MENTAL HEALTH SERVICES ACT ANNUAL PLAN UPDATE

FISCAL YEAR 2021-2022

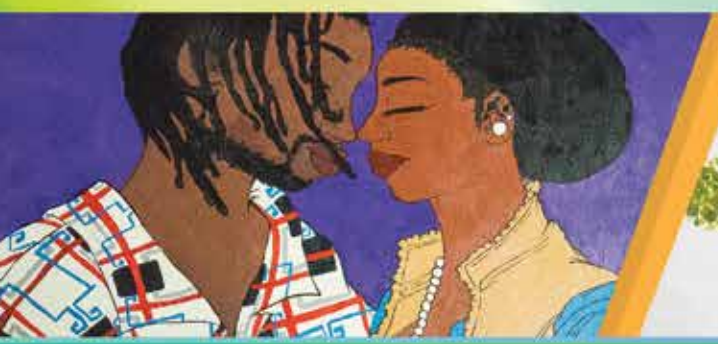
MENTAL HEALTH SERVICES ACT (MHSA) DIVISION | ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES DEPARTMENT RELEASED FOR PUBLIC COMMENT: APRIL 15, 2021 – MAY 17, 2021

Approved by the Alameda County Board of Supervisors on August 3, 2021

alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES


HOPE


POWER
PATIENCE
Strength
FRIENDS
TRUST
FAMILY
EXERCISE
LEARNING
MEDS
BALANCE



MENTAL HEALTH SERVICES ACT
FY21-22 ANNUAL PLAN UPDATE
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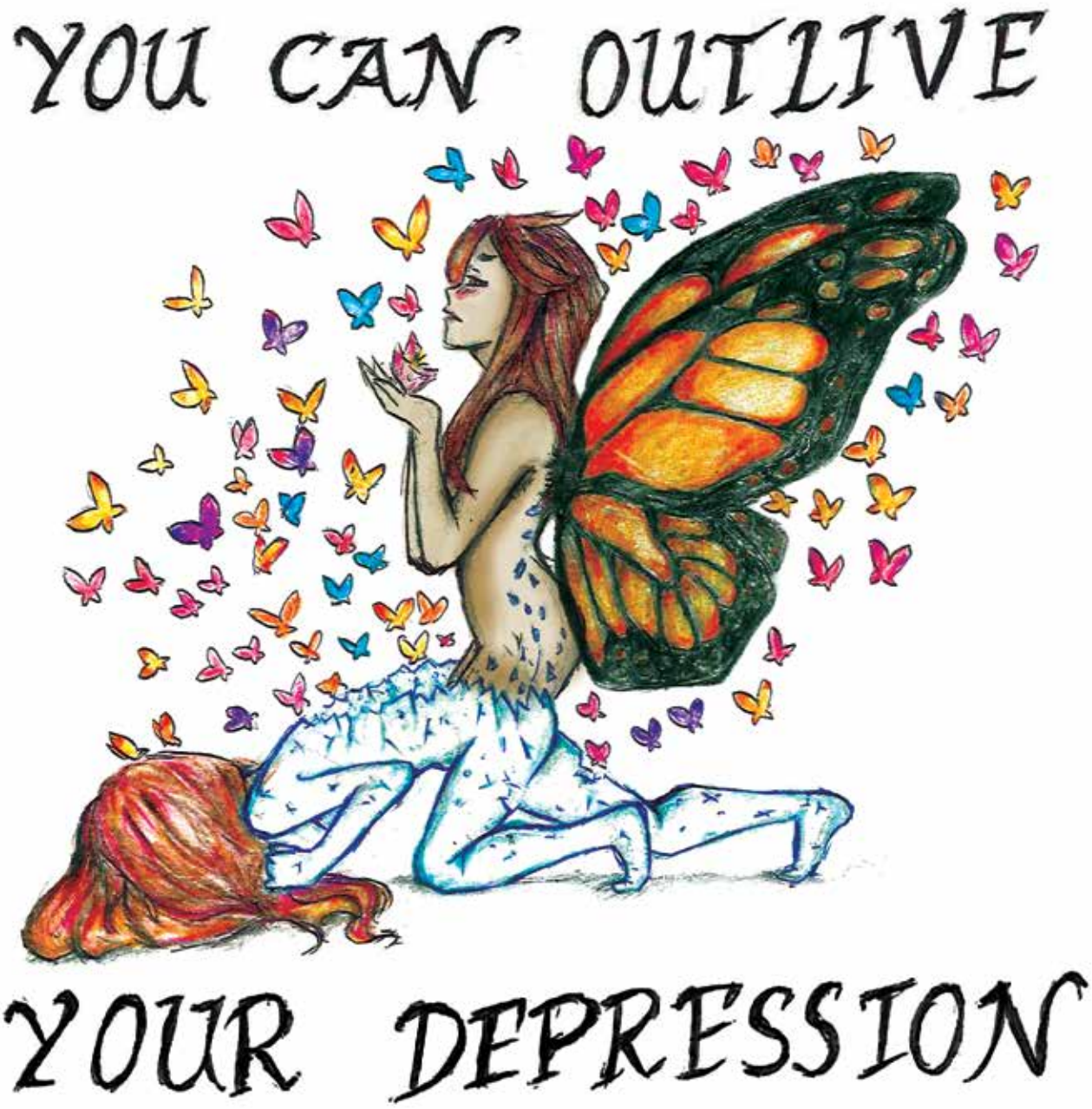


DeFung Su
Young Adult, Oakland CA

Message From the Director

Welcome to Alameda County Behavioral Health Care Services (ACBH) Department's Fiscal Year (FY) 2021-2022 Mental Health Services Act (MHSA) Program and Expenditure Plan Update.

Fiscal year 2021-2022 marks the second year of our current MHSA Three-Year Plan (FY 20/21-22/23) which has been guided and developed through a clear vision of health equity, the California economy and the devastating impact of the Novel Coronavirus (COVID-19). However, 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 Behavioral Health, I invite you to explore our new Plan Update and provide public comment through our various forums. I'm also looking forward to having a deeper level of engagement with our consumer and family member community, local nonprofit stakeholders, community advocates committed to system change, the Mental Health Advisory Board and our public systems. This continued engagement will assist us in serving our most vulnerable communities utilizing a cultural and racial/ethnic equity lens as well as the principles of trauma informed care.

As we weather economic uncertainty, the health implications from COVID-19 and the racial and ethnic injustices we've experienced has informed my own vision of how our department may be poised to be of service to our Community. We remain committed to ensuring that our system responds to critical needs across the community, while balancing the very real need to ensure that services continue with the least disruption possible during this most critical time. This national change has also affirmed our department's choice to adopt a priority framework designed to foster strategic decision-making while ensuring that we are aligned with our county, agency, and departmental mission, vision and values; improve communication with our internal and external stakeholders; and improve our organizational structure to promote the development of a seamless and supportive care delivery system. These priorities have served as a guiding light and helped to shape these three departmental priority areas during this next Three-Year MHSA Plan:

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

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

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

Sincerely,

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

Alameda County Behavioral Health Mission and Vision

MISSION

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

VISION

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

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

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

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

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

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

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

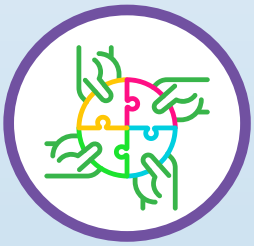
MHSA GUIDING PRINCIPLES

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

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

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

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



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

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

Executive Summary

Alameda County Behavioral Health Care Services (ACBH) is pleased to present the Mental Health Services Act (MHSA) Annual Plan Update for fiscal year 2021-22. The Annual Plan is based on data from fiscal years 2019-20 and 2020-21. This report is the second 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 will be updated annually in 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 a proportion of overall mental health funding in Alameda County has grown over time. For State Fiscal Year (FY) 21/22, ACBH set aside up to $136,068,732 million in budget authority, which is very similar to the previous fiscal year of 2020-21. ACBH has been able to maintain 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 slow project start up, staff vacancies and service/engagement issues due to the Novel Coronavirus (COVID-19).

Within the past few years all counties in California have experienced high MHSA allocations due to the success of the California economy. However, it should be noted that the MHSA funding stream is highly volatile; 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, the actual fiscal impacts or potential reductions for future years that associated with COVID-19 are unknown. 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. As an example of this accountability, in order to be proactive and safeguard against significant impacts on the Alameda County community, fiscal planning to evaluate and strategize surrounding future changes in our financial landscape was initiated Fall 2020. Additional information on any potential future reductions will be included within the FY 22/23 MHSA Plan Update.

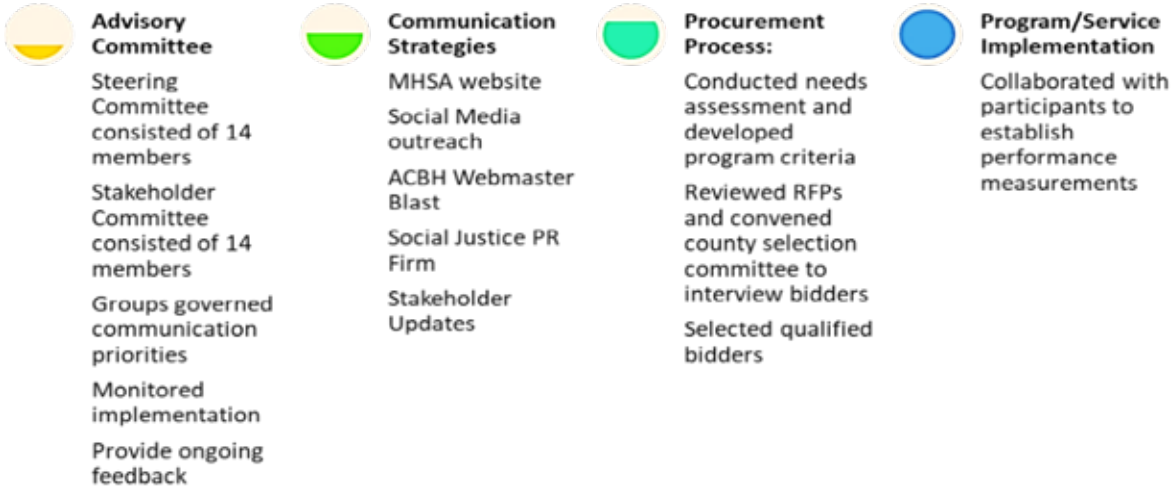
MHSA Community Program Planning & Stakeholder Engagement Process

Exhibit 1 provides an overview of Alameda County's ongoing Community Program Planning Process (CPPP). Alameda County utilizes five MHSA principles to guide planning and implementation activities and employs a range of strategies to engage stakeholders at all levels of planning and implementation. Our CPPP provides a number of opportunities for a 15-member stakeholder group and other representatives to participate in the development of our Plans and stay informed of our progress in implementing MHSA-funded programs. During fiscal year 2019-20 and 2020-21, MHSA increased the membership of the MHSA Stakeholder Group (MHSA-SG) by 27% and its underserved/unserved demographics (including Transitional Aged Youth representation) by 250%.

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 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 the 12 focus groups facilitated during the Three-Year Plan CPPP (which included 198 group participants), the MHSA Steering Committee and MHSA-SG coordinated a smaller CPPP between February 19, 2021- March 16,2021, and facilitated an additional 5 focus groups totaling 45 participants. Each focus group represented an important cross section of Alameda County populations in accordance with data from the Three-Year Plan CPPP. Some reoccurring themes form participants include: 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, and requests to target services for underserved and unserved communities- specifically African-Americans, veterans, transition age youth (TAY), persons experiencing homelessness and immigrants & refugees.

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



Cross-Component findings:

- *Factors Related to Expenditures*: Expenditures to support an enhanced behavioral system of care through Community Services and Supports comprises 76 cents out of every Mental Health Services Act dollar. This proportion is in keeping with Welfare and Institutions Code Section 5892, which specifies the percentage of Mental Health Services Act monies to be expended on each component.
- *Local Trends Impact Report*: 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 2021-22 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:

- Assisting the startup of a Mental Health Urgent Care Service for East County/Tri-Valley residents.
- Introducing an 18-month pediatric care coordination pilot project within eight local Federally Qualified Health Centers (FQHCs) in Alameda County.
- Expanding mental health collaborative courts by providing an additional 1.0FTE Behavioral Health Clinician to assist with meeting the mental health needs of court clients.

- Absorption of the City of Berkeley MHSA's trauma support group school-based program targeting Albany Unified' s elementary and high school age students.
- Launched the Community Assessment & Treatment Team (CATT) with three teams, one of each in Oakland, Hayward and San Leandro. CATT pairs a clinician with an EMT to respond to individuals who are experiencing a crisis due to mental health and or substance use.
- Launched the Alameda County Loan Repayment Program (ACLRP) to provide up to $10,000 awards to mental health professionals in ACBH that share the same ethnic, cultural and language backgrounds of the underserved and unserved communities that ACBH serves.
- Funding to support the planning and development of a new pilot project for Transition Age Youth (TAY) focusing on African American TAY. This pilot will pair mental health and higher education academic supports to reduce adverse negative outcomes associated with the criminal justice system, hospitalizations, housing instability and unemployment.
- Funding to support an Asian and Pacific Islander (API) graduate student internship pilot program to address the needs of API consumers.
- Funding to support: 1) the replacement of the current billing system, which will be linked with ACBH's future electronic health record, 2) Updating ACBH's web-based data and outcome reporting system called *YellowFin* and 3) the finalization and usage of a newly created reporting dashboard on Full Service Partnership (FSP) clients that covers hospitalizations, housing, incarcerations, primary care linkage, employment, education, cost, and data quality.

General System Improvement Efforts

Performance indicators for the County's FSP Programs and Prevention and Early Intervention component have been updated for FY 21/22 based on FY19/20 data, and include performance measurements and outcomes. In addition, a new Performance Management section contains a summary of quality assurance and improvement strategies. Appendices C and D contain individual program profiles of MHSA programs and plan elements.

Closing

In summary, ACBH has aggressively approached its CPPP process in a manner designed to eliminate as many barriers as possible to promote inclusive outreach and engagement. Our resulting MHSA 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 (FY20/21)

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. Outreach, Engagement and System Development (OESD) Programs

II. PREVENTION AND EARLY INTERVENTION (PEI)

a. Albany Unified School-based Trauma Support Groups

III. INNOVATIONS (INN)

a. Approved INN Programs being Implemented in FY 20/21
b. New INN Programs under Development

IV. WORKFORCE, EDUCATION, AND TRAINING (WET)

a. Alameda County Loan Assumption (Repayment) Program
b. Greater Bay Area Workforce Development Needs Assessment Survey
c. New TAY Focused Academic and Career Pathway Pilot Project
d. Asian and Pacific Islander (API) Graduate Student Internship Program

V. CAPITAL FACILITIES AND TECHNOLOGICAL (CFTN) NEEDS

a. African American Wellness Hub Update
b. 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

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

Mental Health Urgent Care Pilot Project

ACBH will be 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 (July 1, 2021 through June 30, 2022). 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 would 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.

This program will be listed in the FY 22/23 MHSA Plan Update under the Primary Care Integration WorkPlan, OESD # 25.

Pediatric Care Coordination Pilot through the Alameda Health Consortium (AHC)

ACBH will be 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.

This program will be listed in the FY 22/23 MHSA Plan Update under the Primary Care Integration WorkPlan, OESD # 25.

Collaborative Courts Mental Health Expansion

The partnership between Alameda County Behavioral Health and the Superior Court goes back to 1990 when together they created the county's first treatment courts for people with co-occurring disorders. These courts are behavioral health's change agents in the justice system. The staff who lead the collaborative court system have witnessed countless judges, prosecutors, probation officers and child welfare workers change their perspective to become effective, trauma-informed practitioners of collaborative justice.

There are eight collaborative courts serving about 200 participants on any given day. These are justice-involved people assessed at high risk to recidivate due to high need for mental health (and addiction) services. This expansion will provide one additional FTE Behavioral Health Clinician to assist with meeting the mental health needs of the court clients for the goal of reduced recidivism and increased quality of life.

This program will be listed in the FY 22/23 MHSA Plan Update under the Mental Health Court Specialist Program WorkPlan, OESD # 7.

Service Team Case Management Program

ACBH will be supporting the development and change process to bring the existing Service Teams and Case Management programs under the umbrella of MHSA for the goal of system transformation and increase in quality of life for our clients who have a severe and persistent mental illness (SPMI).

The Service Teams assist clients living with an SPMI in attaining a level of autonomy within the community of their choosing. They also aim to help with:

- Increased community connections among clients;
- Promoting fiscal/benefits and stability;
- Supporting clients in maintaining basic needs including but not limited to housing, food,
- utilities, and clothing;
- Increasing client choice around appropriate housing;
- Reducing utilization of emergency services and hospitalization, and
- Assisting and empowering clients to transition into the least intensive and most independent level of service appropriate for their need, such as a wellness center or primary care.

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 may also self-refer to ACCESS. All Client are 18+ years old.

These programs will be listed in the FY 22/23 MHSA Plan Update under the Service Team Program WorkPlan, OESD # 29.

Re-entry Treatment Teams

ACBH will be supporting the continued development and implementation of two of the Re-entry/Forensic Treatment Teams currently being administered by the community-based organizations La Familia and Bay Area Community Services (BACS). During the public comment period for last year's

Three-Year Plan FY 20/21-22/23 there were over one hundred comments about the positive mental health impact and reduced recidivism of these two programs.

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.

These programs will be listed in the FY 22/23 MHSA Plan Update under the Re-entry Team WorkPlan, OESD # 37.

II. PREVENTION AND EARLY INTERVENTION (PEI)

b. Albany Unified School-based Trauma Support Groups

In FY 21/22 ACBH will support a small school-based program through Albany Unified to continue the provision of trauma support groups to both elementary and high school age students. This was a program previously funded by the City of Berkeley; however due to funding shortages and an understanding that the City of Berkeley is not responsible for the City of Albany under MHSA regulations this program is being transferred to ACBH from the City of Berkeley.

This program will be listed in the FY 22/23 MHSA Plan Update under PEI # 25, workplan: Trauma Informed Services.

III. INNOVATIONS (INN)

a. Approved INN Programs being Implemented in FY 20/21

The Community Assessment & Treatment Team (CATT) was approved by the MHSOAC on October 25th 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.

Between the roll out date in July, 2020 and October 21, 2020, there were 364 requests for a CATT team response. A CATT team was dispatched to 214 of these requests.

Of the 214 CATT responses, 33% (71) of the calls ended in transports to appropriate service facility or safe location. The remaining 64 % (137) had alternative dispositions which included cancellations prior to scene arrival or no patient located; refusal to be treated or transported; and patient treated/transfer by another EMS professional or treated/transported by private vehicle.

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

b. New INN Programs under Development

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

The themes recurring most often include:

- Community and Home-base Services
- Services for Transition Age Youth (TAY)
- Outreach/Education for Stigma Reduction
- Housing Supports
- School-based Services
- Increasing Culturally Responsive Services
- Care Coordination/Provider Communication
- Telehealth – individual and group
- Creativity and recreation-based therapies
- Increasing peers in the workforce
- Supporting Families

Based on budget and funding, ACBH will be looking to embark on new INN programs in the next year that will provide opportunities to engage more with consumer and family members, local nonprofit stakeholders and our diverse communities here in Alameda County. At the same time, it is important to acknowledge the effects of the pandemic, the extensive unemployment and current social movements.

Two Priority areas under Innovation, which will be linked to the above CPPP themes include:

- Community Holistic Response Teams
- New/Innovative Service Team Model with a focus on the forensic population

These priority areas will be further developed in FY 21/22.

Please see the INN section for more details on current and future INN projects.

IV. WORKFORCE, EDUCATION, AND TRAINING (WET)

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

a. Alameda County Loan Assumption (Repayment) Program

In the beginning of FY 20/21 the WET unit restarted the Alameda County Loan Repayment Program (ACLRP). This was unfortunately phased out in FY 17/18 when funding from the Office of Statewide Health Planning and Development (OSHPD) was cut. ACBH recognizes the need and importance of this type of financial incentive as a strategy to retain mental health professionals in ACBH who reflect Alameda County's diverse population and share the same ethnic, cultural and language backgrounds of the underserved and unserved communities that ACBH serves.

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

b. Greater Bay Area Workforce Development Needs Assessment Survey

In September 2020, the ACBH Workforce Education and Training (WET) unit 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 group. 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 will inform our system on further developing our workforce and training programs. The survey results can be found in the Appendix. Please see the WET section for additional program and project information.

c. New TAY Focused Academic and Career Pathway Pilot Project

ACBH will be supporting the planning and development of a new pilot project for Transition Age Youth (TAY) focusing on African American TAY, to assist in the goal of academic success and career exploration. This pilot will pair mental health and higher education academic supports to increase positive impacts and reduce other negative outcomes such as association with the criminal justice system, hospitalizations, housing instability and unemployment.

In FY 22/23 this pilot will be listed under WET Action Plan #11.

d. Asian and Pacific Islander (API) Graduate Student Internship Program

ACBH will be supporting the development and implementation of a new pilot project funding an API graduate student internship program to support the Department's vision of equity and the needs of the consumers from the API communities.

In FY 22/23 this pilot will be listed under WET Action Plan #3.

V. CAPITAL FACILITIES AND TECHNOLOGICAL NEEDS (CFTN)

a. African American Wellness Hub Complex

ACBH is excited to begin work on the development of an African American Wellness Hub Complex. ACBH staff are working closely with community consultants and the Alameda County General Services Agency department.

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

On November 11, 2020 the Alameda County Board of Supervisors approved to amend the Capital Improvement Plan (CIP) to include the African American Wellness Center Project, and award $92K for

Architectural Services. ACBH is currently working with the General Services Agency (GSA) to set up this architectural contract. Once in place, space planning and project development meetings can commence. It is the hope that these meetings will begin in February 2021.

This Complex will be developed over multiple years, starting in FY 19/20, and will be a beacon of hope and energy for the African American community in Alameda County. Currently ACBH has budgeted $2 million/year for three years for a total of $6 million dollars (the funds will be transferred to the CFTN component from CSS in FY 20/21, 21/22 and 22/23).

More information will be available on the progress of the land purchase or building purchase renovation as it becomes available and will be posted on MHSA website and in the FY 22/23 MHSA Plan Update.

b. MHSA Technology Project

ACBH has utilized CFTN funds to:

1) Replace the current billing system, which will be linked with ACBH's future electronic health record; the contract with the vendor will begin in April 2021 for the pre-implementation planning phase. The Implementation planning phase will begin in July 2021 (FY 21/22). More information will be published as it becomes available.

2) Update ACBH's web-based data and outcome reporting system called *YellowFin* and,

3) Finalize and begin using a newly created reporting dashboard on Full Service Partnership (FSP) clients that covers hospitalizations, housing, incarcerations, primary care linkage, employment, education, cost, and data quality.

FY 2021/22 Mental Health Services Act Annual Update
Funding Summary

County: Alameda Date: Date: 3/19/21

	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 2021/22 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	46,215,178	1,434,630	18,912,997	(0)	2,327,776	
2. Estimated New FY 2021/22 Funding	78,285,249	19,571,312	5,150,345			
3. Transfer in FY 2021/22[a/]	(13,355,890)			3,420,182	9,935,708	
4. Access Local Prudent Reserve in FY 2021/22						
5. Estimated Available Funding for FY 2021/22	111,144,537	21,005,942	24,063,343	3,420,182	12,263,484	
B. Estimated FY 2021/22 MHSA Expenditures	99,718,125	16,218,767	8,991,126	3,420,182	12,263,483	
G. Estimated FY 2021/22 Unspent Fund Balance	11,426,411	4,787,175	15,072,216	(0)	0	

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2021	14,593,038
2. Contributions to the Local Prudent Reserve in FY 2021/22	0
3. Distributions from the Local Prudent Reserve in FY 2021/22	0
4. Estimated Local Prudent Reserve Balance on June 30, 2022	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 2021/22 Mental Health Services Act Annual Update
Community Services and Supports (CSS) Funding

County: Alameda Date: 3/19/21

		Fiscal Year 2021/22					
		A	B	C	D	E	F
		Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs							
FSP 3	Support Housing for TAY	2,969,073	1,389,526	1,579,547			
FSP 4	Greater Hope Project	4,398,759	3,197,898	1,200,861			
FSP 7	SSI Advocacy & Support Services	1,753,736	973,695	145,241			634,800
FSP 10	Housing Services	15,221,992	13,809,076	1,287,330			125,586
FSP 11	Community Conservatorship	1,230,364	824,344	406,020			
FSP 12	Assisted Outpatient Treatment (AOT)	127,462	86,674	40,788			
FSP 13	CHANGES	4,462,982	4,462,982				
FSP 14	STRIDES	2,974,105	1,799,334	1,174,771			
FSP 16	Alameda Connections 0-8	734,580	448,094	286,486			
FSP 17	East Bay Wrap 8-18	735,585	367,793	367,793			
FSP 18	Homeless Engagement	4,398,760	3,054,499	1,344,261			
FSP 19	No. Co. Senior Homeless	2,905,008	2,905,008				
FSP 20	Lasting Independence Forensic Team	2,969,072	2,197,113	771,959			
FSP 21	Prevention, Advocacy, Innovation, Growth, and Empowerm	1,484,534	979,792	504,742			
FSP 22	Justice and Mental Health Recovery	4,237,129	3,918,222	318,907			
Non-FSP Programs							
OESD 4A	Mobile Integrated Assess Team for Seniors	668,495	375,694	292,801			
OESD 5A	Crisis Response Program - Capacity for Valley and Tri-City	2,891,875	2,024,313	867,563			
OESD 7	MH Court Specialist Program	596,230	417,361	178,869			
OESD 8	Juvenile Justice Transformation of Guidance Clinic	165,456	115,819	49,637			
OESD 9	Multisystemic Therapy	907,385	593,430	281,289			32,666
OESD 11	Crisis Stabilization Service	11,198,757	7,661,927	3,536,830			
OESD 14	Staffing to Asian Population	4,045,190	2,739,460	1,305,730			
OESD 15	Staffing to Latino Population	855,196	627,418	227,778			
OESD 17	Residential Treatment for Co-occurring Disorders	981,057	163,837	686,740			130,481
OESD 18	Wellness Center	7,299,360	5,701,062	1,525,729			72,569
OESD 19	Medication Support Services	3,995,301	2,216,167	1,775,781			3,353
OESD 20	Individual Placement Services	6,172,779	4,183,905	1,988,874			
OESD 23	Crisis Residential Services	1,685,716	1,636,079	49,637			
OESD 24	Schreiber Center	365,919	256,143	109,776			
OESD 25	Behavioral Health - Primary Care Integration Project	6,149,482	5,561,947	538,903			48,632
OESD 26AB	Culturally-Responsive Treatment Programs for African-Am	721,062	721,062				
OESD 27	In Home Outreach Team	2,893,531	1,598,673	1,294,858			
OESD 28	SAGE Case & Care Management	2,669,040	1,046,511	1,612,586			9,942
OESD 29	Older Adult Service Team	6,261,792	3,682,343	2,323,517			255,932
OESD 30	Peer Respite	1,056,352	1,056,352				
OESD 31	1st Onset	1,340,001	972,841	367,160			
OESD 32	Suicide Prevention/Crisis Line	275,165	275,165				
OESD 33	Deaf Community Counseling Services	297,752	276,046	16,049			5,657
OESD 34	School-Based Behavioral Health	1,363,634	1,363,634				
OESD 35	Family Education Resource Center & MH Outreach	1,917,125	1,917,125				
OESD 36	Presumptive Transfer Program	762,973	762,973				
OESD 37	Re-entry Treatment Teams	1,477,358	1,034,151	443,207			
CSS Administration		14,746,631	10,322,639	4,423,992			
CSS MHSA Housing Program Assigned Funds		0					
Total CSS Program Estimated Expenditures		134,363,754	99,718,125	33,326,012	0	0	1,319,617

FY 2021/22 Mental Health Services Act Annual Update
Community Services and Supports (CSS) Funding

County: Alameda

Date: 3/19/21

FSP Programs as Percent of Total	50.7462%

FY 2021/22 Mental Health Services Act Annual Update
Prevention and Early Intervention (PEI) Funding

County: Alameda Date: 3/19/21

		Fiscal Year 2021/22					
		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	924,725	825,452	99,273			
PEI 1B	School-Based Mental Health Access & Linkage in Elementary, Middle, & High Schools	1,007,655	1,007,655				
PEI 1C	Early Childhood Mental Health Outreach & Consultation	303,063	300,000				3,063
PEI 1D	Unaccompanied Immigrant Youth Outreach	749,901	472,438	277,463			
PEI 4	Stigma & Discrimination Reduction Campaign	1,439,220	1,439,220				
PEI 5	Outreach, Education & Consultation for Latino Community	1,364,922	818,953	545,969			
PEI 6	Outreach, Education & Consultation for Asian Pacific Islander Community	1,849,643	1,507,247	331,591			10,805
PEI 7	Outreach, Education & Consultation for South Asian/Afghan Community	1,549,525	1,376,908	172,617			
PEI 8	Outreach, Education & Consultation for Native American Community	309,905	267,758	23,553			18,594
PEI 9	Outreach, Education & Consultation for Middle Eastern Community	309,905	309,905				
PEI 10	Outreach, Education & Consultation for African Community	309,800	309,800				
PEI 12	Suicide Prevention and Trama-Informed Care	1,704,044	1,704,044				
PEI 17AB	TAY Resource Centers	1,027,933	1,027,933				
PEI 19	Older Adult Peer Support	298,924	298,924				
PEI 20A-E	Community	909,147	907,433				1,714
PEI 22	LGBT Support Services	339,671	339,671				
PEI 24	Sobrante Park Comm Proj	350,000	350,000				
PEI 25	Trauma Informed Servcies	114,042	114,042				
PEI Programs - Early Intervention							
PEI 3	Mental Health for Older Adults, Geriatric Assessment & Response Team	949,348	664,543	284,804			
PEI Administration		2,570,434	2,176,842	393,592			
PEI Assigned Funds		0					
Total PEI Program Estimated Expenditures		18,381,806	16,218,767	2,128,862	0	0	34,177

FY 2021/22 Mental Health Services Act Annual Update
Innovations (INN) Funding

County: Alameda

Date: 3/19/21

	Fiscal Year 2021/22					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
INN 2 Community Assessment & Transport Team	8,424,492	7,419,505	1,004,987			
INN 4 Supportive Housing Community Land Alliance (SHCLA)Land Trust	612,763	612,763				
INN 5 MH Technology (MH Tech 2.0)	658,775	658,775	26,485			
INN 6 INN CPPP Expansion	176,569	150,083				
	0					
	0					
	0					
	0					
	0					
	0					
	0					
	0					
	0					
	0					
	0					
	0					
	0					
INN Administration	150,000	150,000				
Total INN Program Estimated Expenditures	10,022,599	8,991,126	1,031,473	0	0	0

FY 2021/22 Mental Health Services Act Annual Update
Workforce, Education and Training (WET) Component Worksheet

County: Alameda Date: 3/19/21

		Fiscal Year 2021/22					
		A	B	C	D	E	F
		Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs							
Action 1	Workforce Staffing & Support	549,353	384,547	164,806			
Action 2	Staff Development, Training/Conference and Consultants	140,526	140,526				
Action 4	ACBH Training Institute	547,915	547,915				
Action 5	Post Graduate Certificate Program	111,000	111,000				
Action 6	Psychiatry and Integrated Behavioral Health Care	186,000	186,000				
Action 7	Graduate Intern Stipend Program	125,000	125,000				
Action 8	Loan Assumption Program	300,000	300,000				
Action 9	PEER Training & Support	513,939	513,939				
Action 10	MHSA Support and Public Education Campaign & CBL	479,366	479,366				
Action 11	WET pipeline/academic support for TAY	631,889	631,889				
		0					
		0					
		0					
		0					
		0					
		0					
		0					
		0					
		0					
		0					
WET Administration		0					
Total WET Program Estimated Expenditures		3,584,988	3,420,182	164,806	0	0	0

FY 2021/22 Mental Health Services Act Annual Update
Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: Alameda

Date: 3/19/21

		Fiscal Year 2021/22					
		A	B	C	D	E	F
		Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Program - Capital Facilities Projects							
CF2	Respite Bed Expansion	2,000,000	2,000,000				
CF3	County Facility Renovation	1,900,000	1,900,000				
CF5	AA Wellness Hub	2,000,000	2,000,000				
CF6	A Street Shelter Project	900,000	900,000				
		0					
		0					
		0					
		0					
		0					
		0					
CFTN Program - Technological Needs Projects							
TN1	Behavioral Health Management System	2,543,336	2,543,336				
TN2	Web-based dashboard	97,000	97,000				
TN3	County Equipment & Software Update	1,237,056	1,237,056				
TN4	Consulting Services	727,980	727,980				
		0					
		0					
		0					
		0					
		0					
		0					
CFTN Administration		1,225,874	858,111	367,762			
Total CFTN Program Estimated Expenditures		12,631,246	12,263,483	367,762	0	0	0

Alameda County Profile

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 2018 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**).

