other clinically relevant information.
- Current program and service participation, including program, service type, procedure code, provider type, dates of service, length of encounter, length of episode, disposition. This includes for INN-funded programs as well as all other MHP-funded services, such as crisis and hospitalization as well as other residential and outpatient services.
- Current justice system interactions, including jail bookings and discharge dates, charges filed, court dispositions. If feasible, police contact and arrest data that did not result in a jail booking may also be included.
- Referrals, including referrals sources into the INN-funded programs as well as referrals and linkages provided from the INN-funded programs into other mental health services.
- Experience of services from consumers, family, behavioral health providers, and justice professionals.

- Perception of knowledge, understanding, and collaboration between behavioral health providers and justice professionals.

Quantitative data will be collected directly from the County's Electronic Health Record, the Sherriff's Office via existing Memorandum of Understanding, the Community Health Record funded through the Whole Person Care Initiative, and via data request to the courts. Experience of services and perception of knowledge, understanding, and collaboration will be collected via interviews and focus groups; there may also be a brief survey developed for service recipients and their families or involved professionals.

Data will be collected on an ongoing basis and reported annually to providers and partners in order to support communications and continuous quality improvement as well as to the Mental Health Services Oversight and Accountability Commission (MHSOAC) in order to meet INN reporting requirements.

Section 3: Additional Information for Regulatory Requirements

Contracting

The County expects to contract the Forensic CRT to a community-based provider and may also choose to contract for the other services. Additionally, the County intends to contract for an external evaluator for this project to work with our internal data support team in exploring the learning goals and evaluation questions listed above as well as complete required reporting for the project. The County will appoint a contract monitor for each of these contracts to ensure contract compliance as well as a portion of the County project/program manager to supervise the quality of work performed.

Community Project Planning

These projects arose out of a longer term planning and system improvement process dedicated to improving services for justice involved mental health consumers. The Justice Involved Mental Health (JIMH) Task Force included representatives from the Health Care Services Agency, Alameda County Behavioral Health, Public Defender, District Attorney, provider and advocacy organizations, consumer and family representatives, faith based and other community leaders. After a more than year long process, the JIMH Task Force published a report in September 2020 with multiple stakeholder recommendations, including a focus on preventing law enforcement contact and arrest diversion, among other suggestions. Concurrently, ACBH published a Forensic Mental Health and Reentry Plan in October 2020 that was informed by JIMH

and included additional actions informed by evidence based practice and ACBH's strategic direction.

During 2021, ACBH systematically went through the Forensic Mental Health and Reentry Plan and identified aspects of the plan that either warranted further development and/or consideration or may meet criteria for INN funds. As a part of this process, ACBH contracted with the Indigo Project to engage in INN Project planning. The Indigo Project met with a number of internal and external stakeholders to gather information and workshop the ideas and concepts as they evolved, including:

- Consumer representatives and members of the Pool of Consumer Champions
- Family representatives and individuals from NAMI
- Providers who represent communities who are underrepresented because of cultural affiliation and language access
- Members of the African American subcommittee
- Members of the MHSA Stakeholder group
- Healthcare for the homeless providers
- System of Care Directors for Adult, Crisis, and Forensic Mental Health Services
- Consumer and Family Empowerment Managers

With each discussion, the concepts evolved and were further developed and clarified. These projects will be included in the MHSA Annual Update Community Program Planning (CPP) process in 2022 with the hopes of beginning implementation in FY2022.

MHSA General Standards

This project arose out of a community effort to address the needs of mental health consumers who are forensically involved. It was developed by consumers, family, and communities to support wellness and recovery and avoid incarceration.

This project arose out of a community effort to address the needs of mental health consumers who are forensically involved. It was developed by consumers, family, and communities to support wellness and recovery and avoid incarceration. Community collaboration is exemplified in not only how this project was developed but also in how the project itself works to keep individuals within their communities rather than removing them and placing them in a jail environment. Cultural Competency is included as a foundational component in that this project seeks to address the overincarceration of people with mental illness, the majority of whom are BIPOC individuals, by preventing police contact and jail booking as well as supporting individuals to successfully exit the justice system. Additionally, the services themselves will be informed by and primarily staffed by individuals who represent our County's diverse populations. Services will be

client and family driven in that services aim to preserve a person's freedom, independence, and ability to consent to their own services by using person centered planning with family member input that respects an individual's needs and preferences and works in partnership with each individual and their family to discover how they understand the issues that they're facing and helps them develop a plan that they are willing to do to address what is most important to them. The services are wellness, recovery, and resiliency focused in that they are built upon the belief that participation in mental health services is more productive and meaningful than incarceration and that services that respect an individual's ability to invest in their own recovery journey are more likely to result in sustained freedom than "rehabilitation" provided by the jails. Finally, services are intended to be integrated in that these programs seek to strengthen collaboration between mental health and justice organizations so that individuals and families can streamline efforts and communication between mental health services and criminal justice requirements in order to promote community-based recovery and minimize or avoid criminal justice involvement.

Cultural Competence and Stakeholder Participation in Evaluation

On a quarterly basis, ACBH will convene a stakeholder meeting with individuals who are invested in both forensic mental health INN projects, which include this project and the *Peer Led Continuum of Forensic Mental Health Services.* This meeting will serve dual purposes to gather information from stakeholders and partners about their perspectives on the project and its implementation as well as to provide data from the evaluation to support a CQI process. As a part of this project, we will explore the extent to which the project is reaching its intended target population and that people receiving services are reflective of the jail population (i.e., the population receiving services is comparable to the Santa Rita population in terms of race/ethnicity and age). This will be one component of what is discussed in the quarterly meetings as well as overall feedback and evaluation data described in the preceding section.

Innovation Project Sustainability and Continuity of Care

This project will primarily serve individuals with serious mental illness. If this project accomplishes its intended objectives of 1) reducing jail bookings and jail days and 2) increasing participation in ongoing mental health services, the County will continue to fund the project using a combination of MHSA Community Services and Supports funding and Federal Financial Participation (FFP). All of the services described in this plan should be eligible for Medi-Cal reimbursement following completion of the INN project.

Communication and Dissemination Plan

If this project is successful at 1) reducing jail bookings and jail days and 2) increasing

participation in ongoing mental health services, ACBH will apply to present learnings at California-specific conferences, including the forensic mental health association, California Institute of Behavioral Health Services, and California Association of Counties (CSAC) conferences. Additionally, ACBH will request that the contracted evaluator prepare a white paper that can be distributed through the California Behavioral Health Directors Association, California Probation Officers Association, and the MHSOAC listserv.

Keywords include:

1. Jail diversion
2. Pre-arrest diversion
3. Reducing revocations
4. Forensic Crisis Residential Treatment
5. Forensic mental health diversion

Timeline

ACBH proposes a 5 year Innovation project in which the first two years of the project allow for facility start-up. While the non-residential services may be able to be implemented more quickly, we believe that it is important to have all elements available at the same time, particularly with a co-located service model. To that end, ACBH will begin the site identification and procurement process upon MHSOAC approval. This may take up to nine months to facilitate a competitive bid process and then enter into contracts. The second year will focus on preparing the site and program for opening, including preparing the application for Community Care Licensing as well as the materials, including policies and procedures, for Medi-Cal certification. Concurrently, the evaluators will be working with the department and stakeholders to develop the evaluation approach. Years 3-5 will focus on service provision as well as data collection and analysis to support learning. In the final year, ACBH will also develop an ongoing funding strategy using MHSA, realignment, and FFP dollars. In year 5, the evaluators will also draft the summative evaluation report and a white paper detailing project implementation, outcomes, and lessons learned.

Year 1	Project Start-up - County Procurement • Identify program location • Procure mental health provider and evaluator services • Execute INN service provider and evaluator contracts
Year 2	Project Start-up - Facility Preparation

	• Building Modifications • Facility Licensing and Medi-Cal Certification • Staff Hiring and Training • Outreach to justice agencies and mental health providers Project Start-up - Project Evaluation • Evaluation planning, including stakeholder input Milestone: Services Commence Milestone: Evaluation Plan Complete
Year 3	Ongoing: Service provision Ongoing: Data collection Quarterly: Stakeholder convening to support CQI Annual: INN reporting
Year 4	Ongoing: Service provision Ongoing: Data collection Quarterly: Stakeholder convening to support CQI Annual: INN reporting
Year 5	Ongoing: Service provision Ongoing: Data collection Quarterly: Stakeholder convening to support CQI End of Project: Sustainability Plan End of Project: Summative INN report

Section 4: INN Project Budget and Source of Expenditures

INN Project Budget and Source of Expenditures

The next three sections identify how the MHSA funds are being utilized:

A) BUDGET NARRATIVE (Specifics about how money is being spent for the development of this project)
B) BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY (Identification of expenses of the project by funding category and fiscal

year)

C) BUDGET CONTEXT (if MHSA funds are being leveraged with other funding sources)

Budget Narrative

Provide a brief budget narrative to explain how the total budget is appropriate for the described INN project. The goal of the narrative should be to provide the interested reader with both an overview of the total project and enough detail to understand the proposed project structure. Ideally, the narrative would include an explanation of amounts budgeted to ensure/support stakeholder involvement (For example, "$5000 for annual involvement stipends for stakeholder representatives, for 3 years: Total $15,000") and identify the key personnel and contracted roles and responsibilities that will be involved in the project (For example, "Project coordinator, full-time; Statistical consultant, part-time; 2 Research assistants, part-time…"). Please include a discussion of administration expenses (direct and indirect) and evaluation expenses associated with this project. Please consider amounts associated with developing, refining, piloting and evaluating the proposed project and the dissemination of the Innovative project results

A slower start-up will be implemented due to overstaffing and expenditure concerns expressed by the systems of care managers. Managers agreed that expanding staffing as the project progresses will be more efficient and beneficial as appropriate adjustments are identified. The following budget outlines the start-up and projected annual expenditures:

alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

Staffing				
Position	**Quantity**	**Salary**	**Start-up**	**Annual Cost**
A/DTC Program Director/Clinical Supervisor	1	$ 125,000	$ 46,875	$ 62,500
A/DTC Program Manager	1	$ 92,000	$ 46,000	$ 92,000
A/DTC Clinician - License Eligible	5	$ 85,000	$ 106,250	$ 425,000
A/DTC Case Manager	5	$ 74,000	$ 92,500	$ 370,000
A/DTC Nursing	5	$ 82,000	$ 102,500	$ 410,000
A/DTC Forensic Peer Specialist	5	$ 68,000	$ 85,000	$ 340,000
F-CRT Program Director/Clinical Supervisor	1	$ 125,000	$ 46,875	$ 62,500
F-CRT Program Manager	1	$ 92,000	$ 46,000	$ 92,000
F-CRT Therapist - License Eligible	2	$ 85,000	$ 42,500	$ 170,000
F-CRT Case Manager	1	$ 74,000	$ 18,500	$ 74,000
F-CRT Forensic Peer Specialist	2	$ 68,000	$ 34,000	$ 136,000
F-CRT Mental Health Rehabilitation Specialist	15	$ 62,400	$ 234,000	$ 936,000
Total Salaries			**$ 901,000**	**$ 3,170,000**
CBO Benefits @ 33%			$ 306,340	$ 1,077,800
Total Staffing	**46**		**$ 1,207,340**	**$ 4,247,800**
Operations				
Contractors and Other Staffing Needs				
F- CRT Relief Staff	4000 hours per year	$28/hour	$ -	$ 112,000
Consutant - Psychiatrist (CRT)	16 hours per week	$350/hour	$ -	$ 291,200
Consultant - Licensing and Certification			$ 300,000	$ -
Recruitment			$ 18,000	$ 6,000
Pre-employment Expenses			$ 36,000	$ 8,000
Reducing Revocations Training			$ 12,000	$ 18,000
Programmatic/Staff Training			$ 60,000	$ 20,000
Supplies				
Food			$ 8,000	$ 166,400
Household Supplies			$ 12,000	$ 38,400
Personal Hygeine Items			$ 8,000	$ 14,400
Medical and First Aid			$ 8,000	$ 10,000
Office Supplies			$ 42,000	$ 7,200
Program Supplies			$ 40,000	$ 48,000
Facilities/Utilities				
Lease Payment		$ 20,000		$ 240,000
Gas and Electric		$ 2,000	$ 12,000	$ 24,000
Water		$ 1,800	$ 10,800	$ 21,600
Garbage		$ 600	$ 3,600	$ 7,200
Comcast/Xfinity		$ 1,200	$ 7,200	$ 14,400
Maintenance (Furniture and Equipment)			$ 60,000	$ 12,000
Maintenance (Property)				$ 48,000
Housekeeping		$ 4,000	$ 24,000	$ 48,000
Laundy		$ 2,400	$ 14,400	$ 28,800
Landscaping		$ 2,000	$ 12,000	$ 24,000
Communications				
Telephone		$ 600	$ 3,600	$ 7,200
Cell Phones	20 cell phones	$ 600	$ 3,000	$ 12,000
Digital Signage		$ 1,200	$ -	$ 14,400
Microsoft 365		$ 2,079	$ 1,040	$ 2,079
Transportation				
Vehicle Lease and Fees	2 leased vans	$ 800	$ 4,800	$ 33,600
Vehicle Maintenance (incl gas, oil, etc)			$ -	$ 10,000
Transportation Assistance			$ -	$ 29,200
Other Services				
Insurance			$ 4,500	$ 18,000
Total Operations			**$ 704,940**	**$ 1,334,079**
Total Staffing			**$ 1,207,340**	**$ 4,247,800**
Total Operations			$ 704,940	$ 1,334,079
Total Direct Costs (Staffing + Operations)			$ 1,912,280	$ 5,581,879
Total Indirect (15%)			$ 286,842	$ 837,282
Total Costs			**$ 2,199,121**	**$ 6,419,161**
Potential Medicaid Revenue				$ 3,209,580
Total INN funds needed			**$ 2,199,121**	**$ 3,209,580**

Indigo Project

Alameda County's Request of Mental Health Services Oversight and Accountability Commission Approval for use of Innovation Funds to Develop a Peer to Peer Dialectical Behavior Therapy (DBT) Online Training and Skills Groups for Peers

Introduction

Alameda County Behavioral Health (ACBH) continues to be fully invested in supporting a dynamic, skilled peer community. Peer involvement from consumers and family members of Alameda County is essential not only to Mental Health Services Act (MHSA) Innovation planning and program development, the Peers Organizing Community Change[1] (POCC) is utilized for, but not limited to, outreach, focus groups, and surveys to assist in developing programs by all systems of care. The POCC's role is to provide a strong consumer voice in Alameda's mental health system and in the community.

Alameda County began a comprehensive peer organization in 2006 holding their first major peer event in 2007 with an undertaking to educate, advocate, and lead. The POCC's mission is to improve the quality of life for the county's residents who have mental health, mental health and substance use issues in whatever setting they find themselves and to provide consumer perspective in transforming the County's behavioral systems of care to a recovery vision that consumer-driven, culturally, responsive, and holistic in its services and supports.[2]

The County is dedicated to robust approaches to ensure opportunities and uplift peers within the county regarding their skill level. Peer delivered health and wellness services are important complements for an integrated care team model working to help a system merge the concepts of recovery with physical well-being and overall recovery.[3] With the passage of California's Peer Support Specialist Certification Program Act of 2020, ACBH is looking to further build trainings and increase employment opportunities of its diverse peer workforce in crisis care.