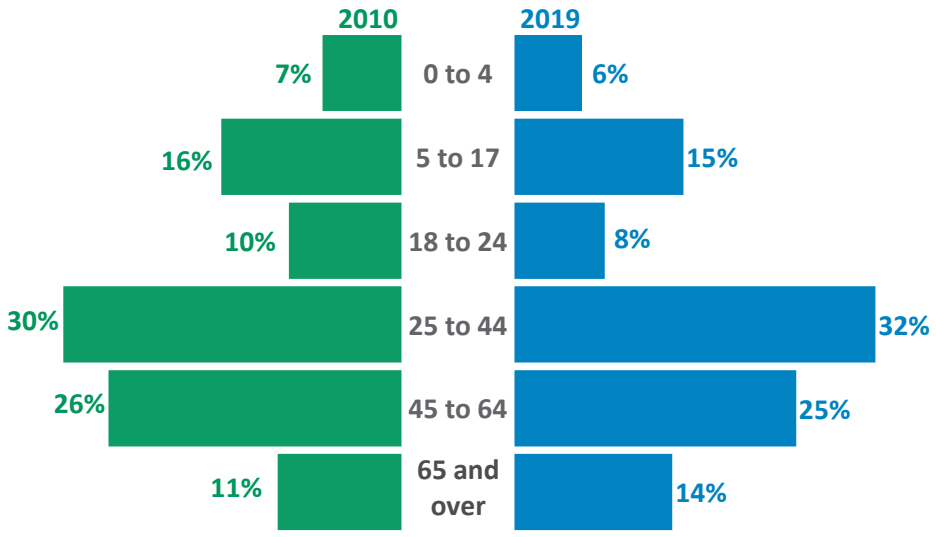
Table 1: Alameda and Select Bay Ares Counties Population Characteristics

Description	Alameda	Contra Costa	Marin	San Francisco	Santa Clara
Census, April 1, 2010	1,510,271	1,049,025	252,409	805,235	1,781,642
Estimates base, April 1, 2010, (V2019)	1,510,271	1,049,204	252,430	805,184	1,781,686
Estimates, July 1, 2019, (V2019)	1,671,329	1,153,526	258,826	881,549	1,927,852
Change April 1, 2010 (estimates base) to July 1, 2019, (V2019)	11%	10%	3%	10%	8%
Total change estimates, July 1, 2018 to July 1, 2019	4,576	3,311	-840	-1,756	-9,718
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, U.S. Census Bureau, Population Division, Release Date: March 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.

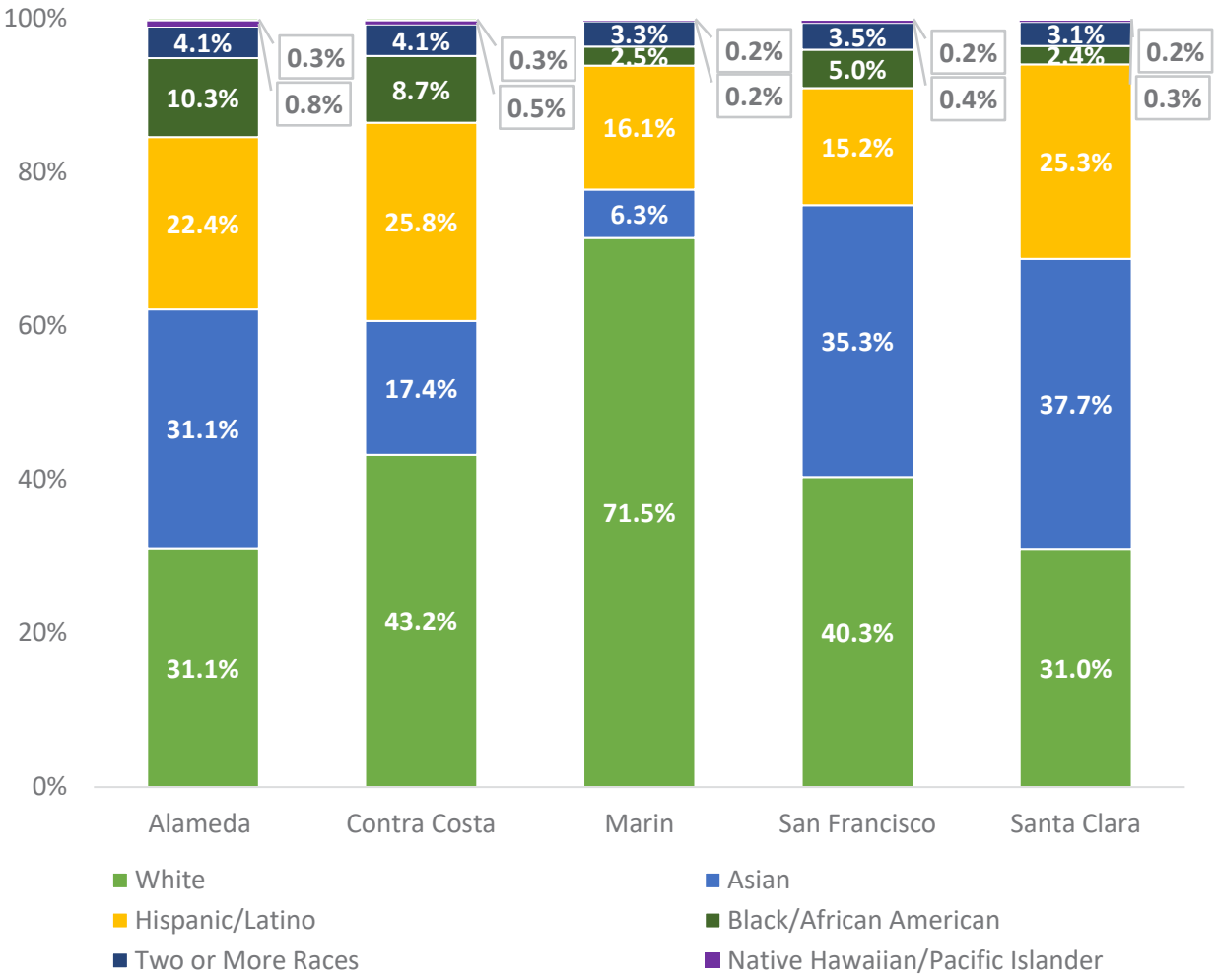
Figure 1: Alameda County Age Group as a Percentage of Total Population, 2010 v. 2019



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

Asian, 22.4% Hispanic/Latino, 10.3% Black or African American, 4.1% Two or more races, 0.8% Native Hawaiian or Pacific Islander, and 0.3% American Indian or Alaska Native (**Figure 2**). The percent of Asian residents in Alameda County is approximately double the State of California's (14.8%).

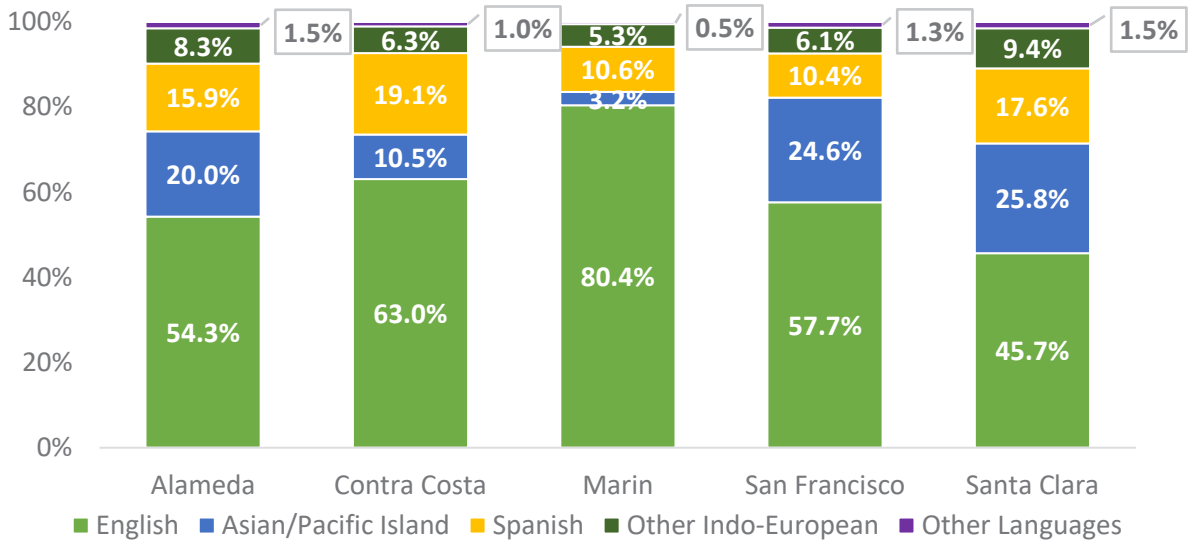
Figure 2: Bay Area Counties Percent Race and Ethnicity Estimates as of July 1, 2019



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

At home, Alameda County residents speak a variety of languages. Among the neighboring Bay Area Counties, Alameda has the second highest percent of residents who speak non-English languages at home. While over half of residents speak English at home (54.3%), 20.0% of residents speak Asian/Pacific Island languages, 15.9% speak Spanish, 8.3% speak Other Indo-European languages, and 1.5% speak Other Languages (**Figure 3**). Due to this diversity of languages, Alameda County has seven threshold languages: English, Spanish, Vietnamese, Arabic, Tagalog, and Chinese if written Traditional and Simplified or when spoken Cantonese and Mandarin. Threshold languages are those where at least 3,000 residents or five percent of the Medi-Cal beneficiary population, whichever is lower, identify that language as their primary one. 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: Bay Area Counties Languages Spoken at Home by 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, almost 50% of those that rent spend 30% or more of their income on their rent, this means that the rent they pay is burdensome. Alameda County also has the second highest percent of people in poverty for all ages and for children. The Supplemental Nutrition Assistance Program (SNAP) is a federal program for low-income individuals that provides help with purchasing food and beverages. Even though only 5.4% of Alameda County residents receive SNAP, this is tied for the second highest percent compared to neighboring counties, 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	**$1,797.00**	$1,819.00	$2,069.00	$1,895.00	$2,268.00
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%

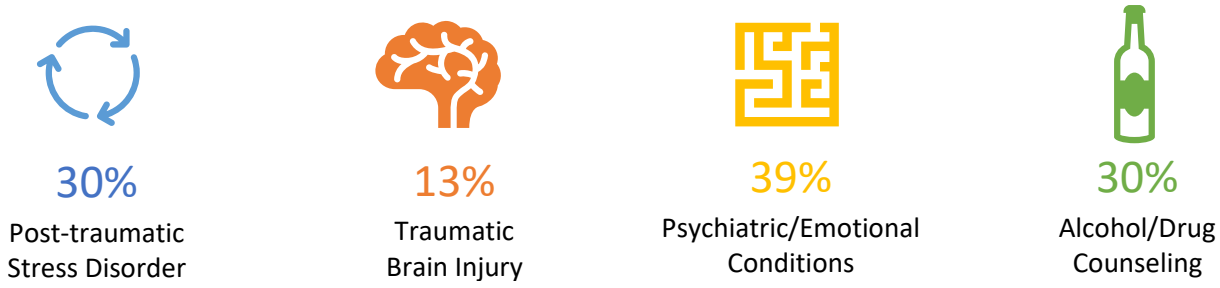
±In 2019 dollars; Source: 2020 Census Quickfacts; Annual Estimates of the Resident Population for Counties in California: April 1, 2010 to July 1, 2019; and 2019 ACS 1-Year Estimates Subject Tables; Retrieved: 1/26/2021

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

required Point-in-Time Count. The 2019 count recorded 8,022 people experiencing homelessness, which is a 43% increase from the last count in 2017. Seventy-nine percent were unsheltered—living in tents, parks, vehicles, vacant buildings, underpasses, etc. According to the EveryOne Counts 2019 report, Alameda, San Francisco, and Santa Clara reported increases in overall homelessness in 2019. The full report can be found here.

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

Survey respondents reported the following health conditions:

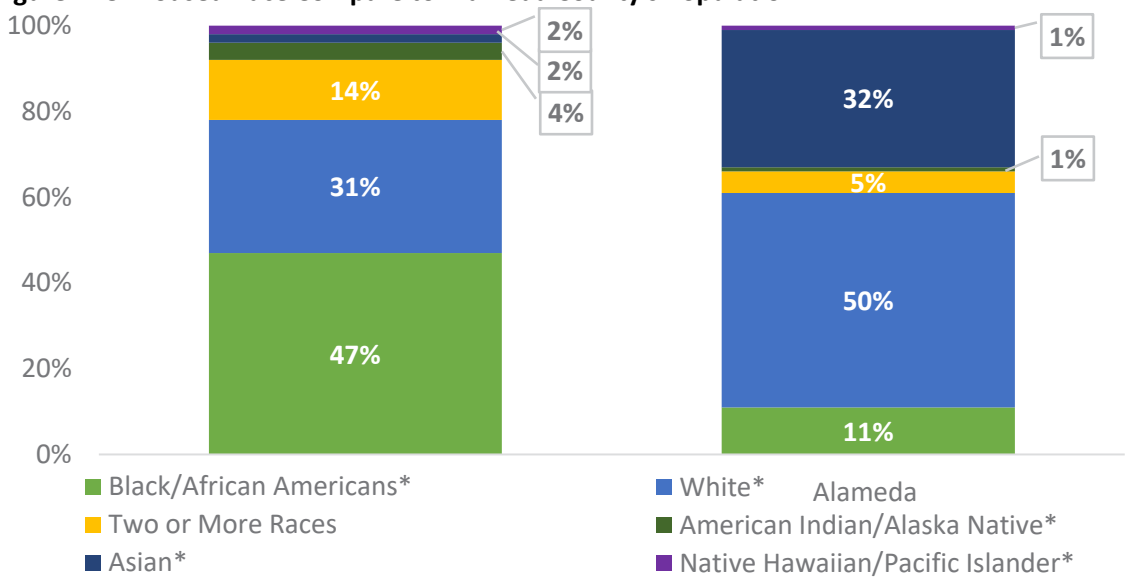


Only three percent of respondents were not interested in independent, affordable rental housing, or housing with supportive services. The lack of affordable housing has impacted Alameda County residents, the workforce, and consumers and family members in MHSA programs. During the MHSA Community Program 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 an overrepresentation 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% of the homeless population.

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

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



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

Physical Health

Alameda County has the second lowest life expectancy, at 82.9 years compared to the neighboring counties (range 82.4 - 85.4). Alameda and San Francisco Counties have much higher rates of violent crime than the other neighboring counties. Those without health insurance under the age of 65 (range 4.8% - 5.9%) have similar rates across all neighboring Bay Area Counties. The percent of those under 65 that are disabled, defined as limited or restricted to fully participate in activities at school, home, work, or in their community, is 5.6% (**Table 3**).

Table 3: Health Indicators for Bay Area Counties

Indicator	Alameda	Contra Costa	Marin	San Francisco	Santa Clara
Life expectancy, years	**82.9**	82.4	85.4	83.8	84.6
Violent crime rate (per 100,00 people)	**629**	336	178	760	264
Persons without health insurance, under age 65 years	**5.0%**	5.9%	4.8%	4.8%	5.1%
With a disability, under age 65 years, 2015-2019	**5.6%**	7.5%	5.1%	5.7%	4.6%

Source: 2020 Census Quickfacts and Annual Estimates of the Resident Population for Counties in California: April 1, 2010 to July 1, 2019, U.S. Census Bureau, Population Division, Retrieved: 1/12/2021 and County Health Rankings 2019

In contrast to life expectancy, Alameda County has the second lowest age-adjusted[3] death rates due to drugs (9.6) or suicide (8.9) per 100,000 when compared to its neighboring counties (**Table 4**). These are lower than the Healthy People 2020 Objective of 11.3 and 10.2 per 100,000, respectively. However, these low rates do not reflect the differences in these rates among different populations in Alameda County. For example, the Centers for Disease Control and Prevention reports that nationally the highest rates of suicide across the life span occur among American Indian/Alaska Natives and Whites. Veterans and sexual minority youth also have higher rates of suicide. Additionally, suicide is the second leading cause of death for those between the ages of 10 to 34 and increased from 6.8 in

[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, 2016-2018

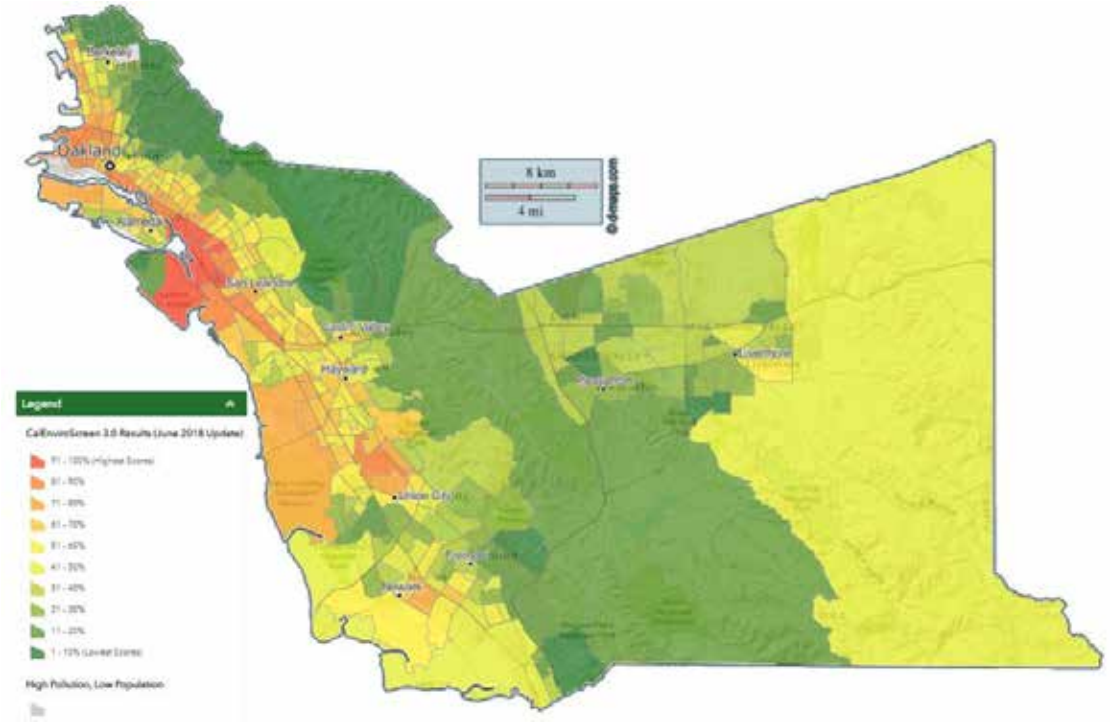
County	Drugs		Suicide	
	Deaths (Average)	Age-Adjusted Death Rate	Deaths (Average)	Age-Adjusted Death Rate
Alameda	**173.0**	**9.6**	**156.3**	**8.9**
Contra Costa	148.0	12.2	121.7	10.3
Marin	36.0	13.6	42.7	13.9
San Francisco	209.3	20.3	98	9.7
Santa Clara	170.7	8.0	148.7	7.4
Healthy People 2020 Objective	-	11.3	-	10.2

Source: California Department of Public Health, California Comprehensive Master Death Files, [2016-2018] Compiled, April 2020.

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 2018 CalEnviroScreen results for Alameda County (**Figure 5**). Briefly, the areas with lower burden and vulnerability to pollution are green and the neighborhoods with the highest are red. Areas of Oakland, San Leandro, and Union City have the highest burden of pollution and vulnerability to pollution.

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. Alameda has the second highest percentage of people that reported to have "likely had psychological distress during the last year" (9.7%), moderate or severe "social life impairment" during the past year (16.7%), and "ever seriously thought about committing suicide" (11.2%) compared to other Bay Area counties (**Table 5**). Additionally, 20.8% of Alameda County respondents reported that they "needed help for emotional/mental health problems or use of alcohol/drugs" and of those, 74.8% of them reported receiving treatment, which is the second lowest percent. The ratio of mental health providers to residents is 160:1 in Alameda County, which makes it in the middle among neighboring counties.

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

Indicator	Alameda	Contra Costa	Marin	San Francisco	Santa Clara
Likely has had serious psychological distress in the past year	**9.7%**	9.4%	5.8%	10.7%	7.6%
Moderate or severe social life impairment in the past year	**16.7%**	15.6%	13.2%	19.5%	13.6%
Ever thought about committing suicide	**11.2%**	10.9%	8.8%	14.2%	9.2%
Needed help for emotional/mental health problems or use of alcohol/drugs	**20.8%**	19.4%	23.7%	28.8%	17.0%
Of those that needed help, received treatment for mental/emotional and/or alcohol/drug issues	**74.8%**	81.8%	78.9%	81.1%	74.0%
Mental health providers	**160:1**	300:1	130:1	110:1	290:1

Source: 2015, 2016, 2017, 2018, and 2019 California Health Interview Survey and County Health Rankings 2019

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

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

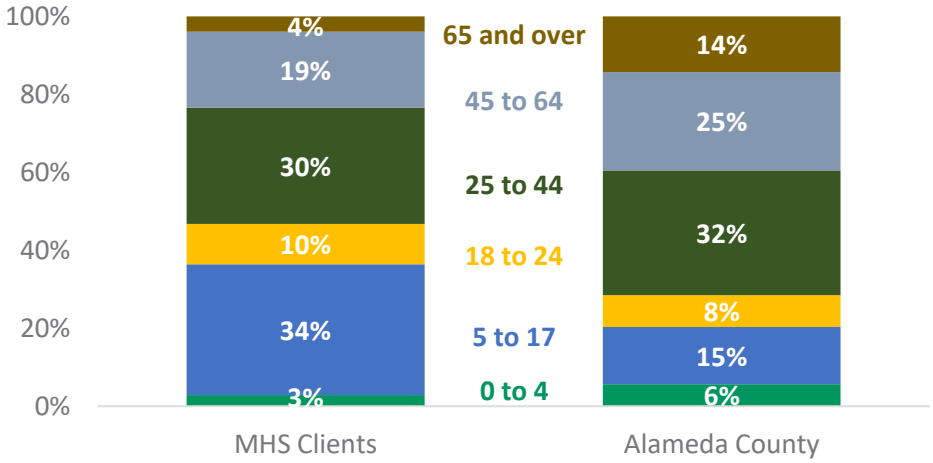
Indicator	Hispanic/ Latino	White	African American	Asian	Two or More Races
Likely has had serious psychological distress in the past year	6.6%	9.8%	7.9%	6.3%	*
Moderate or severe social life impairment in the past year	11.5%	17.4%	14.1%	*	*
Ever thought about committing suicide	6.1%	13.3%	11.4%	*	*
Needed help for emotional/mental health or alcohol/drugs	15.0%	24.9%	19.9%	14.1%	34.4%
Of those that needed help, received treatment for mental/emotional and/or alcohol/drug issues	55.0%	69.2%	61.8%	54.9%	*

* = 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: 2013, 2014, 2015, 2016, 2017, 2018, and 2019 California Health Interview Survey

Alameda County Behavioral Health Care Services Utilization

During FY2019/2020, ACBH provided behavioral health services to total of 28,361 clients and consumers. Adults 25 and over make up over half of the consumer population (53%), which is less than the County's population (72%). Children and Youth 0 to 17 are 37%, and Young Adults 18 to 24 are 10% of the clients both of which are higher than the Alameda County population. ACBH serves more men (55%) than women (45%). Nationally adult women have higher rates of any mental illness (25% versus 16%), serious mental illness (7% versus 4%), and treatment for serious mental illness (71% versus 57%)[5].

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 and MHSA Demographic Yellowfin Data

Table 7 shows the mental health services penetration rate by race and ethnicity. The penetration rate is the percentage of eligible Medi-Cal insured individuals who are utilizing mental health services. Despite having the second highest number of beneficiaries, Asians and Pacific Islanders have the lowest penetration rate at 1.6%. Alaska Native/American Indian represent the highest penetration rate (8.2%), with the other rates by race/ethnic groups penetration rates as follows 7.8% of Black/African Americans, 6.2% of Whites, 4.5% of Hispanic/Latinos, and 4.4% of Other/Unknown of Alameda County Medi-Cal beneficiaries.

Table 7: Fiscal Year 19/20 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	101,123	1,638	1.6%	1,452	1.4%	696	2334
Other/Unknown	106,845	4,663	4.4%	3,781	3.5%	1,540	6,203
Hispanic or Latino	117,183	5,306	4.5%	4,824	4.1%	172	5,478
White	51,328	3,166	6.2%	2,603	5.1%	1,395	4,561
Black or African American	79,225	6,180	7.8%	4,998	6.3%	1,469	7,649
Alaska Native or American Indian	1,141	93	8.2%	70	6.1%	43	136
Total	**456,845**	**21,046**	-	**17,728**	-	**5,315**	**26,361**

[5] Substance Abuse and Mental Health Services Administration's National Survey of Drug Use and Health, 2019

Exploring the Medi-Cal penetration rate by language shows that the lowest penetration rates are among Chinese (0.9%), Tagalog (1.1%), Arabic (1.2%), and Vietnamese (1.3%) speaking individuals (**Table 8**). English speakers are the largest group of beneficiaries and have the highest penetration rate (5.6%). Overall, 4.6% of beneficiaries are accessing mental health services in the Alameda County Behavioral Health system. Results from the Substance Abuse and Mental Health Services Administration's National Survey of Drug Use and Health (2019), showed that rates of serious mental illness are 5.2% of adults and 21.7% of residents are provided health insurance through Medicaid/CHIP[6].

Table 8: Fiscal Year 19/20 Alameda County Mental Health Services Medi-Cal Penetration Rate by Language

Language Group	Number of Recipients	Served with Medi-Cal	Penetration Rate	Served in Outpatient	Outpatient Penetration Rate	Served without Medi-Cal	Total Served
Chinese	37,393	334	0.9%	315	0.8%	28	362
Tagalog	3,468	39	1.1%	34	1.0%	0	39
Arabic	3,235	39	1.2%	36	1.1%	8	47
Vietnamese	11,419	144	1.3%	130	1.1%	6	150
Other	16,900	589	3.5%	529	3.1%	418	1,007
Spanish	83,583	3,227	3.9%	3,074	3.7%	737	3,964
Farsi	2,588	114	4.4%	109	4.2%	9	123
English	298,259	16,560	5.6%	13,501	4.5%	4,109	20,669
Total	**456,845**	**21,046**	-	**17,728**	-	**5,315**	**26,361**

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 28, 2021, Alameda County the highest number of cases of any Bay Area county with 72,024 cases and 929 deaths, which is the second highest. However, the Alameda's case rate is 4,381 per 100,000, which is the fourth highest rate in the bay area, and the death rate is 56.5 per 100,000, which is the third highest (**Table 9**).

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

Indicator	Alameda	Contra Costa	Marin	San Francisco	Santa Clara
Number of Cases	**72,024**	56,252	12,118	30,674	99,702
Case Rate (per 100,000)	**4,381**	4,963	4,655	3,525	5,186
Number of Deaths	**929**	525	170	308	1,314
Death Rate (per 100,000)	**56.5**	46.3	65.3	35.4	68.4

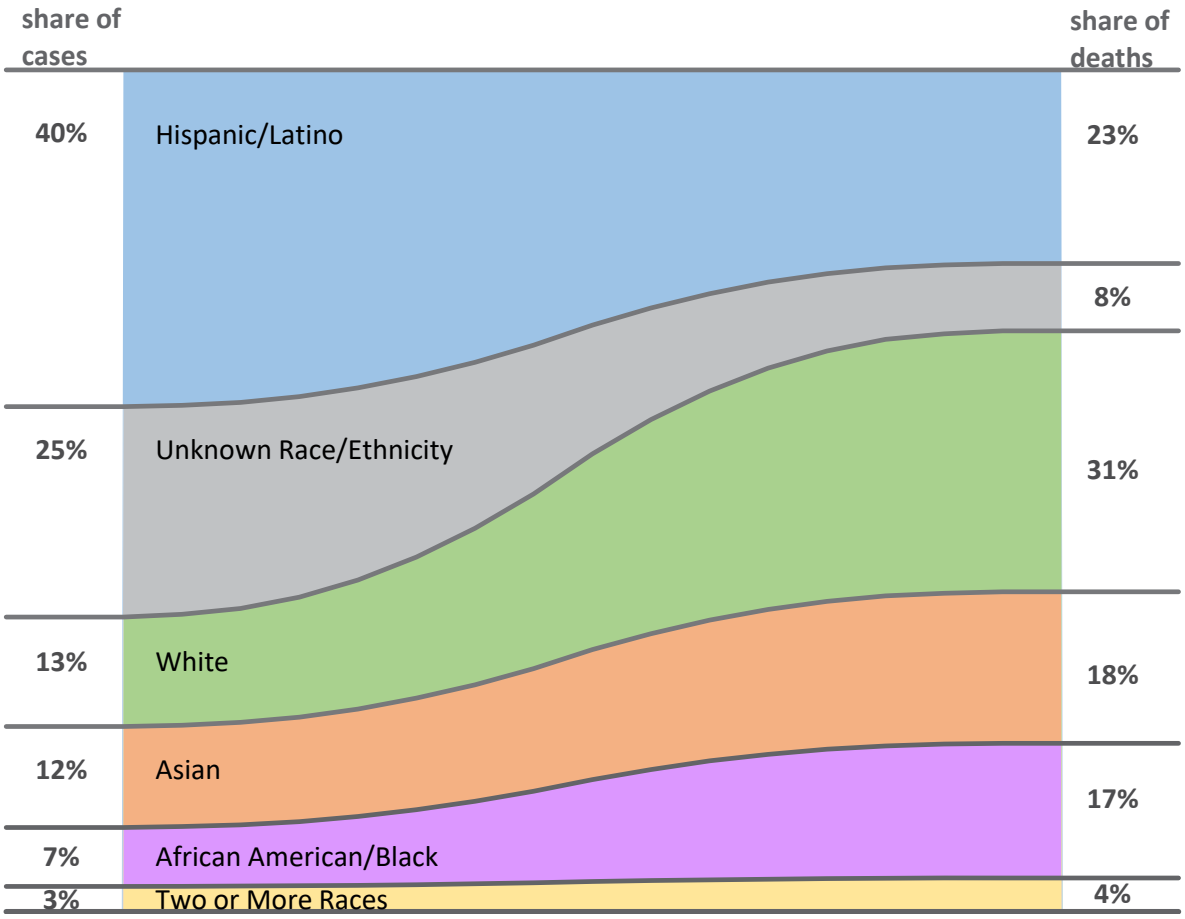
Source: San Francisco Chronicle Coronavirus Tracker, https://www.sfchronicle.com/projects/coronavirus-map/#about-data; Updated: 1/28/2021

Residents of Alameda County are disproportionately affected by the virus. **Figure 7** shows the cases and deaths by race and ethnicity. The group with the most cases by far is Hispanics/Latinos which make up 40% of the confirmed cases and followed by those of Unknown Race/Ethnicity with 25% of

[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.