As the peer support specialist workforce has grown over the years, their roles have evolved, which in turn, has led to gaps in knowledge about their activities within systems of care. ACBH is seeking to develop an online Dialectical Behavioral Therapy Peer to Peer training program to train peers with the skills of DBT. This program is to provide new skills as peers enhance their hire ability. ACBH wishes to provide a learning environment that is removed from restrictive time and space. The overall goal is to deliver a self-paced, recovery-oriented mode of learning for peers to cultivate relationships with others committed to learning, practicing, educating others about, and building mastery of the 4 DBT skill sets: core mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness. The county and POCC is committed to

[1] Formerly known as the Pool of Consumer Champions.
[2] See https://www.pocc.org/about-us/history-mission-values
[3] Swarbrick, M. A. (2013). Integrated care: Wellness-oriented peer approaches: A key ingredient for integrated care. Psychiatric Services, 64, 723–726. http://dx.doi.org/10.1176/appi.ps.201300144

eliminating stigma against people with emotional health challenges by creating hope through sharing stories of recovery and advocating in our communities through enhancing peers' skills. Building peer skills with DBT training, is an excellent addition to the POCC's mission of providing an empowered and informed voice: of, by, and for consumers in the behavioral health care system, related systems, and in the community.[4]

California's Peer Support Specialist Certification Program Act of 2020 has led ACBH to opt-in to:

1) Peers being a provider type under Medi-Cal that could bill for peer services as well as other services; and
2) Providing a process for certification of peer support specialists.

DBT is primarily a cognitive-behavioral treatment, with roots in Eastern and Zen mindfulness practices. DBT generally treats severe emotional dysregulation, suicidality, and non-suicidal self-injury in clients.[5] However, its principles are being expanded to many other populations. DBT's core philosophy includes its basis in mindfulness, clear prioritizing of treatment targets, and a dialectical balance between acceptance and change strategies.

It is well documented that peer supported services provide a unique and beneficial aspect to mental health treatments. With the pandemic unintentionally showing that online meetings, trainings, and learning are feasible, ACBH is progressing forward into the future using technology to develop a DBT online training for peers to improve/add to their skills avoiding high costs and low accessibility associated with standard DBT training; developing peer to peer skills practice groups offered in person or virtually to support the strengthening of mindfulness, distress tolerance, emotional regulation, and interpersonal effectiveness skills; supporting the emerging certification process for peer support specialists empowering peers in their supportive roles; and decrease mental health stigma.

What Has Been Done

During the course of POCC's history, major efforts to get MHSA dollars to fund consumer run programs was first sought so consumers could be hired through MHSA's Workforce, Education and Training funding. The POCC developed a Peer Employment Tool Kit during the planning period, and contributed greatly by participating on the county's initial MHSA planning group that was deciding where resources would go. An initial hire by the county's behavioral health care was done to implement the hiring of consumers' initiative. Eventually the POCC's efforts received approval for a consumer organization to provide the hiring of consumers.

As the POCC grew with more members, more committees were needed to reflect the consumer perspective on system of care changes. These changes were to reflect ethnic diversity, age and gender identity. Additional committees were formed to address important issues in the community. These issues included Healing Trauma, Substance Use Recovery, Public Policy & Education, and Veterans.[6] Today, the

[4] See https://www.pocc.org/about-us/history-mission-values
[5] Koerner K. What must you know and do to get good outcomes with DBT? Behav Ther. 2013 Dec;44(4):568-79. doi: 10.1016/j.beth.2013.03.005. Epub 2013 Apr 6. PMID: 24094782.
[6] Ibid

POCC has its own annual conference each summer.

Why the Need

Peer support has been around for decades. There are thousands of peer support programs in the United States. However, many who need peer support in order to maintain their life, be it treating their diabetes, veterans with PTSD, or maintaining one's recovery, do not always receive the support they need.

Peer support programs all too often have small budgets while trying to help many people. The lack of resources tends to delay development of new approaches especially for peer support programs as these tend to have inadequate funding.

The passing of the Affordable Care Act (2010) has provided a heavy focus on prevention, and created many opportunities for developing and funding peer-delivered whole health and wellness services. This landmark legislation coupled with the unique qualifications peers have brought to behavioral health systems has brought much needed resources to those with mental health challenges. However, as with any profession, as it grows and becomes more established, there is a need to create new opportunities to take advantage of existing expertise, while keeping individuals in the profession interested and feeling like they are advancing their careers.[7]

Peer support is based on the belief that "people who have face, endured and overcome adversity can offer useful support, encouragement, hope, and perhaps mentorship to others facing similar situations…"[8] Peer delivered health and wellness services are important complements for an integrated care team model working to help a system merge the concepts of recovery with physical well-being and overall recovery.[9] Since the beginning, the POCC has operated under this recovery vision along with its commitment to ensure that the consumer viewpoint was a significant part of ACBH.

ACBH and POCC are determined to advance and promote peer support programs. When providing peer support that involves positive self-disclosure, role modeling, and unconditional regard, peer staff have also been found to increase participants' sense of hope, control, and ability to effect changes in their lives; increase their self-care, sense of community belonging, and satisfaction with various life domains; and decrease participants' level of depression and psychosis.[10] Doing so will require testing innovative treatment modalities.

Although DBT was developed to treat borderline personality disorder (BPD), evidence has shown that DBT is not only an effective treatment for BPD, it has successfully been adapted or modified to populations

---

[7] Daniels, A. S., Tunner, T. P., Bergeson, S., Ashenden, P., Fricks, L., & Powell, I. (2013, January). Pillars of Peer Support Summit IV: Establishing standards of excellence. Retrieved from www.pillarsofpeersupport.org

[8] Davidson, L., Chinman, M., Sells, D., & Rowe, M. (2006). Peer support among adults with serious mental illness: A report from the field. Schizophrenia Bulletin, 32(3), 443-450. doi: 10.1093/schbul/sbj043.

[9] Swarbrick, M. A. (2013). Integrated care: Wellness-oriented peer approaches: A key ingredient for integrated care. Psychiatric Services, 64, 723–726. http://dx.doi.org/10.1176/appi.ps.201300144

[10] Davidson L, Bellamy C, Guy K, Miller R. Peer support among persons with severe mental illnesses: a review of evidence and experience. World Psychiatry. 2012 Jun;11(2):123-8. doi: 10.1016/j.wpsyc.2012.05.009. PMID: 22654945; PMCID: PMC3363389.

besides those who have BPD.[11] Evidence already shows the benefits of peer inclusion in general is successful for consumers, staff, and peers. Adding DBT to the skills of peers is a natural extension.

There are several DBT techniques that coincide with the recovery philosophy making it a good fit:

- Validation is the non-judgment belief that consumers 'experiences are understandable and important. The peer practices validation by respecting the program participants self-knowledge;
- Radical genuineness is a validation strategy that believes in the client's strengths and capacity for change; and
- Collaboration which in DBT is viewed as a strategy that strengthens the working relationship[12] and coincides with peer process "to arrive at a mutually acceptable plan for moving forward in the treatment process."[13]

It is these parallels in philosophy that makes DBT training to peers very appealing to refresh and broaden the skills of peer support specialists.

No one knows when the pandemic will end or if it will become endemic. What we do know is there are already studies showing the negative impact on mental health the pandemic is afflicting upon our communities. With DBT online training, peers will safely be able to uplift their skills with a practice that is proven to work and assist in alleviating the growing number of community members who need support with their mental health.

Budget

Alameda County is requesting Commission approval to earmark $2,163,844 of MHSA Innovation funds over a four-year timeline for the creation and development of an online DBT training program for peers, peer to peer skills practice groups and research.

Outcomes

Creating and developing DBT online training modules geared for peer support specialists and in person or virtual peer to peer skills practice groups will support the County's commitment to build on its Peer Support Specialist Certification trainings and increase employment opportunities of the diverse peer workforce in its systems of care. The Peer to Peer DBT program is to provide new skills as peers enhance their hire ability; and test if these new skills are effective in practice groups.

Developing an online DBT training will also be complimentary to ACBH's Crisis Care Management Services (CCMU) grant which was awarded to ACBH in December, 2021. The CCMU grant was awarded from the Department of Health Care Services. The funding will provide additional Peer Support Specialist to be trained and certified to respond to those in crisis; develop a crisis training curriculum; and provide funds to

[11] Linehan, M. M. (2015). DBT skills training manual. (2nd ed.). New York: Guilford Press.
[12] Ibid.
[13] Deegan, P. E., & Drake, R. E. (2006). Shared decision making and medication management in the recovery process. Psychiatric Services, 57(11), 1636-1639.

upgrade mobile devices which will allow the county's team to be better equipped to respond to those experiencing crisis.

Conclusion

Alameda County will be adding this request to the County's MHSA Annual Update Fiscal Year 22/23. The annual update is projected to be finalized with an approval by the Alameda County Board of Supervisors in June 2022.

PERSONNEL COSTS (salaries, wages, benefits)		FY xx/xx	FY xx/xx	FY xx/xx	FY xx/xx	TOTAL
1.	Salaries	$ 86,361	$ 440,786	$ 454,007	$ 464,384	$ 1,445,538
2.	Direct Costs					
3.	Indirect Costs	$ 12,854	$ 66,118	$ 68,101	$ 69,658	$ 216,831
4.	Total Personnel Costs	$ 99,215	$ 506,904	$ 522,108	$ 534,042	$ 1,662,369
OPERATING COSTS		**FY xx/xx**	**FY xx/xx**	**FY xx/xx**	**FY xx/xx**	**TOTAL**
5.	Direct Costs	$ 143,500	$ 67,000	$ 47,000	$ 29,000	$ 286,500
6.	Indirect Costs	$ 10,275	$ 19,800	$ 5,850	$ 2,850	$ 42,975
7.	Total Operating Costs	$ 153,775	$ 86,800	$ 52,850	$ 31,580	$ 329,475
NON- RECURRING COSTS						
8.	Laptops; technology equipment		$ 12,500	$ 12,500		$ 25,000
9.	Legal Fees	$ 10,000				$ 10,000
10.	Total Non-recurring costs					$ 35,000
CONSULTANT COSTS / CONTRACTS (clinical, training,						
11.	Direct Costs	$ 10,000	$ 10,000	$ 54,000	$ 54,000	$ 138,000
12.	Indirect Costs	$ 3,000	$ 3,000	$ 3,000		$ 9,000
13.	Total Consultant Costs	$ 40,000	$ 29,000			$ 69,000
OTHER EXPENDITURES (please explain in budget narrative)						
14.						
15.						
16.	Total Other Expenditures					
BUDGET TOTALS						
Personnel (line 1)		$ 99,215	$ 506,904	$ 454,007	$ 464,384	$ 1,445,538
Direct Costs (add lines 2, 5 and 11 from		$ 153,500	$ 77,000	$ 101,000	$ 83,000	$ 414,500
Indirect Costs (add lines 3, 6 and 12 from		$ 26,129	$ 88,918	$ 76,951	$ 72,508	$ 268,806
Non-recurring costs (line 10)		$ 10,000	$ 12,500	$ 12,500		$ 35,000
Other Expenditures (line 16)						
TOTAL INNOVATION BUDGET						**$ 2,163,844**

Appendix B-6 MHSA Suggestion Box

alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

2000 Embarcadero Cove, Suite 400
Oakland, Ca 94606
510-567-8100 / TTY 510-533-5018
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. ***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 County requests ***YOUR*** feedback to help identify which of the **THREE** innovative concepts to implement. Please submit your suggestions by **April 30, 2022.**

1. **Consumer Empowerment Using DBT (Dialectical Behavioral Therapy)**
The DBT project will develop an online Dialectical Behavioral Therapy (DBT) Peer to Peer training program to train peers with the skills of DBT. An online training program is able to provide an avenue that is self-paced, recovery-oriented mode of learning for peers to cultivate relationships with others committed to learning, practicing, educating others about, and building mastery of the 4 DBT skill sets: *core mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness.*

2. **Peer-led Continuum of Forensic Services**
The Peer-led Continuum of Forensic Services is a collection of four (4) components, three of which are peer-led and one that is family focused: *Reentry Coaches, WRAP for Reentry, Forensic Peer Respite, and Family Navigation and Support*. The project seeks to support mental health consumers who are justice involved transitioning back into the community. This project also seeks to build capacity of family members to advocate for loved ones with a serious mental illness who has become justice involved.

3. **Alternatives to Confinement Continuum of Forensic Services**
The Alternatives to Incarceration Continuum of Forensic Services is a collection of three (3) services that work together and are intended to prevent incarceration and divert individuals from criminal justice system into mental health services. Diversion is sought when early signs of crisis occur, police contact which may lead to arrest, and probation or parole non-compliance. The services include: *Forensic Crisis Residential Treatment, Arrest Diversion/Triage Center, and Reducing Probation/Parole Violations*.

1. Innovative Ideas: Please check the primary concept below that your recommendation will address.

☐ Consumer Empowerment Using DBT ☐ Peer-led Continuum of Forensic Services

☐ Alternatives to Confinement Continuum of Forensic 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. Which of the three innovative ideas should the County test/try out? (Limit: 250 characters)

alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

2000 Embarcadero Cove, Suite 400
Oakland, Ca 94606
510-567-8100 / TTY 510-533-5018
Karyn L. Tribble, PsyD, LCSW, Director

4. What challenging problem does this idea 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 why this innovative idea should 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: MHSA Innovation Unit. Thank you for your participation!

alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

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

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

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

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

How Much Did We Do?

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

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

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

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

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

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

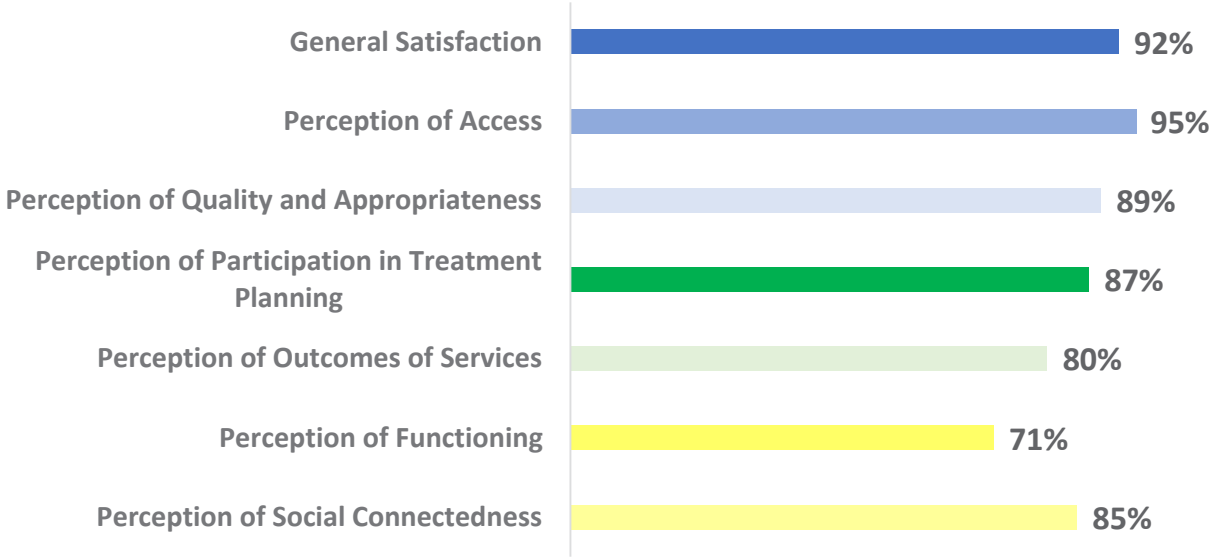
*All costs exclude administration costs, but do include a level of staff, training, and capacity building money in addition to all client focused costs.
[+]All counts contain duplicates

How Well Did We Do?

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

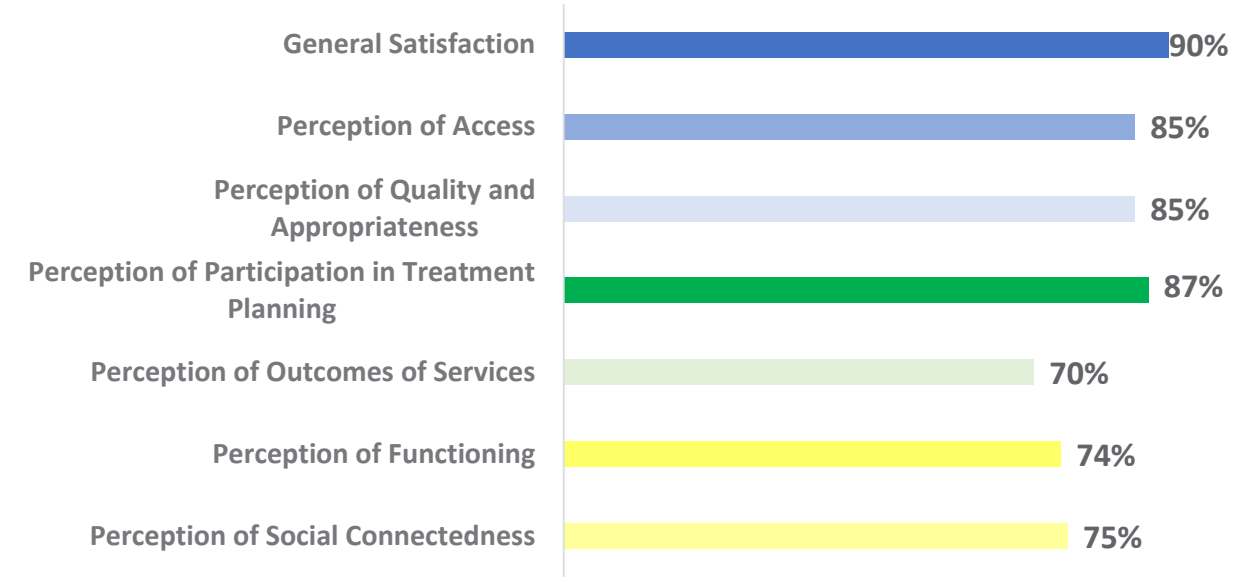
Spring 2020 Consumer Perception Survey Results Older Adults Ages 60+

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



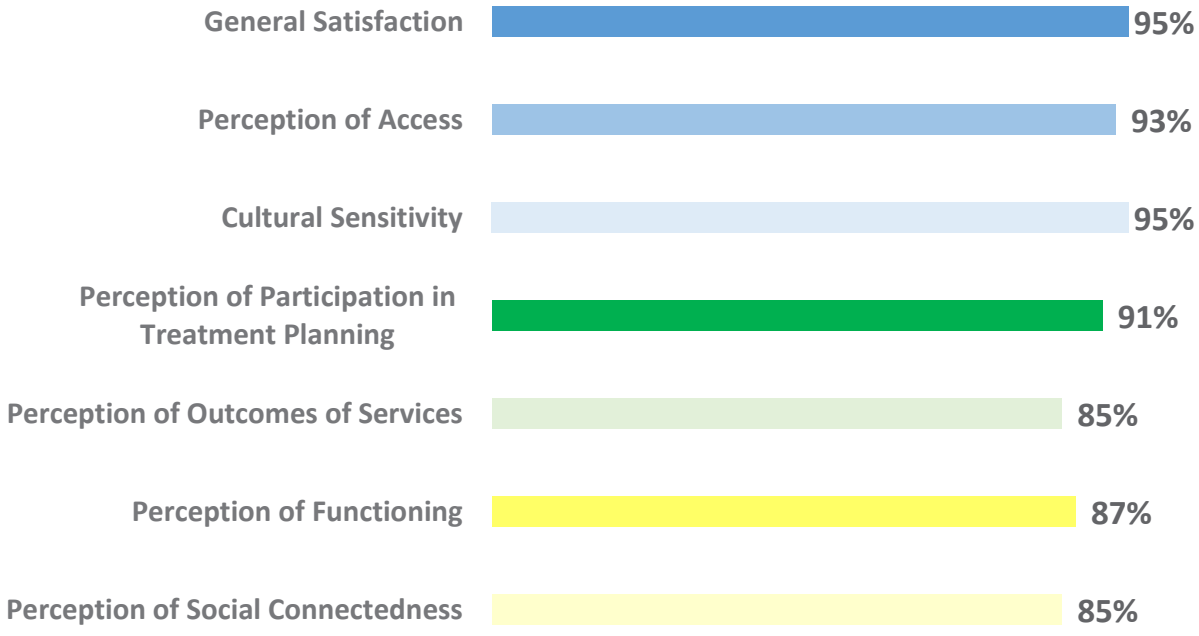
Spring 2020 Consumer Perception Survey Results Adults Ages 18-59

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



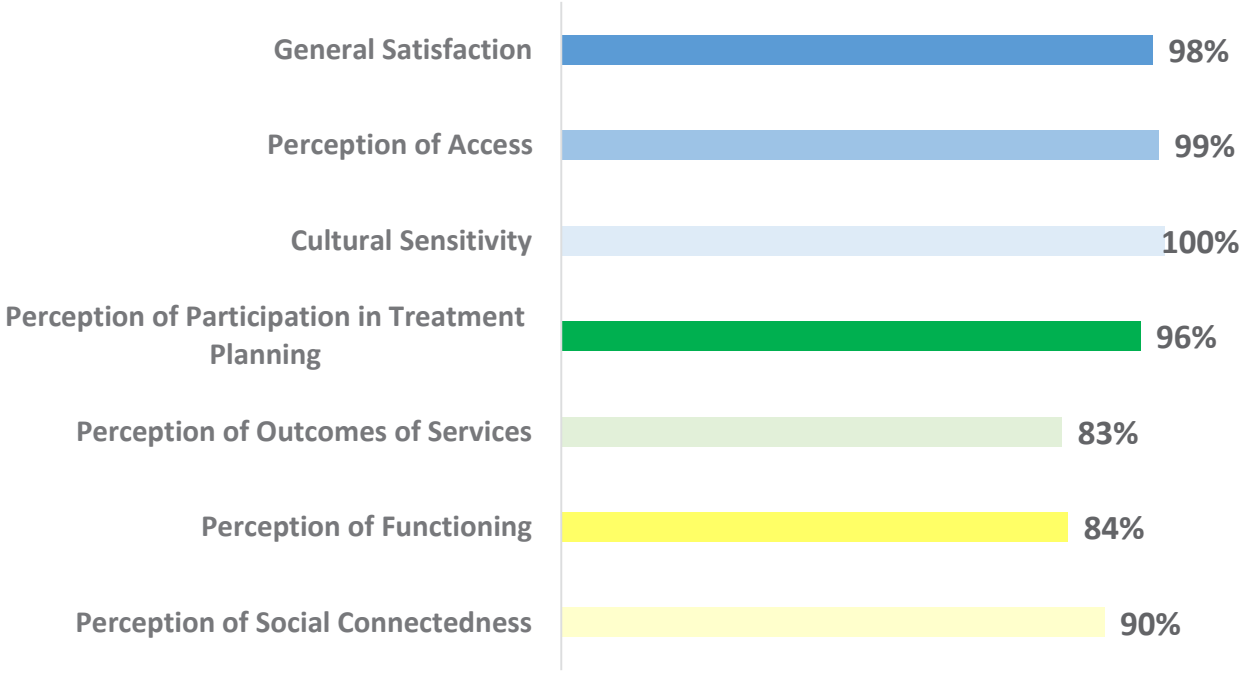
Spring 2020 Consumer Perception Survey Results Youth Ages 13-17

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



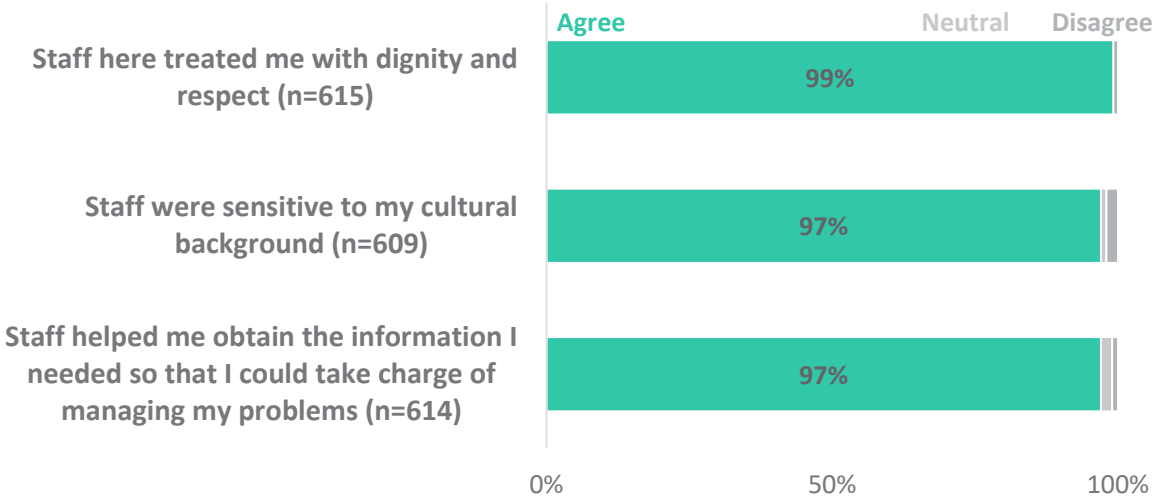
Spring 2020 Consumer Perception Survey Results Family/Caregivers of Youth Under 18

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

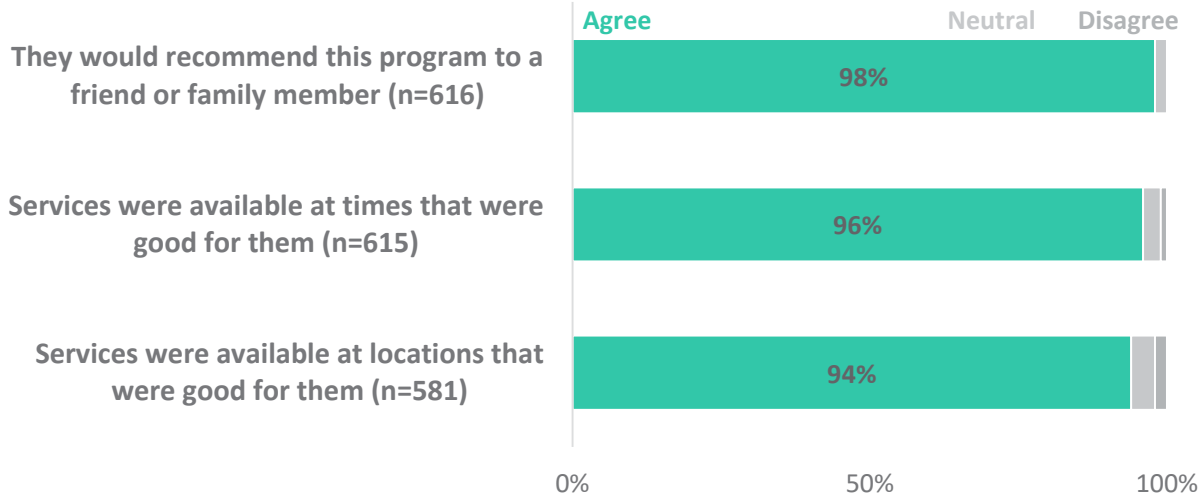


The subset of **PEI** programs, called **UELPs,** also complete a client satisfaction survey every year. The UELPs ask their program participants to fill out the survey during November to January during the fiscal year[1]. Overall, **UELP** clients are very happy with the services that they received.

UELP Clients were Satisfied with Services



UELP Clients think that Services were Convenient



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

Is Anyone Better Off? Selected Program Outcomes

FSP Client Quotes

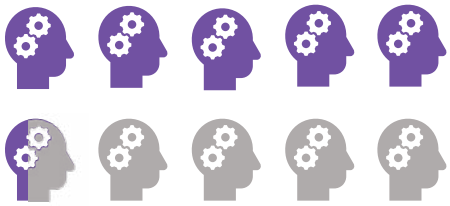
"They help me make it to appointments, they helped me get a phone, they helped me get the right medication so it's really nice of them."
"I got my own spot. They come through. They be helping. I wouldn't be here if not for [them]."

8 in 10

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

53%

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



UELP Client Quote

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

84%

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

86%

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

alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

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

Introduction

Program Background

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

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

Service Team Program, Population Served, and Agency Type

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

Report Rationale and Methods

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

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

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

Program Description

Program Activities

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

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

Outpatient Services

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

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

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

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

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

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

2. Hygiene kits – Asian Health Services and Oakland

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

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

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

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

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

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

1. Housing help – Asian Health Services and BACS

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

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

2. Wellness Centers – Bonita House, Eden, BACS

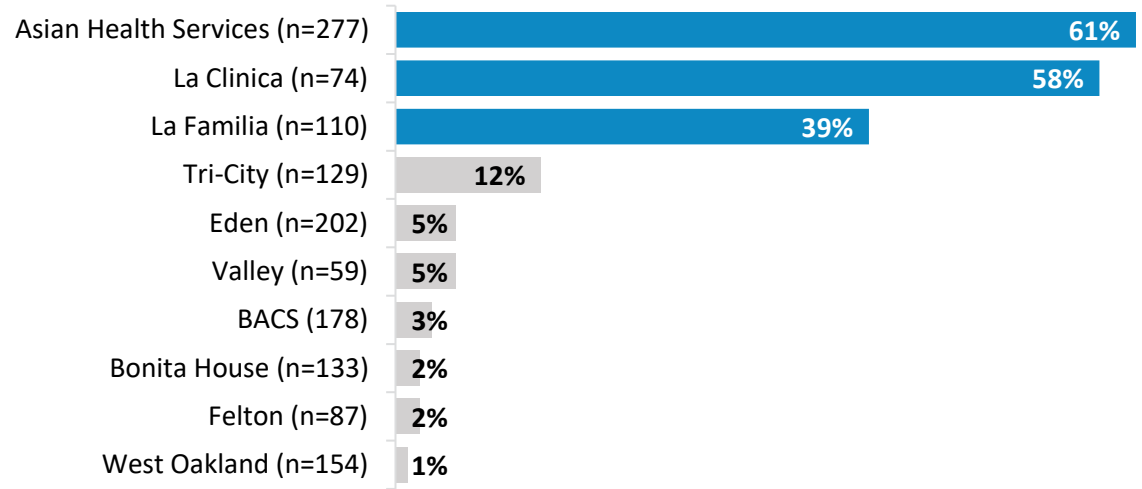
"We also just reopened the Wellness Center, which is fantastic. It was closed for over a year and before we closed we would literally have I don't know 30 people a day in there. We would serve food and people could come in first thing in the morning that have been outside all night and then you have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

In-language Services

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

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

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



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

Primary Care and Health Focused Resources

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

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

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

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

Substance Use Disorder Treatment

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

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

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

Individual Placement and Support (IPS) or Supported Employment

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

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

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

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

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

Substitute Payee

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

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

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

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

Staffing Patterns and Strengths

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

Program Manager Role

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

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

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

Team Staffing and Roles

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

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

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

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

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

Other Staffing Resources

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

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

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

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

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

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

Staffing Strengths

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

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

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

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

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

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

Client Success and Measuring if Anyone is "Better Off"

Success Definition

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

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

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

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

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

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

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

Other Data the Agencies Collect

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

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

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

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

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

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

Changes to the Program due to the COVID-19 Pandemic

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

In-person Groups and Transportation

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

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

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

System-level Changes due to the Pandemic

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

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

Telehealth Implementation

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

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

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

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

Telehealth Definition

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

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

Client Responses to Telehealth

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

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

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

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

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

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

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

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

Staff Responses to Telehealth

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

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

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

Areas for Change or Improvement

Program Activities to Streamline or Change

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

Clinical Documentation

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

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

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

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

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

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

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

Telehealth

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

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

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

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

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

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

Remote Work

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

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

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

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

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

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

Separate Substitute Payee from Clinical Relationship

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

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

Increasing use of Peer/Group Supports

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

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

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

Staffing Changes and Improvements

Increase Staffing and Adjustments

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

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

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

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

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

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

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

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

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

Data Collection Areas of Improvements and Needs

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

Improve Information on New Referrals

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

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

Comparison Dashboards

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

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

System Challenges

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

Hiring and Staff Retention

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

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

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

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

Need for More Clients

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

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

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

Resources Agencies Want and Need

Housing

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

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

Transportation

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

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

Day Programs or Groups

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

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

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

More in-language services

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

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

Funding for Incentives

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

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

Dementia Care

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

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

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

Program Recommendations

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

1. Define Client Success:

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

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

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

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

2. Measure Client Success:

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

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

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

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

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

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

4. Expand Internships Programs to all Service Teams:

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

alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

Mental Health Services Act's Primary Care Integration Evaluation Fiscal Year 2020-2021

Introduction

The **Mental Health Services Act (MHSA)** or Proposition 63 funds mental health services in Alameda County through a one percent tax on personal annual incomes that exceed one million dollars. It is designed to expand and transform California's mental health systems to better serve individuals with, and at risk of, serious mental health issues and their families.