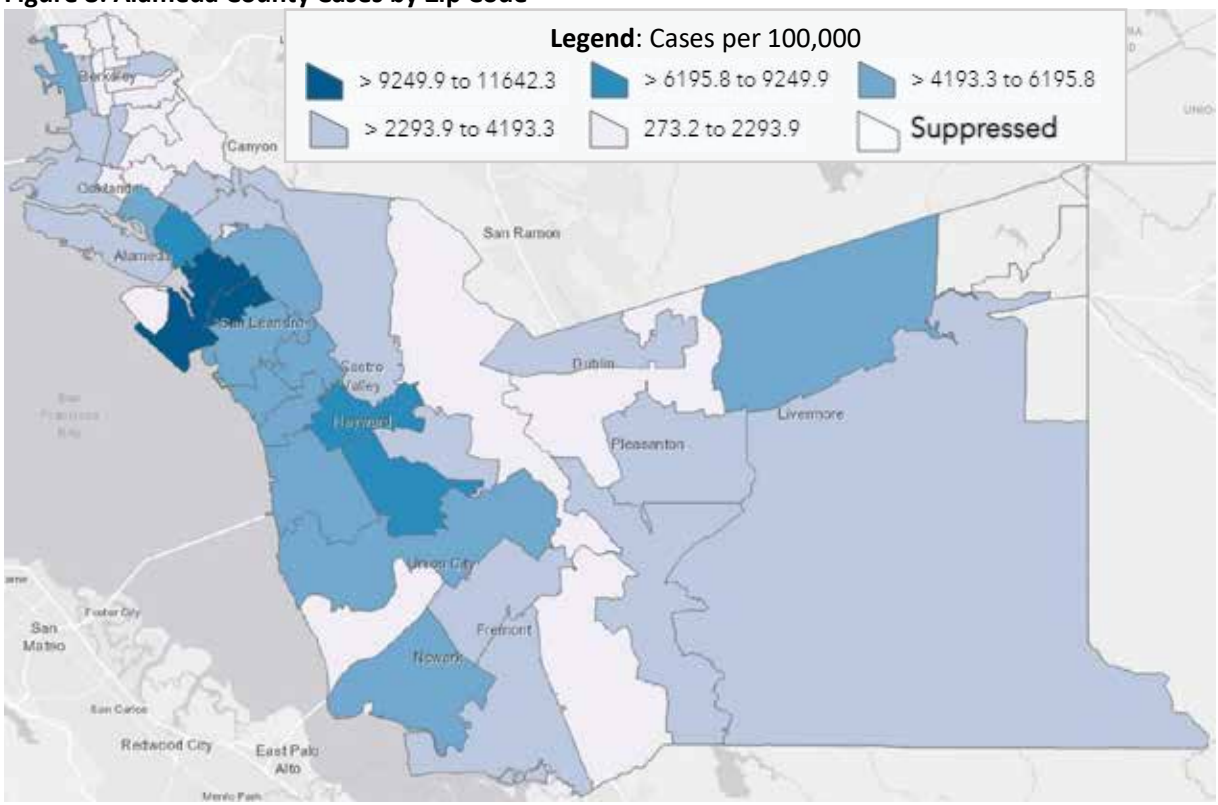
cases. In the unlikely scenario that all the cases that have Unknown Race/Ethnicity were some other race/ethnicity than Hispanic/Latino they would still have the highest burden of COVID-19 cases in Alameda County. The group most affected by deaths is Whites with 31% followed by Hispanics/ Latinos with 23%. White people could be dying at a higher rate because they tend to be older on average than Hispanics/Latinos. **Figure 8** 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.

Figure 7: Alameda County Cases and Deaths by Race/Ethnicity



Source: Alameda County Department of Public Health's COVID-19 website; https://covid-19.acgov.org/data; Retrieved: 1/28/2021

Figure 8: Alameda County Cases by Zip Code



MHSA Community Program Planning Process (CPPP)

MHSA Community Program Planning Process And Stakeholder Engagement

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

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

Community Program Planning Process Steering Committee

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

Table 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 focus groups, conducted virtual site visits, provided input on program implementation, and made recommendations for quality improvement.

Table 11: MHSA-SG Demographics, FY19/20

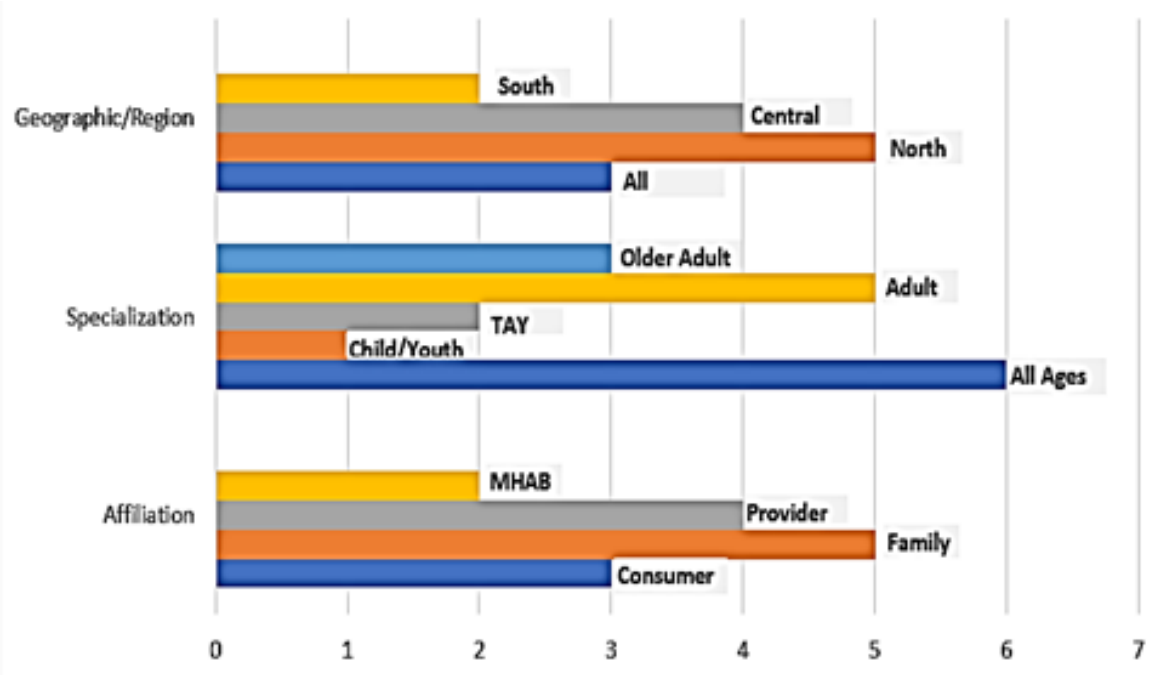


Table 12: MHSA Stakeholder Group Membership and Participating ACBH Leadership

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
Danielle Vosburg	Provider	Administrator, Telecare Corporation
James Wagner	ACBH	Deputy Behavioral Health Director
Mark Walker	Provider	Associate Director of East Bay Programs, Swords to Plowshares
Shawn Walker-Smith	Family Member	Business Owner
Javarre Wilson	ACBH - Agency Leadership	Ethnic Services Manager

FY20/23 Three-Year Plan Community Input Process

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

The MHSA community input process for the Three-Year Plan was conducted from April 27, 2020 – May 31, 2020. ACBH conducted outreach to providers, consumers, family members and residents of Alameda County. For outreach, ACBH collaborated with the MHSA CPPP-SC consisting of community-based providers, consumers, family members, and ACBH leadership. The MHSA CPPP-SC collaborated with community-based agency Health & Human Resource Education Center (HHREC), and Alameda County's consumer empowerment group, Pool of Consumer Champions (POCC). More than 14,069

MHSA Community Input Meeting invitations were distributed by mail, listservs, or email to stakeholders, providers, consumers, family members, and other community members.

FY21/22 Annual Plan Community Input Process

The MHSA Steering Committee and MHSA-SG coordinated a smaller CPPP for the Annual Plan Update. The MHSA community input process was conducted from February 19, 2021 – March 16, 2021. During the process, MHSA staff provided programmatic updates and information on current MHSA programs. Community members participated in 5 focus groups to provide input 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, and 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 2021 - 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**)

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 key implementation challenges:

- **Administrative barriers:**
    - Communication delays: Public information offices prioritized COVID-19 safety messages and/or participation in emergency response activities.
    - Lack of state guidance related to the MHSA planning process.
    - Resources: Many government agencies, government affiliates, and community providers reported staff shortages related to emergency response deployment, COVID-19 time-off, or noticed a decrease in responsivity.
- **Resource Disparities**
    - A remote/online process required emotional and social resources to know about the information or be affiliated with MHSA service providers.

  - Capacity Building: remote learning requires knowledge and illuminated the need for capacity building.
  - Digital Divide: POCC members reported some consumers lacked the technological capacity or resources to complete online surveys, or used flip phones to collect survey responses.
- **Community Stress**: Requests to prioritize/participate in community planning efforts may not have been client-centered, addressed the immediate needs of the community during a COVID-19 crisis, and could increase stress.

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

- **MHSA Staff Support**: The MHSA CPPP-SC highlighted the importance of the MHSA Sr. Planner/MHSA CPPP-SC chair who remained flexible with diverse members and opinions, identified roles & responsibilities, established boundaries, encouraged engagement, championed and increased visibility of efforts, and reduced duplication of efforts.
- **Macro-level Outreach:** The CPPP outreach strategies expanded to included macro-level strategies such as utilizing paid ads on social media platforms; leveraging online ethnic-oriented news outlets (e.g. Bay Area Reporter), posting PSAs on traditional media outlets (KRON, KPIX, KTVU, Tri Valley Paper, Post News group, East Bay Times, Alameda Contra Costa Medical Association newsletters), and utilizing social justice public relations firms to distribute information to thousands of Alameda County residents.
- **Stakeholder Engagement:** The MHSA CPPP-SC leveraged the expertise and knowledge of established and engaged MHSA funded programs, services and stakeholder groups to coordinate planning and outreach strategies.
- P**ool of Consumer Champions 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)

Figure 9: MHSA Community Input Website (at https://acmhsa.org/community-input**):** CPPP & 30-Day Public Comment Outreach Period: February 19, 2021 – May 19,2021

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 E-Flyer/Palm Card (see **Appendix B-2)**

ALAMEDA COUNTY BEHAVIORAL HEALTH SERVICES INVITES YOU TO:

- **Contribute** ideas about how to improve the County's mental health services between 4/15/21 – 5/19/21
- **Share** information about the Mental Health Services Act.

Thu April 8	**Podcast***	COVID-19 Vaccine: Impact on African American's mental health
Thu April 22	**Podcast***	How to effectively navigate Telehealth online platforms
Mon April 26 2-3:30pm	**Webinar**	**"How to Read the MHSA Plan"** Please join the webinar from your computer, tablet, or smart device: https://global.gotomeeting.com/join/412991397 You can also dial in using your phone: United States (Toll Free): 1 (877) 309-2073 Access Code: 412991397#
Thu May 13	**Podcast***	MHSA Plan & Community Input for the upcoming May 17th Public Hearing
Mon May 17 5pm	**Public Hearing**	Mental Health Advisory Board - Public Hearing
Thu May 27	**Podcast***	The Telehealth new "normal" and how it Impacts our youth

*View this podcast at: acmhsa.org

RSVPS encouraged, but not required.
Learn more about MHSA podcasts and events, read the MHSA plans, and provide public comment at http://acmhsa.org

alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

HHREC
HEALTH & HUMAN RESOURCE EDUCATION CENTER

MHSA Community Input Focus Groups

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

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

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

Table 13: MHSA Community Input Focus Groups (Please see **Appendix B-3** for complete list of focus group recommendations)

MHSA Focus Group	Description / # Participants	Recommendations
Alameda County Behavioral Health Care Services Department (ACBH)	Group consisted of senior executives and the finance division held on 2/10/21, 8 participants	ISSUES: 0 RECOMMENDATIONS: 6
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 2/26/21, 11 participants	ISSUES: 9 RECOMMENDATIONS: 14
PEERS Wellness, Recovery Action Plan (WRAP ®)	PEERS' WRAP is an evidence-based practice focusing on self-empowerment and wholeness, and offers orientations, workshops, & training. The group consisted of Spanish speaking participants, held on 2/19/21 with 9 participants.	ISSUES: 27 RECOMMENDATIONS: 12

Law Enforcement Mental Health Units: Crisis Intervention Team (CIT), Mobile Evaluation Team (MET), & MHSA Community Assessment and Transport Team (CATT)	Law enforcement mental health units and/or embedded emergency response programs including crisis intervention teams (CIT), mobile evaluation team (MET), MHSA Community assessment treatment team (CATT). Held on 3/10/21, 9 participants	ISSUES: 28 RECOMMENDATIONS: 19
African American Veterans with Swords to Plowshares & African American Family Outreach Project	African American and faith-based community members held on 3/10/21 with 5 attendees.	The group had less than 6 participants attend and was rescheduled.
Ohlone College Ambassadors Program- Transition Aged Youth (TAY)	Target membership reflects college students ages 18-24, (including those involved in the WET ambassador programs) and other TAY from community-based programs. Held on 3/16/21 with 8 participants.	ISSUES: 27 RECOMMENDATIONS: 9
Veterans	Target membership are veterans receiving services through the Alameda County Superior Court, Veterans Court– specific emphasis on black, indigenous and people of color (BIPOC). Will be held in May 2021.	ISSUES: TBD RECOMMENDATIONS: TBD
5 Completed Focus Groups	**Total number participants: 45**	

Local Review Process

The initial Approved of the FY 21/22 Plan Update was developed by the ACBH MHSA Division and Finance Unit. It was approved by the ACBH Executive Leadership, planning staff and fiscal staff in consultation with the ACBH MHSA Stakeholder Group. ACBH posted the Approved Plan Update on two websites: http://www.acbhcs.org/mhsa-doc-center/and https://acmhsa.org/reports-data/#mhsa-plans on April 15, 2021 for thirty (30) days for public comments. Announcements about the draft Plan being posted for the thirty day public comment period were circulated throughout ACBH multiple times and listed in the Alameda County Health Care Services Agency newsletter on April 15, 2021. Additionally, targeted emails were conducted to various Stakeholder Groups (Mental Health Advisory Board, Alameda County Consortium of Mental Health providers, Alameda County MHSA Stakeholder Group, etc.) to increase awareness and outreach regarding the draft Plan Update.

The Mental Health Board hosted a public hearing on Monday May 17, 2021. Public comments received and response from ACBH are listed in the Appendix F.

FY 20/23 MHSA Community Input Survey Results

During the Three-Year Plan community input period of April 27, 2020 – May 31, 2020, community members were asked to complete a 23-question survey that was hosted on SurveyMonkey and linked to the MHSA website. The survey was available in English, Chinese, Spanish, Farsi, Korean, Tagalog, and Vietnamese, seven of Alameda County's threshold languages. A total of 627 unduplicated surveys were completed, while the survey was translated into 6 non-English languages over 90% of the surveys were English (**Table 14**). The following sections detail the demographics of survey participants and the results of the survey.

Table 14: Number of Survey Respondents by Survey Language

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

Demographics

Survey participants were mostly adults aged 26-59 (68.58%), older adults 60 and over (24.08%), and Female (69.38%) (**Figures 11 and 12**). Compared to the general Alameda County population these three groups are overrepresented among the survey participants (**Figure 1**).

Figure 11: Participant's Age Groups (n=627)

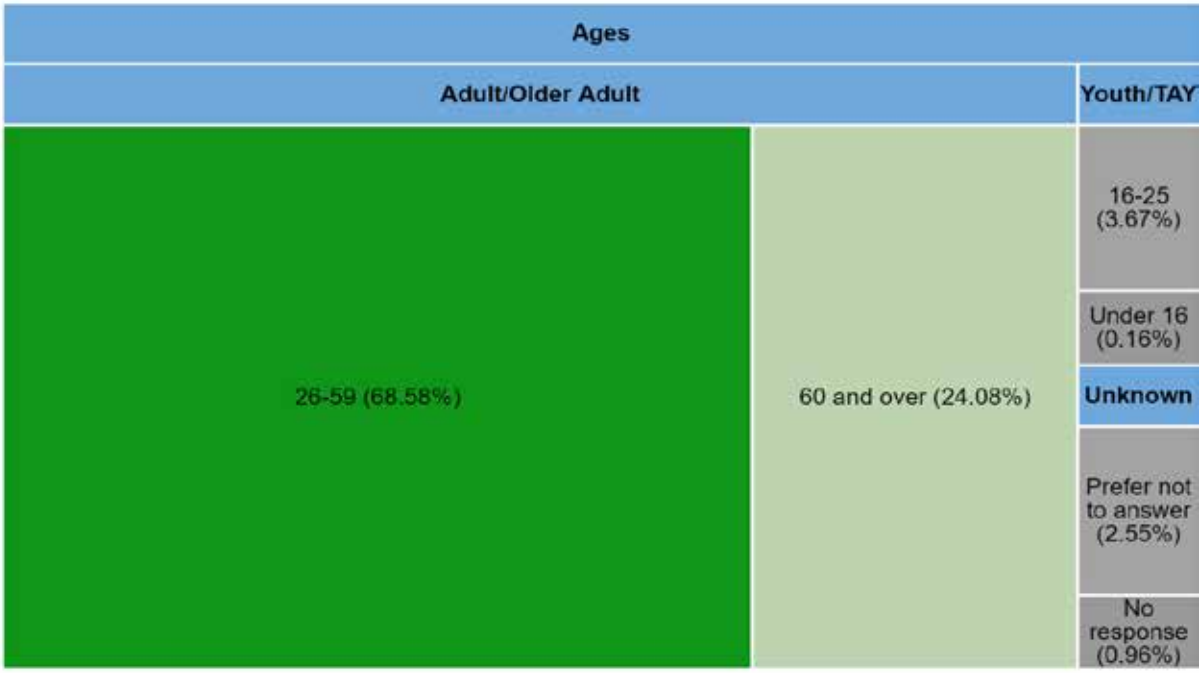
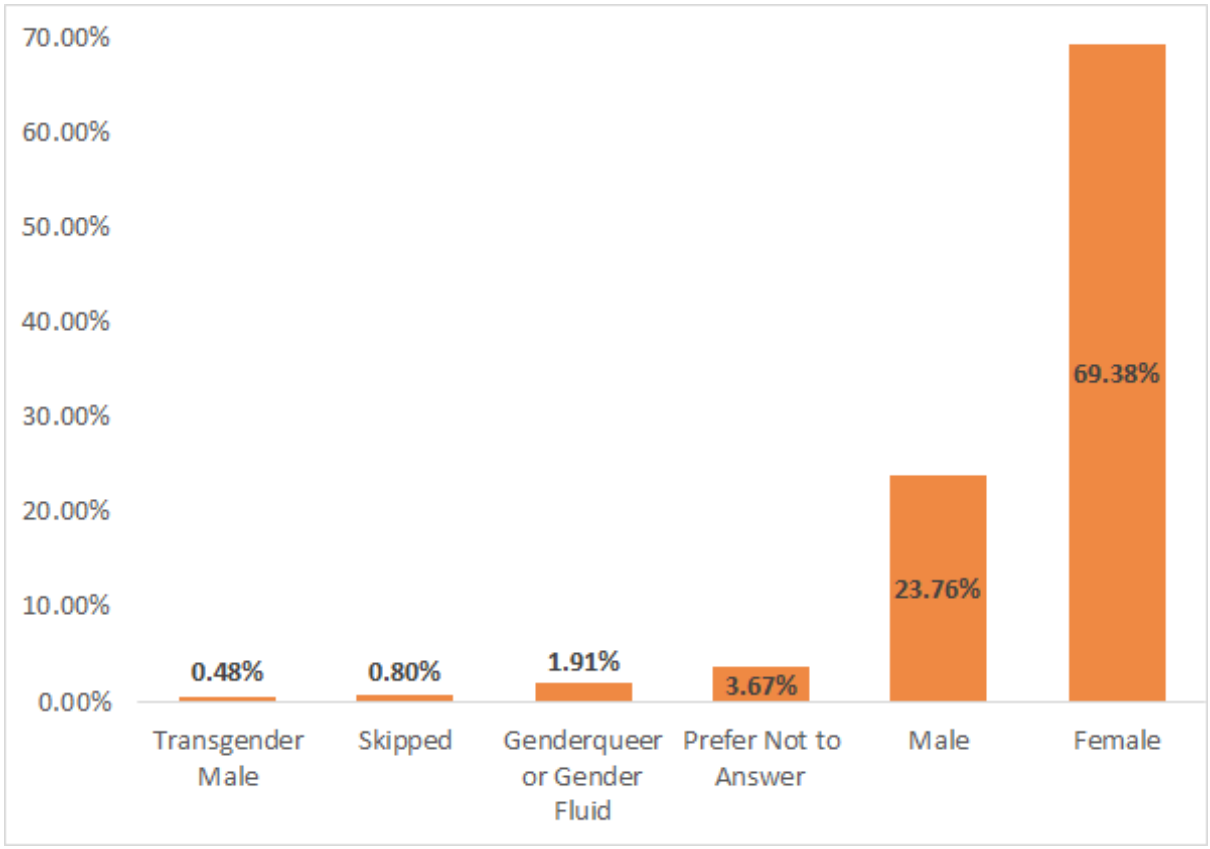


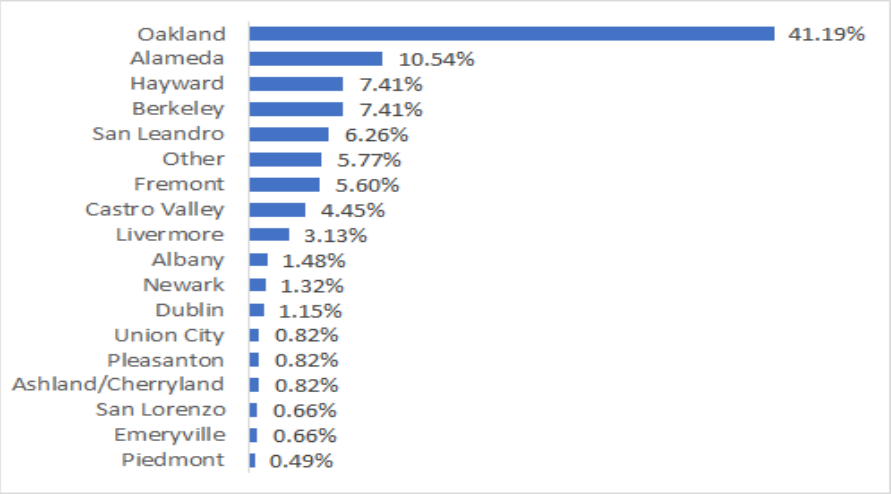
Figure 12: Participant's Gender Identity (n=627)



*No Transgender Female participants.

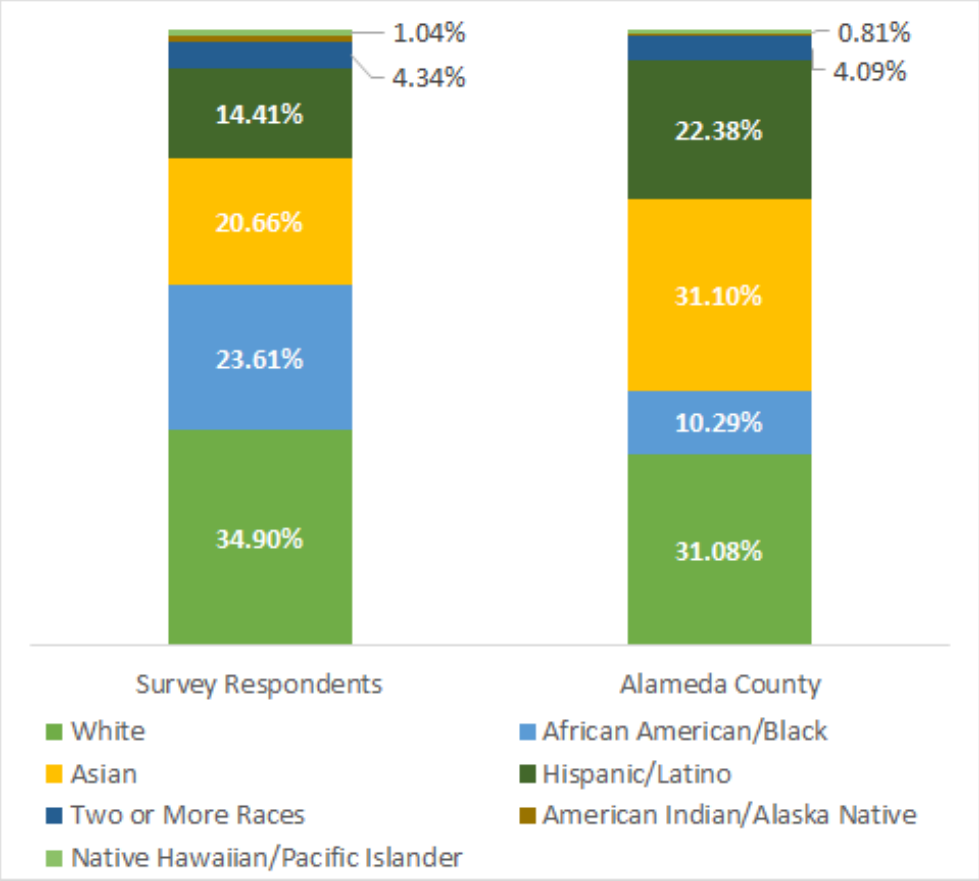
Outreach was conducted throughout the county and compared to the previous MHSA Community Program Planning Process there was an increase in resident representation throughout the county. Oakland is 26.04% of the county's population, however 41.19% of the survey participants reported living in Oakland.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

Figure 13: Participant's City of Residence (n=607



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

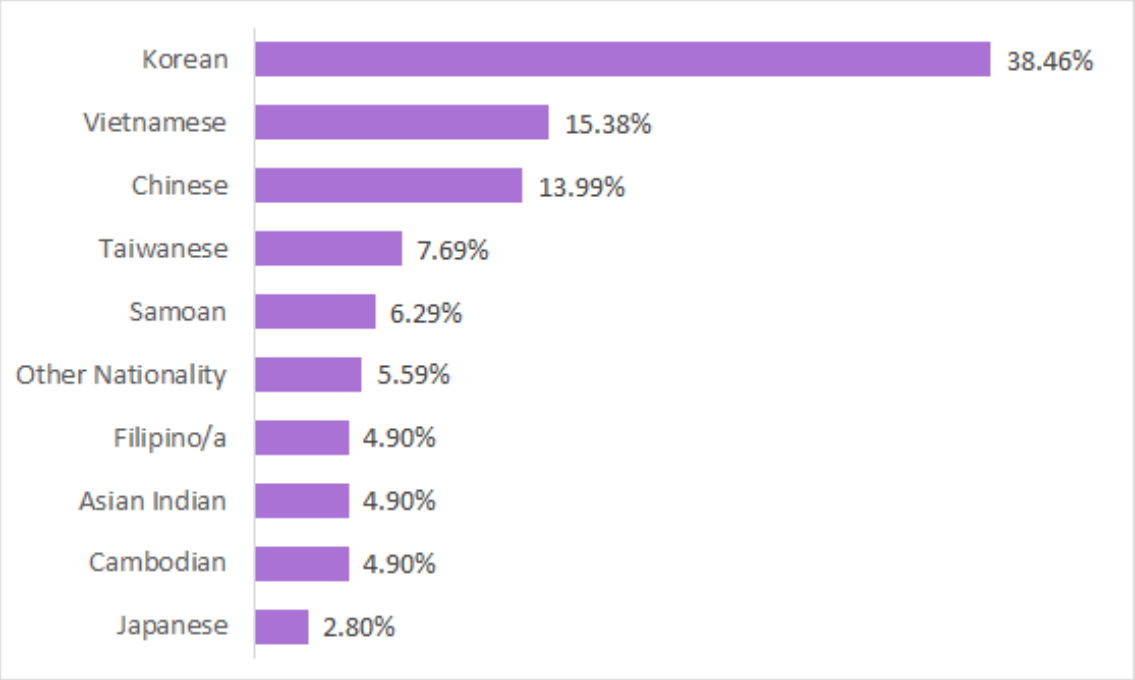
Figure 14: Race and Ethnicity Survey Respondents (n=579) and Alameda County



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

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

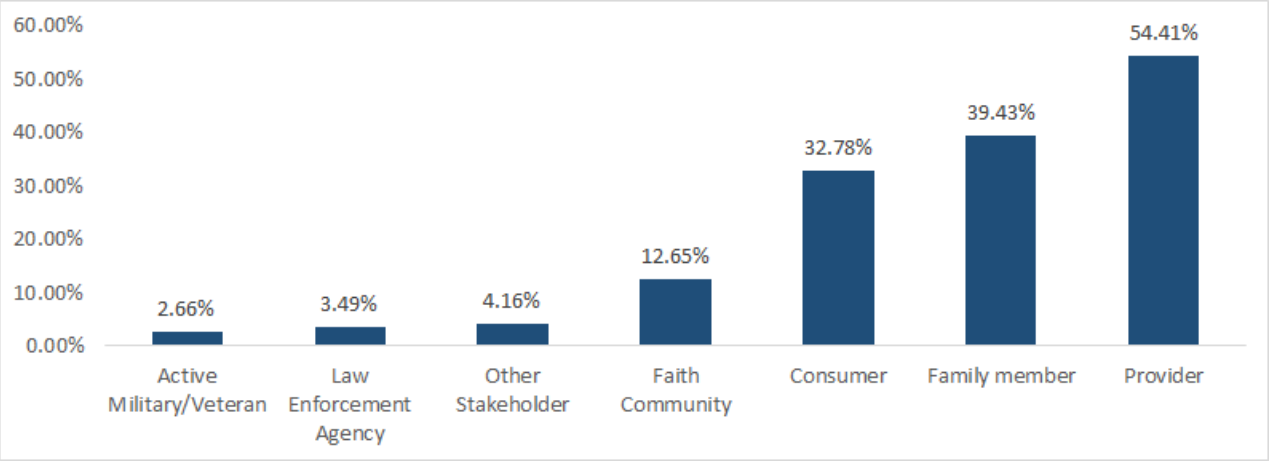
Figure 15: Participant's Nationality or Country of Origin (N= 144)



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

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

Figure 16: Participant's Stakeholder Group (n= 601)



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

ACBH offers a variety of services to residents of Alameda County. Most participants of the survey are not currently receiving services (n= 449) or skipped the question (n= 18). Of the 160 participants that recorded that they were currently receiving services 78.13% were receiving mental health services, 31.88% were in a community group, 8.75% were receiving vocational rehabilitation, 5.00% were receiving homeless services, and finally, 3.13% were receiving alcohol and other drug services. Participants were allowed to choose more than one service.

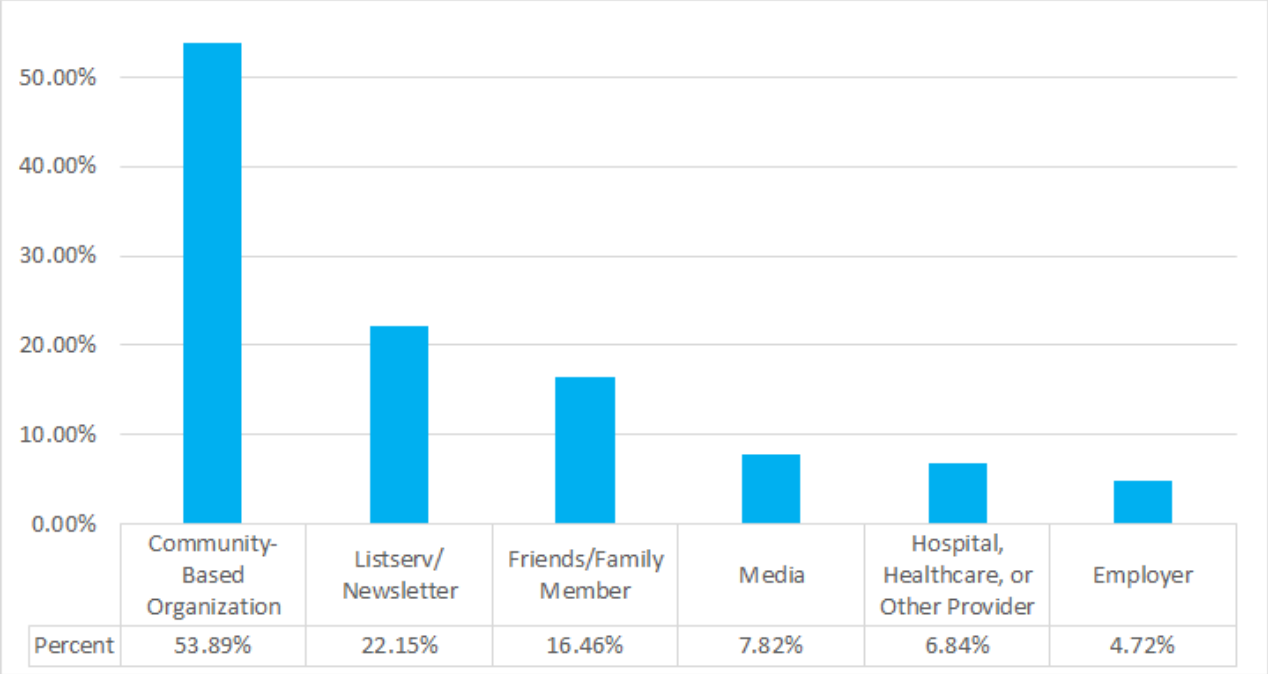
Table 15: Services Received by Participants (n= 160)

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

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

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

Figure 17: Learn about Community Participation and Feedback Survey (n=614)



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

Table 16: First Time Participating in MHSA Community Program Planning Process (n= 627)

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

MHSA Survey Results

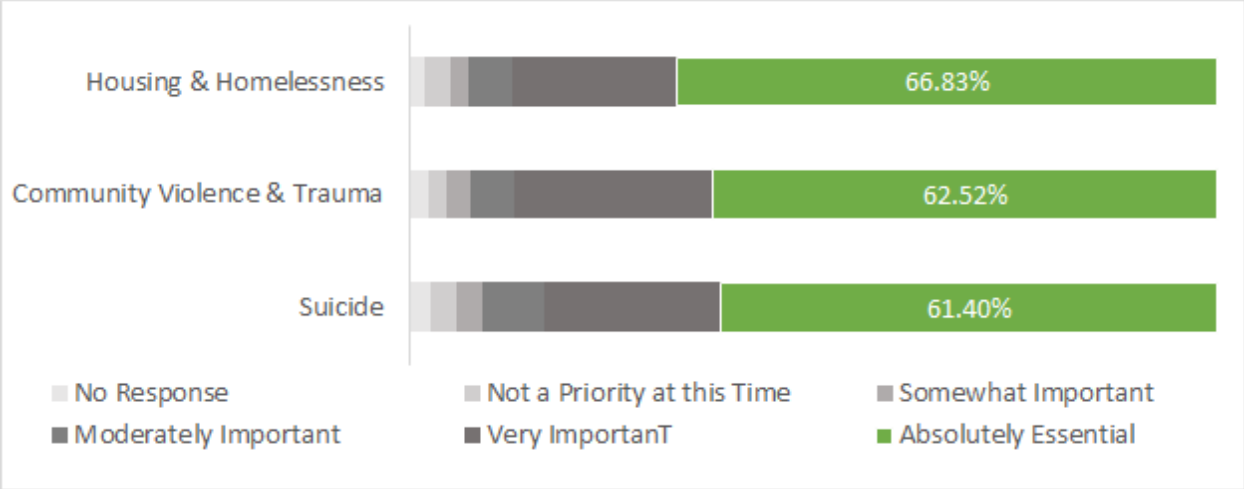
The following are the results of the MHSA Survey provided by 627 unduplicated individuals living and/or working in Alameda County. In response to the community input, ACBH has provided information on current programs and focus group recommendations that address each of the top identified needs.