MHSA funds are divided among five components, one of which, **Community Services and Supports (CSS)**, uses funds for direct services to adults with severe mental illness (SMI) and children with severe emotional disturbance (SED). CSS is divided between:

1. **Full Service Partnerships (FSP)**, which provide voluntary wrap around services to partners diagnosed with an SED or SMI.
2. **Outreach and Engagement/System Development Programs (OESD)**, which cover multiple treatment modalities and services to those with SED or SMI.

The **Promoting Access to Health (PATH)** programs, which provides and coordinates integrated health care to adults with SMI, and has a wellness program to provide group health education and encourage socialization, are funded through **OESD**. They were created to increase the life expectancy of those diagnosed with SMI who were on average dying 24 years earlier than the general population, primarily due to chronic diseases. The first **PATH** clinic opened at the Oakland Eastmont Adult Community Support Center in east Oakland through a partnership with a local Federally Qualified Health Center. The program has since expanded to include Tri-City Adult Community Support Center in Fremont in 2012 and Eden Adult Community Support Center, the newest clinic, that opened in 2020 in San Leandro.

The following data sources, all from Fiscal Year 2020-2021, were used in this report:

1. Annual report including client demographic information that **PATH** teams submitted.
2. Results of consultant conducted interviews with staff at the **PATHs** for a needs assessment.
3. Quotes from interviews conducted with one client from each of the **PATH** clinics.
4. Results of a survey the **PATH** Teams administered that asked about the client's experience and self-reported health, person-centeredness of the services received, and how the practitioner did at population health management. Oakland Eastmont surveyed 25 clients for an 8% response rate, Tri-City surveyed 16 clients for a 3% response rate, and Eden surveyed 29 clients for a 17% response rate.

Combining these data sources increases the robustness of this report and informed the recommendations provided.

How Much Did We Do?

348
partners served at Oakland Eastmont Adult Community Support Center

511
partners served at Tri-City Adult Community Support Center

29
partners served at Eden Adult Community Support Center

Clients received services in English, Spanish, Mandarin, Farsi, Khmer, and Korean. Most of the **PATH** clients speak English. Clients were provided with regular and timely health assessment screenings including BMI, Blood Pressure, Hb/A1c, and Lipid Profile.

When speaking with clients from each of the clinics they reported receiving help with not only their physical care, but also information on wellness like cooking classes and socialization activities.

"Oh yeah, I came in with a broken heel and that they helped me take care of. Then I had a broken toe, they helped me take care of that. I'm obese so they sent me to an endocrinologist. I have a hernia so they sent me to a hernia doctor. Let me think, what else? They've done everything." - Tri-City Client

"They may have a class on why you shouldn't smoke or a class on how to cook a certain dish. I don't mind sitting in on those things. They're normally informative when you do anyways." – Oakland Eastmont

"Like the group. They have group stuff where you color, and dance, and eat food and you just kind of like have fun with the clients there." - Eden

How Well Did We Do?

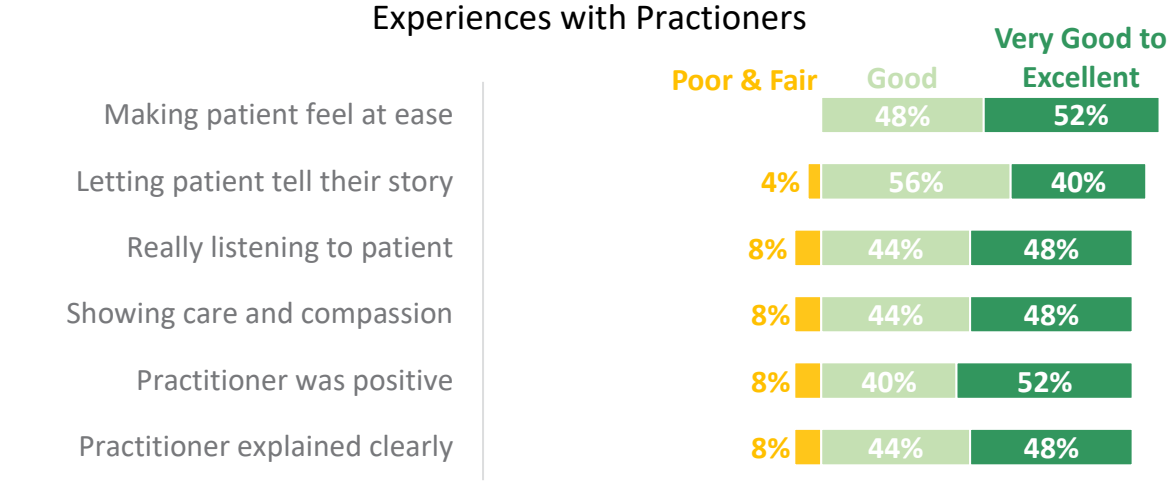
Staff Program Description from Needs Assessment	Oakland Eastmont	Tri-City	Eden
PATH improves access to care for SMI clients by offering co-located services and a warm hand off to Primary Care physicians – this makes it easier for clients to overcome barriers to walking into a strange doctor's office.	✓	✓	✓
PATH handles extremely complex cases which can be difficult to diagnose, and require extra time and attention and interpretation. For example, physical symptoms may be masked by medication, delusion, paranoia, and /or an inability to articulate what is wrong.	✓	✓	✓

The follow tables are the results from the **PATH** administered surveys.

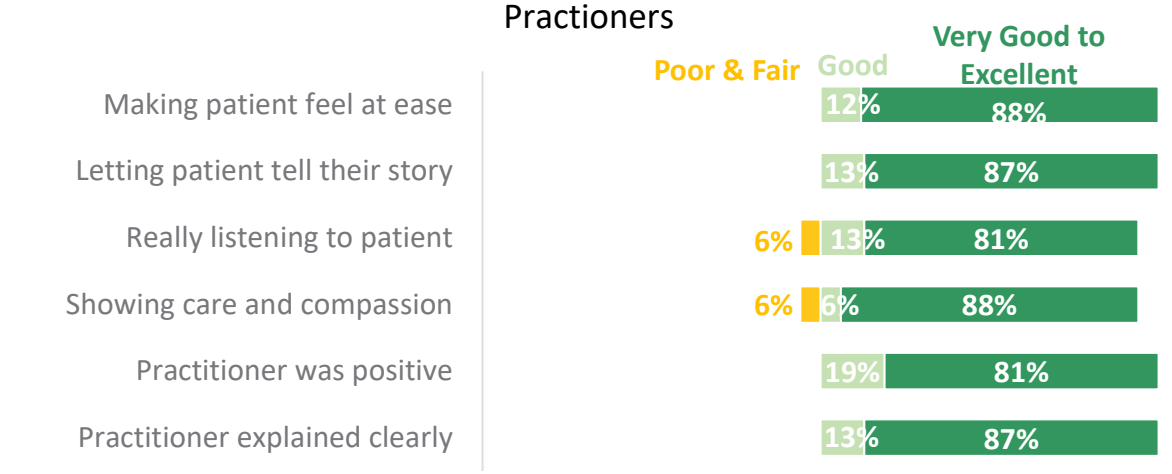
Client Experience

Survey respondents at all three PATH clinics had positive experiences with practitioners.

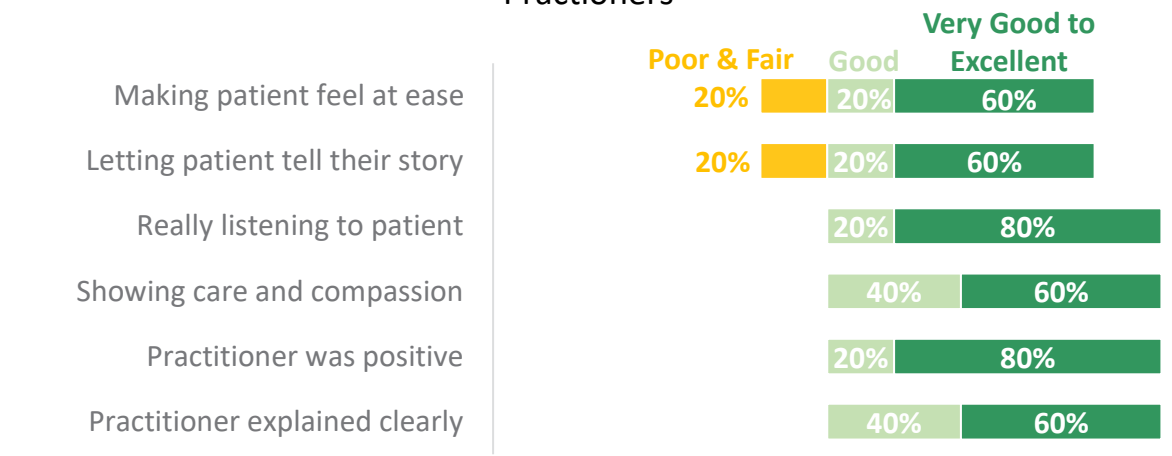
Overall **Oakland Eastmont's** Survey Respondents had Good to Excellent Experiences with Practioners



Overall **Tri-City's** Survey Respondents had Good to Excellent Experiences with Practioners



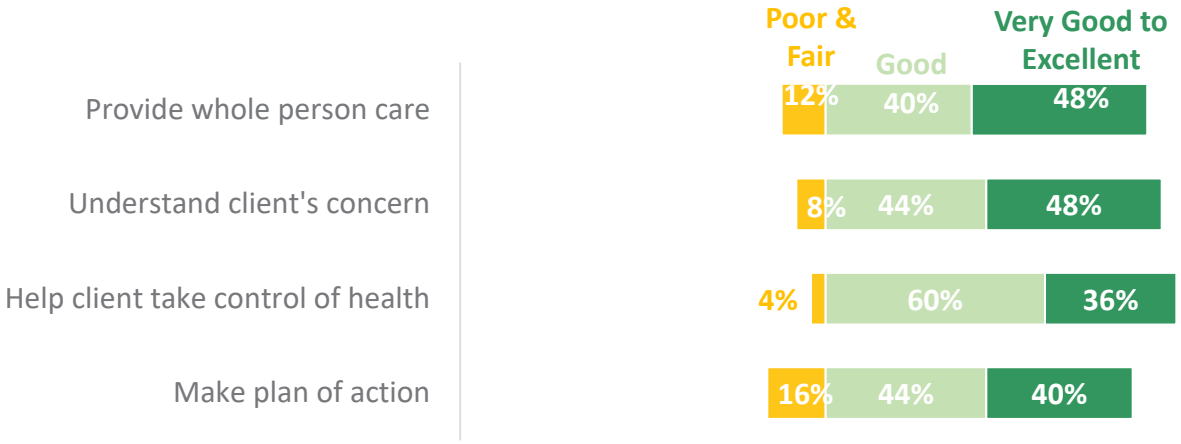
Overall **Eden's** Survey Respondents had Good to Excellent Experiences with Practioners



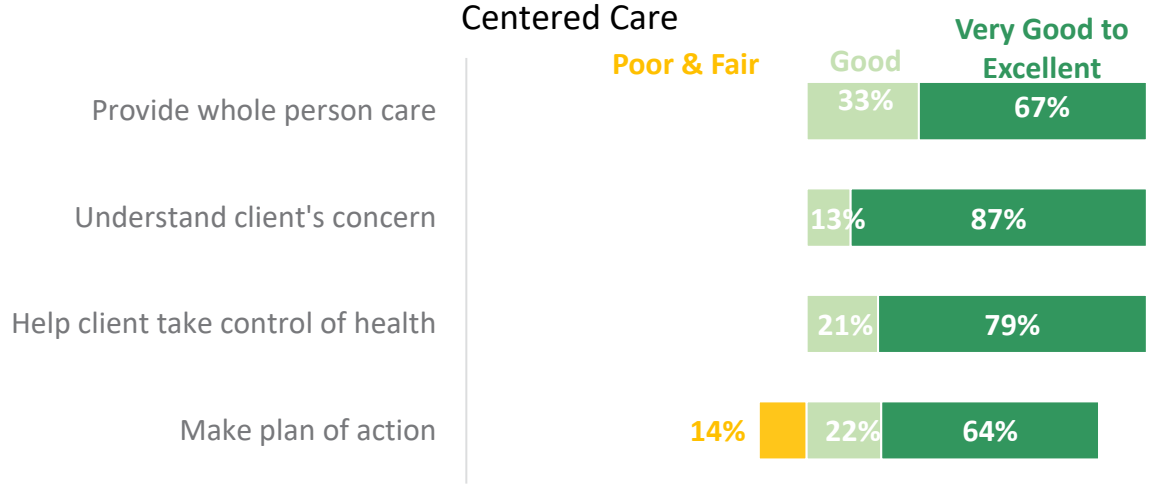
Person-Centered Care

Survey respondents at all three PATHs felt that practitioners provided person-centered care.

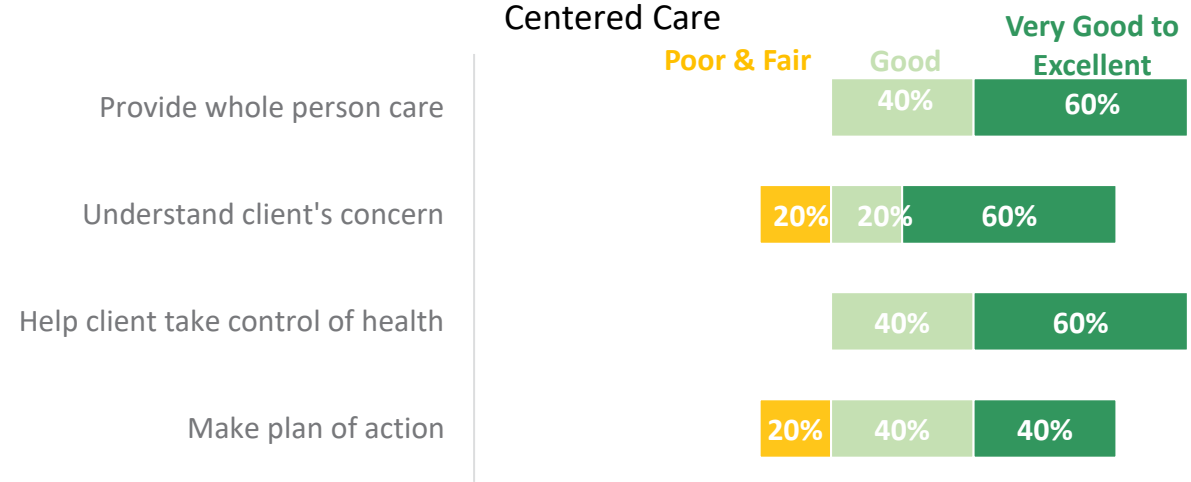
Overall **Oakland Eastmont's** Survey Respondents felt that Practioners Provided Person-Centered Care



Overall **Tri-City's** Survey Respondents felt that Practioners Provided Person-Centered Care



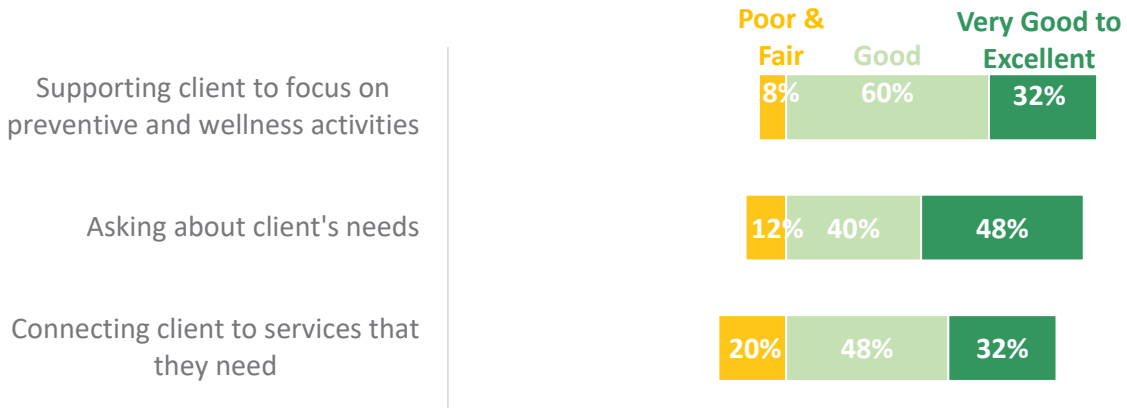
Overall **Eden's** Survey Respondents felt that Practioners Provided Person-Centered Care



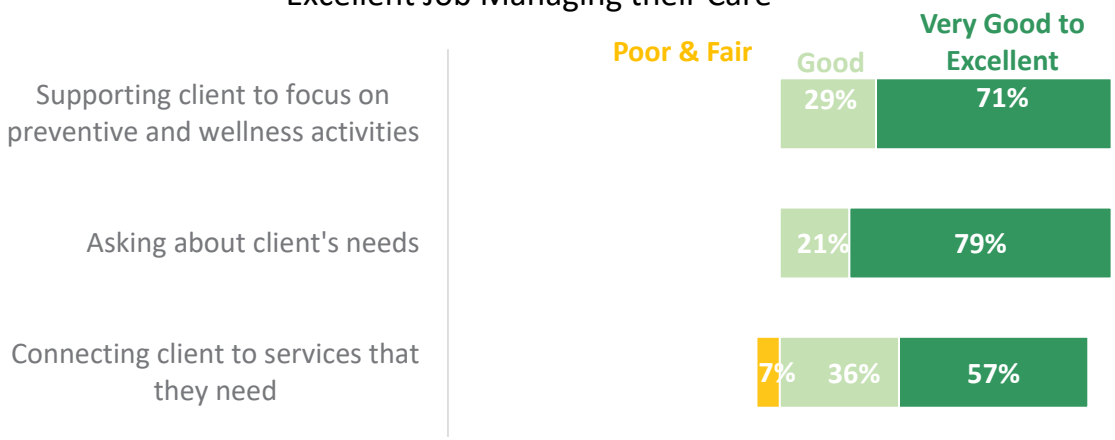
Population Health Management

Survey respondents at all three PATHs felt that practitioners did a Good to Excellent job managing their care.

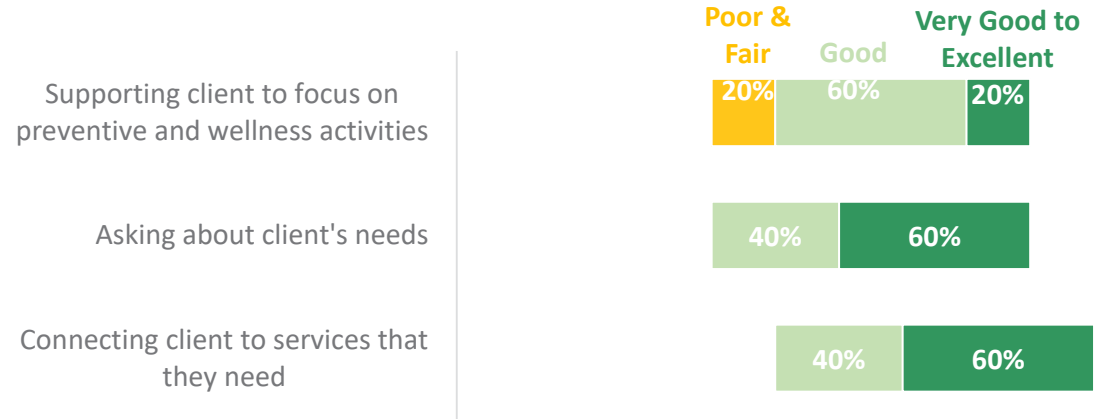
Overall **Oakland Eastmont's** Survey Respondents felt that Practioners did a Good to Excellent Job Managing their Care



Overall **Tri-City's** Survey Respondents felt that Practioners did a Good to Excellent Job Managing their Care



Overall **Eden's** Survey Respondents felt that Practioners did a Good to Excellent Job Managing their Care



COVID-19's Impact on Client Care

While surveyed clients were happy with the services they received, when interviewed clients and staff reported that the COVID-19 Pandemic affected the primary care clinic's ability to provide care.

Transition to Telehealth

Summary of Telehealth and the Effects of COVID-19 on Client Care from Staff Needs Assessment

Technology/Telehealth Comments	Oakland Eastmont	Tri-City	Eden
Due to COVID-19 pandemic protocols, most primary care, case management, and psychiatry visits took place via teleconference or telephone. While many primary care visits do require in person visits and exams, some providers said that the use of telehealth had many benefits, and they would like to see this expanded, and integrated into PATH services.	✓	✓	✓
Providers said that not all clients had the proper equipment (smart phone or laptop) to participate in teleconferencing.	✓	✓	✓
Providers expressed a need for additional training in technology for those who did have access to a smart phone or laptop.	✓	✓	✓
Clients may be referred to mental health therapists for additional help and it was noted that telehealth may be easier for them than an in-office visit.	✓		

Staff expanded upon the benefits of phone visits for clients saying that transportation was a barrier to coming into the office:

> *"He noted that patients are comfortable with the phone and communication by phone and this can also save them money; otherwise they have to travel an hour or more by bus just for a ½ hour appt. Phone can save lots of time, so they are used to it and like that means of communication as well."*
> *– PATH Needs Assessment*

> *"Transportation is a challenge all around, and funding was cut for Alameda County and Para Transit was cut; not everyone is capable of taking bus or BART so transportation alternatives are needed."*
> *– PATH Needs Assessment*

The clients that were interviewed also spoke about the phone visits. One expressed concern over being able to get in touch with their providers, especially during the first lockdown and before vaccines were widely available:

> *"There was a while where they weren't keeping in touch, understandably. Because they did close down, they did call me and inform me about them not seeing clients in the office anymore and if there was any issues that were an emergency then I could come in or go to the emergency at the hospital. It was what was to be expected, I mean everyone was crazy. When they got themselves pulled together then they started you know calling and making sure that we were ok. That I was ok. Like I said they did all they could during the time. I mean they*

scheduled me after I got my shots and I got everything done when everything started picking up again." -Tri-City Client

However, a client at a different PATH clinic did see a benefit to the phone calls:

"I think if they continued with the phone call or teleservices that would be a great benefit as well. You've been in the house for what 16, 19 months? You kind of get, I don't know some people, some people may not want to go back outside so I think those services would still be valuable for folks like that." – Eastmont Client

Socialization Activities

There were other services that the pandemic affected, including no longer providing socialization activities. Both staff and a client spoke about this:

"The COVID-19 pandemic caused not only a loss of co-location, which led to difficulties in communication and coordination between providers, it led to clients living in isolation and having a lack of things to do/activities. They reported seeing an increase in client symptoms, and a need to re-instate services that had been provided by PATH (including providing clients with physical and educational activities, and socialization). There was a perceived increase in depression and anxiety." - PATH Needs Assessment

"I like to hang around the people they nice, cool people. They just good people to be around and we all have a common interest and a common goal. Like we all need help. We all sick. But we trying to get better. So that, I like that setting. It's not all about me." – Eden Client speaking about how the PATH used to have activities for clients

"I think through the PATH system that they should have some sort of program that is able to get people out of their homes and interacting with each other in a group setting with something that is interesting or that they would go to. Because I know people here that may not get out of their house for two or three weeks because they have nowhere to go. No friends, can't vocalize what they need, really don't know what they need but there needs to be some type of more in-depth program to get people to A) get something that they're interested in... Actually, the PATH when it first opened they had like you know we could walk around the lake with them and it was a small group also. But that's kind of shut itself down because there is no one to do it. But I think programs like that would help because my heart bleeds for some of the people that don't have friends or family coming." – Tri-City Client

Clinic Hours, Services, and Transportation

Prior to the Pandemic, the clients interviewed felt that the PATH services provided were useful:

"So, the health part I thought was a really brilliant idea because at one point I was running around pretty much trying to find doctors and they were referring me to the places I need to go and it was really difficult getting around." – Tri-City Client

However, even prior to the pandemic, the limited hours that the clinics functions can make it harder to get in touch with the PATH staff:

> *"The return calls are hard to get from the clinic because it's only open Tuesday and Thursday, and that is a little more difficult to deal with because it takes two weeks for them to get back to you. So, you call them and ask them a question, the second call is usually just setting up the third call, then the third call, especially now since the Coronavirus, is over the phone and before it was just coming into the office." – Tri-City Client*

During the needs assessment, staff also mentioned the need for transportation help, expanding the hours of the clinic, and the types of services provided:

> *"Some specific requests for improving services included: a request to bring the podiatrist on site more frequently, to add dental care, for the staff to help clients get vaccinated against COVID-19 (to break through the resistance to the vaccine because of conspiracy theories that it was dangerous); to purchase a van for transportation; and to schedule the medical team to spend more time with their patients." – PATH Needs Assessment*

> *"But care would be better if it was daily instead of 1 ½ days per week, Mon and Wed his clients don't have the luxury of seeing primary care providers those days. Clients are on a tight budget so they pay $4 round trip on public transportation, and transportation is very slow. A clinic van would be very beneficial." – PATH Needs Assessment*

When asked if there were ways that they want the program to expand beyond what is already offered, the clients were concerned about the space in the clinic or did not think that services needed to be expanded:

> *"I guess they could, but I don't think the space would permit it. Like I said it's made for maybe two or three people to be in there at once. Anything else, I couldn't imagine them not having to send people out." – Tri-City Client*

> *"They don't need any improvement at all. I don't see anywhere where they need improvement." – Oakland Eastmont Client*

Clients Prefer PATH Services

Importantly, clients preferred the care they received at the PATH clinics to care they received at other clinics:

> *"It wasn't a rush job. A lot of times you would wait in another doctor's office and you wouldn't get in for an hour and they'd spend five minutes with you and then you'd be out. They were more into this prescribing than actually listening to what you had. They weren't able to help you because like I said they would have to book it a month or two in advance before you could get there. So most of the time you know would either subside*

or get a lot worse which was horrible. But on the most part with the clinic, I haven't had to go through that with them. Which I have with the other places." – Tri-City Client

"If I have a problem they'll look into it. If I'm complaining about something or I feel that something is not right they'll look into it. As opposed to going to Kaiser or Alta Bates I don't want to talk about the doctors but it's almost like they're there but they don't want to be there. And that's the kind of service you get." – Oakland Eastmont Client

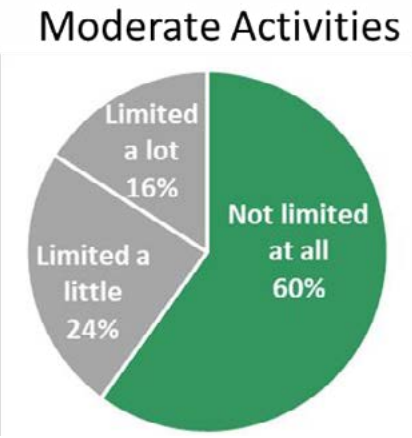
"They didn't have any activities, I didn't know the staff. They were still friendly, but Eden offers more." – Eden Client

Is Anyone Better Off?

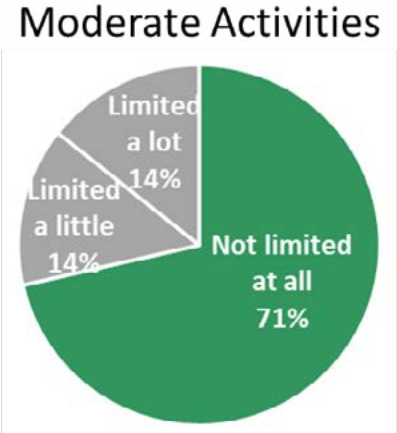
Below are the results of the health status questions that were asked to clients in the survey that the PATH programs administered during FY 20-21.

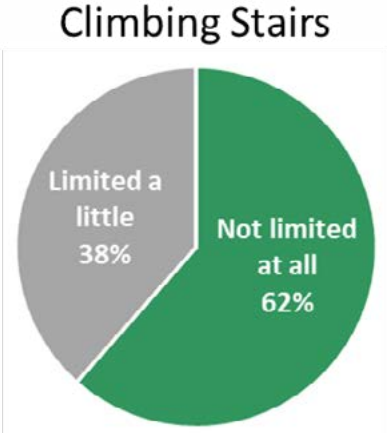
Activities Limited by Client Health

More than half of Oakland Eastmont's Survey Respondent's health did not limit their moderate activities, but did limit climbing several flights of stairs.



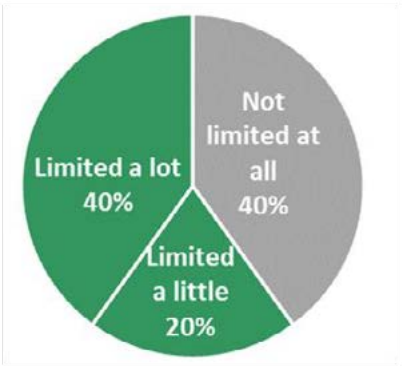
More than half of Tri-City's Survey Respondent's health did not limit their moderate activities or climbing several flights of stairs.



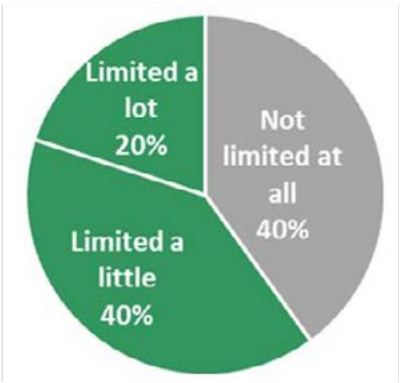


More than half of Eden's Survey Respondent's health limited their moderate activities and climbing several flights of stairs.