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

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

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

Figure 18: Top Three Concerns Related to Children/Youth/Transitional Age Youth (n=627)



Analysis of Children/Youth/TAY Concerns

Table 17: Available Programs and Focus Group Recommendations for Children/Youth/TAY

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

Concern 1: Housing & Homelessness

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

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

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

Current Programs

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

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

Focus Group Recommendations

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

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

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

Concern 2: Community Violence & Trauma

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

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

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

Current Programs

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

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

Focus Group Recommendations

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

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

Concern 3: Suicide

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

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

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

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

Current Programs

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

Focus Group Recommendations

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

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

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

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

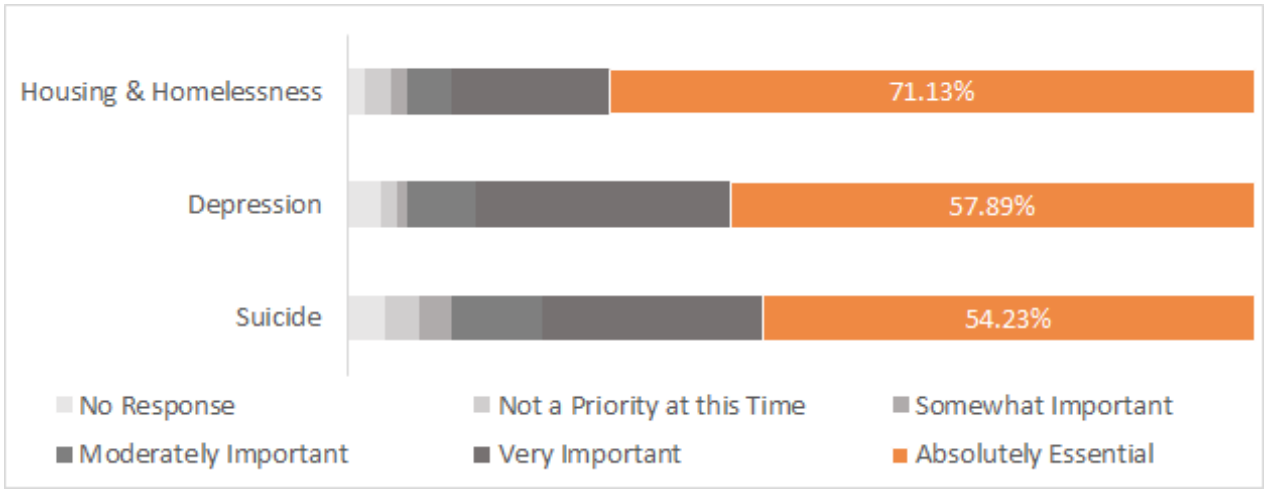
"... Diversion programs/location for youth experiencing mental health crisis and appropriate training for law enforcement" - ACBH Operations Expanded Leadership Focus Group participant

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

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

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

Figure 19: Top Three Concerns Related to Adults/Older Adults (n=627)



Analysis of Adults and Older Adults

Table 18: Available Programs and Focus Group Recommendations for Adults/Older Adults

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

Concern 1: Housing & Homelessness

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

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

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

Current Programs

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

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

Focus Group Recommendations

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

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

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

> "... MHSA spending needs to focus on the seriously mentally ill--people who cannot lobby or petition or agitate for their own treatment. The most important thing MHSA money can do under current restrictions is build more board-and-cares. If the most seriously ill are not to be

hospitalized, they need to be in the best possible housing specifically for them" - MHAB Criminal Justice Committee Focus Group participant

Concern 2: Depression

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

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

"Help for vocational training and depression in life."

Current Programs

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

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

Focus Group Recommendations

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

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

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

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

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

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

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

Concern 3: Suicide

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

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

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

Current Programs

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

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

Focus Group Recommendations

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

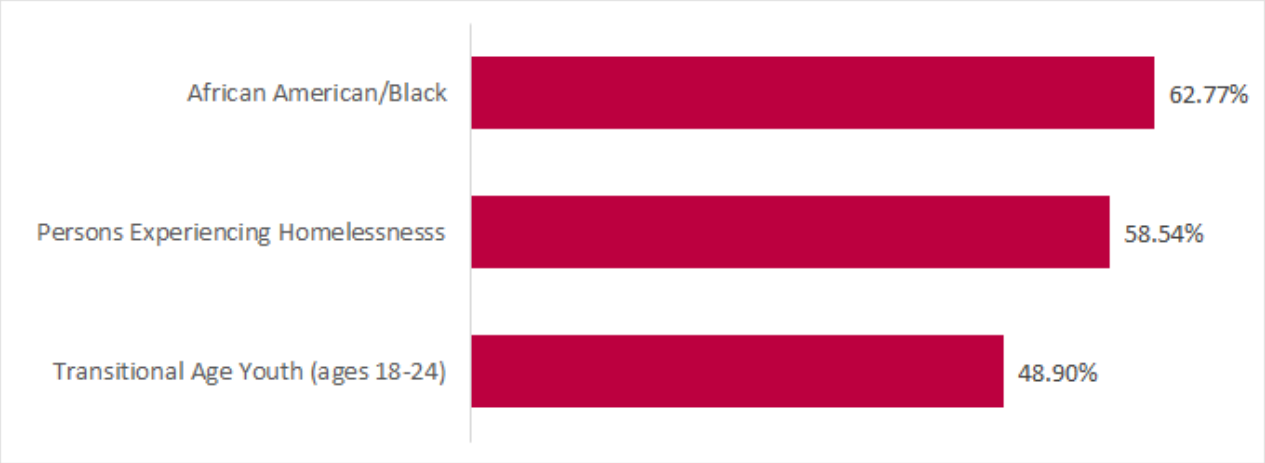
Survey Question #4 and #5: Unserved & Underserved Populations

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

[2] Hedegaard H, Curtin SC, Warner M. Suicide rates in the United States continue to increase. NCHS Data Brief, no 309. Hyattsville, MD: National Center for Health Statistics. 2018.
[3] Hedegaard H, Curtin SC, Warner M. Suicide rates in the United States continue to increase. NCHS Data Brief, no 309. Hyattsville, MD: National Center for Health Statistics. 2018.

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

Figure 20: Top Three Populations or Groups not Adequately Served by System (n=591)



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

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

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

Table 19: Available Programs and Focus Group Recommendations for Underserved Populations

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

**Identified by free response in question 5.*

Underserved Population 1: African American/Black

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

Current Programs

Programs funded through the CSS component to serve or increase the quality of service to the African American/Black community include Pathways to Wellness's trainings to providers on the complexity of trauma in the community and accurate diagnosis, African American Wellness Hub Complex Planning Phase, and ROOTS's AfiyaCare. Culturally responsive PEI programs that serve the African American community include:

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

Focus Group Recommendations

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

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

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

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

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

Underserved Population 2: Persons Experiencing Homelessness

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

Current Programs

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

Focus Group Recommendations

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

Underserved Population 3: TAY, ages 18-24

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

Current Programs

See information about TAY services under question 2 above.

Focus Group Recommendations

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

Underserved Population 4: Older Adults

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

Current Programs

See information about Older Adult services under questions 3 above.

Focus Group Recommendations

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

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

Underserved Population: Emerging Populations

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

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

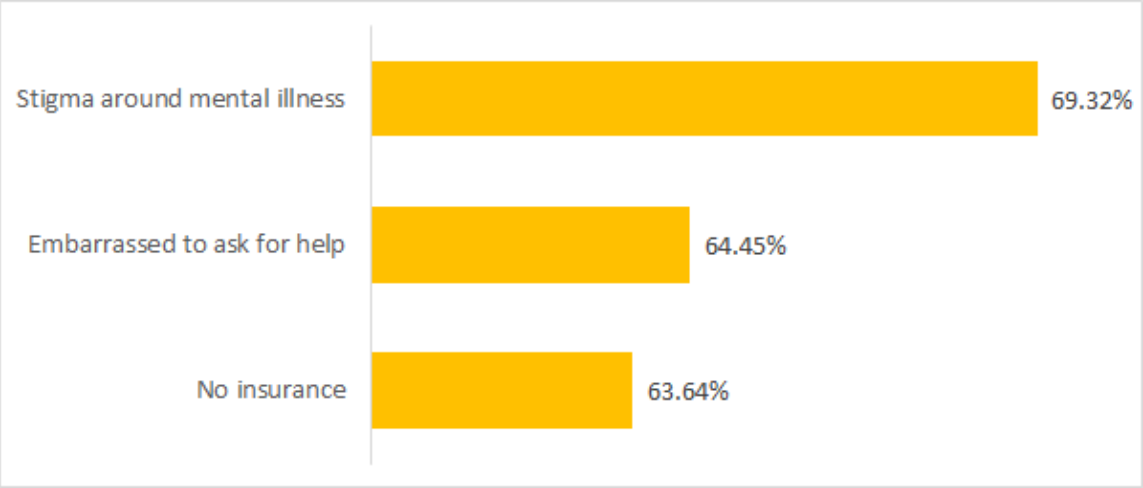
ACBH will continue to monitor these emerging populations and evaluate their needs further.

Survey Question #6: Barriers towards Accessing Mental Health Services

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

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

Figure 21: Top Three Barriers to Accessing Mental Health Services (n=616)



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

Table 20: MHSA Programs to Address Barriers to Mental Health Services

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

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

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

Current Programs

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

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

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

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

Focus Group Recommendations

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

Barriers 3: No Insurance

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

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

Barriers: Emerging Populations

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

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

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

Survey Question #7. Effectiveness of MHSA Services

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

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

Figure 22: Top Three Most Effective MHSA Service Areas (n= 584)

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

Below are some selective responses from the focus group:

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

Survey Question #8. Innovative Services (see **INN Component Summary, Table 27** for innovative priorities**)**

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

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

Table 21: Top Three Innovative Ideas

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

POCC and CAMPHRO Innovation Webinar

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

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

- "2connect 2": Laptop, Internet & Peer Trainer: Polling Vote: 78%
- Peer respite for new target population (for INN eligibility): Polling Vote: 47%

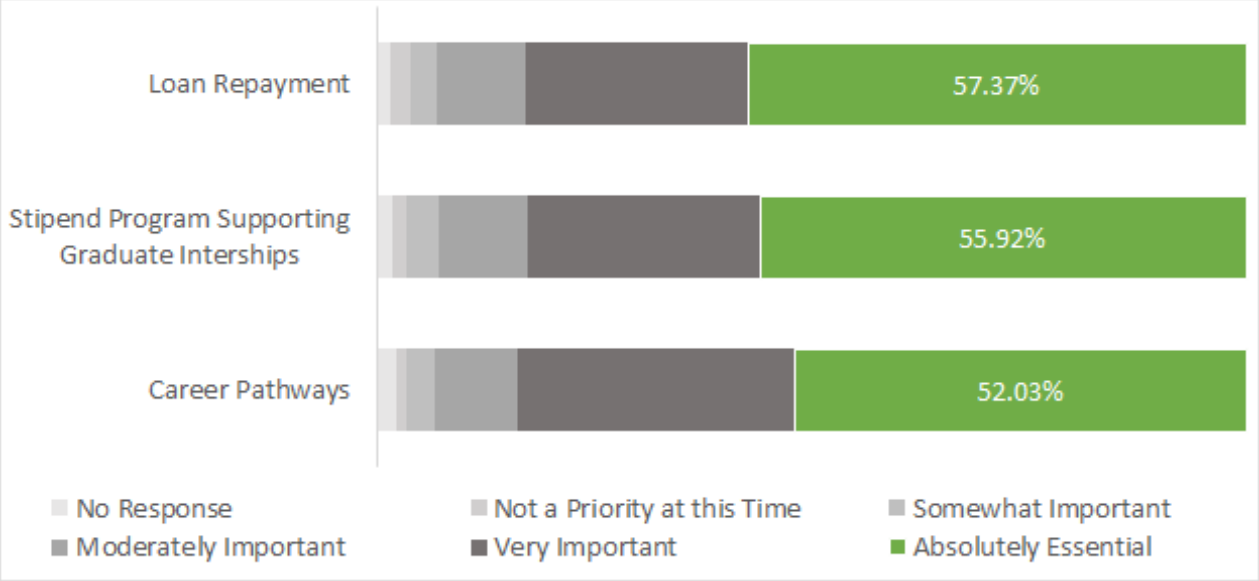
- Virtual live events online with mental health speakers: Polling Vote: 26%

Survey Question #9. Workforce, Education & Training Activities – Priorities

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

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

Figure 23: Top Three Absolutely Essential WET Activities (n= 617)



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

Table 23: MHSA WET Activities Available Programs and Future Opportunities

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

Financial Incentive Program

The Workforce, Education and Training (WET) Unit offers financial incentives to increase local workforce diversity. Financial Incentives are offered to individuals employed in ACBH, graduate interns placed in ACBH, and contracted community-based organizations who are linguistically and or culturally able to

serve the underserved and unserved populations of the County. During FY 18/19 WET launched the seventh cycle of the Graduate Stipend Program, awarding twenty stipends of $6,000 each for 720 internship hours. Seventy percent of awardees represented the diverse communities of Alameda County.

Career Pathways Pipeline Programs

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

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

FY 20/23 MHSA 30-Day Public Comment Results

The 30-day public comment period for the FY2020/23 MHSA Three-Year Plan commenced August 21, 2020 – September 21, 2020. Out of 227 public responses, 223 were unduplicated. Public Comments fell into six broad categories: *(1) funding/sustainability, (2) quality improvement and assurance, (3) innovative ideas/future project proposals, (4) public comment submitted in error, (5) validation/consensus for plan content, and (6) CPPP/Outreach.* The top six public comments comprised 90.58% of total responses and addressed categories one through three.

Table 24: MHSA Public Comment Summary (F20/23 MHSA Three-Year Plan CPPP)

Top 6 Public Comment	**Number Submissions**	**% Total Unduplicated Submissions (n=223)**	**Available in MHSA Annual Plan, FY21/22** (Programs in planning implementation phases)
1. Prop 47/Mental Health Treatment Teams/Re-entry	175	78.47	
2. Mental Health Collaborative Courts-Telecare (see **Plan Update & Changes** section)	10	4.48	X
3. African Immigrants/African-American Innovation grants (see **Plan Update & Changes** section)	6	2.97	X
4. PEI UELP 5: Outreach, Education & Consultation-Latinx Community	5	2.24	
5. Zero Out Incarceration of Mentally Ill	3	1.34	
6. Increase Oversight & Accountability of Contractors (see **Performance Management Initiatives** section)	3	1.34	X

The County is currently evaluating public input presented during the FY20/23 MHSA Three-Year Plan CPPP and 30-day public comment period. These discussions have been narrowed to a number of possible new projects and are broadly represented in the Plan Update and Changes section of this annual plan update. Alameda County looks forward to working collaboratively with the community to uncover additional recommendations to further strengthen and enhance the mental health system of care.

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 20/21, CSS component funds 12 Full Service Partnerships (FSP) programs and 43 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 19/20 AGGREGATED FSP DEMOGRAPHICS & PERFORMANCE INDICATORS

FY 19/20 FSP Demographic Data[1]

During FY 19/20 1,076 individuals were served in one of ACBH's FSP programs. Below is demographic information on these partners.

RACE/ETHNICITY

Fiscal Year	Ethnic Group	Clients	% of Clients
FY 2019-2020	Alaska Native or American Indian	3	0%
	Asian	39	4%
	Black or African American	361	34%
	Hispanic or Latino	74	7%
	Other/Unknown	393	37%
	Pacific Islander	2	0%
	White	204	19%
		1,076	100%

GENDER

Fiscal Year	Sex	Clients	% of Clients
FY 2019-2020	Female	370	34%
	Male	706	66%
		1,076	100%

PRIMARY LANGUAGE

Fiscal Year	Language Group	Clients	% of Clients
FY 2019-2020	Arabic	1	<1%
	Chinese	5	<1%
	English	1,005	93%
	Other	41	4%
	Spanish	21	2%
	Tagalog	1	<1%
	Vietnamese	2	<1%
		1,076	100%

AGE

Age	Clients	% of Clients
0-8 yrs.	27	
9-18 yrs.	59	
18-24 yrs.	122	
25-59 yrs.	668	
59+ yrs.	200	
	1,076	**100%**

COUNTY REGION CLIENTS RESIDE IN

Fiscal Year	Region	Clients	% of Clients
FY 2019-2020	1. North	560	52%
	2. Central	383	36%
	3. South	54	5%
	4. East	32	3%
	5. Out of County	47	4%
		1,076	100%

FY 19/20 FSP Performance Indicators

FSP providers are continually working with ACBH to develop and/or refine performance indicators in order to document and highlight the impact of FSP services. Additional metrics regarding reductions in incarceration, increases in stable housing, employment/education have been developed and will be shared in the upcoming FY 20/21 FSP Annual Outcome Report, which when available will be posted on the www.ACMHSA.org website.

Below are a number of indicators ACBH is tracking for the FSP partners. This is data from FY 19/20.

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

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

Eligible Episodes	Episodes with Reduction	% with Reduction
288	252	88%

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
695	279	40%

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

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

Hospital/Crisis Episodes	Follow-Up in 5 Days	Success Rate
804	574	71%

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

Clients with Episode(s)	Clients with Average of 4+ Visits Per Month	Success Rate (%)
836	594	71%

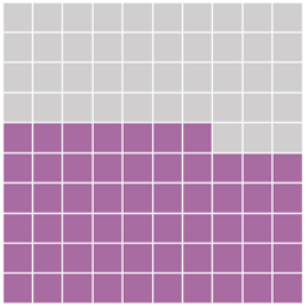
5. No Gaps in Service over 30 days: The percent of FSP partners who did not have a service gap of over 30 days during the fiscal year. To qualify for this metric FSP partners needed to be open for at least three months during the fiscal year.

Clients	Clients with No Gap Over 30 Days	% No Gap Over 30 Days
35	23	66%

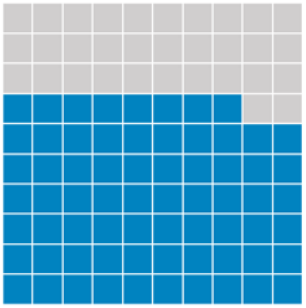
6. Incarceration: The percent of active FSP episodes that were open during FY 19/20 compared to the number of incarcerations from the year before enrollment to after one year enrolled in an FSP. The number of eligible episodes for each age group is: Older adults (n=16); Adults (n=136); and TAY (n=28).

More than half of all age groups served during FY 19/20 had a *decrease* in the number of incarcerations.

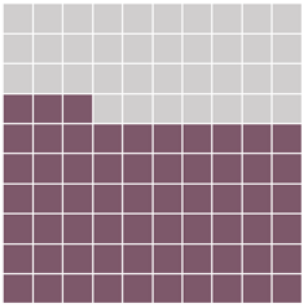
57% of open **TAY** episodes had a decrease in the number of incarcerations.



68% of open **Adult** episodes had a decrease in the number of incarcerations.



63% of open **Older Adult** episodes had a decrease in the number of incarcerations.

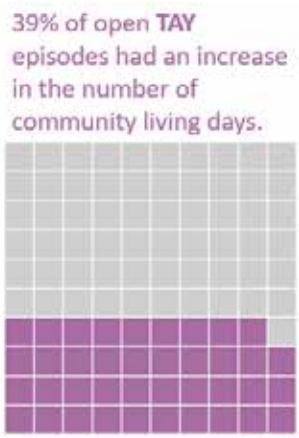


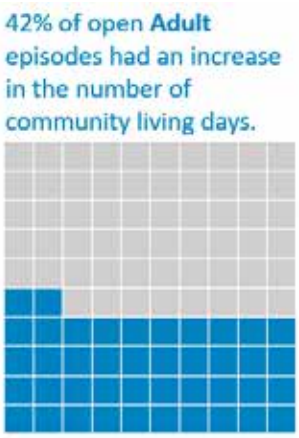
7. Housing: The percent of active FSP episodes that were open during FY 19/20 compared to the number of episodes that had an increase in community living days from the year before enrollment to after one year enrolled in an FSP. The number of eligible episodes for each age group is: Older adults (n=99); Adults (n=273); and TAY (n=74).

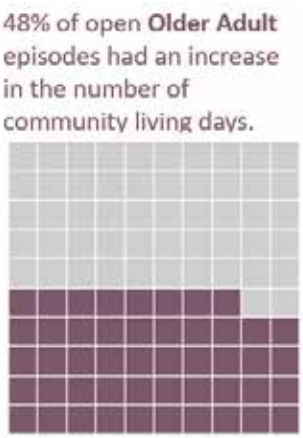
Housing Types Considered "Community Living": - In an apartment or house - With one or both biological parents - With adult family member - Assisted Living Facility - Unlicensed but supervised individual placement - Unlicensed but supervised congregate housing - Unlicensed but supervised congregate placement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

Not community living – homeless [Emergency Shelter / Temporary Housing (includes people living with friends but paying no rent) - Homeless (includes people living in their cars)]; institutional [- Acute Medical Hospital - Acute Psychiatric Hospital / Psychiatric Health Facility (PHF) - Jail - Licensed Residential Treatment (includes crisis, short-term, long-term, substance abuse, dual diagnosis residential programs) - Long-Term Institutional Care (IMD, MHRC) - Skilled Nursing Facility (physical) - Skilled Nursing Facility (psychiatric) - State Psychiatric Hospital]; and Other/Unknown Settings [- "Other" - "Unknown" - Missing data]

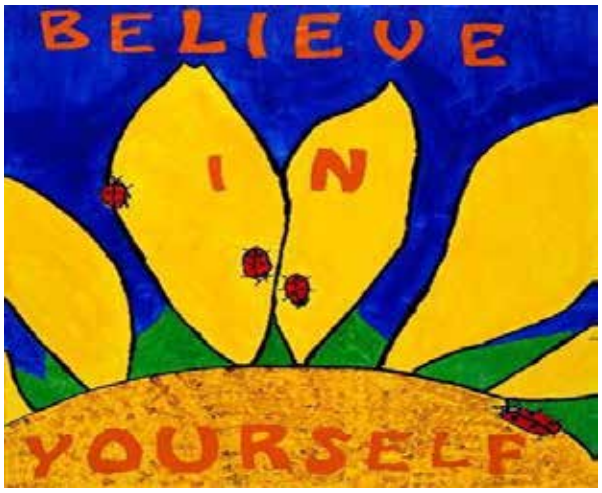
More than a third of all age groups served during FY 19/20 had an *increase* in the number of community living days.







Client Vignette (Success Story)



The Assisted Outpatient team (AOT) is run by the Telecare Corporation. This is one of their success stories of an AOT client.

When "Daniel" was first introduced to the AOT team, he was receiving treatment at John George Acute Psychiatric facility. He was dirty, disheveled, experiencing psychosis and had paranoid and delusional thoughts. He was admitted to JGP after one of his delusions led to a physical altercation with a family member. He was not adherent to medications and spent his days wandering through his parents' home.

This is in stark contrast to the Daniel we know today. He is currently adherent to all his medications and appointments. He engages with the AOT team 3 times a week and is receptive to increasing social interaction by taking walks with the AOT team. Daniel has been successful maintaining housing stability: he lives independently in his family home and his brother checks in on him daily. When the AOT team meets with Daniel, he is pleasant, the house is clean and in order and he is receptive to being directed to improving his hygiene so he can take walks with the team.

CHILDREN & YOUTH FSPs

FULL SERVICE PARTNERSHIP (FSP) REPORT
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 19/20

a. **Number of clients served:** 26

How Well Did We Do?

II. Please describe ways that the program strives to:

a. **Reduce mental health stigma:** Our program works to reduce stigma related to mental health by providing services on our clients' terms – in the community and during flexible times to meet the needs of our children and families. We work very hard to focus on the families' goals for services and build relationships through the delivery of practical/tangible support (financial, transportation, etc.). For some families, we provide a Family Partner who has personally experienced challenges with their own children (CPS, IEPs, etc.) in ordert to validate the caregivers' experiences and show them that receiving mental health support is valuable.
b. **Create a welcoming environment:** In order to create a welcoming environment, we work to meet families where they are most comfortable – in their own home, at a public park, or a coffee shop. We regularly offer to bring food to appointments in order to create a sense of community and safety. We strive to have a diverse staff team in order to be able to reflect the diversity of our client population. Our staff works to talk openly

about issues of difference, systemic oppression, and to validate the experiences of our often marginalized children and families. Since COVID 19, we have worked to create systems to continue to offer service as often as possible in a way that works for families. For example, we often use technology to see clients "face to face" and we do meetings in person, when clinically indicated and when we can maintain physical distancing and safety.

III. Language Capacity for this program: English and Spanish

IV. FY19/20 Challenges: COVID 19 has obviously impacted our service delivery model**.** We have had to pivot from a largely in person to service to one delivered mostly via screens (cell phone or computer). We have worked hard to mitigate as much disruption to our families as possible. Additionally, COVID 19 has also had an impact on the finances of our families who have historically struggled to find and maintain steady work outside their home. Schools have continued with distance learning but, for our youngest clients, this remains a challenge.

Is Anyone Better Off?

V. FY 19/20 Client Impact: Alameda Connections has been working with a single mother and her 4 children since March of 2019. Her almost 3-year-old son was referred to our program due to intense behavioral challenges at his preschool which included hitting other children, screaming, throwing objects, and refusing to nap with his class. The referral indicated that his family had been homeless since prior to his birth and the constant moving between motels, shelters, and sleeping in cars had a profound impact on his ability to regulate. Our Care Coordinator quickly moved to gather her provider team and work to ensure housing stability. However, the more our program worked with his family, the more we realized how significant his mother's mental health needs were. We could track that when mom was taking her medication, she was more present and available to engage in services, while at other times- she would disappear and be unreachable for chunks of time. Our Support Counselor provided in-school support and would also work with our client and his siblings wherever they were staying at the time (hotel room, etc.) Our Care Coordinator helped mom make a psychiatry appointment and accompanied her to the appointment. Our Care Coordinator realized that housing applications would get started but never turned in and that shelters knew of this family and would no longer work with this mother. The complicated nature of this case meant that our Care Coordinator had to go above and beyond to advocate and support mom in following-up and working with various agencies.

When the pandemic hit, our care coordinator worked closely with the school district to enroll the family in a program that paid for longer-term motels. Our team worked to pick-up needed groceries and delivered them to the family. We obtained masks and cleaning supplies for them as well. Although we attempted to provide telehealth services, we quickly realized that they could not reliably engage in virtual services, so we adjusted and offered to see them in-person (with PPE and in outdoor spaces). Our Care Coordinator continued to search for new housing opportunities for the family and frequently supported mom with filling-out low-income housing applications and hoping that they would win the lottery. She also connected with the Women's Drop-In Center in Berkeley and helped mom connect to a new housing program there. Fortunately, the timing for this connection could not have been better. The City of Berkeley had a new program which provided the Drop-In Center with a limited number of new Section-8 housing vouchers. Our Care Coordinator worked relentlessly to support mom in completing all the steps necessary to enroll in the program. Just two weeks ago, their family received the voucher! Our

program will continue to support this family for another month or two to ensure that they find a home, move into the home, and obtain what they need to set-up their home. This will be the first time in our client's life that he will benefit from the security of having a place to call home.

Although securing housing has been a huge priority for the family, we have also supported the family in school enrollment, technological support, requesting IEP assessments, and obtaining TBS services for an older sibling who has been experiencing regular crises. We are hopeful that the team we've worked to establish will continue to support this family even after we close.

VI. FY 19/20 Additional Information: None

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

VIII. FY 20/21 Program or Service Changes: None

Metrics	% of FY 19/20 FSP clients that achieved the metric
Received a follow up visit within five days after a mental health hospitalization or crisis	0%
Average of four or more visits per month per client	84%

TRANSITION AGE YOUTH FSPs

FULL SERVICE PARTNERSHIP (FSP) REPORT
FSP # FS17

PROVIDER NAME: Fred Finch Youth and Family Services

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 19/20

a. **Number of clients served:** 24

How Well Did We Do?

II. Please describe ways that the program strives to:

a. **Reduce mental health stigma:** In FF, we aim to help families and youth talk about their mental health issues openly and safely. Having Partner staff helps to reduce stigma by having a staff share their own lived experiences and helping to normalizing some of the frustrations associated with mental illnesses. We focus on what is going positively in a youth's life which are often the building blocks for more successful management of symptoms.
b. **Create a welcoming environment**: In FF, we always try to create a welcoming environment. Since we do most of our work in the community, it starts by being respectful of time. We work around a youth and care giver's schedule and aim to arrive to those appointments promptly. Staff are trained to use Motivational Interviewing strategies so we will meet a youth or family member where they are at. The Wrap philosophy is to "do what it takes" to meet a need. Sometimes, this conveys welcome and appreciation that staff attempted to "lighten the load" that a youth or family member is carrying. We also strategically use flex funds to meet an important unmet need for a family. All staff receive clinical supervision so that are addressing clinical stuck issues as they arise. We want all staff to approach the youth/family with hope and some clinical direction.

III. Language Capacity for this program: We have staff that speak Spanish that work both with youth and Care Givers.

IV. FY19/20 Challenges: We saw some significant challenges this year. A main concern was staffing. All 3 clinical staff members left their position after less than 1 ½ years of employment. One clinician quit after only 8 months of employment. The Clinical Supervisor vacated their position as well. We needed to place a hold on accepting new youth into the program for about 6 months. Additional challenges came in the form of COVID-19. The team had to quickly adapt services to meet with youth and family safely. We quickly understood that our population was at greater risk for poor outcomes with COVID. We learned how to do most of our services via Telehealth, phone and when needed, in the community using social distancing practices. Some youth adapted well to this modality, while others had a significant challenge with engagement. During this shelter at home order, we were able to rehire the 3 Clinical positions, however the training and on-boarding new staff under these conditions is still a work-in-progress. Another challenge is the demanding paperwork requirements. Medi-Cal standards are difficult to implement and manage. Most staff express that paperwork demands are the greatest factor that they considered when they have left their position. Staff understand the importance of this task but see that this work task is often excessive.

Is Anyone Better Off?

V. FY 19/20 Client Impact: We believe that our services have had a positive impact on our youth served. In the incentive measurements, we partially met the goal of no gaps of 30 days or more. We met the goal of having a face to face appointment with a youth within 5 days after discharge from a crisis facility. On the incentives for this, we did not meet the threshold of 10 events. Perhaps our services helped to reduce the frequency of entering a psych hospital for our youth.

The work we did with one of our clients truly highlights how a team worked to keep a youth stable and safe. Client “L” identifies as transgender. Their Aunt (primary care giver) accepted their identity whereas their Uncle was less accepting. During our services, the Aunt passed away as her health deteriorated. Prior to our involvement, this youth had been hospitalized due to suicidal ideation. Having our Care Coordinator support helped them deal with many of the complex feelings that she had about her Aunt’s death. The Uncle had indicated that once the youth turned 18, they would have to move out of their home right away. The Youth Partner and Parent Partner worked with L’s support system and with L to navigate some of the family disagreements. The Youth Partner found our client a supportive living home, but due to COVID, that plan was placed on hold. L successfully transitioned to TAY support and they expressed that our coaching and reassurance was very helpful in navigating Social Security and following through on tasks that they tended to avoid.