Moderate Activities



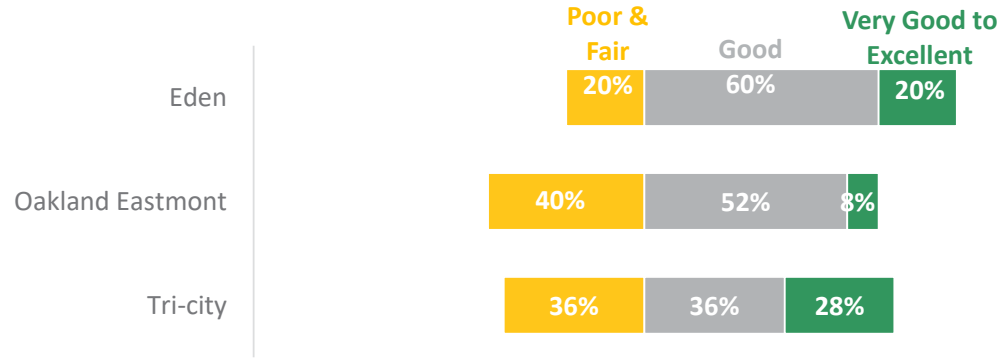
Climbing Stairs



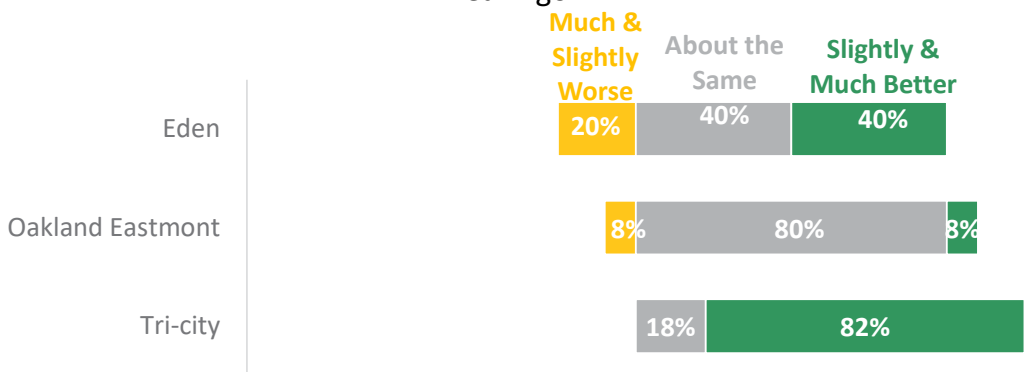
Self-Reported Health

Survey Respondents at all three PATHs felt that they have good to excellent health and their health improved compared to a year ago.

Most **PATH** Clients have Good to Excellent Health



Most **PATH** Clients' Health Stayed the Same or Improved Compared to One Year Ago



3 in 5

Oakland Eastmont clients **did have pain** interfere with their daily activities in the four weeks prior to the survey.

55%

Tri-City clients **did not have pain** interfere with their daily activities in the four weeks prior to the survey.

3 in 5

Eden clients **did not have pain** interfere with their daily activities in the four weeks prior to the survey.

Interviewed clients also felt better off after receiving services at the PATHs.

"When they put the PATH program in with the doctors it was probably one of the smartest things that they've done. Just the sheer fact that you can, I was getting my visit with the psychiatrist on the same day as the PATH program so instead of it taking multiple days and multiple transportations I was able to go there for a day and spend maybe two hours." – Tri-City Client

"The good things are we have fun, the people are nice, they care." - Eden

"They are very crucial to my well-being." – Oakland Eastmont

Recommendations

The findings suggest that the PATH services are important to the staff at and clients of the clinics. To continue to provide and strengthen these services the following recommendations are made from areas over overlap among the staff-based needs assessment and client interviews.

1. **Improve Data Quality** - Currently, ACBH does not collect results on the results of the BMI, Blood Pressure, Hb/A1c, and Lipid Profile screenings, which makes it unclear whether the PATH clinics are improving client's health. The ACBH program staff that work with the PATH clinics should explore whether these results can be shared. Even if it is at the population-level report, which would indicate if the PATH clinics are improving the health of their clients.
2. **Explore Program Expansion** - Further assess whether expanding clinic hours, adding sites, and/or adding more transportation options would improve access for ACBH clients who are not currently being served, or who are under-served. While, the clients interviewed for this evaluation did not mention transportation as a barrier that can be a barrier for other clients in the system.
    a. One way to improve access might be through phone calls if clients are comfortable and this may decrease the transportation barrier. However, this would not replace an in person visit.
3. **Re-implement Socialization Activities through Peers** - Further examine how to recruit and retain Peers, especially because they can be used for socialization activities and may be able to help facilitate or set-up Wellness Classes.

Alameda County CATT Program

Annual Report Brief: Year One

Project Background

- Over the last five years Alameda County has made a concerted effort to transform the ways in which individuals experiencing acute behavioral health crises are responded to and treated. This has meant **moving away from** a system where services are primarily accessed through law enforcement and emergency medical personnel (EMS), often as a result of an involuntary hold. Instead, the county is **moving towards** a system of coordinated in-community response by behavioral health professionals and teams who are equipped to provide the most appropriate level of care and link individuals **to the right place to receive the right services at the right time.**
- Existing programs, such as the Alameda County Behavioral Health Mobile Crisis Teams (MCTs) and Mobile Evaluation Teams (METs), have been reformed with policy and procedure updates to continue to meet this need. In addition, new behavioral health mobile crisis response teams, such as the Fremont MET have been formed to provide additional support. These organized changes will reduce the call volume and amount of time law enforcement and EMS teams spend responding to individuals experiencing a behavioral health crises, creating better synergy for them to respond to other calls and for behavior health calls to be addressed by trained crisis teams.

Alameda County Health Care Services Agency (HCSA) recognized the need for an innovative approach to this problem at a county level and has enhanced partnerships with behavioral health care services, EMS, Alameda County Care Connect and other partners to create client-centered, evidence-based approach through the Alameda County Community Assessment and Transport Team (CATT) Program.

The CATT Program consists of:

- **A mental health provider (licensed Clinician) teamed with an Emergency Medical Technician (EMT) in an SUV to provide mental and physical assessment to individuals in crisis and transport them to a wide range of services.**
- **Technological support, such as ReddiNet to identify current availability of beds and Community Health Records to provide up-to-date information about the client's physical and mental health history. This assists with connecting a client to the most appropriate service in the moment, especially if they are not on a 5150 hold.**

This brief reflects the efforts of the CATT Program in Year One of implementation, July 21, 2020, through July 20, 2021.

Alameda County CATT Program
Annual Report Brief: Year One

Program Overview

The CATT program is a multidisciplinary collaborative effort between **ACBH, EMS, FALCK (provides EMT) and Bonita House (provides Clinician)** which aims to enhance the crisis response system and better serve clients coping with behavioral health crises; including mental health, substance use disorder, and gravely disabling related episodes which impose a risk of harm on the individual in crisis and/or those around them.

The CATT Program intends to serve individuals by **providing on-scene assessment and triaging of needs and transportation to appropriate levels of care, using alternative dispositions, such as community-based organizations (CBOs).**

The goals of the CATT are to:

1. **create more responsive crisis services and timely system improvements**
2. **increase the accuracy of behavioral health assessments**
3. **transport individuals to non-emergency services, resulting in more planned services for clients**
4. **reduce the time law enforcement and ambulances spend on addressing psychiatric emergencies.**

The goals of this issue brief are to:

- **describe how the interdisciplinary collaboration among different stakeholder groups involved in the implementation of the CATT Program has evolved over the first year, and**
- **assess updates to policies and procedures of the CATT Program which have been made over the first year to improve program outcomes.**
- **provide information on how changes in the crisis response system support Alameda County's goals for the CATT Program.**

PCG analyzed:

- **how many collaborative partners have participated in the CATT Program in the first year,**
- **how many clients were diverted to appropriate services, and**
- **how many involuntary holds resulting in ambulance transports to emergency departments medical clearance were able to be avoided.**

ACBHCSA's two primary learning goals are:

1. **Determine if and how collaboration among agencies responding to mental health crisis can contribute to developing an effective and efficient crisis response system.**
2. **Determine if and how the changes in the crisis response system will result in community and county priorities: better client services and more efficiency in the system.**

Alameda County CATT Program
Annual Report Brief: Year One

Process Evaluation Findings

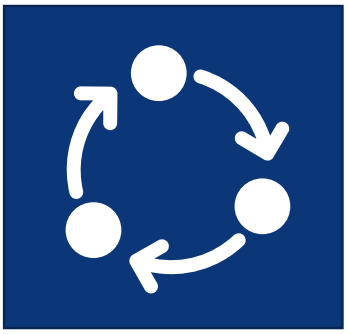
1. **The clinician and EMT partnership is invaluable – EMTs can identify conditions the patient may have or medications they may take that could mimic a mental health crisis and clinicians have an advanced understanding of mental health, from assessments to de-escalation techniques and together they are able to determine what is best for the client at the time of crisis.**

2. **Most field employees indicated most of the time or almost all the time they and their field partner establish a sense of trust among one another, encourage and support open communication, and strive to achieve mutually satisfying resolutions for differences in opinions.**

3. **Key stakeholders stated they had developed strong working with relationships with each other. CATT Program collaborators have high energy and intensity but remain extremely approachable to meeting the needs of external stakeholders.**

4. **CATT Program leadership has continued recruitment efforts to hire more field employees and have made updates to field training over the last six months. Training updates included a day of rig shadowing and additional courses related to emergency response.**

5. **CATT Program collaborators applied a prominent policy and procedure change for dispatching CATT Units in the second half of Year One. CATT Program Units are now permitted to deny a dispatch if the location of the call is too far outside of their dispatch zone for them to respond in under 15 minutes as required.**



Process Evaluation Questions:

1. To what extent are collaborators and key stakeholders engaging in the implementation of the CATT Program?
2. What is the perception of efficiency and effectiveness of the implementation of the CATT Program among involved stakeholders?
3. How is Continuous Quality Improvement (CQI) being applied to the CATT Program?

Process Evaluation Data Source	Participants
Interviews	7
Field Employee Focus Groups	10
Client and Family Focus Groups	5
CATT Program Collaborator and Key Stakeholder Survey	55
CATT Program Field Employee Survey	12

Alameda County CATT Program
Annual Report Brief: Year One

Process Evaluation Findings

6. **The Bonita House data reporting system is being updated to better align with the needs of the CATT Program. Bonita House will merge their reporting system with FALCK's ESO system to streamline all CATT Program data into a centralized repository. This update will have two significant impacts, decreasing duplicative administrative reporting for field employees who had expressed in the past the data reporting requirements were cumbersome and timely and making evaluating outcomes of the program more efficient.**

7. **Half of all field employees stated they have conducted outreach with CBOs and service providers and a little over half of program collaborators and key stakeholders stated the same but that efforts could be improved upon.**

8. **Client and family focus group feedback was largely positive in nature. Participants enjoyed having an effective alternative to law enforcement-only responses for their behavioral health crises. They also expressed how they appreciated the empathy and understanding of the CATT clinicians and EMTs who provided services.**

9. **Of most concern to clients and family members of clients who utilized CATT Program services is the persistence of police interaction in order to access CATT Program services. Focus group participants vocalized how racial tensions in the County have been heightened over the last year, they often do not feel safe or comfortable interacting with law enforcement and finding ways to make law enforcement more knowledgeable of behavioral health crises or not the first point of contact would be beneficial.**

10. **Client and family focus group participants expressed they called the countywide ACCESS hotline to request a CATT team and the operator was not aware of what the CATT Program was. Field employees who participated in focus groups also expressed concerns related to utilizing ACCESS to receive referrals to ongoing services for clients, specifically it typically takes days to receive a referral so clients cannot be transported in real time to behavioral health service providers when experiencing a crisis.**

Alameda County CATT Program
Annual Report Brief: Year One

Outcome Evaluation Findings

Outcome Evaluation Questions:

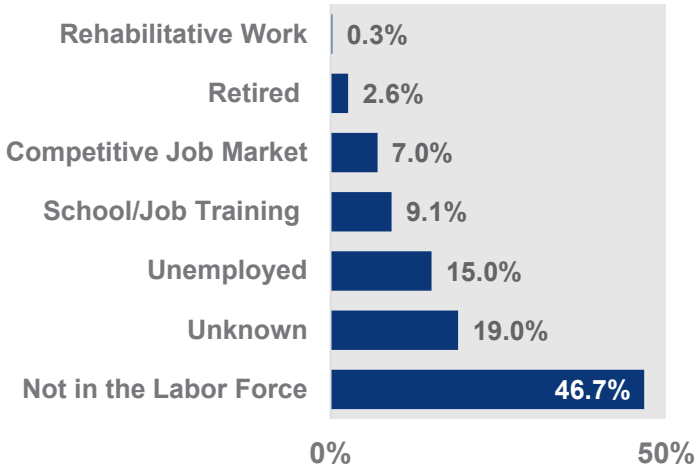
1. How many collaborative partners have participated in the CATT Program?
2. How many clients have been served by the CATT Program, thus far?
3. What is the reduction in the rate of behavioral health involuntary holds?
4. Was time law enforcement spent on behavioral health crisis response calls decreased in the cities the CATT Program operates in throughout the first year of implementation?
5. Has the CATT Program been received as an efficient and effective alternative behavioral health crisis response program for Alameda County?

Client Demographics

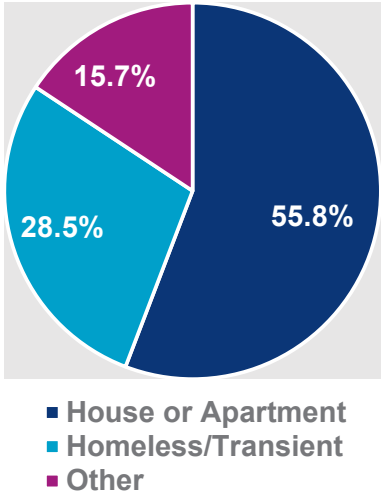
The median age of clients was 35 years old; 11.1 percent of CATT clients were aged 17 and younger and 6.5 percent of CATT clients were aged 66 and older.

Nearly two-thirds of all CATT clients served in Year One were male.

Over a third (36.9%) of all CATT clients were White, while nearly another third (30.3%) were Black or African American, and 12.7 percent were Hispanic or Latino.



1. **Nearly half of all CATT clients are homeless or housing insecure and nearly two-thirds are either unemployed or not in the labor force.**



Nearly two-thirds of all CATT clients are either not in the labor force or unemployed.