VI. FY 19/20 Additional Information: 73% partially reached their treatment goals at discharge and 82% stayed at the same level of care at discharge. We often get referrals and the care giver is or has contemplated moving the youth to a residential facility. For the youth who ended up in

a facility, we attempted to build skills in those homes but ultimately ended up helping the youth and/or care giver that safety needs were not adequately being met in the home.

VII. FY 20/21 Projections of Clients to be Served: We hope to be fully enrolled and serving 20 youth. We currently have openings.

VIII. FY 20/21 Program or Service Changes: With COVID, we are mainly doing services via Telehealth or phone. We are trying to find ways to engage in care. We attempted to start a parent support group. We will try to explore times that our families can attend this and hope to offer this opportunity in the near future.

Metrics	% of FY 19/20 FSP clients that achieved the metric
Received a follow up visit within five days after a mental health hospitalization or crisis.	100%
Average of four or more visits per month per client.	71%

FULL SERVICE PARTNERSHIP (FSP) REPORT
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 19/20

a. **Number of clients served:** 66

How Well Did We Do?

II. Please describe ways that the program strives to:

a. **Reduce mental health stigma:** The STAY Program acts to reduce stigma by providing psychoeducation to participants and family aimed at normalizing mental health issues and educating about treatment options, by employing Peer Mentors who serve as role models for participants and family partners who help support family members in developing acceptance and understanding of mental health issues, by providing employment services using a model (IPS) promoting full inclusion of participants with mental health diagnoses in the competitive job market, and providing ongoing psychoeducation and support to community members and organizations we interact with to further acceptance and understanding of the needs of TAY with mental health issues to replace fear and judgement.
b. **Create a welcoming environment:** The program creates a welcoming environment at the program site by providing comfortable, TAY friendly spaces for participants for meetings or in which to spend time. Program leadership communicates with other program leaders who share our agency campus to assure that all agency staff on site understand the needs of our TAY participants and are prepared to respond to them in a welcoming manner when the TAY come to the agency campus. With the exception of the current pandemic restrictions, the program invites program participants to the campus for participant social and skill building groups in our agency community spaces. Program staff respond to all calls from participants, families and community members promptly, and attempt to address their presenting needs or connect them to needed resources. The program encourages participants who have aged out of the program to return to attend program groups or to periodically drop by to say “hello” to STAY staff and update them on their lives.

III. Language Capacity for this program: The program currently employs a Peer Mentor who is can provide services in Spanish. We use interpreter services, either in person or by phone, to meet most participant and family language needs.

IV. FY19/20 Challenges:

Housing: The housing crisis continues to impact the STAY Program participants' access to stable affordable living spaces, and to squeeze available transitional and emergency resources.

COVID: The COVID pandemic impacted the program's ability to outreach to participants and to provide in person services, including participant groups. Since many of our participants lack smart phones or computers, we were not able to provide telehealth services to most participants. Staff attempted to support participants by phone primarily in the early months of the epidemic, and later, after establishing clear safety protocols and obtaining PIP, resumed socially distanced face to face contacts.

Coordination of care: The program faced ongoing challenges with inadequate communication and coordination of care when trying to support participants admitted to inpatient units and in jail. The STAY Program learned of participant admissions to John George several days after they had happened on more than one occasion, with no contact from social work staff. Weekend staff at John George do not communicate with the STAY program regarding admissions or discharges. Nursing staff and psychiatrists are often unreachable, and do not return calls in a timely manner when STAY staff need to convey critical information regarding a participant's need or discharge concerns. The STAY Program had particularly difficulty when trying to work with the Heritage facility to obtain information about participant status and collaborate regarding discharge. For participants at Santa Rita, lack of advance notice or predictability regarding discharge and on-site support to help participant reconnect with services after release impacted our ability to service several of our participants. This issue will hopefully be ameliorated somewhat by the new onsite, trailer-based services at Santa Rita.

Staffing: The STAY Program had difficulty recruiting and retaining needed staff, particularly in the positions of Family Partner, Personal Services Coordinator, and Psychiatric Nurse Practitioner. Staff vacancies impacted the program's ability to take on new referrals and meet expected contract capacity.

Is Anyone Better Off?

V. FY 19/20 Client Impact:

Housing: During the period, the program supported 10 participants in accessing permanent housing options, 7 with independent apartments and 3 with licensed board and care placements. The program supported 4 former foster youth in obtaining sec. 8 vouchers through the county's new foster initiative program.

"Assure that clients obtain and maintain enrollment in health insurance and other public benefit program for which they are eligible."

The STAY program supports participants in applying for GA and SSI benefits, and assuring assists them in applying for or reactivating their Medi-Cal coverage when needed. During the fiscal year, the STAY Program supported 9 participants in their SSI application process, whether by helping them begin the application, or supporting them in accessing legal advocacy through BALA and HAC. Staff supported 7 participants in enrolling in General Assistance.

"Connect clients to ongoing primary healthcare services and coordinate healthcare with clients primary care providers."

All STAY Participants who do not have an established primary care provider at intake are offered support connecting to the on-site, TAY friendly Rising Harte Wellness Clinic. STAY staff support participants in making and attending healthcare appointments and tending to needed follow up care. Of the 66 participants served during the year, 52 were connected to primary care providers. 10 STAY program participants attended an onsite health fare in December sponsored by Rising Harte Wellness Center where they received health education, and opportunities for dental screenings and HIV, Hep C testing.

"Increase education and vocational attainment among clients"

During the fiscal year, the STAY program supported 14 participants in enrolling in educational classes, including diploma and GED program, vocational training programs, or community colleges. 1 participant successfully completed their GED during the period. Another succeeded, with support from his STAY clinician, in completing a multi-step assessment process in order to obtain needed accommodations for the GED test. 29 participants received IPS employment services during the period and 13 IPS enrollees secured employment at some point during the year. During the period, connected 3 participants with the Department of Rehab and supported 4 in obtaining benefit counseling through the Center for Independent Living in support of their interest in working.

"Help client increase their monthly income and financial assets."

The STAY program supports participants in increasing income by assisting them in accessing public benefits for which they qualify and supporting those interested in working with obtaining and maintaining employment. As before mentioned, IPS supported 13 STAY participants in obtaining or maintaining employment, 9 with their SSI application and appeal process and 7 in connecting to general assistance. The program supported 1 participant in establishing an SSI ABLE savings account during the year, and another in beginning the process.

"Decrease social isolation among clients"

The STAY program supports participants in accessing opportunities for social connection and friendship building through bimonthly social and skill building groups. During the fiscal year the program also collaborated with Beats Rhymes and Life (BRL)to offer a series of onsite support and self-expression groups. 8 STAY participants attended the BRL groups.

"Assist and empower clients in transitioning to the least intensive level of services appropriate to meet their needs"

The program supported 3 participants during the year in transitioning to less intensive services in the TAY system of care. 5 participants who discharged from the program after aging out transitioned to less intensive levels of care in the Adult System.

Participant Success Story:

During the year, a female participant in the STAY program continued to makes strides in maintaining stability with her mental health and functioning, while taking steps forward with her goals. The participant had stabilized on injectable medications a year and a half ago after a period of significant crisis including a serious suicide attempt and long-term hospital stay. During this past year, the participant completed a six-month stay in a transitional residential program, where she worked on independent living skills, looked for a job and maintained regular engagement with her STAY treatment team. In the late summer and early fall, with the support of her STAY team, the participant completed all the necessary steps to apply for and secure a subsidized apartment unit in a brand-new complex in

Berkeley. Since moving in to her unit the past November, the participant has created a home for herself, and experienced living on her own for the first time. She has had friends over to spend time in her new apartment and gone to visit her grandmother who lives nearby. She has continued to engage with her STAY team, including her Employment Specialist. Just recently, after a period of ambivalence, she asked her Employment Specialist to help her enroll in a GED prep program to continue her education.

VII. FY 20/21 Projections of Clients to be Served: 75

VIII. FY 20/21 Program or Service Changes: The STAY Program has hired a psychiatrist to meet the medication needs of our participants, in place of the Psychiatric Nurse Practitioner and Lead Psychiatric Nurse Practitioner. The program will use this staffing pattern for the upcoming fiscal year to serve the medication needs of our participants. Due to the health constraints imposed by the COVID pandemic, the program will continue to refrain from providing in person groups to participants and will limit transportation of participants.

Metrics	% of FY 19/20 FSP clients that achieved the metric
Reduction in Hospital Admits*	68%
Reduction in Hospital Days*	80%
Reduction in Psychiatric Emergency Services (PES)*	67%
Reduction in Incarceration Days*	53%
Increase in the number of days Stably Housed*	36%
Primary Care visit within the previous year	68%
With a vocational goal who are employed	30%
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	52%

*The metrics above measuring “reductions” are looking at FSP clients served in FY 19/20 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 # 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 19/20

a. **Number of clients served:** 54

How Well Did We Do?

II. Please describe ways that the program strives to:

a. **Reduce mental health stigma:** PAIGE works collaboratively with participants and their families and any natural supports and utilizes a client-centered approach to meet participants where they are at in terms of recovery, insight, and ability to manage symptoms. PAIGE provides psychoeducation to families to support them in supporting their loved ones, provides linkage support to receive much needed support (FERC, NAMI) and develops community through peer support groups to help participants feel less isolated in their recovery. As part of the PAIGE service model the participant's natural supports are drawn in as stakeholders in their care and contributors to the treatment. This Wraparound approach supports building community around the participant and empowers their voice and choice while reducing the isolation that so frequently accompanies severe mental health challenges.
b. **Create a welcoming environment:** The PAIGE team is flexible in location, meeting time, and engagement style to support participants and families to feel comfortable in their desired setting. The PAIGE team will meet participants at parks, at their homes, at our office or anywhere in the community that they prefer. PAIGE ensures safety by taking steps during COVID-19 to both wear and provide PPE to participants during meetings and take temperatures before entering buildings. PAIGE 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 PAIGE program was designed with Culturally and Linguistically Appropriate Services (CLAS) standards in mind.

III. Language Capacity for this program: Spanish, Dari/Farsi, limited Tagalog.

IV. FY19/20 Challenges: The pandemic and uncertainty of the "new normal" was a challenge faced by the PAIGE team this year, however PAIGE met it with understanding and was able to adapt. One challenge was problem solving how to outreach and engage with the new parameters set by inpatient settings—where much of our engagement with new participants had previously taken place. Adapting to technological differences between agencies has also been challenging, when attempting to support with intakes. PAIGE has met the challenge however, and managed increase participant engagement, including face to face contacts with physical distancing parameters.

Is Anyone Better Off?

V. FY 19/20 Client Impact: Many participants served through PAIGE were able to successfully begin and stabilize on medication, where they had previously refused causing great deficit in functioning. One success story was a participant who had 60+ presentations in PES/ John George Psychiatric Pavilion (JGPP/Kaiser ER in a span of 3 months before the PAIGE team became involved. The participant had regular ideation of self-harm and would engage in these behaviors often; this youth dropped her presentations to about 1-2x week, eventually going over a month without any presentations in emergency settings. When the participant closed to PAIGE program, she had gone without self-harm behaviors or ER visit for about 2 months and was stable on meds, living independently with family support at time of closing.

Another youth, had multiple JGPP presentations and they had limited support and resources due to participant's sharp decline in functioning going from prom king, playing sports and working full time to needing constant supervision due to paranoia, disorganization, auditory hallucinations, insomnia that led to violence in the home, involvement with criminal justice, and causing the mother to almost lose her job. This participant was hesitant to work with the PAIGE team, but after about a month of sessions, they agreed to medication, and now is exploring an opportunity at Amazon with limited symptom interference in daily life.

A 3rd success story is that we have two youth (1) who was referred due to a violent episode leading to harm of a family member and (2) a youth who struggles with bipolar symptoms, both of whom successfully graduated from the PAIGE program due to their great response to treatment and obtaining employment and stability that made them ineligible for Medi-Cal.

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. These are a few success stories, but the PAIGE team continues to be a great source of support to many disenfranchised youth.

VI. FY 19/20 Additional Information: One of the major successes for the team was their response to the Covid-19 pandemic. Within a matter of weeks, the team was able to adjust and adapt to a "new normal," but still continue to provide support and resources to all the partners and their natural supports. The team's empathy and passion to "do whatever it takes," was clearly illustrated during this period of time. The PAIGE team was able to support clients in meeting their basic needs (food, shelter, etc.) and goals in a safe and secure manner (masks, social distancing, good hygiene, cleanliness).

Throughout these challenging times, the PAIGE team was able to maintain contact with participants 1-7 days per week. The PAIGE team continued to facilitate regular TDMs with family, participant, providers, and other members of the treatment team by utilizing MS Teams for enhanced safety while continuing to support with goals. The team focused on supporting participants in linking them to primary care and ensured all homeless partners had completed the coordinated entry assessment. Prior to May, the PAIGE team was successfully hosting social events, groups, and wellness activities (hikes, walks, movie night, game night) 3+ times a month with typical attendance at these events between 3-18 participants.

VII. FY 20/21 Projections of Clients to be Served: 65

VIII. FY 20/21 Program or Service Changes: The PAIGE team would like to increase wraparound services and increase the number of TDM's each partner has each month. We would like to get more natural supports involved and engaged in each partner's treatment plan. For this upcoming year PAIGE would also like to increase the diversity and frequency of staff contacts with each partner to be closer to exemplary fidelity standard. PAIGE did very well this fiscal year in ensuring that each partner was seen at least once a week, even during the pandemic, but would like to increase contact with each partner for this fiscal year. PAIGE is also working very closely with John George Psychiatric Pavilion, Villa Fairmont, Jay Mahler, Woodroe and Amber House to be involved in all steps of discharge planning and will continue to do so during this fiscal year.

Metrics	% of FY 19/20 FSP clients that achieved the metric
Reduction in Hospital Admits*	88%
Reduction in Hospital Days*	96%
Reduction in Psychiatric Emergency Services (PES)*	85%

Reduction in Incarceration Days*	67%
Increase in the number of days Stably Housed*	53%
Primary Care visit within the previous year	71%
With a vocational goal who are employed	16%
Received a follow up visit within five days after a mental health hospitalization or crisis	83%
Average of four or more visits per month per client	86%

*The metrics above measuring “reductions” are looking at FSP clients served in FY 19/20 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
FSP #: FS4

PROVIDER NAME: Abode Services

PROGRAM NAME: Greater HOPE FSP

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

Target Population: Chronically homeless adults

How Much Did We Do?

I. FY 19/20

a. **Number of clients served:** 235

How Well Did We Do?

II. Please describe ways that the program strives to:

a. **Reduce mental health stigma:** Our team employs Peer Specialists and staff with lived experience at all levels to support participants with linking to mental health services, learning about the ways in which people recover and live in their communities with mental health symptoms.
b. **Create a welcoming environment:** Participants are welcomed with water and food at our office to ensure basic needs are met before engaging in treatment interventions. Participants are treated with respect and dignity despite any behavioral or hygiene challenges they are experiencing. We train our staff to engage participants warmly at every interaction all the way from our front desk staff to Executive level staff. If participants reach out or request assistance from anyone our staff are trained to do whatever it takes to try to find assistance for anyone who reaches out.

III. Language Capacity for this program: Portuguese, American Sign Language, Khmer, Spanish, Cantonese

IV. FY19/20 Challenges: Hiring has been an ongoing challenge. COVID-19 also presented a lot of new challenges for staff in regards to safety protocols, access to primary care, accessing homes and locked settings. Staff are consistently trying identify work arounds to provide telehealth linkage to primary care and psychiatry (not community based at this time) as well as in person services while upholding safety protocols for themselves and partners.

Is Anyone Better Off?

V. FY 19/20 Client Impact: The team has been able to provide 15 new participants with long acting injectable antipsychotic medication in the last year. This is a tremendous increase from previous years. This has resulted in an increase in engagement in services, housing placement, connection to IPS services, and wellbeing for the participants served. The team has also seen an increase in graduating to lower levels of care. Eight participants were stepped down to lower levels of care in the last year, many of which had been with the program over 5 years.

VI. FY 19/20 Additional Information: N/A

VII. FY 20/21 Projections of Clients to be Served: 150+

VIII. FY 20/21 Program or Service Changes: Our agency will expand to a second office in the next fiscal year which has been approved by BHCS and is in process of being site certified. No other planned program or service changes.

Metrics	% of FY 19/20 FSP clients that achieved the metric
Reduction in Hospital Admits*	78%
Reduction in Hospital Days*	81%
Reduction in Psychiatric Emergency Services (PES)*	67%
Reduction in Incarceration Days*	89%
Increase in the number of days Stably Housed*	38%
Primary Care visit within the previous year	68%
With an educational goal who are enrolled in school	0%
With a vocational goal who are employed	6%
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	52%

FULL SERVICE PARTNERSHIP (FSP) REPORT
FSP #: FS10

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

PROGRAM NAME: Housing Solutions for Health

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

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

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

Age Group: Adults

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

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

6) Supporting an affordable housing search website and news alerts related to current housing opportunities relevant to people with serious mental illness and extremely low incomes;
7) Referrals, coordination, clinical consultation, training ,and oversight of a network of more than 450 licensed board and care and permanent support housing slots countywide;
8) Housing education and counseling sessions at ACBH-funded Wellness Centers and other community locations;
9) 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: FY19/20

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

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

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

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

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

PERFORMANCE INDICATORS: Is Anyone Better Off?

FY 2019-20 Impact: Home is one of SAMHSA's four key dimensions of recovery (health, home, purpose, and community). Stable, safe and supportive housing reduces emergency and crisis service utilization, increases access to quality outpatient services, and improves overall health outcomes.

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

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

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

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

The Landlord Liaison project has led to a growing number of Landlord participation is access to accurate and dependable monthly rent payments, 1st months security deposits, risk mitigation funds that can be used for damages that exceed the security deposit or cover one-month's rent for a vacant units in preparation for new tenants and a dedicated landlord hotline answered by staff with housing expertise that may be utilized for crisis needs, property management needs and problem solving. Staff triage the call and provide immediate problem solving based on the initial need 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.
Over the past 3 years the program has acquired and currently maintains approximately 594 affordable units. In the month of October 2020, Mental Health Services Act funded $300,000 in rental assistance for 107 units and a housing retention rate of close to 95%.

FULL SERVICE PARTNERSHIP (FSP) REPORT
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 19/20

a. **Number of clients served:** 29

How Well Did We Do?

II. Please describe ways that the program strives to:

a. **Reduce mental health stigma:**
Reducing stigma is a natural part of the work that we do. We help partners reduce their internalized stigma by always treating them with dignity and respect, meeting partners where they are, using a strengths-based approach, having expectations that our partners that can make progress in their recovery, helping them to identify their values and motivations for change, appreciating their individual uniqueness. We provide partners with psychoeducation so they can understand their symptoms and reduce self-blame. We teach them skills to help them manage their symptoms, using concepts from CBT, DBT and Motivational Interviewing. We also help reduce outside stigma by providing psychoeducation to family/loved ones and to community members (medical providers, housing providers, etc). We coach staff at congregate living homes to see our partners as unique individuals and encourage them take a strengths-based approach with partners. We are out in the community with our partners and model respectful interactions with them so other community members to observe and learn.

b. **Create a welcoming environment:**

We warmly welcome our partners throughout their tenure with us, regardless of whether we are meeting them at our office or in the community. When they are newly referred, we utilize a long engagement period to build rapport and really get to know them and their individual unique qualities. We meet our partners where they are in their recovery journey. We provide ongoing education to staff about how to provide person-centered care, cultural humility and curiosity, recognizing individual uniqueness and strengths. We take a harm reduction approach to partners' substance use and are not judgmental. We encourage meaningful activity and help our partners work towards education and employment using the IPS model. We recognize and celebrate successes large and small!

III. Language Capacity for this program: Community Conservatorship program 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.

IV. FY19/20 Challenges:

All CC partners, by program definition, are on conservatorship, and as such, are required to reside in licensed care homes. This greatly restricts the housing options available to our partners, and sometimes results in partners being dropped from the program if they are not able to succeed in licensed care homes. Covid 19 brought unique challenges in the past year. Our staff quickly stepped up, 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, etc. Our staff increased their creative approaches to ensure that our partners continued to have their needs met during Covid 19 restrictions, including; engaging with partners through the use of art, poetry, music, journaling, book clubs, engaging in discussions using tools from Personal Medicine, Seeking Safety and Telecare's own Recovery Centered Clinical System. These services were provided while practicing social distancing, through house windows or by telephone, celebrating milestones with car parades, social distance lunches. The high cost of living in the Bay Area was an ongoing challenge last year, limiting housing options, especially for partners who are traditionally not successful in congregate living.

Is Anyone Better Off?

V. FY 19/20 Client Impact:

Partners were quickly provided education about Covid 19 and how to minimize their risks. Partners who were unhoused were quickly linked to safe residences to allow them to reduce their risk of Covid by sheltering in place. Mental health service provision changed, but partners were able to continue to receive their much-needed services. Prior to Covid, partners were able to benefit from a new Seeking Safety group to help them address how their trauma histories affected their current level of functioning. Partners benefited from staff instruction on how to utilize art, journaling, music and poetry as part of their personal set of coping skills. Families who took part in the monthly family support group gained insight and education about how to best support their loved ones with mental health diagnoses.

Client story:

When "Lisa" joined the Community Conservatorship program, she was a referral from Napa State Hospital, where she spent many years in treatment. She was consistently at risk of 'danger to self' as she spent her time cutting into her skin and sharing lengthy details of the feelings and sensations she experienced while cutting. She experienced a high level of psychosis and delusional ideation. She lacked the insight as to why her cutting could be dangerous and even possibly deadly for her.

By the time Lisa graduated from the Community Conservatorship program early 2020, she was adherent with all her medications and appointments, taking swimming, parenting and Spanish classes. She was able to manage her own money and use public transportation independently. Lisa maintained her success long enough to move to family home in Arizona and become a part of her young daughter's life again. Lisa had insight into her risks, so much that she took responsibility for ensuring that she was referred to a proper mental health agency in Arizona and had plenty of medications to tide her over. She was instrumental in making sure that her transition from California to Arizona was as seamless as possible. And when she said goodbye, she was pleasant and sweet as pie!

VI. FY 19/20 Additional Information:

VII. FY 20/21 Projections of Clients to be Served: CC will work towards meeting and maintaining a census of 25 partners.

VIII. FY 20/21 Program or Service Changes:

Ongoing flexibility with service provision during rapidly changing directives regarding Covid 19 restrictions. Instituting virtual 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 19/20 FSP clients that achieved the metric
Reduction in Hospital Admits*	89%
Reduction in Hospital Days*	100%
Reduction in Incarceration Days*	100%
Increase in the number of days Stably Housed*	64%
Primary Care visit within the previous year	53%

With an educational goal who are enrolled in school	0%
With a vocational goal who are employed	0%

*The metrics above measuring “reductions” are looking at FSP clients served in FY 19/20 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
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 19/20

a. **Number of clients served:** 38

How Well Did We Do?

II. Please describe ways that the program strives to:

a. **Reduce mental health stigma:**
Reducing stigma is a natural part of the work that we do. We help partners reduce their internalized stigma by always treating them with dignity and respect, meeting partners where they are, using a strengths-based approach, having expectations that our partners that can make progress in their recovery, helping them to identify their values and motivations for change, appreciating their individual uniqueness. We provide partners with psychoeducation so they can understand their symptoms and reduce self-blame. We teach them skills to help them manage their symptoms, using concepts from CBT, DBT and Motivational Interviewing. We also help reduce outside stigma by providing psychoeducation to family/loved ones and to community members (medical providers, housing providers, etc). We coach staff at congregate living homes to see our partners as unique individuals and encourage them take a strengths-based approach with partners. We are out in the community with our partners and model respectful interactions with them so other community members to observe and learn.

b. **Create a welcoming environment:**
We warmly welcome our partners throughout their tenure with us, regardless of whether we are meeting them at our office or in the community. When they are newly referred, we utilize a long engagement period to build rapport and really get to know them and their individual unique qualities. We meet our partners where they are in their recovery journey. We provide

ongoing education to staff about how to provide person-centered care, cultural humility and curiosity, recognizing individual uniqueness and strengths. We take a harm reduction approach to partners' substance use and are not judgmental. We encourage meaningful activity and help our partners work towards education and employment using the IPS model. We recognize and celebrate successes large and small!

III. Language Capacity for this program: 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, Cantonese.

IV. FY19/20 Challenges: A challenge specific to the AOT program is that many of our partners are homeless and disengaged from services. This impacts the staff's ability to outreach, create rapport and provide the services as expected. It also creates a challenge in meeting and maintaining our census. Covid 19 brought unique challenges in the past year. Our staff quickly stepped up, 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, etc. Our staff increased their creative approaches to ensure that our partners continued to have their needs met during Covid 19 restrictions, including; engaging with partners through the use of art, poetry, music, journaling, book clubs, engaging in discussions using tools from Personal Medicine, Seeking Safety and Telecare's own Recovery Centered Clinical System. These services were provided while practicing social distancing, through house windows or by telephone, celebrating milestones with car parades, social distance lunches. The high cost of living in the Bay Area was an ongoing challenge last year, limiting housing options, especially for partners who are traditionally not successful in congregate living.

Is Anyone Better Off?

V. FY 19/20 Client Impact: Partners were quickly provided education about Covid 19 and how to minimize their risks. Partners who were unhoused were quickly linked to safe residences to allow them to reduce their risk of Covid by sheltering in place. Mental health service provision changed, but partners were able to continue to receive their much-needed services. Prior to Covid, partners were able to benefit from a new Seeking Safety group to help them address how their trauma histories affected their current level of functioning. Partners benefited from staff instruction on how to utilize art, journaling, music and poetry as part of their personal set of coping skills. Families who took part in the monthly family support group gained insight and education about how to best support their loved ones with mental health diagnoses.

Personal Client Story:

When "Daniel" was first introduced to the AOT team, he was receiving treatment at John George Acute Psychiatric facility. He was dirty, disheveled, experiencing psychosis and had paranoid and delusional thoughts. He was admitted to JGP after one of his delusions led to a physical altercation with his brother. He was not adherent to medications and spent his days wandering through his mother's home.

This is in stark contrast to the Daniel we know today. He is currently adherent to all his medications and appointments. He engages with the AOT team 3 times a week and is receptive to increasing social

interaction by taking walks with the AOT team. Daniel has been successful maintaining housing stability: he lives independently in his family home and his brother checks in on him daily. When the AOT team meets with Daniel, he is pleasant, the house is clean and in order and he is receptive to being directed to improving his hygiene so he can take walks with the team.

VI. FY 19/20 Additional Information:

VII. FY 20/21 Projections of Clients to be Served: AOT will be working towards meeting and maintaining a census of 30 partners.

VIII. FY 20/21 Program or Service Changes:

Ongoing flexibility with service provision during rapidly changing directives regarding Covid 19 restrictions. Instituting virtual 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. Increasing partner access to IPS vocational and substance use services.

Metrics	% of FY 19/20 FSP clients that achieved the metric
Reduction in Hospital Admits*	86%
Reduction in Hospital Days*	71%
Reduction in Incarceration Days*	86%
Increase in the number of days Stably Housed*	11%
Primary Care visit within the previous year	100%
With a vocational goal who are employed	0%

*The metrics above measuring “reductions” are looking at FSP clients served in FY 19/20 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
FSP # FS13

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

Target Population: Describe information about consumers'/ clients' age group (i.e., Children/ youth, Transitional Age Youth, Adults or Older Adults; and Partners' unique needs.

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.

How Much Did We Do?

I. FY 19/20

a. **Number of clients served:** 100

How Well Did We Do?

II. Please describe ways that the program strives to:

a. **Reduce mental health stigma:** CHANGES FSP uses Telecare's Recovery-Centered Clinical System (RCCS) to inform its program culture and the relationships that staff have with consumers and the important people in their lives - friends, family members, landlords and other housing providers, as well as other mental health and medical providers. The CHANGES managers and staff consciously and deliberately use the RCCS in our conversations and interactions with consumers and their significant others to decrease judgment and blame and help explore the invisible burden of stigma in the lives of our members.

b. **Create a welcoming environment:** Prior to March 16, 2020, the CHANGES program created a welcoming environment by encouraging members to "drop in" anytime during the program's hours of operation if they needed support, whether it was in the form of a quiet, clean space to

hang out and watch TV, to take a nap or chat with staff, to get a snack or some clothes from the free clothes closet, pick up mail, check their email or look for housing on the client computer, or get a referral to a community resource. Due to the lockdown we've had to close our office space to members, but we continue to serve them in front of our office, providing as many of the "pre-Covid" drop in services as can safely be delivered.

III. Language Capacity for this program: The CHANGES staff have Spanish-language capacity and the program has an account with Language Line for translation services.

IV. FY19/20 Challenges: Maintaining full FSP staffing was an ongoing challenge during FY20, requiring a significant amount of time from managers in recruitment and hiring activities, as well as time spent identifying and addressing factors impacting retention (ex: high housing costs, highly competitive job market, etc.). The onset of the cornoravirus pandemic and the subsequent county shutdown were unquestionably the greatest challenges faced by the CHANGES FSP staff and consumers during the past year. The shutdown and the pandemic required major changes to service delivery methods, as well as staff behavior, in order to keep both staff and members safe. A particular challenge to service delivery uncovered by the shutdown is the lack of access to communications technology (ex: cell phones, smart phones, tablets, computers, etc.) that is the reality for many CHANGES members. Without this technology providing remote services was impossible, and scheduling in-person services extremely difficult. Staff experienced an increase in work-related stress, combined with an increase in stress in their personal lives, as they coped with childcare issues, school closures, spouses and partners losing their jobs, and fears for their at-risk family members. Consumers also experienced increased stress as stores, restaurants, parks, and social service providers closed their doors or limited their hours, and new and unfamiliar safety protocols were put in place. Often the increased stress related to the pandemic resulted in psychiatric de-stabilization.

Running a close second to the pandemic's disruptive impact on the program were the demonstrations and social unrest that followed George Floyd's murder and which resulted in increased calls for racial justice and equality. CHANGES Black staff and consumers were especially hard hit by these events, often describing their experience as being "re-traumatized."

Is Anyone Better Off?

V. FY 19/20 Client Impact: Two CHANGES FSP members epitomize the kinds of gains that individuals can make with the support of an FSP program that has good ACT fidelity: (1) Client M is a middle-aged African American male with a history of paranoid schizophrenia, substance abuse, and significant co-morbid medical conditions. Last year the board & care where he lived and where he had achieved relative housing stability for the first time in many years, was forced to close. As a result, Client M experienced a period of psychiatric decompensation resulting in a period of homelessness and several crisis contacts and an acute hospitalization. With the support of the CHANGES FSP, and especially the FSP nurses, he was able to find new housing, where he's been living stably for several months. He's begun managing his psychiatric and medical conditions with daily medication. He's also partnered with the FSP nurse to get linked to a PCP, a podiatrist, a cardiologist, and a dentist to get the health and dental care that he desperately needed but which had been neglected in the past. He successfully completed a sleep study, which determined that he suffered from severe sleep apnea, and he is now in line to receive a CPAP machine. Perhaps most importantly, whereas in the past Client M always denied having any behavioral health issues, he is now able to verbalize his mental health symptoms, as well as the ways that his medication helps. He's also developed a set of coping skills and knows when and how to use them. (2) Client B is a mid-40s African American woman with Bipolar Disorder who early in her time with the CHANGES FSP expressed the goal of returning to work. Some years ago, she had been an

in-home care giver, but she had experienced her most recent mental health decompensation while on the job. As a result, she had a lot of anxiety and trepidation about returning to work, but she also knew that she enjoyed the sense of independence and control over her life that came with working. With the support of the CHANGES IPS specialist, Client B developed a "return to work" plan. First, she tried finding employment through an in-home care agency, but found this route to be too stressful and over-whelming. She processed her experience with the CHANGES IPS specialist and decided to take a short break from job seeking. During the break, she continued to talk about her employment goal and her return to work plan with the IPS specialist, and with her support decided to apply to IHSS. She completed each step of the IHSS application process, applied for and got a job, and has been working since April.

Some other less detailed examples of the positive impact of the CHANGES FSP program on client outcomes include: (3) Client D has maintained his housing since his release from Napa State Hospital and has been working with his FSP case manager to get his SSI reinstated. In the meantime, he's applied for GA and food stamps. (4) Client A, who has participated in the county sub-payee program for many years, is currently collaborating with her FSP case manager and actively taking steps to become her own payee. (5) Client T, who was described in her CHANGES FSP referral packet as catatonic and selectively mute, successfully completed her first semester at a local community college and has registered to continue her studies in the upcoming school year. (6) Client S came to CHANGES after a very long hospitalization at Villa Fairmont. Since joining the program, she has successfully maintained her housing, managed her mental health condition, and not needed to be re-hospitalized.