Alameda County CATT Program
Annual Report Brief: Year One

Outcome Evaluation Findings

Response Dispositions

2. **The CATT Program received a total of 1,185 calls from July 21st, 2020, to July 20th, 2021. Of those 1,185 CATT Units provided services to 758 clients (64 percent of all calls). Nearly a third of all CATT call dispositions resulted in a CATT Unit transporting a client with no lights or siren, and almost another quarter resulted in a CATT Unit evaluating a client and determining no treatment or transport was required.**

3. **On average, there are 65 calls per month and two calls per day. Calls are most numerous in the middle of the week, and less frequent on the weekends**

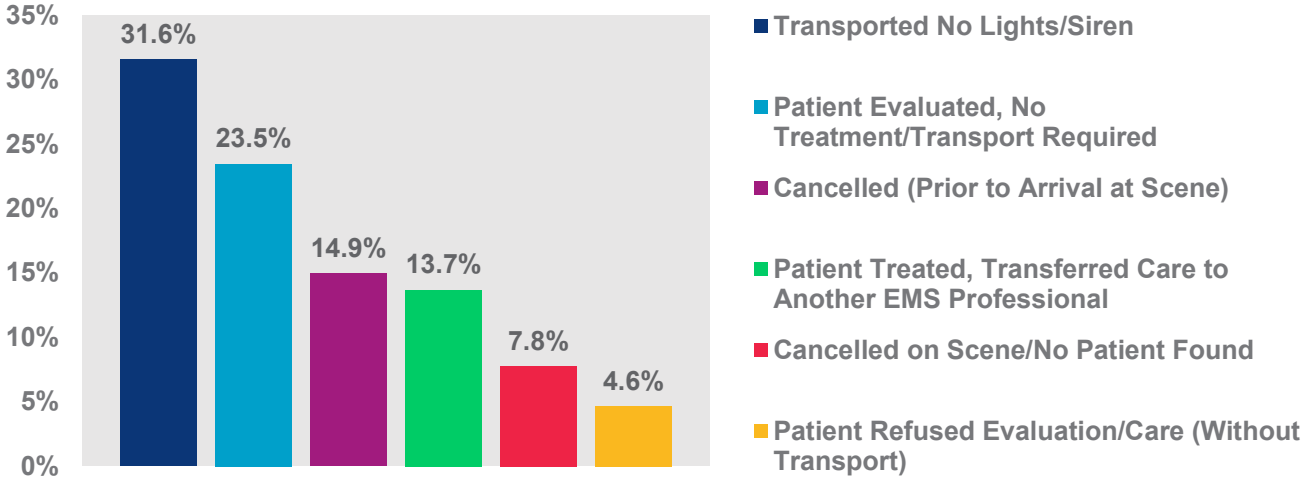
4. **More than 80 percent of all CATT Units responded to clients in Hayward, San Leandro and Oakland. Nearly a third of all responses were in Hayward, close to another third was in San Leandro and nearly a quarter were in Oakland.**

5. **It takes 20 minutes on average for CATT Units to arrive on scene to a call once dispatched. Quarter-over-quarter, the time it takes to respond to calls has been reduced from the start of Year One to the end, likely due in part to policy changes made in the second half of Year One.**

6. **It takes 20 minutes on average for CATT Units to arrive on scene to a call once dispatched. Quarter-over-quarter, the time it takes to respond to calls has been reduced from the start of Year One to the end, likely due in part to policy changes made in the second half of Year One.**

7. **There is a wide range of times CATT field employees spend with clients. The median amount of time is one hour and thirteen minutes. The time CATT Units spend with clients varies depending on their needs and disposition.**

The CATT Program received a total of 1,185 calls from July 21st, 2020, to July 20th, 2021. Of those 1,185 CATT Units provided services to 758 clients (64 percent of all calls). Nearly a third of all CATT call dispositions resulted in a CATT Unit transporting a client with no lights or siren and almost another quarter resulted in a CATT Unit evaluating a client and determining no treatment or transport was required

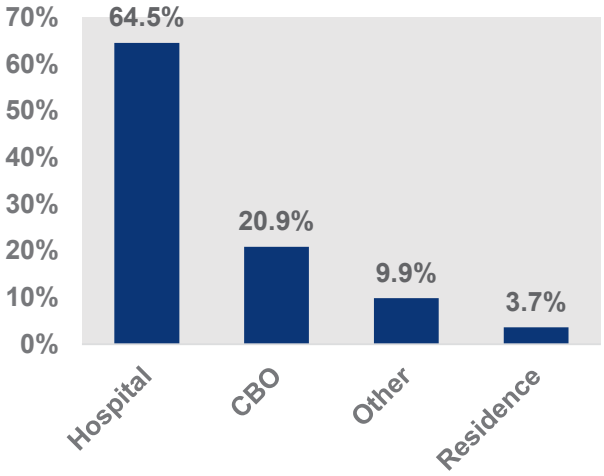


Alameda County CATT Program
Annual Report Brief: Year One

Outcome Evaluation Findings

Transport Dispositions

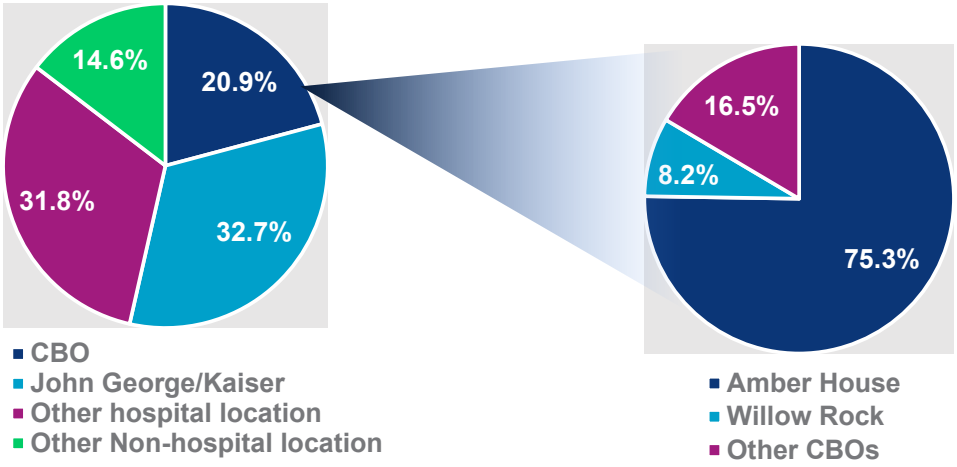
8. **Of the 758 calls where the CATT Units responded and treated clients, 465 (62%) resulted in a client transport. Approximately 26 CATT calls per month result in a hospital transportation. These transports to hospital would likely occur whether the CATT Unit or a more traditional ambulance response was sent.**



9. **About 40 CATT calls a month avoid what would likely be a hospital transportation 5150 involuntary hold. These avoid resource-wasteful traditional responses of automatically sending the client to the hospital.**

10. **Of the 465 clients CATT clients transported, 22.6 percent of transports were to John George Psychiatric Hospital and another 10.1 percent of transports were to a Kaiser facility; comprising about half of all hospital transports (31.8% were transported to other hospital locations).**

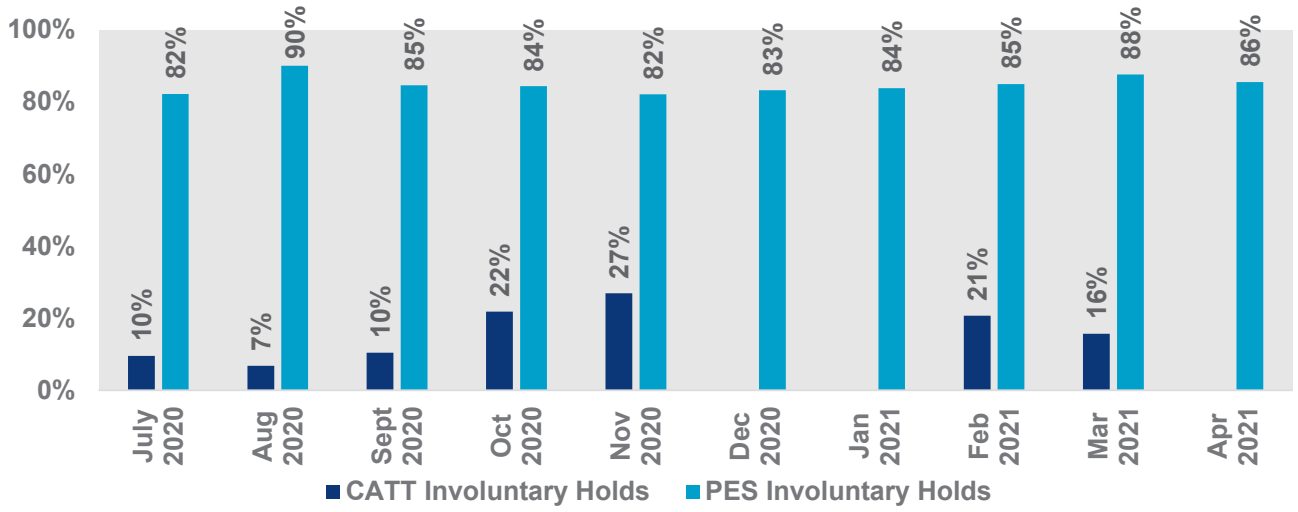
11. **CBOs were the disposition for 20.9 percent of transports and 14.6 percent of transports were to other non-hospital locations. This data can further be disaggregated, showing Amber House as the most frequently utilized CBO by CATT Units, accounting for three-quarters of all CBO transports.**



Alameda County CATT Program
Annual Report Brief: Year One

Outcome Evaluation Findings

Involuntary Hold Dispositions



12. **Involuntary holds were issued for 21.0 percent of all CATT clients treated by a CATT Unit, overall, throughout the first year of the program. Of the 300 CATT clients who were transported to hospital, over half were transported for an involuntary hold.**

13. **Comparing the rates of subsequent involuntary holds for individuals who had received CATT Program services to individuals who had been placed on involuntary holds and transported to John George PES, individuals who receive CATT Program services are much less likely to subsequently be placed on an involuntary hold.**

Follow-Up Care

I have had a better experience with CATT than MCT (Mobile Crisis Teams), they always follow up, even when time goes by; they follow up and ask how I am doing, if there is anything they can help with, information or anything. They have done a great job!"

CATT Program Client and Family Focus Group Participant

14. **Nearly half of all CATT Program clients had a primary diagnosis of unspecified psychosis not due to a substance or known physiological condition. Almost a quarter were diagnosed as having some type of depressive disorder including single episodes, severe with or without psychotic features, recurrent episodes and persistent episodes.**

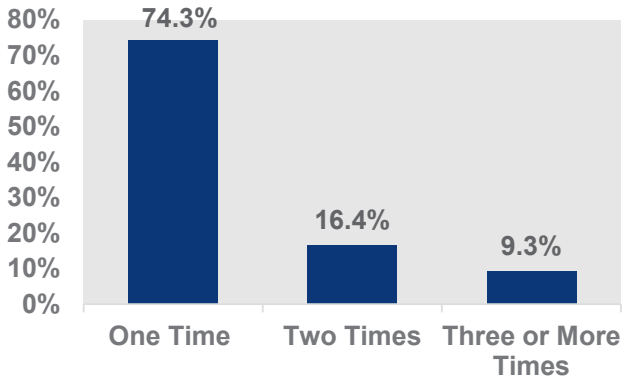
15. **The CATT Program is more likely to conduct follow-up with clients within 30 days to ensure individuals were connected to outpatient services, compared to ACBH who does post-crisis follow up for individuals who present at John George PES but are not admitted (32% versus 24%, respectively).**

Alameda County CATT Program
Annual Report Brief: Year One

Outcome Evaluation Findings

CATT Program Recidivism

16. Nearly three quarters of all CATT clients in Year One only utilized CATT Services one time. Compared to recidivism rates of individuals placed on an involuntary hold and transported to John George PES, the CATT Program has lower 30-day recidivism rates (32.8% vs 9.1%, respectively).



Countywide Involuntary Holds

Between July of 2019 through September of 2020 Alameda County had a total of 15,386 unduplicated 72-hour 5150 holds, and 7,831 unduplicated short-term (14-day) LPS conservatorships. In the first year of implementation of the CATT Program Alameda County had a total of 13,951 unduplicated 5150 holds, and 6,192 unduplicated short-term LPS conservatorships. This accounts for a percentage increase of 14.9 percent for 5150 holds and one percent for short-term LPS conservatorships

Countywide MCT & MET and Fremont MET

17. In the baseline year (July 21, 2019–July 20, 2020) MCT and MET programs overseen by ACBH and Fremont MET placed 1,026 involuntary holds, while in Year One of CATT Program implementation, they placed only 717 involuntary holds for an overall reduction of 30.1 percent. The rate of reduction in involuntary holds placed by these mobile crisis units was 11.3 percent.

Law Enforcement CAD

18. In the baseline year law enforcement officers in the cities of Fremont, Hayward and San Leandro responded to a total of 2,440 behavioral health crisis related calls while in year one of CATT Program implementation only responded to 1,826 accounting for a reduction of 25.4 percent. Overall, rates of involuntary holds across the three cities decreased by 2.5 percent during the last year.

City	5150 Hold Rate Baseline	5150 Hold Rate Year One	% Change
Fremont CAD	98.7%	94.7%	**-4.0%**
Hayward CAD	22.4%	20.5%	**-2.0%**
San Leandro CAD	42.9%	48.5%	**+5.6%**
Total	**42.2%**	**39.8%**	**-2.5%**

Alameda County CATT Program
Annual Report Brief: Year One

Recommendations

Create a One-Day Strategic Planning Working Session for CATT Program Collaborators

The CATT Program proposes to make the collaborative process a major component of the program and evaluation, recognizing the need for systems-level change. This focus will guide Alameda County to put the necessary time and resources behind working together to design the system improvements, monitor the results, and make timely course corrections.

Timeline	Within the next month

Conduct Monthly Field Employee Debriefing Sessions with CATT Program Collaborators

This time should be used to discuss successful and difficult field cases and other challenges and opportunities being experienced by different teams.

Timeline	Within the next month

Produce More Rigorous Follow-Up Care Policies and Procedures for Clinicians

CATT Program collaborators should work together to assist Bonita House in developing rigorous policies and procedures with guidance on the most effective approaches to conduct follow-up care with special focus on hard-to-reach populations.

Timeline	Within the next 3 months

Implement a Community Engagement Plan for Field Employees

CATT Program collaborators should work together to develop a community engagement plan and select a member of the team to spearhead the effort of implementing the plan and providing direct assistance to field employees.

Timeline	Within the next 6 months

Develop a Marketing Plan for Client Outreach

CATT Program collaborators should spend time refocusing efforts on developing a marketing plan and select a champion to spearhead the efforts to implement it.

Timeline	Within the next 6 months

Addendum 1_FY20-21 MHSA-WET Plan update_CSUEbay Early Chilhood Pilot Pgm

alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

2000 Embarcadero Cove, Suite 400
Oakland, Ca 94606
510-567-8100 / TTY 510-533-5018
Karyn L. Tribble, PsyD, LCSW

Fiscal Year 20-21 Annual Report: Post Graduate Continuing Education Certificate Program: An Alameda County Behavioral Health & Cal State University East Bay Collaboration

Submitted By:
Laphansa Gibbs, Division Director
ACBH Child & Young Adult System of Care
12.29.2021

Post Graduate Continuing Education Certificate Program

Program Description: Mental Health Services Act – Workforce Education and Training (MHSA WET) provides funding that allows for the completion of a two-year *Infant & Early Childhood Mental Health Post Graduate Continuing Education Certificate Program* at Cal State University, East Bay (CSUEB). The overarching goal of this program is to build capacity in the early childhood workforce by increasing the number of qualified practitioners who understand and can address the culturally diverse and specialty early childhood mental health needs of young children and their families in Alameda County. The reporting for the *pilot* follows.

Program Background and Updates

In FY18/19[1], California State University East Bay (CSUEB) and Alameda County Behavioral Health (ACBH) launched the pilot *Early Childhood Mental Health Post Graduate Continuing Education* Certificate Program (program), which focused on the developmental foundations of infant and early childhood mental health. The program's content examined the developmental foundations of relationship-based clinical work between infants, young children, families, and caregivers, and combined theory and practice. The curriculum places a strong emphasis on working with families from diverse cultural, racial, and ethnic backgrounds, which is especially important given Alameda County's socioeconomic, racial, cultural, ethnic, and immigrant diversity.

The program began with a cohort of fifteen (15) students, fourteen (14) of whom were subsidized by Mental Health Services Act Workforce, Education & Training (MHSA WET) funds and one (1) paid out of pocket. Of the fifteen (15) students, eleven (11) were clinicians of color, ten (10) spoke one of the identified threshold languages, and all fifteen (15) worked in Alameda County early childhood

[1] *This report covers fiscal year (FY) 20/21 (July 1, 2020 - June 30, 2021). From July 2020 -December 2020, the first cohort completed (December 2020) and the second cohort recruitment took place. This second cohort started in Spring semester (January 2021). This report also covers FY 21/22 updates covering July 1, 2021 through December 15, 2021.*

community-based organizations (CBOs).