VI. FY 19/20 Additional Information:

VII. FY 20/21 Projections of Clients to be Served: 100

VIII. FY 20/21 Program or Service Changes:

Metrics	% of FY 19/20 FSP clients that achieved the metric
Reduction in Hospital Admits*	60%
Reduction in Hospital Days*	69%
Reduction in Psychiatric Emergency Services (PES)*	73%
Reduction in Incarceration Days*	89%
Increase in the number of days Stably Housed*	42%
Primary Care visit within the previous year	57%

With an educational goal who are enrolled in school	0%
With a vocational goal who are employed	0%
Received a follow up visit within five days after a mental health hospitalization or crisis	70%
Average of four or more visits per month per client	66%

*The metrics above measuring “reductions” are looking at FSP clients served in FY 19/20 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
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 19/20

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

How Well Did We Do?

II. Please describe ways that the program strives to:

a. **Reduce mental health stigma:** Reducing stigma is a natural part of the work that we do. We help partners reduce their internalized stigma by always treating them with dignity and respect, meeting partners where they are, using a strengths-based approach, having expectations that our partners that can make progress in their recovery, helping them to identify their values and motivations for change, appreciating their individual uniqueness. We provide partners with psychoeducation so they can understand their symptoms and reduce self-blame. We teach them skills to help them manage their symptoms, using concepts from CBT, DBT and Motivational Interviewing. We also help reduce outside stigma by providing psychoeducation to family/loved ones and to community members (medical providers, housing providers, etc.). We coach staff at congregate living homes to see our partners as unique individuals and encourage them take a strengths-based approach with partners. We are out in the community with our partners and model respectful interactions with them so other community members to observe and learn.
b. **Create a welcoming environment:** We warmly welcome our partners throughout their tenure with us. When they are newly referred, we utilize a long engagement period to build rapport and really get to know them and their individual unique qualities. We meet our partners where they are in their recovery journey. We warmly welcome everyone whether at our office or in community. We provide ongoing education to staff about how to provide person-centered care, cultural humility and curiosity, recognizing individual uniqueness and strengths. We take a harm reduction approach to partners' substance use and are not judgmental. We encourage meaningful activity and help our partners work towards education and employment using the IPS model. We recognize and celebrate successes large and small!

III. Language Capacity for this program: In addition to English, STRIDES staff are able to provide services in Spanish, Khmer, Cantonese and Taiwanese. We utilize a certified language line for all other languages.

IV. FY19/20 Challenges: COVID 19 brought unique challenges in the past year. Our staff quickly stepped up, 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, etc. Our staff increased their creative approaches to ensure that our partners continued to have their needs met during COVID 19 restrictions, including; engaging with partners through the use of art, poetry, music, journaling, book clubs, engaging in discussions using tools from Personal Medicine, Seeking Safety and Telecare's own Recovery Centered Clinical System. These services were provided while practicing social distancing, through house windows or by telephone, celebrating milestones with car parades, social distance lunches. The high cost of living in the Bay Area was an ongoing challenge last year, limiting housing options, especially for partners who are traditionally not successful in congregate living.

Is Anyone Better Off?

V. FY 19/20 Client Impact: Partners were quickly provided education about COVID 19 and how to minimize their risks. Partners who were unhoused were quickly linked to safe residences to allow them to reduce their risk of COVID by sheltering in place. Mental health service provision changed, but partners were able to continue to receive their much-needed services. Prior to COVID, partners were able to benefit from a new Seeking Safety group to help them address how their trauma histories affected their current level of functioning. Partners benefited from staff instruction on how to utilize art, journaling, music and poetry as part of their personal set of coping skills. Families who took part in the monthly family support group gained insight and education about how to best support their loved ones with mental health diagnoses.

Personal client story: George was part of STRIDES program from 2015-19, when he went missing for over a year during which time he was transient. Eventually, he was closed to services. He resurfaced at a crisis residential program in March 2020, where it was discovered that he had a connection with STRIDES. STRIDES staff was successful in re-engaging and re-establishing rapport with George, and linked him to Social Security so he could reinstate his benefits. STRIDES also supported George with assistance in finding stable independent housing, connecting him to primary care, and helping him create a plan to stabilize on his psychiatric medication. Since March 2020, George has not required rehospitalization and he has been able to manage the symptoms of his mental health diagnosis. He has returned to being the resilient, independent, and self-sufficient man he was previously.

VI. FY 19/20 Additional Information:

VII. FY 20/21 Projections of Clients to be Served: We project that we will be able to serve 110 unique individuals this year.

VIII. FY 20/21 Program or Service Changes: Ongoing flexibility with service provision during rapidly changing directives regarding COVID 19 restrictions. Instituting virtual 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 19/20 FSP clients that achieved the metric
Reduction in Hospital Admits*	77%
Reduction in Hospital Days*	94%
Reduction in Psychiatric Emergency Services (PES)*	78%
Reduction in Incarceration Days*	91%
Increase in the number of days Stably Housed*	62%
Primary Care visit within the previous year	50%
With an educational goal who are enrolled in school	50%
With a vocational goal who are employed	0%
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	64%

*The metrics above measuring “reductions” are looking at FSP clients served in FY 19/20 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
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 19/20

a. **Number of clients served:** 127

How Well Did We Do?

II. Please describe ways that the program strives to:

a. **Reduce mental health stigma:** As a program HEAT strives to reduce mental health stigma through the stories they tell, by creating trauma informed approaches, and discussing the importance of therapy for everyone including providers. HEAT has team members who experienced mental health challenges, this is part of the supervision, the understanding of the work as a team, and the way HEAT interfaces with the larger county system. As part of the HEAT service model the participant's natural supports are drawn in as stakeholders in their care and contributors to the treatment. This Wraparound approach supports building community around the participant and empowers their voice and choice while reducing the isolation that so frequently accompanies severe mental health challenges HEAT reframes the stories about clients to be strengths based, focusing on the intelligence and drive of the client to remain resilient despite ongoing adversity.
b. **Create a welcoming environment:** HEAT creates a welcoming environment through playfulness, centering around family, relationships and connection. HEAT looks our partners in the eye, and smiles. HEAT welcomes them in. HEAT calls them partners, so they know they are a member of their treatment team, and are the manager of their lives. These folks have been surviving for many years without the HEAT team and the

team is there to support opening the doors, and elevating partners to create the lives that they can look forward to living.

HEAT 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 HEAT program was designed with Culturally and Linguistically Appropriate Services (CLAS) standards in mind.

III. Language Capacity for this program: We have clinicians and staff who speak, English, Spanish and Cantonese.

IV. FY19/20 Challenges: The biggest challenge faced by HEAT this year were the intersections of three public health crisis', racism, homelessness and COVID-19. 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 health, and having new housing oppurtunties for clients. There was a decrease in permamate supportive housing matches, transitional housing programs decreased their census, and nonprofits which usually assist with support tasks were no longer seeing clients in the community.

Is Anyone Better Off?

V. FY 19/20 Client Impact: R. is a 40+ year old Mexican-American cis-male who uses he/him pronouns. He came into our program after having one of the higher recidivism rates and hospitalizations in Alameda County. When he was brought into program, he was able to secure stable housing. He was a chronic methamphetamine user, who struggled with alcoholism. He worked towards abstinence only for 2 months when he first came into program. He was connected to the full-service partnership, HEAT, who offered him therapy, connection to psychotropic medications, and a larger support system. We connected him to outside recovery support system. He ended up using again, and HEAT utilized a harm-reduction model. R. reached out to his support team instead of utilization the hospital for de-escalation. He has not been hospitalized or used.

VI. FY 19/20 Additional Information:

VII. FY 20/21 Projections of Clients to be Served: 150

VIII. FY 20/21 Program or Service Changes: HEAT was expanded by 50 slots midway through. HEAT will be focusing on ACT and wrap fidelity to increase compliance with metrics. HEAT will be hiring a care coordinator with an emphasis on substance use counseling and will continue to work to assertively outreach to our clients.

Metrics	% of FY 19/20 FSP clients that achieved the metric
Reduction in Hospital Admits*	75%
Reduction in Hospital Days*	79%
Reduction in Psychiatric Emergency Services (PES)*	88%
Reduction in Incarceration Days*	73%
Increase in the number of days Stably Housed*	24%
Primary Care visit within the previous year	60%
With an educational goal who are enrolled in school	0%
With a vocational goal who are employed	0%
Received a follow up visit within five days after a mental health hospitalization or crisis	63%
Average of four or more visits per month per client	71%

*The metrics above measuring “reductions” are looking at FSP clients served in FY 19/20 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
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 19/20

a. **Number of clients served:** We served 105 partners for the 2019/2020 fiscal year

How Well Did We Do?

II. Please describe ways that the program strives to:

a. **Reduce mental health stigma:** We help the partners in mirroring the clients' strong points relative to their individuality and increasing self-esteem, confidence and holding one-self in a positive regard. We include them in structured social activities in an effort to reduce isolation and in creating a sustainable self-supportive community that they can embrace and one that embraces them for their wellbeing. As the central axiom of the LIFT treatment modality, the team uses a wraparound model to draw in natural supports to increase connection, resiliency, and connection to their community.
b. **Create a welcoming environment:** The LIFT Team creates a welcoming environment by providing an open, non-judgmental stance in meeting the partner no matter how they're presenting or what their needs may be. We meet partners in their natural living environments and strengthen familial relationships which help ensure the family has support outside of community resources and help ensures better outcomes because of the support they have in their life. 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.

III. Language Capacity for this program: For the 2019/2020 fiscal year we had two of our team clinical members who are fluent in Spanish, one who is fluent in Hindi and Gujurati, and a team member fluent in Mandarin and Cantonese.

IV. FY19/20 Challenges: COVID-19 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. We have met the challenges of these external stressors in meeting partners where they are by employing a combination of increased physical distancing protocol, PPE, and tele-counseling, leaving them feeling supported and helping to stabilize them in the face of heightened challenges.

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?

V. FY 19/20 Client Impact: Here are a couple of stories that stood out to us in the last fiscal year and we can think of several more that have made significant headway in moving towards their treatment goals and objectives as well as improving the quality of their lives. We believe each of the partners has become more independent and self-sustaining relative to their individual level of functioning from when beginning services.

Partner has been doing really well in the community in the last fiscal year. He was someone that had extensive incarceration history as well as assault history prior to his release in the community this last time. Partner has been actively engaged with our employment coordinator in efforts to find employment in the private sector in the community to supplement his SSI income. He was initially reluctant to accept housing and medication support and has overcome those challenges in maintaining his housing and consistent medication compliance.

When another partner began with the LIFT Team, he was expelled from his licensed board and care due to impulsive sexual behavior towards another female resident due to his command auditory hallucinations. Upon beginning LIFT services, partner was found a housing placement at an all-male board and care and with the oversight of the LIFT team has been able to maintain his housing by remaining medication compliant, attending structured day program, using coping skills such as coloring, utilizing the supportive friendships he has developed with two other males at the same housing placement and taking walks in his community. Medication compliance has helped the partner with largely in minimizing the negative impact of his mental health symptoms of auditory hallucinations, disorganized thinking, anxiety and rapid pressured speech. Partner has dreams and aspirations to get to part time employment in the private sector of the community doing landscaping which he is capable of to supplement his SSI income.

VI. FY 19/20 Additional Information: N/A

VII. FY 20/21 Projections of Clients to be Served: LIFT has a program goal and projects to serve 105-110 individuals for FY 20-21.

VIII. FY 20/21 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 19/20 FSP clients that achieved the metric
Reduction in Hospital Admits*	72%
Reduction in Hospital Days*	75%
Reduction in Psychiatric Emergency Services (PES)*	73%
Reduction in Incarceration Days*	81%
Increase in the number of days Stably Housed*	24%
Primary Care visit within the previous year	53%
With an educational goal who are enrolled in school	50%
With a vocational goal who are employed	9%
Received a follow up visit within five days after a mental health hospitalization or crisis	66%
Average of four or more visits per month per client	70%

*The metrics above measuring "reductions" are looking at FSP clients served in FY 19/20 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
FSP # FS22

PROVIDER NAME: Telecare Corporation

PROGRAM NAME: JAMHR

Program Description: JAMHR is a full-service partnership program based on the Assertive Community Treatment model.

Target Population: JAMHR serve individuals with severe mental illness who have a history of justice involvement, are high utilizers of mental health services and who are considered to be at great risk for psychiatric hospitalization and recidivism.

How Much Did We Do?

I. FY 19/20

a. **Number of clients served:** 101 unique partners

How Well Did We Do?

II. Please describe ways that the program strives to:

a. **Reduce mental health stigma:** Reducing stigma is a natural part of the work that we do. We help partners reduce their internalized stigma by always treating them with dignity and respect, meeting partners where they are, using a strengths-based approach, having expectations that our partners that can and will make progress in their recovery, helping them to identify their values and motivations for change, appreciating their individual uniqueness. We provide partners with psychoeducation so they can understand their symptoms and reduce self-blame. We teach them skills to help them manage their symptoms, using concepts from CBT, DBT and Motivational Interviewing. We also help reduce outside stigma by providing psychoeducation to families/loved ones and to community members (medical providers, housing providers, etc.). We coach staff at congregate living homes to see our partners as unique individuals and encourage them take a strengths-based approach with partners. We are out in the community with our partners and model respectful interactions with them so other community members can observe and learn.
b. **Create a welcoming environment:** We warmly welcome our partners throughout their tenure with us, whether at our office our out in the community. When they are newly referred, we utilize a long engagement period to build rapport and really get to know them and their individual unique qualities. We meet our partners where they are in their recovery journey. We provide ongoing education to staff about how to provide person-centered care, cultural humility and curiosity, recognizing individual uniqueness and strengths. We take a harm reduction approach to partners' substance use and are not judgmental. We encourage meaningful activity and help our partners work towards

education and employment using the IPS model. We recognize and celebrate successes large and small!

III. Language Capacity for this program: In addition to English, JAMHR has capacity to provide services in Spanish and Urdu. We also use a certified language line to provide services in other languages.

IV. FY19/20 Challenges: COVID 19 brought unique challenges in the past year. Our staff quickly stepped up, 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, etc. Our staff increased their creative approaches to ensure that our partners continued to have their needs met during COVID 19 restrictions, including; engaging with partners through the use of art, poetry, music, journaling, book clubs, engaging in discussions using tools from Personal Medicine, Seeking Safety and Telecare's own Recovery Centered Clinical System. These services were provided while practicing social distancing, through house windows or by telephone, celebrating milestones with car parades, social distance lunches. COVID prevented face-to-face visits with partners who were incarcerated and made re-entry planning more difficult. The high cost of living in the Bay Area was an ongoing challenge last year, limiting housing options, especially for partners who are traditionally not successful in congregate living.

Is Anyone Better Off?

V. FY 19/20 Client Impact: Partners were quickly provided education about COVID 19 and how to minimize their risks. Partners who were unhoused were quickly linked to safe residences to allow them to reduce their risk of COVID by sheltering in place. Mental health service provision changed, but partners were able to continue to receive their much-needed services. Prior to COVID, partners were able to benefit from a new Seeking Safety group to help them address how their trauma histories affected their current level of functioning. Partners benefited from staff instruction on how to utilize art, journaling, music and poetry as part of their personal set of coping skills. Families who took part in the monthly family support group gained insight and education about how to best support their loved ones with mental health diagnoses. Partners gained increased awareness about risk factors for justice-involvement, and were coached on skills to minimize those risks and avoid recidivism.

Personal client story: Jessie was referred to JAMHR when his previous FSP closed. At the time of his referral, he was living in a supported apartment with his beloved dog. JAMHR team spent four months visiting his door at least once a week to engage, but Jessie was experiencing so much paranoia, bizarre behavior and grandiose delusions, that he would not open the door or respond verbally. JAMHR received regular desperate phone calls from his mother and listened actively to her concerns, providing general psychoeducation, but without confirming or denying Jessie's referral to the program, as he had not signed a release of information. Eventually, Jessie got into an altercation with a neighbor while walking his dog, and the neighbor hit Jessie with his car, breaking his femur and requiring surgery. While in the hospital emergency room, JAMHR staff was finally able to see Jessie's face in person for the first time. JAMHR advocated that Jessie desperately needed longer term sub-acute psychiatric care

after recovery from his surgery. During his three months in the sub-acute setting, JAMHR staff visited weekly, built rapport and trust with Jessie, learned about his many strengths and helped him transition back into the community. Jessie lived successfully in a congregate living home for the past year, recently moved to an SRO for increased independence, has a plan to work his way off of payee services, and studied to take the guard card test, finally achieving his dream of landing a job as a security guard. Next step – finding somewhere to live so he can get his dog back!

VI. FY 19/20 Additional Information:

VII. FY 20/21 Projections of Clients to be Served: JAMHR currently has 94 partners enrolled with 6 referrals. JAMHR projects to be at full census with enrolled partners at 100 this year, with the ability to transition at least 5 to a lower level of care, opening up spots for new referrals.

VIII. FY 20/21 Program or Service Changes:

- JAMHR will demonstrate ongoing flexibility to meet the latest recommendations for providing COVID-informed services.
- JAMHR will restart groups that partners and families can attend virtually, such as; Creative Coping Art Group, Seeking Safety, Family Support Group, and Motivational Group to help partners consider their motivations for change
- JAMHR will utilize partner housing funds creatively to increase the opportunities for partners to have safe and reliable housing at a variety of levels of care

Metrics	% of FY 19/20 FSP clients that achieved the metric
Reduction in Hospital Admits*	54%
Reduction in Hospital Days*	65%
Reduction in Psychiatric Emergency Services (PES)*	59%
Reduction in Incarceration Days*	82%
Increase in the number of days Stably Housed*	60%
Primary Care visit within the previous year	65%
With an educational goal who are enrolled in school	0%
With a vocational goal who are employed	0%

Received a follow up visit within five days after a mental health hospitalization or crisis	78%
Average of four or more visits per month per client	81%

*The metrics above measuring “reductions” are looking at FSP clients served in FY 19/20 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 19/20

a. **Number of clients served:** 100

How Well Did We Do?

II. Please describe ways that the program strives to:

a. **Reduce mental health stigma:** As a team Circa 60 works to integrate partners into their communities. We provide psychoeducation to the partners, their families, housing managers, and community organizations. We have a diverse, multidisciplinary team that have a wide variety of lived experience, including struggling with mental health issues. Circa 60 works to bring-in and build up natural supports through the use of Team Decision Making (TDM) meetings. The purpose of TDMs are to highlight the partner's voice in treatment. Team Circa60 engages in family therapy, family outreach, and has a family advocate on team to advocate for the families of our partners. We provide medication services, including education, prescriptions, and monitoring. Circa 60 uses a trauma informed approaches, motivational interviewing, and a harm reduction philosophy to engage partners. Circa 60 also has established relationships with property managers who understand mental health and strive to create a healthy independent environment.
b. **Create a welcoming environment:** Team Circa60 uses the wrap-around philosophy and this means the entire team outreaches and engages the partner wrapping around them while pulling in significant community supports. Circa 60 build positive relationships with its partners through a combination of community engagement, humor, comfort,

and compassion. We support our partners through dialysis appointments, PCP appointments, routine grocery shopping, walking around the community, and religious services. Circa 60 and its partners are on a first name basis and we are highlight that the partner's "voice and choice" guide treatment. Circa 60 was also designed to with Culturally and Linguistically Appropriate Services (CLAS) standards in mind. Circa 60 approaches substance abuse problems through the harm reduction philosophy and this allows partners to feel safe and welcomed even if they continue to use substances.

III. Language Capacity for this program: Circa60 has the capacity to provide treatment fluently in English and Spanish.

IV. FY19/20 Challenges: The main challenge confronting Circa 60 continues to be housing. Many of Circa 60s partners have complex physical and mental health diagnoses. These complex needs demand a level of supportive housing that is not achievable without a housing subsidy. Often our partners with complex physical health needs disqualify them for the HSP program meaning our partners end up in a lower level of housing support. Likewise, the community based CRTs and CSUs have strict regulations regarding touching partners. Many Circa 60 partners require physical support when changing clothes or using the restroom and unfortunately since this support is not allowed at community based residential crisis treatment centers Circa 60 partners go to psychiatric hospitals. Finally, COVID struck towards the end of the fiscal year and due to Circa 60's unique population all of our partners are at high-risk. Circa 60 also has several staff at high risk population. Both staff and partners worked together to safely engage and continue treatment.

Is Anyone Better Off?

V. FY 19/20 Client Impact: A 71-year-old partner who struggles with severe mania had been banned from all dialysis centers due to behavioral issues. The partner will die without this treatment. Circa 60 outreached to community dialysis centers and was able to forge an agreement with one center. Circa 60 accompanies the partner to and through the entire dialysis 3-days per week. Circa 60 has maintained its part of the bargain and the partner continues to receive life-saving dialysis treatment. Circa 60 has also been able to successfully house several chronically homeless partners. Circa 60 has wrapped around these partners to buttress their success. 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.

VI. FY 19/20 Additional Information:

VII. FY 20/21 Projections of Clients to be Served: 100

VIII. FY 20/21 Program or Service Changes: Circa60 promoted two program supervisors from with-in the program during the 19-20 fiscal year. Circa60 also brought on a new program manager promoted from with-in the FSPs. Circa60 will build on the foundation established with a focus on its psychiatry department. Circa 60 will also continue to build up its staff to full capacity and focus on meeting all fidelity requirements.

Metrics	% of FY 19/20 FSP clients that achieved the metric
Reduction in Hospital Admits*	69%
Reduction in Hospital Days*	71%
Reduction in Psychiatric Emergency Services (PES)*	76%
Reduction in Incarceration Days*	86%
Increase in the number of days Stably Housed*	51%
Primary Care visit within the previous year	41%
With an educational goal who are enrolled in school	0%
With a vocational goal who are employed	0%
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	73%

*The metrics above measuring “reductions” are looking at FSP clients served in FY 19/20 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 19/20

a. **Number of clients served: 54**

How Well Did We Do?

II. Please describe ways that the program strives to:

a. **Reduce mental health stigma:**

City of Fremont's mission is to deliver excellent services to all consumers in a caring, nurturing and respectful environment while improving their quality of life free of stigma and discrimination.

ACBHCS mission is to maximize the recovery, resiliency and wellness of all eligible clients who are developing or experiencing mental illness so they can successfully realize their potentials and pursue their dreams and free if stigma and discrimination.
In order to support City of Fremont and ACBHCS mission, we implement the following:

- Senior Mobile Mental Health program continues to conduct anti-stigma presentation to community partners to increase their awareness about mental illness.
- The program takes the lead in educating other staff about mental illness to increase awareness of their attitudes and behavior. The City of Fremont hired a consultant to provide CLAS (Culturally and Linguistic Appropriate Services) training to all Human services staff and have this training available to other city departments in the near future.
- During program presentations, we encourage potential clients and family to seek needed mental health services as early diagnosis and treatment are predictive of improve outcome.

- We invite our client/s to be part of the team when conducting program presentation to share their lived experiences of mental illness and describe their challenges and stories of success. When we integrate our peers into service provision, peers can help others to identify problems and suggest effective coping strategies. They can also foster the provision of non-judgmental and non- discriminatory services while identifying their own experiences.
- We continue to provide advocacy to our clients.
- We encourage our clients to openly talk about their illness and their treatment.
- We encourage our clients to not isolate and define themselves with their illness and to join support groups. Lack of human contact fosters discomfort, distrust and fear. All Human Services program facilitates positive interaction and connection between clients.
- We support NAMI'S motto "all members to become stigma "busters"
- Program administrator, Karen Grimsich, plays an active role as she participates in addressing and reducing stigma on the mental health legislative and policy change level.

b. Create a welcoming environment:

- City of Fremont provides the following protective factors for our clients: sense of belonging, positive work climate and access to needed services. Human Services Department provides mental health training for staff to equip themselves with in order to help create and support mental health friendly environment.
- City of Fremont promotes mental health friendly events to generate awareness in the creation of workplace of culture of tolerance and acceptance.
- Posters supporting mental health can be found in many areas of Human Services Department building.
- City of Fremont is ADA compliant

III. Language Capacity for this program:

Aging and Family Services has the following language capacity:

1. Spanish
2. Farsi
3. Mandarin/Cantonese
4. Tagalog and other Philippine dialect
5. Hindi
6. American Sign Language

We also have other language capacity provided by our student interns. This year we have Vietnamese speaking intern. We also utilize language line and volunteers for other languages we don't have capacity for.

IV. FY19/20 Challenges:

- Stigma and discrimination are still the foremost barriers deterring clients who need treatment from seeking services which also extend to their family members.
- Our program clients have multiple co- occurring medical and physical conditions leading to treatment cancellation thus trigger increase in their mental health symptoms.
- Due to their multiple medical/physical conditions, they also take so many medications. Some clients prefer not to add any psychiatric medication to their regimen.

- Language. Using language translator could also affect the effectivity of the treatment process.
- Religious beliefs and rituals: During Ramadan celebration, most of our Afghan clients postpone mental health services until the season is over.
- Most of our clients' lack capacity to utilize high technology devices except for their smart phones especially during the pandemic where the program must make a significant shift in service delivery.
- Medication adherence: Some of our clients will discontinue prescribed medication after they feel better without consulting with the prescriber.
- Losing independence: i.e. decline in mobility, losses, can easily trigger increase in symptoms.
- Low perceived need for services. There are referrals to the program who feel they don't need mental health services.
- Other mental health symptoms are very subtle and can be dismissed as attitude or personality, i.e. depression can be dismissed as laziness or fatigue.

Is Anyone Better Off?

V. FY 19/20 Client Impact:

In the year 2019 to 2020, most of our clients were able to maintain needed stability and functioning with the services we provided and no mental health hospitalization. Some clients were d/c to s step down program to gain additional independent skills before d/c from R and R program and re-integrate back to the community. Most of our clients are receptive to treatment once referred to the program leading to successful treatment outcome.

During the public health crisis (pandemic) we needed to shift our service provisions to telehealth or other high technology structure. Unfortunately, most of our clients do not have the capacity to use high technology to connect at this time.

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

55 clients for the Senior Mobile Mental Health Program

10 to 12 for the Recovery and Resiliency Program.

VII. FY 20/21 Program or Service Changes:

None currently. We will continue to use existing program structure and staffing.

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 19/20

a. **Number of clients served:** 963 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 Pool of Consumer Champions (POCC) in the past or are currently involved with POCC at this time. Crisis Services has worked closely with ACBH's 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. 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. FY19/20 Challenges: Crisis Services on-going expansion and services are impacted by this year's 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, 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 19/20 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):

- Law enforcement requested the MET team to evaluate an unidentified elderly woman who was refusing to leave a storage unit and walking around partially nude. MET clinician determined that

this woman was gravely disabled and unable to care for herself in the community and she was transported to a psychiatric facility for treatment.

- 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.
- Helen is an elderly woman who was experiencing hearing impairment, lives in a senior housing with IHSS supported by daughter. She was successfully referred to GART for mental health treatment and additional linkages.
- 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.

VI. FY 19/20 Additional Information: Crisis Services has received a fleet of new vehicles this year and has more on the way. These vehicles increase 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.

Crisis Services has continued to operate and provide services as usual despite on-going effects of COVID-19, California wildfires, and political unrest. We have taken precautions such as providing and requiring staff use PPE, sanitize work areas, as well as socially distance in our offices. Crisis Services staff also provide PPE to their clients in the community and provided support to Alameda County's Operation Room Key by having clinical staff provide telephonic outreach and follow up to clients who are residing in COVID hotels. Crisis clinicians have also responded to numerous crisis calls from COVID hotels and provided services to clients in person. Crisis Services Division Director Stephanie Lewis has conducted training and provided on-going support to COVID hotel staff. Despite the challenges faced by mental health providers this year, Crisis Services has actually continued to grow, hiring additional staff and moving forward with the planned expansion.

VII. FY 20/21 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 also begin a partnership in the field with Healthcare for the Homeless, which will likely lead to increased access and more services provided to individuals who are not securely housed.

VIII. FY 20/21 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. We also hope to expand operating hours and provide coverage into the weekends within the next year.

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 2019-20 Outcomes

a. Number of unique consumers/clients served: 132 clients

   FY 2019/2020 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 2019/20 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. FY2019/20 Challenges:

The BHC Program has had a steady decline in enrollment throughout 2020. Part of this is due to the closure of the courts during the first part of 2020 and pause on all new admissions due to the Covid pandemic. BHC has since resumed meeting in a virtual online platform, but continues to operate on a limited basis. Some clients who were previously engaged on a weekly basis with the court have become disengaged. While the online platform works for some individuals it does not work for all clients and many lack the access to technology to be able to engage with the court process. Mos providers who were previously able to provide transportation are no longer able to transport clients. The collaborative partners continue to make adjustments to improve the quality of the court experience for clients and those who support them.

Additional challenges to census include the COVID-19 emergency bail schedule that allows for the discharge of potential clients/inmates from jail before connecting to behavioral health services and in many of these cases the lack of contact information availalbe for their Public Defender or ACBH Clinician to be able to locate them for initial assessment.

VI. FY 2020/21 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; growing from a small 30-person program serving only individuals on Full Service Partnership Teams, to a 100 plus person program serving individuals at all outpatient levels of care. The program has also grown from serving only those with misdemeanor charges to expanding to serving individuals with misdemeanor and felony charges as pre-plea and individuals with strike charges as post-plea. BHC does not admit individuals who are post-conviction and/or on Probation unless there are new charges involved.

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 1:30 for staff to client ratio.

VII. FY 2020/21 Program or Service Changes:

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, we are actively in the process of working toward a MOU with our collaborative court partners, and adjusting the work flow procedures and related policies.

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.

How Much Did We Do?

I. FY 19/20

a. **Number of clients served:** 72

How Well Did We Do?

II. Please describe ways that the program strives to:

a. **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.
b. **Create a welcoming environment:** CAP believes it's 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 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.
As a result of CAP services:

- Clients spent fewer days in jail and more time connected to community treatment at the right-matched level of behavioral health care support
- Criminal Justice Professionals were better able to recognize, understand, and address the underlying issues leading to recidivism
- 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

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. FY19/20 Challenges: The Court Advocacy Project has had a steady decline in enrollment throughout 2020. Part of this is due to the COVID-19 emergency bail schedule that allows for the discharge of potential clients/inmates from jail allowing them to access services direcly in the community. Additional census challenges due to Covid during the first part of 2020 include the and increase of potential clients/inmates being cited and released instead of being booked at the jail, resulting in few clients being transported to and from the court house, and the closure of criminal courts.

Is Anyone Better Off?

V. FY 19/20 Client Impact: In reflecting on all of the clients I have had the opportunity to serve this year, one stands out in my mind as someone whose recovery I was able to directly support through the Court Advocacy Program. This referral was for a 62-year-old African American man with a significant amount of mental health history in Alameda County, including multiple hospitalizations and incarcerations. His referral came to me from a felony court room where he was represented by a public defender who was concerned about his mental health issues. This public defender sought support from CAP so we could craft an appropriate treatment-based option for him in the community. As a Mental Health Clinician/Advocate, my primary tasks are to engage with clients referred by the courts and make necessary referrals to mental health treatment. Since I noticed this gentleman had no outpatient treatment provider, I referred him to Alameda County's ACCESS Program. Through ACCESS he was assigned to an outpatient program in Alameda County. The team he was assigned to was one of our Full-Service Partnerships (FSP), Bay Area Community Services, Living Independently Forensic Team (LIFT). As one of the FSP teams who specialize in working with individuals with criminal justice history, they were uniquely qualified to provide this gentleman with a full array of services aimed at reducing recidivism. I also referred him to short term (2 weeks) Crisis Residential Treatment program to help in his

transition from jail back into the community. When I initially met him, this man stated that his main goal was "I need a place to live.". LIFT, along with providing case management and psychiatric services, connected him with their housing specialist. The LIFT housing specialist found him a licensed board and care home, and moved him in. By finding this gentleman stable housing, it has allowed LIFT to maintain his psychiatric stability in the community. Since CAP was able to intervene and provide essential mental health referrals and services, this man was able to effectively use these supports to break his pattern of recidivism.

VI. FY 19/20 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. FY 20/21 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 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 mental health programs at the Project RoomKey Hotels.

VIII. FY 20/21 Program or Service Changes: 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.

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.

How Much Did We Do? **I. FY 19/20**

a. **Number of clients served: 437**

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:

This fiscal year, the GC worked 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 FY19/20, 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. FY19/20 Challenges:

The biggest challenge this fiscal year was 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 shifted 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.

Is Anyone Better Off?

V. FY 19/20 Client Impact:

Below is an example of a Guidance Clinic (GC) staff member initiating support for a youth while in detention and connecting the youth and family to services in the community.

A youth was detained at the Juvenile Hall because of a domestic violence situation with mom. Youth had a history of parents calling 911 and having the young person hospitalized. It was the youth's first time at Juvenile Hall.

The Courts mandated family therapy. However, the youth only wanted individual therapy because they were not ready to talk to their parents. Upon the youth's release, a GC staff member made a referral to Eden Counseling Services. The GC staff member also provided the young person with her contact info in case the youth needed to speak to someone urgently.

While waiting to be connected to a therapist in the community, the young person had several disputes with the parents and would reach out to the GC staff person for support. The GC staff person was able to provide social emotional support and psychoeducation, thereby avoiding escalation and potential arrest or hospitalization. The GC staff person continued to support the youth until the youth was established with the community therapist. When the therapist was prepared to see the youth, the GC staff person provided a warm hand-off and shared any pertinent information to support the youth's treatment. The youth was also referred to an Alameda County Behavioral Health contracted provider who serves youth on probation. The provider was able to work with the youth and parents to begin family therapy.

VI. FY 19/20 Additional Information:

There are several additional changes/improvements that occured this fiscal year:

- The Guidance Clinic (GC) hired a new Clinic Manager who started in August.
- The GC worked with the medical clinic at the Juvenile Justice Center to implment the Patient Health Questionnere-9 (adolescent module) to better screen youth for risk of suicide/self-harm.
- The GC worked with Probation and the medical clinic to strengthen the care coordination process for youth in order to begin referrals for community services as early as possible.

VII. FY 20/21 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 20/21. We project 400 youth will be served in the next fiscal year.

VIII. FY 20/21 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 19/20

a. **Number of clients served: 42**

How Well Did We Do?

II. Please describe ways that the program strives to:

a. **Reduce mental health stigma:**
MST works to reduce stigma related to mental health by providing services on our clients' terms – in the community and during flexible times to meet the needs of our youth and families. We work very hard to focus on the families' goals for services and build relationships through the delivery of practical/tangible support (financial, transportation, etc.).

b. **Create a welcoming environment:**
Many of the families we provide services to have experienced multiple traumas and have Family members who have mental health issues that have impaired their ability to successfully function in the community. MST provides in home and community-based service which reduces the stigma many families feel related to being in a facility that provides mental health services. By providing services in the home and community, MST strives to remove this stigma. MST is also present-focused and strength-based which empowers the families to utilize the positive aspects of their family system to develop

effective strategies and interventions that support and assist them with managing any mental health issues they are encountering. The goal is to provide an experience with the client and the family that will disconfirm their negative beliefs about mental health treatment and the stigma that's often attached to it.

One of the primary tenants of MST is engagement. Family and caregiver engagement is critical to ensure positive treatment outcomes. The other purpose of engagement is to ensure that the family feels heard and understood; we achieve engagement by spending a great deal of time listening to the "story" of the family. This creates an environment of acceptance and understanding which leads to higher level of engagement between the clinician, the client and their family.

III. Language Capacity for this program: English and Spanish

IV. FY19/20 Challenges:

Is Anyone Better Off?

V. FY 19/20 Client Impact:

MST is a service which demonstrates continuous effort and increasing responsibility of involved participants to support youth in being released from the Juvenile Justice System. This is an account of a young man, "Marcus," who participated in services with his mother, Wendy, and MST clinician to manage his decision making and target his responses to anger and frustration. Marcus was ultimately released from probation due to the support that he received in working in collaboration with MST, Wendy, his probation officer, and extended family members.

Marcus is a 17-year-old male who identifies as African-American and is Wendy's youngest child. This was his first time on probation, according to probation officer, Wendy, and self-reports. Marcus has had a history of challenges with anger, frustration, and adverse decision making. Marcus was placed on probation after having been arrested and charged for burglary of a store. Marcus was referred to the MST program by his probation officer to target aspects of parenting such as communication, conflict resolution, and supervision and monitoring of youth. Concerns at the time of referral also included Marcus' ability to make sound decisions that do not adversely impact him as well as his ability to utilize coping skills when he is angry or frustrated. His behaviors when angry or frustrated also contributed to the probation officer having a negative cognition of youth, officer also stating "I'm worried that when he is angry he's going to make a dumb decision and create another crime." Initially, at the beginning of treatment which consisted of twice-a-week meetings between Marcus and Wendy, he expressed indifference to participation in the program and expressed that the "problems" were with others and not necessarily with him. Marcus engaged with a treatment team consisting of the MST clinician, a covering MST clinician for one month, probation officer, school staff, and extended family members such as his older adult sister. Marcus eventually came to participate less indifferently and more pro-actively. He was able to eliminate substance use, which he connected as having an impact on his anger and frustration. He also grew in his ability to communicate frustration to Wendy and his probation officer without exhibiting explosive behaviors such as yelling and pounding on nearby objects. While participating in MST, Marcus also completed his high school requirements six months early before graduation. He obtained employment and he was also dismissed and discharged from the juvenile justice system. MST was instrumental in supporting the above advances via focusing on Marcus' adherence to his mother's expectations and her increasing supervision

and monitoring, thus increasing their home-to-school link. Marcus' older sister, who was a full time student, also supported Wendy.

Therapeutic trust and alliance were also built between the family and the two MST clinicians in order for the family to trust and consider the interventions that were provided. Marcus and Wendy met their goals through the continuous effort made by them, their supports, and the MST team.

VI. FY 19/20 Additional Information: None

VII. FY 20/21 Projections of Clients to be Served: 45

VIII. FY 20/21 Program or Service Changes: None

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 11

PROVIDER NAME: Bay Area Community Services (BACS)

PROGRAM NAME: 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 19/20

a. **Number of clients served:**
   Amber House CRT- 283 total (263 non-duplicated clients)
   Amber House CSU- 949 total (383 non-duplicated clients)

How Well Did We Do?

II. Please describe ways that the program strives to:

a. **Reduce mental health stigma:**

Amber House serves a disproportionately aided population, wherein chronic homelessness, severe and persistent mental illness, and co-occurring substance use disorders are the primary concerns of our partners. Amber House, both in philosophy and practice, encompasses a holistic, strengths-based, and harm-reduction approach through crisis interventions and connecting our partners with a wide array of services that can be utilized post-discharge. It is Amber House's practice to reduce mental health stigma by providing interventions that foster collaboration, support, and community, while simultaneously integrating culturally-sensitive interventions that elevate our partners' strengths and attempt to reduce the severity of symptoms via group and individual therapy, daily skill building, and medication management.

b. Create a welcoming environment:

Given the diversity of our population, Amber House strives to provide treatment that fosters a multicultural approach. Staff are regularly trained in interventions that emphasize collaboration and culturally-sensitive techniques that respect clients' cultural backgrounds and identities. In addition, it is our mission to provide a warm, welcoming environment via warm meals, a comfortable living space, and unconditional support, in order to serve their basic needs; this is the catalyst for healing.

III. 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

IV. FY19/20 Challenges:

COVID-19 has posed 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.

Is Anyone Better Off?

V. FY 19/20 Client Impact:

Amber House CRT clients discharged to lower level of care: **186 (65.9%)**

Amber House CSU clients discharged to lower level of care: **869 (91.6%)**

Amber House CRT clients discharged to higher level of care/5150: **25 (8.8%)**

Amber House CSU clients discharged to higher level of care/5150: **33 (3.4%)**

Amber House CRT clients discharged as a result of AMA: **72 (25.3%)**

Amber House CSU clients discharged as a result of AMA: **47 (5%)**

VI. FY 19/20 Additional Information:

VII. FY 20/21 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.

VIII. FY 20/21 Program or Service Changes: None

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 19/20

a. **Number of clients served**: 1,036

How Well Did We Do?

II. Please describe ways that the program strives to:

a. **Reduce mental health stigma:** psychoeducation for clients and caregivers; normalizing and disconfirming stance toward presenting concern; sponsor trainings for school, community and outpatient practitioners to orient them to suicide prevention and our program

b. Create a welcoming environment: gender affirming policies and practices in direct care and clinical documentation; non-institutional décor; inclusive posters; culturally representative staffing; access to religious/spiritual materials (texts, prayer rugs, etc.); library with developmentally and culturally relevant reading material; sensory items for emotionally dysregulated clients; proactive engagement and responsiveness to client survey comments

III. Language Capacity for this program: Spanish, Vietnamese, Japanese, Tamil

IV. FY19/20 Challenges: adapting face-to-face services while preventing COVID 19 exposure to staff and clients; distance learning means less structure for youth with intellectual disabilities and ASD; telehealth taking the place of face-to-face services creates gaps in the continuum of care; increased number of youth from Riverside and San Bernardino counties placed in Alameda county without being connected to psychiatry and/or therapy; inconsistent COVID 19 screening protocols across inpatient units creates

bottlenecks in placing youth; no placement options for youth who are COVID positive or suspected positive who need inpatient hospitalization.

Is Anyone Better Off?

V. FY 19/20 Client Impact:

- Only 4.9% of youth served at the CSU returned within 7 days;
- Only 6.87% youth served at the CSU returned within 30 days;
- 91% of youth responded positively when asked about feeling safe at the CSU;
- 92% of youth responded positively when asked about feeling supported at the CSU;
- 98% of caregivers responded positively when asked if staff responded in a timely manner;
- 98% of caregivers responded positively when asked if staff were professional and friendly, and
- 94% of caregivers responded positively when asked if staff kept them informed about their child's care.

VI. FY 19/20 Additional Information: N/A

VII. FY 20/21 Projections of Clients to be Served: 1,000

VIII. FY 20/21 Program or Service Changes: N/A

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 API 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 API 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 all consumers living in Alameda County, with primary focus on individuals and families who identify themselves as Asian and Pacific Islanders. The consumers can 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/service linkage – served 498 unduplicated intake clients with 2,112 service contacts.
   - Crisis stabilization outpatient treatment - served unduplicated 120 clients.
   - Outreach/psychoeducation – served 1,880 community members (21 street fairs & community groups, 6 specialty clinic tabling, 3 community education events, 2 ZOOM service promotions)

How Well Did We Do?

II. Please describe ways that the program strives to:

a. **Reduce mental health stigma:**
   - Conducted tabling and screening at an API-focused dental clinic to foster trust building with community members through leveraging API holistic health concept.
   - Partnered with Stanford CHIPAO and/or API-focused CBO's to conduct community education events with skits, workshops, resource booths, cultural performances to address MH stigma.
   - Tapped into standing community meetings, youth groups, and interest classes to mobilize community leaders on raising MH awareness and promoting help seeking behaviors.
   - Experimented the use of holiday season greeting cards in multiple languages (English, Chinese, Vietnamese, Korean, Japanese) to raise MH awareness amongst API populations.
   - Produced audiovisual/infographic materials to prepare for launching a sustainable mental health awareness/anti-stigma campaign on social media.

b. **Create a welcoming environment:**
   - All clinicians are bilingual/bicultural staff with experiences from immigration families to effectively access clients' social and cultural needs and deliver comprehensive MH services.
   - Psychoeducation, flyers, and brochures are available in API languages (Chinese, Vietnamese, Khmer, Korean, and Filipino) to meet cultural and language needs of the populations.

- Mobile outreach and pre-treatment case management are piloted to help intake clients address life stressors, remove help-seeking barriers, and prioritize mental health needs.
- Home-based and hospital-based visits are conducted to enhance clients' engagement and service participation.
- PCP, board and care home, pharmacy, ACVP, HSO, IHSS, para-transit, and relevant service agencies are involved in ongoing collaboration to support clients and families.

III. Language Capacity for this program:

- Services are provided in API languages including but not limited to Cantonese, Mandarin, Vietnamese, Khmer, Korean, Japanese, Mien, and Tagalog. Interpretation for other API languages.

IV. FY19/20 Challenges:

- The exacerbation of COVID-19 pandemic in March and social justice rallies and protest later led to client's safety concerns, no shows, and appointment cancelations. Telehealth services were promptly expanded to enable client's access to continuous services.
- Challenges for recruiting bilingual and culturally responsive MH providers to fill staff openings disrupted outreach efforts, referral process, case opening, and service delivery.
- Due to API untimely service seeking and severe psychiatric symptoms upon referrals, difficulties were encountered making urgent psychiatric service arrangement with limited resources.
- With service presentation and site visits to API-focused Prevention Programs, there was mild improvement in the 2-way referral processes. More work has to be done for collaboration.

Is Anyone Better Off?

V. FY 19/20 Client Impact:

- Among 498 Intake clients, 182 clients were fully screened/referred to proper level of services.
- Among 120 Treatment clients, 49 recovered from distributing symptoms and were discharged to PCP or lower level of care. 10 with chronic symptoms were referred to higher level of proper care.
- Improved timely access to screening & service linkage by completing 1st phase of intake coverage restructuring with both primary and secondary specialists for 40% of intake shifts.
- Presented API social/cultural barriers to MH Services and BHCS service info to 60 PCPs and disseminated service info to all API-focused MediCal PCP clinics in Alameda County.
- Mailed service flyers to Chinese and Vietnamese churches/temples and promoted services in two 3rd party "Psychological Dynamic in SIP" ZOOM sessions for Chinese Christian leaders.
- Explored alternative channels to promote community education events on school district e-flyer platform (Peachjar), traditional media (World Journal, KEST 1450, KVTO 1400, KTSF 26, City Councilmember newsletter), and social media (Facebook, WeChat, Eventbrite)
- A case study "Mr. T is an 18 years old Chinese male. He immigrated from China with parents at age 13. He struggled with acculturation difficulties, communication issues with parents, depressive mood, and suicidal ideation and attempts. Due to the lack of understanding about mental health and available community resources from Mr. T and his parents, proper services were not sought until his PCP made a referral to AHS ACCESS. During referral process and initial service arrangement, Mr. T expressed concerns about frequent treatment sessions and refused his parents' involvement in his wellness recovery process. With engagement and psychoeducation effort from his therapist, Mr. T managed to actively participated in therapy and medication treatment and achieve gradual improvement in addressing his depressive symptoms and suicidal struggles. Later he became open to join family sessions with his parents together to process

intergenerational communication challenges, establish adaptive parental expectations, and strengthen the support system. With the improvement in symptom management and overall functioning, he was discharged back to PCP clinic for regular health care services."

VI. FY 19/20 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.

VII. FY 20/21 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

- Crisis stabilization outpatient treatment - 3,691 hours of service to 130 unduplicated clients, including 322 hours of medication support

VIII. FY 20/21 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**
   - Implement a call center system with both primary and secondary intake specialists for all intake shifts to improve timely access from clients to screening and service linkage
   - Expand mobile outreach and pre-treatment case management to help clients address life stressors, remove help-seeking barriers, and prioritize mental health needs
   - Leverage API holistic health concept and help seeking pattern to provide consultation and service referrals at health clinics, community service centers, and school/religious settings

b. **Audience-targeting Outreach - Promote API help-seeking through audience targeting outreach/psychoeducation at API-focused cultural events and standing community meetings**
   - Conduct frequent small/medium scale community education events to address cultural barriers and promote help-seeking in local communities
   - Provide audience targeting psychoeducation at API-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 of mental illness to raise mental health awareness/acceptance among API communities through social/traditional media**
   - Launch a MH awareness website and disseminate audience-targeting materials (recovery stories, sound tracks, video clips, infographic materials, etc.) on social media
   - Prepare PSA for API-focused traditional media newspapers/radio/TV channels

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
   - Define geographic clusters of clients by cultural and linguistic needs and secure pro bono or hourly rented space at welcoming community spots for mobile/field-based service delivery

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 15

PROVIDER NAME: La Familia

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 Familia 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 19/20

a. **Number of clients served: 171**

How Well Did We Do?

II. Please describe ways that the program strives to:

Reduce mental health stigma and creating a welcoming environment for all:
La Familia's organizational values aligned with MHSA's principles. We strive to operate our program with these values in mind.

- Belonging – we help those around us feel important, connected, and confident in a community of hope. This sense of belonging is rooted in compassion and respect for shared cultures, values, and lived experiences
- Partnership – we engage in meaningful partnerships with organizations, communities, and the people we serve.
- Self-determination – we help people to recognize and build on their talents, strengths and goals to enhance their self-determination, leadership and power.
- Social Justice – we amplify the voices of our community to fight for systems, policies, opportunities and services that promote social and economic justice and improve the quality of life for all.
- Integrity – we hold ourselves to the highest standards of respect, truthfulness, follow through and accountability. As a result we achieve measurable results for the people and communities we serve.

More specifically, in relation to MHSA principles.

- Cultural Competence – our staff is comprised of native Spanish speakers who practice cultural competency and cultural humility to the clients we serve.
- Community Collaboration – we make many efforts to collaborate with other health institutions as well as local educational and workforce institutions in the spirit of serving our clients and connecting them to appropriate services.
- Client, Consumer and Family involvement – we engage clients in developing their own treatment goals. When appropriate we engage family members in this process.
  Integrated Service Delivery – our agency
- Integrated Service Delivery – our agency has PEI services as well as Level 1 services and we work collaborative throughout the agency when appropriate referral of services are needed in order to make transitions for clients as seamless as possible.
- Wellness and Recovery – we work collaborative with clients to participate and define their own goals.

III. Language Capacity for this program:

The Spanish Language Acute Crisis Care and Evaluation for System-Wide Services (ACCESS) program provides crisis stabilization services for Latino and/or Spanish speaking clients ages 18 and older who are experiencing acute mental health symptoms. Through the ACCESS program, we provide needs assessment services, brief stabilization treatment, and referrals to longer-term outpatient counseling, medication management or to the Service Team program.

Clients are referred to our Spanish Language ACCESS Program through the Alameda County Behavioral Health Care Services (BHCS), psychiatric hospitals, primary care doctors, or by calling the La Familia's Adult Outpatient Department's main phone number at 1-510-881-5921.

IV. FY19/20 Challenges:

La Familia was below target goal due to a few items that have already been addressed in previous reports:
-Our program was understaffed due to staffing changes. The program is working towards fully staffing as of 8/1/2020: we have a full-time clinician and a full time Program Manager in our program. In addition, we have on boarded two clinical interns for this program.

-Another item affecting our target goal was having fewer requests for services from Alameda County ACCESS in the previous quarter. Sr. Director, Wajeeha Khan, LMFT, had reached out to Dr. Jon Stenson to request more referrals and to inform them of availability. Requests have been coming through in the month of July 2020 and August 2020. We will continue to collaborate with La Clinica and TVHC, Inc. to increase support for our clients. We also contact our other internal programming, such as La Familia's EPSDT program and Cultura y Bienestar, to increase our referrals. Recently, perhaps due to COVID-19, we have not seen referrals from neighboring primary clinics.
-We anticipate that our numbers will increase gradually increase, despite challenges currently faced with the Shelter in Place. We continue to do our best with responding to new calls and attending to current Client's via phone and Telecare services.

Is Anyone Better Off?

V. FY 19/20 Client Impact:

Requests for services have been increasing since June 2020. Client with anxiety, depression, and family relationship problems have been the main concern and reason for clients seeking therapy.

VI. FY 19/20 Additional Information:

We have increased internal training with all staff such as:

Leadership Development, HIPPA training, Self-Care

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

We are reaching out to intake calls and requests within 5 days to increase client support. Request for Services are for clients in the Hayward, San Leandro, and San Lorenzo areas.

VIII. FY 20/21 Program or Service Changes:

- During this reporting period, La Familia continued to provide quality services in the Spanish language. This includes administrative materials and culturally and linguistically congruent services.
- La Familia continued to network and work collaboratively with other providers, especially other Latino organizations such as La Clinica and Tiburcio Vasquez Health Center. When possible we also worked collaboratively with County ACCESS, John George Pavilion, Hayward Wellness Center and other county providers
- We constantly assessed client's needs and provided inter-agency referrals to our own Early Intervention and Prevention Program, "Cultura y Bienestar" to clients who did not meet the moderate to severe criteria.
- Clients who have engaged in services had low psychiatric relapses and were able to provide services to stabilize clients who present in crisis.
- Clients connected well with La Familia's clinicians.
- We successfully on boarded our ACCESS Program Manager, Jennifer Vazquez, LCSW
- We successfully on boarded our Senior Director of Adult Programs, Wajeeha Khan, LMFT
- We have trained our MHRS to complete ANSA forms for review by a licensed clinician.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 17

PROVIDER NAME: Berkeley Place

PROGRAM NAME: Casa de la Vida, Co-occurring Residential

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. We have a wonderful staff of Master's and Doctorate level mental health professionals whom reflect the diversity of our clientele. 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.

Our Services Include:

- 24 Hour Staffing & Crisis Support

Casa de la Vida has well trained staff present 24 hours a day, 7 days a week to meet client's needs & assist in the event of a mental health crisis. Our staff are experienced in de-escalation techniques, suicide assessment and conflict resolution.

- Day Program

Casa de la Vida provides 3 groups every weekday, all led by mental health professionals. These groups are primarily mental health group therapy and psychoeducation, as well as independent living skills groups. Clients are required to attend groups unless they have an outside structured activity, such as work or school.

- One-on-One Counseling & Treatment Planning

Each client is assigned a Primary Counselor from our wonderful team of LMFT's, AMFT's, PsyD's and Mental Health Rehabilitation Specialists. Clients collaboratively create a Treatment Plan with their Primary Counselor based on their self-defined goals, as well as mental health needs. Clients meet at least once a week with their counselor, and counselors are available throughout the week to provide support. In

addition, pre-crisis strategies are made with clients in order to reduce chances of hospitalization or substance relapse.

- A Supportive Housing Environment

Clients generally live at our program for 3-6 months, although length of stay varies based on client needs. While living in the house, clients have the opportunity to make lasting friendships and learn pro-social conduct and communication through staff observation and intervention. These skills can increase client's chances of success in maintaining stable housing in the future.

- Substance Use Support

Clients whom need support with substance use receive counseling and often simultaneously attend outpatient substance use treatment programs. Casa de la Vida can be a wonderful steppingstone from drug treatment facilities to being able to maintain sobriety independently. This is due to the larger level of freedom given to clients, while still providing counseling and support as real life triggers arise.

- Family Counseling

Many of our clients and their families have struggled tremendously due to mental health issues. Clients stay at Casa de la Vida can be a much-needed break for caregivers and a time to heal. We provide family counseling in order to provide psychoeducation to families about mental illness, repair relationships and for those moving home after the program, strategize for a successful stay in the family home.

- Independent Living Skills Training

For many of our clients struggling with severe and moderate mental illness, daily life can be challenging. Our highly trained staff support clients in learning to maintain their hygiene, budget money, cook, clean and manage their medications. These skills can greatly increase client's chances of success in their next living environment, whether it be with family, roommates or alone.

- Recreational & Cultural Activities

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 18

PROVIDER NAME: Network of ACNMHC

PROGRAM NAME: Wellness Centers

Program Description: Wellness Centers provide a welcoming entry point for outpatient services for individuals who are unserved or underserved by the mental health system. They provide step-down service for individuals transitioning from ACBH specialty mental health services in an environment of inclusion and acceptance in facilities that are commonly managed and staffed by consumers who provide or arrange for peer support. Wellness Centers are contracted providers who perform outreach and engagement; offer outpatient services such as mental health services, case management/brokerage, crisis intervention, medication support/dispensing; provide peer support and wellness services; and Tenant Support Services (TSP) for those with housing insecurity.

Target Population: Network of ACNMHC Wellness Centers provide services to some TAY and Adults (ages 18+) who identify as being behavioral health consumers in programs funded through ACBH. They make it a priority to serve behavioral health consumers who: Have histories or current conditions of psychiatric disabilities; are identified or labeled as having severe mental illness (SMI) or severe mental stress; have experienced (or are at risk of experiencing) repeated psychiatric hospitalizations, treatment placements, or episodes of incarceration in the criminal justice system; are experiencing housing insecurity; and those who are experiencing problems with alcohol and/or other drug abuse.

I. FY 2019-20 Outcomes

a. **Number of unique consumers/clients served:** 16,268
b. FY 2019/20 Impact:

II. Please describe ways that the program strives to:

a. **Reduce mental health stigma**: The Network reduces mental health stigma through active peer support, community engagement/consumer input and consumer employment. Housing advocacy and intensive case management provided by individuals who have lived experience receiving mental health services mold recovery.
b. **Create a welcoming environment**: The Network strives to maintain a welcoming environment by offering a warm presentation, possibly a program volunteer, is there to greet consumers when they arrive and a safe and clean waiting space.

Minimally, all of our spaces provide water, coffee and snacks. All of our programs have brochures about the agency available as well as a variety mental health recovery motivated materials.

III. Language Capacity for this program:

A. English, Minimal Spanish. Materials provided in other languages besides English and Spanish

IV. FY 2019-20 Additional Information:

V. FY2019-20 Challenges:

A. Staff shortage / retention: We are developing a more suitable staffing structure to address this challenge.
B. Increased operating costs: Rent, Fringe benefits, Liability insurance
C. Reduced service deliverables: This may impact the quality of what services are being offered.

VI. FY 2019/20 Projections of Clients to be Served:

1. 10% increase in consumer contact. We have increased our contacts by at least 10% annually

VII. FY2019-20 Program or Service Changes:

1. Tenant Support Program: WRAP Groups - 5 cohorts annual off site / 1 weekly open WRAP group on site
2. BestNOW!: The training program will Mental Health Peer Support and Substance Use Disorder. This will include internship opportunities.
3. Reach Out: Increase curriculum and wellness activities

CASA UBUNTU WELLNESS CENTER

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 18

PROVIDER NAME: Bonita House

PROGRAM NAME: Wellness Centers

Program Description: Wellness Centers provide a welcoming entry point for outpatient services for individuals who are unserved or underserved by the mental health system. They provide step-down service for individuals transitioning from ACBH specialty mental health services in an environment of inclusion and acceptance in facilities that are commonly managed and staffed by consumers who provide or arrange for peer support. Wellness Centers are contracted providers who perform outreach and engagement; offer outpatient services such as mental health services, case management/brokerage, crisis intervention, medication support/dispensing; provide peer support and wellness services; and Individual Placement and Support (IPS) Supported Employment services.

Target Population: The Bonita House Wellness Center provides services to adults (age 25+) experiencing mental health challenges. These individuals may or may not be currently enrolled in ACBH specialty mental health programs (such as Service Teams, Full Service Partnerships, etc.).

Additional Requirements for IPS Supported Employment

Contractor shall work with individuals who have expressed interest and motivation in pursuing competitive employment, regardless of their employment readiness, diagnoses, symptoms, substance use history, psychiatric hospitalizations, homelessness, level of disability, or legal system involvement.

How Much Did We Do?

I. FY 19/20

a. **Number of clients served:** 52 Unduplicated Clients were served, which is 30% more than the contracted 40 unduplicated clients which the . Those strong numbers are recorded even though Casa Ubuntu operated completely virtually during March through June 30th.

How Well Did We Do?

II. Please describe ways that the program strives to:

a. Reduce mental health 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 in May. The topic of the training focused 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 an 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 specialist who have lived experience with mental health and substance use issues
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.
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.

b. 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 reach out to their clients via phone on a regular basis and invite 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.

III. Language Capacity for this program:

- We have one Spanish speaking Peer Support Specialist who orients and supports Spanish-speaking clients
- We have and offer 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 Kmer (Cambodian)
- Press 8 for Korean
- Press 9 for Arabic
- Press 0 for All Other Languages to Connect with an Operator

IV. FY19/20 Challenges:

- The biggest challenge of the next year will most certainly be the Shelter-in-Place mandate due to COVID-19 and the temporary closure of our Eastmont facility.
- Due to the necessity of telehealth services while we remain in temporary closure, technology issues are also paramount. They include the following:
    - 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.
    - Some 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
    - 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
    - Increasing comfort levels and productivity of Zoom groups
    - Adding new clients into the Wellness Center when they have never visited the facility or met staff in person
    - Our leadership transition
    - Intervening in meaningful ways when consumers are in crisis
    - With the flailing economy and unemployment rates high, job searches and job placements will likely be challenging for the next several months

Is Anyone Better Off?

V. FY 19/20 Client Impact: Please see the latest results of our Satisfaction Survey, which indicates clearly that 95% of our consumers think that they are significantly better off because of the services they are receiving at Casa Ubuntu. The sample population of 22 for the 4th quarter (while operating virtually) gave our services very high satisfaction marks.

Satisfaction Survey Results July 31 2020.docx

VI. FY 19/20 Additional Information:

- The Wellness Center has new leader, Greg Becker, LMFT, Director of Acute, Residential and Wellness
- A .5 PTE clinician will begin working at Casa Ubuntu in August

- There is an IPS (Individual Placement and Support) specialist on staff. We use an evidence-based model for supported employment.

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

In spite of all the COVID-19 related challenges, we expect to meet the following 2010/2021 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

VIII. FY 20/21 Program or Service Changes:

New:

- Medi-Cal and Federal Funding Requirements Apply

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 18

PROVIDER NAME: Bay Area Community Services (BACS)

PROGRAM NAME: Wellness Centers (HEDCO)

Program Description: Wellness Centers provide a welcoming entry point for outpatient services for individuals who are unserved or underserved by the mental health system. They provide step-down service for individuals transitioning from ACBH specialty mental health services in an environment of inclusion and acceptance in facilities that are commonly managed and staffed by consumers who provide or arrange for peer support. Wellness Centers are contracted providers who perform outreach and engagement; offer outpatient services such as mental health services, case management/brokerage, crisis intervention, medication support/dispensing; provide peer support and wellness services; and Tenant Support Services (TSP) for those with housing insecurity. Wellness Center 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 program was designed with Culturally and Linguistically Appropriate Services (CLAS) standards in mind

Target Population: Wellness Centers provide services to some TAY and Adults (ages 18+) who identify as being behavioral health consumers in programs funded through ACBH. They make it a priority to serve behavioral health consumers who: Have histories or current conditions of psychiatric disabilities; are identified or labeled as having severe mental illness (SMI) or severe mental stress; have experienced (or are at risk of experiencing) repeated psychiatric hospitalizations, treatment placements, or episodes of incarceration in the criminal justice system; are experiencing housing insecurity; and those who are experiencing problems with alcohol and/or other drug abuse.

How Much Did We Do?

I. FY 19/20

a. **Number of clients served:** Hedco Wellness Center served 1,161 unduplicated individuals for the FY 19/20

How Well Did We Do?

II. Please describe ways that the program strives to:

a. Reduce mental health stigma: Hedco Wellness Center strives to provide an open and non-judgmental space to be able to have conversations about mental health and overall wellness and recovery. The center provides educational groups for mental health, resources, and ways to take better care of oneself. Hedco has peer lead groups to create a safe environment for all the partners to freely discuss challenges and coping skills. Staff continue to have trainings about mental health, harm reduction, and ways to better support the partners. The staff at Hedco provide daily groups to support partners with new ways to manage their mental health symptoms. The first group every morning is a wellness check in, during that time partners discuss current events and the impact on

our well-being and our community. Staff also provide resources during the group. The Art and Crafts group is to help understand emotions, behaviors, and feelings through the creative art process, learning to apply art as a coping skill to resolve issues, reduce stress, and increase awareness. One of the most popular and valuable groups at Hedco is Building Self-Esteem. Most of our partners are homeless and struggling with their image of themselves and struggles with their daily ADLs/IADLs. The group teaches techniques to handle mistakes, respond to criticism, foster compassion, achieve goals, and visualize self-acceptance. Dialectical Behavioral Therapy (DBT) group is facilitated by staff that has been through trauma or training them-self.

b. **Create a welcoming environment:** We engage with partners to implement their feedback about the center and collaborate with partners to work on welcoming and safe place for everyone. Starting the day with breakfast and community group helps with creating a welcoming environment and sense of community. Personnel at the Wellness Center 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 Wellness Center program was designed with Culturally and Linguistically Appropriate Services (CLAS) standards in mind.

III. Language Capacity for this program: At Hedco Wellness Center, we have staff that speak Farsi, Spanish, Hindi, and Gujarati to support partners and provide services.

IV. FY19/20 Challenges: During the pandemic and shelter in place, the Wellness Center is able to support partners daily with resources and meals. Our partners have communicated to staff that Hedco has been a safe place for them and that they will continue coming to Wellness Center for support. The biggest challenge has been with the program now being able to provide services from within the center, including not being able to have structure to the days and providing daily groups. Instead, partners call via telephone to check-in with staff inquiring about when the center will be open again because they miss the daily structure Hedco provides, groups, and their social interactions with peers. Our staff work hard to continue providing support to partners with community resources and follow-up check-in phone calls if requested.

Is Anyone Better Off?