In year two (FY 19/20), Cohort 1 saw the fifteen (15) members of the original cohort return intending to complete the second year of the program. However, one (1) student dropped in Fall 2019 and fourteen (14) of the fifteen (15) students completed the program in December 2020.

FY 20/21 Outcomes, Impacts and Challenges

Overview
A collaborative effort allowed for the development of this partnership that aims to address an important need, an informed workforce who are culturally and linguistically informed about the challenges of the communities they will serve. For this pilot, ACBH, CSUEB, and evaluators worked to ensure programmatic coordination, recruitment, methodological design, data collection, and reporting. To address challenges identified in year one, ACBH allocated additional funding for curriculum development.

Year two (2020) presented new challenges resulting from COVID-19. COVID-19 required the development of new teaching methods to address safety concerns. In response, class instruction was moved online (i.e., TEAMS) which ensured ongoing instruction. For administrative coordination, ACBH staff helped to strengthen the reporting systems used by creating a TEAMS administrative page to track requisite student information (i.e., attendance, class participation, grades). This tracking form was also used for grading.

In year two, ACBH had a leadership transition from retiring Margie Padilla, Director of Early Childhood Program, who helped develop the program, to Dr. Clyde Lewis, EPSTD Coordinator. Dr. Lewis was selected to provide on-going program management.

ACBH worked with CSUEB to develop a plan for student recruitment. These efforts were successful in providing information about the program and the application pool increased considerably from the first cohort recruiting efforts. The second cohort had a competitive application process and will also have fifteen (15) students. The range of interest from CBO employees increased and as such, there is a wider range of organizations represented.

Program Evaluation

The program was evaluated by a tool developed by UCSF Benioff Children's Hospital Oakland in the first year of the pilot. In the second year of the cohort, the corresponding evaluation survey was administered by CSUEB Faculty Member and Instructor, Valerie Bellas. The evaluation focused on methodological approaches used for student training. To this end, the evaluation provides ongoing feedback for managers to ensure continuous quality improvement.

Evaluation methods used to assess the program include: a training evaluation (online student satisfaction survey); the Learning Curve Survey (to assess student measurement of knowledge, skills, and integration/application of core concepts), video observation, and reflective writing assessments.

Student Evaluation Metrics

From FY 20/21 evaluation data, student evaluations show overall agreement that the stated learning objectives were met and that instructors were responsive, promoted the ethical and clinically sound treatment of clients. Students felt the content was both current and accurate and that they understood the value of the program. Students agreed that they "…learned something useful from this program that I can put into practice in my work". Further, most students showed high ratings of the instructors demonstrated knowledge/qualifications and clarity of content presentation.

While responses showed an overall agreement that objectives were met, there was a range of responses in several areas including entering student educational experience, instructional delivery method, technology use, program administration, and the physical environment. There was also a range of responses about whether course content was "consistent with the stated objective" and "appropriate for the intended audience," indicating that a few participants were dissatisfied in these areas. A review of these areas will help address areas for improvement for future cohorts. ACBH and CSUEB management will work on addressing these issues for the upcoming cohort.

Student Feedback

Student feedback from the second-year evaluation was collected at the end of Fall 2020. Several students commented on the value of increased understanding of developmental concepts such as child bids for connection and exploration as part of attachment behavior; strengthened observational skills, assessment tools, and case formulation skills, the value of reflective supervision/consultation, and application of relational models to early childhood mental health. One participant noted, "I have always known that the relationship between caregiver and child is important, but I think I have a deeper understanding of what that means now." Another student commented that as a result of the program "I will be more thoughtful of cultural impacts on children's and families functioning and consider more ways to integrate cultural factors in treatment planning and services so that they are as relevant and respectful to each family as possible". These responses example both the want and need for programs that address not only field-specific knowledge but an awareness of the needs specific to the people for which graduates will support.

FY 21/22 Updates

Most recently, in year three (FY 20/21), a new second cohort of 16 students was recruited (22 applicants and 16 accepted into the program). The recruitment process started in Spring of 2020 and was ran by Dr. Clyde Lewis. In the spirit of collaboration, meetings were conducted with Damon Eaves, CYASOC Assistant Director, CYASOC Director Lisa Carlisle, and Valerie Bellas CSUEB Cohort Instructor to review the recruitment and selection criteria, the steps and resources needed and the timeline. A rubric was developed to assess students that meet criteria. The planning team also discussed lessons learned from the last cohort cycle to apply best and improving practices for the new cohort.

Cohort announcements focused on individuals who focus on early childhood skill development as well as exhibit cultural competencies that can meet the unique needs of the diverse Alameda County child and family populations. Announcements were distributed to the Alameda County network of service provider agencies, to networks of CSUEB staff, and to employees and interns at current clinic and outpatient service sites.

Given COVID, a number of factors had to be addressed including recruitment, class instruction and evaluations. First, recruitment is typically done in person. In-person outreach has typically worked well. Online marketing of the program was challenging yet through emails, announcements at meetings and encouragement to find applicants through networks, a full cohort was recruited despite not having in-person access. Second, class instruction is typically offered in person. In-peron learning allows for the group to share, explore and make lasting bonds with other practitioners in the early childhood community. It also allows for more interactive and tactile learning experiences in a focused learning environment. However, all parties adapted to online methods of teaching and learning. To adapt, the instructor used different methods to encourage engagement. For example, there were regular small group activities through the online platform which allowed interactive problem-solving, sharing of new concepts, and overall connection amongst cohort participants. To further support participation, administratively, leadership developed a tracking tool to track class attendance and engagement group activities. This allowed timely outreach to participants to help increase attendance and the learning experience, as well as decrease attrition. Finally, to adopt to COVID protocols, the course evaluation tool used to survey the students was moved from an email-based format to a survey tool (Survey Monkey), which allowed for more accuracy and a higher response rate.

Instructor Feedback

In December 2021, the instructor, Valerie Bellas, was asked several questions to help us receive insight on how the second cohort is progressing. Those questions were:

1. What components of the first CSUEB Early Childhood Program worked well and any special highlights? Please include things you deemed important that were both planned and organic.
2. What components of the first CSUEB Early Childhood Program could be improved?
3. Any other comments or feedback you would like added to the annual report?

Her responsponses are shared below, but overall she expressed that several areas of the program have worked well including recruitment, collaboration, the pedagogy, and the transition to an online learning model. She states that "students have acquired a foundation [in] IECMH [Infant Early Childhood Mental Health] theory and practice approach, including development in relationships, reflective practice, cultural humility, and trauma." She further states that she believes "The county and university partnership is a model that can be disseminated and replicated as a model for IEMCH workforce development and training." Her complete response is below.

Q. What components of the first CSUEB Early Childhood Program worked well and any special highlights?

Recruitment: This was a success. Cohort 2 [was recruited in the Fall of 2020 and] is such an active, thoughtful, and diverse group! Students share their perspectives, listen to each other, and bring rich professional, personal, and cultural experiences to our learning. We were able to recruit a full class with variability and commonalities. Students identify as 2 AAPI, 2 Black, 8 Latinx, 3 White, with bi-cultural representation in the group as well, and vary in age and number of years in the field. We recruited a group of students who are primarily mental health direct service providers, which was a focus of our recruitment.

Collaboration: We have built a strong collaboration with CSUEB and ACBHS with regular contact and communication. I have appreciated how we work together and have developed common language and partnered in roles. In addition, we have established longitudinal connections with local agencies many of whom have supported their staff to engage in the IECMH program for this second cohort after hearing good things from their staff who participated in the first cohort. I am so pleased that we have built a reputation in the community as a high quality, engaging, and useful program.

Pedagogy: This was a fantastic learning year! We engaged in a variety of learning activities, including lecture, large and small group discussion, written assignments, and readings. We achieved all of this as we transitioned to telelearning model during the pandemic. Across this first year, students have acquired a foundation IECMH theory and practice approach, including development in relationships, reflective practice, cultural humility, and trauma and resilience.

- Development in relationships: We have covered core content, such as development prenatal to five and attachment. Students have built skills in observation and application of developmental principles to understanding young children's relationships, needs, and strengths in the context of their families, communities, and systems of care.
- Reflective Practice: Students engaged in personal self-reflection and shared with each other cultural and family experiences as they relate to IECMH work. We have explored how to approach the work with families through a lens of family-driven care. The group is creating relationships with each other to serve as collegial support to sustain a diverse workforce.
- Cultural Humility: We have centered health equity and social justice, including the impact of racism, xenophobia, and the COVID-19 pandemic. We have actively identified inequities in models of service delivery and awareness of our social location and the intersectionalies of identities across relationships. We have benefitted from our guest speakers' contributions, including parents who have generously shared their experiences with systems of care.
- Trauma and Resilience: We have come together to understand the impact of trauma on young children and their primary relationships from multiple angles. We have actively engaged in identifying protective factors in children, families, communities, and how our services and systems can uphold these core protective functions. We have highlighted the importance of self-care to mitigate the impact vicarious trauma on the IECMH workforce.

Q: Please include things you deemed important that were both planned and organic.

What was important to me was to balance core content and its application to a dynamic and developing field, alongside personal and group process centering the perspectives and experiences of a diverse workforce to develop a reflective and inclusive approach to IECMH service provision for children, families, and communities.

What spontaneously has arisen is the rich diversity of perspectives and experiences of our workforce and the students' clear passion and commitment to learn about, engage in, and re-envision the IECMH field and to develop their practice with children, families, communities and the systems of care within which they work.

Q. What components of the first CSUEB Early Childhood Program could be improved?

Recruitment: The program could benefit from a larger pool of applicants. Although the class was fully enrolled, there were few applicants above the enrollment cutoff. Increased applications will help to form a group that is both cohesive and diverse for our next cohort. Early consideration of recruitment approaches may be beneficial for our next cohort.

Collaboration: We engaged in strong collaboration, but I believe our process would have benefited from representation by dedicated early childhood coordinator/director at the county. My understanding is that this position has remained unfilled after a staff retirement left a vacancy. In our first cohort, the former early childhood director had a central role in coordination and direction with a focus on early childhood mental health needs. Ongoing, this role could serve to increase collaborative and sustained relationships with community agencies who employ and supervise the IECMH workforce. Additionally, the first cohort had access to an outside evaluator. Re-engaging a collaboration with an outside evaluator would benefit the program, both to keep track of how the students continue to engage in service delivery and apply their learning across time, as well as to more systematically assess the effectiveness of the program, build its sustainability, and support the dissemination of the model.

Pedagogy: Despite its overall success, there are areas that could be improved.

- It is always a challenge to find the right balance of foundational content, reflective process, and applied learning. This is an ongoing focus of curriculum development.
- The group is working toward continuing to find ways to address racism and other forms of systemic oppression and the dynamics power and privilege in our interactions and practice. This is an unfolding process across relationships and within our communities and will be a continued explicit focus of the program, utilizing identified tools, approaches, and centering lived-experience and perspectives of BIPOC and other targeted identities and communities.
- The amount and type of reading for the class did not always fit with the busy lives of students who are working full-time as they complete this program. I am working to tailor the readings to these needs, by identifying accessible, targeted, and useful readings and resources.
- The cumulative impact of the pandemic has increased challenges for students to participate and engage in the program. Supporting students as they navigate personal and professional challenges and provide services during the pandemic is of the utmost importance, including

increased opportunities to connect with each other and access to available community resources.

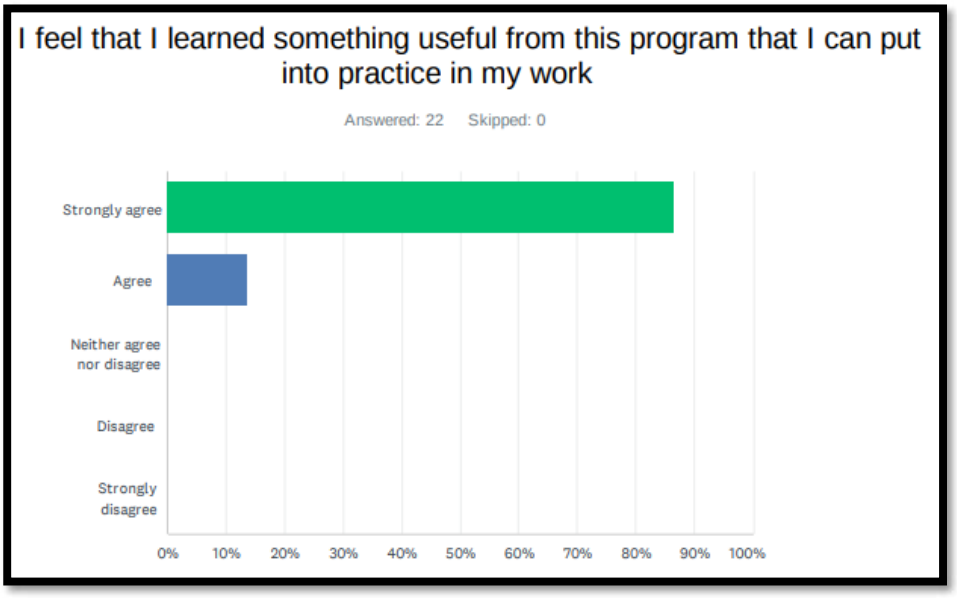
Q. Any other comments or feedback you would like added to the annual report?

I believe that the IECMH program is state of the art. The county and university partnership is a model that can be disseminated and replicated as a model for IEMCH workforce development and training. The program is an invaluable resource in building a diverse IECMH specialty workforce in Alameda County and centralizing training in the crucial area of Early Relational Health. The program offers a foundation for IECMH work, as it centers service providers' perspectives and diversity of experience to increase workforce capacity and retention. These elements are key to building an informed, culturally responsive, ethical, and effective approach to service delivery for the children and families we serve.

Student Feedback

Student surveys were issued and collected at the end of the spring semester (late June and early July 2021) as well as at the end of the fall semester (in December 2021). Of 21 students completing post-semester surveys, data showed that …

- There was a range of experienced practioners represented including LCSWs, ASWs, and LMFTs with active licenses.
- Key areas in which students strongly agreed or agreed with included feeling that this course…:
    - Trained me to be equipped with the skills necessary to demonstrate knowledge of the transactional nature of development and the centrality of relationships in early childhood using 1-2 frameworks (e.g., development of attachment, secure-base/safe-haven behaviors, reflective practice.)
    - trained me to describe the role of environmental stressors, including trauma, in a developmental context using 1-2 related concepts (e.g., the role of early memory, ghosts and angels in the nursery, the impact of racism, xenophobia, and COVID-19 pandemic.)
    - trained me to identify the philosophy and key elements of family-driven care across content and processes using 1-2 approaches to IECMH (e.g., centering fatherhood, cultural humility), and had an instructor(s) [who] demonstrated knowledge, promoted clinically sound and ethical treatment of client/customers, and was responsive to participants.



Ongoing Evaluation

The final evaluation by UCSF Benioff Children's Hospital Oakland for the first cohort was issued in Spring 2021 (after the MHSA report was submitted) and has been used for ongoing programmatic improvement. ACBH management shared that Child & Young Adult community stakeholders shared that they felt that students benefitted greatly from the program and that this resource will continue to strengthen quality services offered by their providers.

FY 22/23 Anticipated Changes: This program has been approved through the end of the second cohort in which participants will graduate in December 2022. The future direction of the program will be discussed in the coming months towards the goal of sustaining the program beyond this pilot. WET funds have supported these efforts as well as the complimentary evaluation services.

Appendix E-1 MHSA Annual Plan Update Public Comments

Appendix F-1 MHSA Certification

Appendix F-2 Alameda County BOS Minute Order and Board Letter

For questions or additional information regarding this report, please contact the report developer:

Mariana D. Real, MPH, MCHES

MHSA Senior Planner

MHSA@acgov.org