V. FY 19/20 Client Impact: At Hedco, staff would provide a housing and employment workshop once a week to support the partners that are struggling on locating stable housing and financial income. The housing workshop creates a safe place for individuals to learn more about housing resources and low-income housing waiting list and also get assessed. The employment workshop support partners with mock interviews, work appropriate presentation, and barriers that presents for partner. During the pandemic, we were able to place two individuals in two different support programs. The first partner was having some difficulties with his mental health symptoms and was referred to Woodroe Place for stabilization and then transferred to Life House for housing. The second partner was struggling with alcoholism and didn't know of any resources on how to get help. He spoke Farsi and staff was able to communicate with him, support him with resources, and get him into cherry hill detox. He is now enrolled in an in-patient program in San Francisco for 3 months. He checks in weekly over the phone to update us about his recovery progress. Partner S.G was struggling with substance use and mental health symptoms such as auditory and visual hallucinations. Partner was encouraged daily by staff at Hedco to reach out to case manager for support, and staff supported partner with community resources. Staff encouraged partner to seek help after encouraging the partner multiple times, she reached out for support. She was admitted into John George Psychiatric Hospital for 3 months for stabilization. When partner was discharged, she came back to the center and was very engaged in the program and groups. Partner shared she is doing much better now, and

thanked staff at the center for always being there for emotional support. Partner was housed in a Board and care in Oakland for housing.

VI. FY 19/20 Additional Information: The Fiscal year 19/20 we served 6,571 individuals here at Hedco Wellness Center. The center provides breakfast and lunch, Monday to Friday until March 16, 2020. During the pandemic, Hedco had 345 individuals here every month for daily support. Hedco still provides snacks, meals, hyigene kits, and resources daily outside the center. Hedco also provided information about COVID-19 and resources for COVID-19 motels. Hedco also hands out masks and hand sanditzers to individuals that need them. We also have a charging station outside for anyone that needs to charge their phone or any electiconic devices.

VII. FY 20/21 Projections of Clients to be Served: Hedco projects that with the pandemic, and shelter in place as of now that we continue serving 20 to 25 people daily at Hedco.

VIII. FY 20/21 Program or Service Changes: The wellness Center does not anticipate any changes right now.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 18

PROVIDER NAME: Bay Area Community Services (BACS)

PROGRAM NAME: Wellness Centers (Fremont)

Program Description: Wellness Centers provide a welcoming entry point for outpatient services for individuals who are unserved or underserved by the mental health system. They provide step-down service for individuals transitioning from ACBH specialty mental health services in an environment of inclusion and acceptance in facilities that are commonly managed and staffed by consumers who provide or arrange for peer support. Wellness Centers are contracted providers who perform outreach and engagement; offer outpatient services such as mental health services, case management/brokerage, crisis intervention, medication support/dispensing; provide peer support and wellness services; and Tenant Support Services (TSP) for those with housing insecurity. Wellness Center 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 program was designed with Culturally and Linguistically Appropriate Services (CLAS) standards in mind

Target Population: Wellness Centers provide services to some TAY and Adults (ages 18+) who identify as being behavioral health consumers in programs funded through ACBH. They make it a priority to serve behavioral health consumers who: Have histories or current conditions of psychiatric disabilities; are identified or labeled as having severe mental illness (SMI) or severe mental stress; have experienced (or are at risk of experiencing) repeated psychiatric hospitalizations, treatment placements, or episodes of incarceration in the criminal justice system; are experiencing housing insecurity; and those who are experiencing problems with alcohol and/or other drug abuse.

FY 2019/20 Outcomes

I. How Much Did We Do?

a. Clients Served: The total number of clients served is 1,612. This number represents unduplicated individuals.

II. How Well Did We Do?

a. The Fremont Wellness Center is reducing mental health stigma using two methods. First, we normalize conversations about mental health conditions by checking in with each client during their initial intake. During this time, we help clients identify wellness goals and support them in achieving them. If a client needs mental health assistance, we provide support with navigating the mental health system. These supports include; assessments, Medi-Cal coverage,

medications, and connection to case management according to their level of need. Additionally, staff are always ready to lend support through active listening.
Second, we host a weekly mental health support group. Pre- Shelter in Place these groups included: Anger Management, Art Therapy, Coping Skills, and Creative Writing. Due to the shelter in place, the meetings occur right outside our office, each participant standing at least six feet away from one another. When our participants share their mental health concerns with their peers, it promotes a culture of connection and understanding at the Fremont Wellness Center. Clients who once stigmatized by their mental health conditions are now more willing to seek help when needed.

b. Our staff at the Fremont Wellness Center understand that our clients often feel stigmatized and unwelcomed in the larger community. So, it is especially important that our staff always engage with clients with warmth and respect. When a client requests help or resources, we meet their needs in a timely fashion to indicate that we value their time and engagement. In the event that they do not request help, we act proactively by asking them if they have any present needs, such as food, water, and housing or employment services. Additionally, our staff hand out flyers that contain information about new resources or changes in social services due to the shelter in place. Actively engaging with our clients is the primary way we show that they are welcome to the Fremont Wellness Center. Personnel at the Wellness Center 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 Wellness Center program was designed with Culturally and Linguistically Appropriate Services (CLAS) standards in mind.

III. Language Capacity

At the Fremont Wellness Center, we provide services in Spanish, Cantonese, Vietnamese and Farsi.

IV. FY 2019/20 Challenges

The success of social service interventions is often determined by the quality of the client-provider relationship. Thus, building strong relationships with our clients has always been a priority at the Fremont Wellness Center. Prior to the shelter-in-place order, we relied heavily on face-to-face interactions between staff and clients to strengthen client engagement. Since our clients can no longer utilize the interior of the Fremont Wellness Center, a place they often came to socialize with one another and staff, some clients visit the center less frequently, or have reduced the time they spend at our property. We continue to make efforts to combat this barrier by actively engaging clients each time they visit, checking in on their housing and employment status, as well as their mental health conditions. Additionally, if we don't see a client for a week or so, our staff calls them to reconnect and offer any supports they may still

need. The Wellness Center has virtual support capacity as well and continues to reach out to our community members.

Is Anyone Better Off?

V. **Impact:** Every time a client comes to the Fremont Wellness Center, our staff have the opportunity to engage them in services that can help them out of homelessness, such as employment services, housing assistance, or mental health supports. For our clients, these services and the relationships they develop with our staff provide steps towards greater economic stability and improved mental health—both of which are necessary to achieve sustained independence. Additionally, improving our clients' financial and housing outcomes benefit the community as a whole; as homelessness is reduced, public safety increases, crime decreases, and the community's overall sanitation improves.

Case Study: ScGa is a Hispanic female in her late 30's who started coming to the Fremont Wellness Center about 2 years ago. Her and her 18-year old daughter fled an abusive living situation and came to Fremont in search of safety. They were living out of their car and ScGa had recently had stroke that had left her wheel-chair bound. As part of her physical recovery, she started attending the Creative Writing group and the Coping Skills group to address her symptoms of PTSD. After staff at the wellness center assisted with completing an assessment with ACCESS, she was connected to a case manager who placed her with a therapist she was comfortable with. The Housing Coordinator at the Wellness Center completed a Coordinated Entry Assessment and developed a housing search plan with her. Her daughter enrolled in the Supported Employment program and with the support of our Employment Coordinator was able to complete her GED and was placed at a retail job she loved. After months of waiting on a housing voucher, she found a landlord with the help of the Housing Coordinator who was willing to give her a chance and accepted her housing voucher. ScGa has been stably housed and is now attending her court mandated Domestic Violence classes via Zoom.

VI. Additional Information

In the months of April- June the Fremont Wellness Center provided 80 meals a day, 5,200 meals served this quarter. 650 showered this quarters, with hygiene kits included to increase safety and reduce spread. Services provided included; carry out meals (breakfast, lunch and dinner), hygiene kits, shower services, food pantry, clean clothing and shoes, linkage to housing resources, CEA assessments, and education regarding COVID-19 (including masks). This quarter the Fremont Wellness Center had 204 new unduplicated sign ins. The Wellness Center hosted a testing event in partnership with the Fremont Fire Department, in which 20 of our most vulnerable partners were tested for COVID-19. It took a team effort to encourage participants to get tested and the team did an amazing job providing education and monitoring the event.

VII. FY 2020/21 Projections of Clients

We project that the number of clients served this year will increase due to reduced services provided by partnering agencies and the increase of families seeking services. We believe it will increase to 1,700.

VIII. FY 2020/21 Program or Services Changes

The changes that we expect will be coordinated closely with the CDC and county Public Health Department to observe Shelter in Place restrictions and regulations set to mitigate Covid-19 spread amidst the pandemic. We will adjust according to those changes.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 18

PROVIDER NAME: Bay Area Community Services (BACS)

PROGRAM NAME: Wellness Centers (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 Tenant Support Services (TSP) for those with housing insecurity. Wellness Center 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 program was designed with Culturally and Linguistically Appropriate Services (CLAS) standards in mind

Target Population: Wellness Centers provide services to some TAY and Adults (ages 18+) who identify as being behavioral health consumers in programs funded through ACBH. They make it a priority to serve behavioral health consumers who: Have histories or current conditions of psychiatric disabilities; are identified or labeled as having severe mental illness (SMI) or severe mental stress; have experienced (or are at risk of experiencing) repeated psychiatric hospitalizations, treatment placements, or episodes of incarceration in the criminal justice system; are experiencing housing insecurity; and those who are experiencing problems with alcohol and/or other drug abuse.

How Much Did We Do?

I. FY 19/20

a. **Number of clients served:** 342 unduplicated clients for 19/20

How Well Did We Do?

Valley Wellness Center (VWC) continues to provide an abundance of services that take each individual's need into perspective, and assist according to that need. Linkage to greater services in the area are a prime example of the level of commitment to mental health and stability, that the center imbues. The staff at the center is well versed in the services that we provide as well as what is available in the general Tri-Valley area.

Many people now call for services or come to the door for a range of services including just needing to talk about life, needing basic hygiene products, and a connection to housing/mental health/and case management services.

II. Please describe ways that the program strives to:

a. **Reduce mental health stigma:** Valley utilizes psychoeducational materials, as well as conducting clinical groups which address stigma and other mental health challenges. Valley staff have been

well-trained in harm reduction, cultural responsiveness, and crisis intervention, and utilize an empathetic approach to all of the clients who seek services here. The staff at Valley understand that stigma plays a big part in the lives of people who seek services here. Knowing that stigma is a great barrier to seeking services, staff and peers alike have knowledge to help people overcome some of the stigma by nonjudgmental attitudes and demeanor. The wellness center operates with a wraparound lens to the work where drawing in natural supports and stakeholders in an individual's wellbeing are essential to the care.

b. **Create a welcoming environment:** Valley has a wealth of peers who greet newcomers as well as familiar people. Valley embraces a resilience and non-judgmental approach and emphasis that in groups and everyday interactions. Valley's peers have been a big part of the success of the center, and have been assisting individuals by running meditation groups and check-ins. Valley listens to the participants and works with them to create groups that work for them as well as helping to create the welcoming environment for all who enter the facility. Valley Wellness Center are trained in Harm-Reduction, Trauma-Informed Care, and cultural responsivity in line with national CLAS standards.

III. Language Capacity for this program: At the present Valley's employees are English speaking, but have utilized the language line when there is a language barrier, which occasionally happens.

IV. FY19/20 Challenges: Challenges have been noted in the area of growth for the center. Valley staff routinely outreach to other organizations and have had success with new clients through this means. Covid-19 also presented challenges, but Valley maintains the standard of supplying resources to those in need. The center maintains a check-in with many of the participants by phone and social distance at the door of Valley Wellness. The community that frequents Valley Wellness Center is the greatest asset of the center, so we try to maintain a level of involvement with those members in the time of Covid-19.

Is Anyone Better Off?

Many of our clients have benefitted greatly during the 19/20 year. Valley Wellness Center embodies a helpful, humanitarian demeanor, and are redily available to assist in whatever is needed. Valley staff, a small part of the bigger Bay Area Community Services (BACS), often have to refer out. If BACS is not able to assist then we help them call 211 for referals. We have one client who was referred to John George Psychiatric Hospital for services. The client spent 2 months there. Valley staff provided transitional services to the individual upon release, helping them to maintain housing, recover missing documents, and now assists the new case manager from another organization to ensure the client does not go back into the hospital unless absolutely necessary.

VI. FY 19/20 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.

VII. FY 20/21 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, Shelter in Place (SIP), and other hardships that people are facing during these times, it is easy to see that we may experience a rise in clients for the year. 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 500+ unduplicated to be served in 20/21.

VIII. FY 20/21 Program or Service Changes: We do not anticipate any changes to what we are currently providing during the SIP pandemic. We will maintain what we are currently doing until the state and county change their recommendations for Shelter In Place protocol.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 18

PROVIDER NAME: Bay Area Community Services (BACS)

PROGRAM NAME: Wellness Centers (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 Tenant Support Services (TSP) for those with housing insecurity. Wellness Center 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 program was designed with Culturally and Linguistically Appropriate Services (CLAS) standards in mind

Target Population: Wellness Centers provide services to some TAY and Adults (ages 18+) who identify as being behavioral health consumers in programs funded through ACBH. They make it a priority to serve behavioral health consumers who: Have histories or current conditions of psychiatric disabilities; are identified or labeled as having severe mental illness (SMI) or severe mental stress; have experienced (or are at risk of experiencing) repeated psychiatric hospitalizations, treatment placements, or episodes of incarceration in the criminal justice system; are experiencing housing insecurity; and those who are experiencing problems with alcohol and/or other drug abuse.

How Much Did We Do?

I. FY 19/20

a. **Number of clients served:** 4,891

How Well Did We Do?

II. Please describe ways that the program strives to:

a. **Reduce mental health stigma:**

The Wellness Center whole goal is to create a welcoming, therapeutic, trauma informed space where individuals can grow and get the resources they need in order to heal and survive. The Wellness Center offers mental health resources so clients can learn how to deal with their trauma and learn how to function in everyday life. The Wellness Center reduces mental health stigma by bringing together a population of individuals that have similar experiences, so they can grow and heal together. The Wellness Center also provides programs and case management services where trained staff can coach and guide partners to function with their mental health diagnosis and cope with their trauma. The Wellness Center

also offers therapeutic and psychiatric services in order to reduce mental health symptoms and provide skills and resources for our clients to thrive with their diagnosis.

b. Create a welcoming environment:

Towne House Wellness Center provides a warm and welcoming environment for individuals to feel safe and be able to grow and learn in a peer managed socially inclusive space. The Wellness Centers model encourages the clients to be involved in everyday tasks which creates pride and helps staff form a strong connection with the clients. The Wellness Center is a partner lead facility, meaning that our clients help with everyday tasks that contribute into the functioning of the center. These tasks are meant to help clients learn life skills that enable them to be successful in everyday functioning. The Wellness Center helps clients build an individualized wellness plan, so clients can cope with the diversity and struggles that they are going through. The Wellness Center is a place opened for all individuals no matter economic, housing, or mental health status and urges partners to participate in daily activities that promotes a healthy lifestyle and reduces anxiety. When the pandemic hit the Wellness Centers structure had to make drastic changes in order to follow CDC guidelines and make sure our staff/partners remain safe. The Wellness Center had to modify the services that are provided and unfortunately limit client interaction at the center. However, the center is still open and is providing resources, psychiatric services, case management services, food/hygiene kits and housing referrals. Many partners depend on the Wellness Center during the pandemic to receive food, psychiatric services and interact with our staff to decrease mental health symptoms. Wellness Center staff are trained in Non-violent crisis de-escalation techniques as well as Harm Reduction and Trauma-Informed Care. The program's orientation is rooted fundamentally and to compliance for the Culturally Linguistic Appropriate Languages (CLAS) Standards.

III. 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.

IV. FY19/20 Challenges:

The biggest challenges and barriers for program implementation has been connecting with our partners during the pandemic and shelter in place orders. Many of our partners depend on the structure and daily activities that the Wellness Center provide to reduce their mental health symptoms and receive mental health resources. Since the pandemic hit it has been extremely hard to get in contact with the partners that utilized the wellness center every day. Even though we are still offering resources and psychiatric/therapeutic services, it is still challenging to connect with clients when they are not able to come into the wellness center and participate in daily activities and access the center. At Towne House have engaged partners outside the building observing physical distancing practices to mitigate risks of Covid-19 transmission. The Wellness Center has deployed some telehealth services as well, including psychiatry.

Is Anyone Better Off?

V. FY 19/20 Client Impact:

The Wellness Center provides a place where partners and their family members can come and receive psychiatric/therapeutic services, case management services and local resources. The wellness center has a prescriber on site that provides psychiatric services to many of our programs, per alameda contact. Also, per our alameda contract under peer support and wellness services: Towne House Wellness Center tracks the engagement and peer support.

Case study: A mother came to the center in tears and was saying she had been searching for her son for the last couple months. Her son who has been on the streets for years, struggles with homelessness and has severe mental health issues. She said she had not been able to find him and was extremely worried about him. The mother entered the Wellness Center to take a second to process her emotions. While she was inside, her son was utilizing the Wellness Center services. The staff at the center was able to host a family unification and connect the son to mental health resources and housing. This partner was reconnected with their service team - in which they helped him receive his SSI. From there he was connected to Intensive Case Management program (a program within Bay Area Community Services) for long term support. He receives weekly case management services and ICM was able to house him in transitional housing. His mother had said that "if it wasn't for the wellness center, she truly believes her son would be dead and that the wellness center has truly changed his life". The partner still comes to the wellness center daily to receive resources and check in with his case manager.

VI. FY 19/20 Additional Information:

During the pandemic our partners are relying on the Wellness Center more than ever. Some clients are coming everyday to get food resources and hygeine resources. Along with meeting with case management services and psychatric services. One partner said " if it wasnt for coming to the wellness center everyday, i wouldnt talk to anyone the whole day". Alot of clients come to Towne House for social interaction (at a safe distance), which helps decrease their mental health symptoms.

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

With the shelter in place orders and the pandemic happening it is very hard to project how many clients the center will be serving. However, the Wellness Center has adjusted the services that are provided and are still providing psychiatric, therapeutic, case management and housing services on the daily bases.

VIII. FY 20/21 Program or Service Changes:

Bay Area Community Services is changing the structure and dynamics at the wellness center which include combining the wellness center services with our Housing resource center. As an agency there is a disconnect between mental health services and housing services. One of the biggest services we are missing at the Wellness Center is to connect our partners to housing resources. Bay Area Community Services strongly believes in the housing first model and by combining the Wellness Center and our housing resource center together the partners that are served will be able to receive all the resources under one program.

OUTREACH/ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: **OESD 19**

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

PROGRAM NAME: **Medication Support Services**

Program Description: Pathways to Wellness provides the following clinic-based services determined by the client's acuity of needs. Our staffing consists of Psychiatrist, Psychiatric Nurse Practitioners, Clinical Pharmacists, RNs, Licensed Therapists and Case Managers. Our services promote the successful transition of patients from our services to primary care through the following modalities: 1. Medication Support Services including an initial assessment and annual assessments; 2. Providing medication management through the issuance of medication prescription(s) for the most accurate medication therapy for the client; 3. Administration of injectable medication(s,) 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, polypharmacy, side-effects, dietary conflicts or any other medication related issues; 5. Mental Health Services including assessment, collateral, plan development, individual rehabilitation, brief individual therapy, 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 client needs.

Target Population: Pathways to Wellness provides services to adults (18-59 years old) who have moderate to severe mental health impairments resulting in at least one significant impairment in an important area of life functioning. All clients must meet the ACBHS specialty mental health criteria for moderate to severe with impairments in an important area of life functioning. 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, California.

How Much Did We Do?

I. FY 19/20

Number of clients served: 2,685

How Well Did We Do?

II. Please describe ways the program strives to:

Reduce mental health stigma: 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.

Client Centered Assessment: is an ongoing service activity of gathering and analyzing information about the client, from multiple sources to help identify behaviors serve in the client's environment. Assessment includes, but is not limited to, one or more of the following: 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 they actually 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 the client's symptom and what is the malady of systemic racism. This way, we can treat the person and not the illness of the institution.

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 in order 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 in order 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 remodeled all of our clinic waiting rooms, laid new carpet and painted. This increased both client and staff fulfillment. 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.

III. Language Capacity for this program:

Multiple providers speak different languages including: Farsi, Spanish, Tagalog,
When clients have language needs, we utilize a language line to provide services for any language spoken and including ASL.

IV. FY19/20 Challenges:

We have seen a significant increase in acuity levels of clients being referred to our clinics from ACCESS. This fiscal year some did not meet medical necessity for this level of care and often needed a Level 1 program vs. the level 3 program that we provide. Clients who were without housing or telephone numbers made it extremely challenging this year to serve as the numbers who are homeless in our county increased considerably.

In early March 2020, a national emergency was declared due to COVID-19. The COVID-19 pandemic impacted local businesses, public transportation, and mental health services across the County, State, and Country. This significantly impacted our clients both in terms of access to mental health services and created a high risk for illness and death. Specifically, the CDC reports that people of color (which are our most seen client population) are at an increased risk for serious illness if they contract COVID-19 due to higher rates of underlying health conditions, such as diabetes, asthma, and hypertension. They are also more likely to live in housing situations, such as multigenerational families or low-income and public housing that make it difficult to social distance or self-isolate; and use public transportation that puts them at risk for exposure to COVID-19.

Pathways to Wellness put an immediate plan of action together to ensure client safety so that there is a continuity of care. We shifted our entire face-to-face model to a telemedicine model that serves client via telephone in order to maintain appropriate social distancing and protect our clients from additional risk when receiving mental health care.

In addition to changing the format of how clients are served, we have also adjusted our treatment goals with clients. Clients who struggle with social skills and isolation, we are encouraging them to distance physical socialization. We now encourage clients to engage social and community events with significant caution with preference being online. The isolation that clients regularly encountered has become heightened producing more stress, greater symptoms, and hopelessness. This is increased when lack of resources are present and or when family members are becoming ill and or die due to COVID-19.

V. FY 19/20 Client Impact:

During the year of 2019-2020, we impacted clients through serving them throughout the entire year at rates higher than previous years even during a pandemic. Our tireless dedication to the well-being of clients even when they are impacted by a serious health disorder, has proven

successful. This is evidenced by the rates of no shows and timeliness with appointments due to 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.

VI. FY 19/20 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 20/21 Projections of Clients to be Served: 2,800

VIII. FY 20/21 Program or Service Changes:

Currently, we are providing ongoing telemedicine services, we implemented an intake assessment form which provides more clinical and health information for the provider prior to the commencement of the initial assessment.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 20

PROVIDER NAME: Alameda County Vocational Services

PROGRAM NAME: Alameda County Vocational Program - Individual Placement and Support (IPS)

Program Description: Vocational Services is a division of the Adult System of Care for Alameda County Behavioral Health (ACBH). The Vocational Services Division is comprised of three units: A specialized, IPS supported employment direct service unit (Alameda County Vocational Program "ACVP"), an IPS training and technical assistance team, and operational and contractual oversight for the CalWORKs Mental Health and IPS programs (Funded by CA Dept. of Social Services, in joint partnership with Alameda County Social Services Agency). The IPS Supported Employment model is seen as a treatment intervention.

ACVP direct service staff are imbedded in ten county operated and four community based specialty mental health programs (the TRUST Clinic, Asian Health Services, La Clinica and La Familia). The IPS training and technical assistance staff oversee IPS services in nine different contracted Community Based Organizations which use the evidence-based supported employment practice IPS.

Our service approach to supported employment is to partner with consumers and engage them around their unique interests and needs in finding a job, meet them in their community to identify employers, apply for jobs and assist with retention, while continuing to collaborate with their clinical team and significant others to aid in their success.

After a consumer 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, we keep looking for jobs to help find a better fit. There is a "zero exclusion" approach to recruiting consumers for services, which means that as long as they are motivated to work and have expressed interest, they will be engaged despite any presenting barrier.

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.

Target Population: Youth (16-17 years old), Transitional Age Youth (TAY- 18-24 years old), Adults (18-59 years old) and Older Adults (60+ years old) with moderate to severe mental health conditions in finding and keeping competitive work using the Evidence Based Practice of Individual Place and Support-Supported Employment. IPS services span across Alameda County: north-county, mid-county, Tri-Valley, and Tri-City locations.

I. FY 2019-20 Outcomes:

a. **Number of unique consumers/clients served:** 259
b. **FY 19-20 Impact:** ACVP is reviewed annually based on the 25 standard Fidelity Review by external reviewers and has sustained a "Good" level of fidelity.
(115 - 125 = Exemplary Fidelity, 100 -114 = Good Fidelity, 74 - 99 = Fair Fidelity,
73 and below = Not IPS).

ACVP has a 28% 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=73) divided by the total number of people in the IPS program (n=259). Benchmarks set by the Westat IPS Collaborative include 30% fair standard, 40% good standard, and 50% exemplary standard.

ACVP helped consumers start 73 new jobs during the FY 19-20 as well as maintain 42 positions with existing employers, for a total of 127 jobs (see list of employers and positions in appendix).

II. Please describe ways that the program strives to:

a. **Reduce mental health stigma:** The majority of individuals (~65% according to NAMI studies) with serious mental illness receiving specialty mental health services express a desire to work, yet within the AACBH systems of care, fewer than 3% of people with serious mental illness have access to evidenced-based IPS employment services. The employment rate of specialty mental health consumers in California is estimated to be only 10% (SAMHSA 2015). In other words, 90% of consumers are unemployed (as compared to only 3% of the general regional population pre COVID-19 Shelter-in-Place Directives). To compound matters, an even smaller fraction of employed consumers are actually working full-time. Facts such as these only reinforce the widespread stigma that mental health consumers are "too sick," "too unreliable/unpredictable," or "too dangerous" to work.

Because of employment related stigma, consumers are typically steered toward volunteer positions or sheltered work where they are paid a fraction of minimum wage while performing trivial assignments/tasks. They are generally isolated from the rest of the workforce, further worsening their experience of stigma.

The ACBH IPS programs help consumers enhance their lives by supporting people fulfill a universal human need of having purpose. Like anyone else, work helps boost consumers' self-esteem and provides an opportunity to be active in the workforce, and to be contributing societal members. At work, consumers have an opportunity to develop meaningful relationships with co-workers and to engage with the public. Through work, consumers are able to dispel the fear, uncertainty and doubt that can be directed toward them. Employment Specialists help reduce stigma as well, by introducing employers to qualified employees who can contribute to their businesses in many ways. Consumer job seekers and employees, along with IPS workers are ambassadors of mental health. They help reduce stigma in workplace settings every day.

b. **Create a welcoming environment:** ACBH Vocational Services strives to create a welcoming environment and promote the idea that work supports recovery. For example, over 100 mental health consumers, workers and natural supports came together to celebrate employment successes of IPS Program participants throughout the ACBH system during the Annual IPS Participant Celebration event. This annual event highlights people's achievement and progress toward their employment goals, and also acts to inspire others to consider obtaining and maintaining competitive/mainstream employment as part of their wellness. Consumer Back-to-Work testimonials, a BBQ buffet lunch, raffle prizes, and inspiration stations were all a part of the event.

   In the everyday work, Vocational Services workers embrace the philosophy of figuratively and literally "meeting people where they are." That is, workers understand the importance of building relationships with consumers through understanding their values, lens through which they view the world, their unique style and personality, needs, emotions, dreams for a better future, and connecting in a way that is effective for them. Vocational Services workers do this by listening, observing, affirming, and asking questions at the right time. To reduce logistical barriers and ensure consumers feel safe and secure, workers meet with people in community settings largely determined by consumer preference.

III. Language Capacity for this program: ACBH Vocational Services 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.

IV. FY 2019-20 Additional Information: None

V. FY 2019-20 Challenges: The biggest challenge in this fiscal year has been the impact of COVID-19 on our service delivery model. Staff have had to adjust to virtual tele-health platforms in order to provide consumers with direct services, and also to engage with employers who are able to operate under the regional Shelter-in-Place Directives. 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 FY 19-20, 4 out of 20 direct service positions were vacant (20% unit vacancy rate).

VI. FY 2020-21 Proiections of Clients to be Served: 275

VII. FY 2020-21 Program or Service Changes: Vocational Services has three divisions – a direct service, county operated, unit (which serve the 14 ACBH programs), a technical and training unit which reviews other community based programs using the IPS model, and the oversight of the CalWORKs Mental Health Program – which recently contracted three providers (Family Paths/CHAA, Bonita House and La Familia/ Fremont FRC) to both treat barriers to employment and assist recipients to find work using IPS. There are currently 9 CBO Agency contracts with 24 programs that include IPS services. Each agency is reviewed annually using a defined fidelity scale and provided with technical assistance by Vocational Services. The Vocational Program intends to embed an IPS Employment Specialist in the Substance Use Disorder program, Schreiber Center's Regional Center service team as well as in the Supported Housing Program.

Appendix

List of Employers:

99 CENT STORES
ABM COMPUTERS
AEROPOSTALE CLOTHING
AMAX ENGINEERING
AMAZON
AMAZON WHOLE FOODS
AMC THEATRE
AMERICA MEDIA
AMERICAN PORTWELL TECHNOLOGY
ANOTHER PLANET
ASHLEY FURNITURE
ASIAN DELIGHT
BACK 2 NATURE
BAY BRIDGE COMMUNICATION DBA THE LIGHT DIGITAL
BEST HOME CARE
BURGER KING
CARDENAS MARKETS
CARE IN TOUCH
CAROL FERREYERA
CVS
CENTER FOR SOCIAL DYNAMICS
COLOR ME MINE
COSTCO
DD ESTABLISHMENT
DENNY'S
DHL
DOLLAR TREE
DOORDASH
DR. LIU ACUPUNCTURE
ELEPHANT BAR
E-RECYCLE
FOOD MAXX
FRENCH AMERICAN INTERNATIONAL SCHOOL
GOOD DOG DAY CARE
GRAND AVENUE SHELL STATION
H&M
HEALTHFLEX HOME HEALTH SERVICES
HOBBY LOBBY
HOME DEPOT
HOMESTEAD SENIOR CARE
HOODLINE
HOP SKIP DRIVE
HYVE SOLUTIONS
ILLUMINA
IN HOME SUPPORT SERVICES
INSPER SYSTEMS
JUN HAUNG COMPANY
KRISPY CRÈME DONUTS
LA QUINTA HOTEL
LABOR FINDERS
LITTLE CEASARS PIZZA
LUCKYS
MCDONALD'S
MERCY HOUSING
MERRILL GARDENS
MICHAEL'S
MURPHY MCKAY & ASSOCIATES
OAKLAND UNIFIED SCHOOL DISTRICT
OIL CHANGERS
OLD NAVY

PAPA SAN ROLLS AND BOWLS

PARTY CITY

PEOPLE READY

PORT OF OAKLAND

PUP TOWN STAY AND PLAY

ROBERT HALF STAFFING AGENCY

RUBIANO'S PIZZA

SAFEWAY

SALLY BEAUTY SUPPLY

SMART AND FINAL

SOUTHGATE ELEMENTARY SCHOOL

SPROUTS

STARBUCKS COFFEE

SWEET TOMATOES

TJ MAXX

U S POST OFFICE

UBER

U-HAUL

UPS

WALMART

YOUNG'S AUTOMOTIVE

List of Positions include:

Activities Assistant

Afterschool Program Monitor

Animal Provider/Care Taker

Assembler Tester Technician

Associate

Auto Mechanic Trainee

Barista

Behavior Specialist

Care Giver

Cart Attendant

Cashier/ Customer Service Associate

Clerical Specialist

Client Success Strategist

Computer Assembler

Computer Technician

Courtesy Clerk

Crew Member

Custodian

Dishwasher

Driver

Escort Care Giver

Flagger

Floor Associate

Food Service Worker

Hostess

Housekeeper

In Home Support Worker

Independent Contractor

Janitor

Laborer

Legal Assistant

Loader

Lot Attendant

Merchandise Associate

Oil Change Technician

Packaging Warehouse Worker

Parking Lot Attendant

Peer Educator

Produce Clerk

Product Demonstrator

Quality Control Tester Technician

Receptionist

Receptionist/Marketing Specialist

Registered Nurse

Relocation Technician

Retail Clerk

Sales Associate

Service Assistant

Service Specialist

Shopper

Sortation Associate

Teacher

Usher

USPS Mail Carrier

Utility Clerk

Warehouse Assistant

Warehouse Clerk

Warehouse Lead

Writer (Freelance)

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.

NOT YET OPERATIONAL, STILL IN PLANNING PHASE.

Additional Information: At this juncture, we are approaching the end of Phase Two Operationalization of the African American Wellness HUB, which concludes on December 31, 2020.

The HUB's Scope of Work for Phase Two consist of five deliverables and an allocation amount totaling $528,867. The team continues to make progress to met those deliverables. The Office of Ethnic Services also continues to partner with the Alameda County Behavioral Health (ACBH) Building Facility Manager and Alameda County General Services Agency (GSA) to identify an outside architectural team.

The GSA brought their proposal to the Alameda County Board of Supervisors this month for approval to hire an architectural team to help fine-tune and validate the programmatic template submitted by the HUB Team. The architectural team will support GSA to validate the programmatic template and get realistic expectations of what our budget will allow. In other words, the architectural team will provide more specificity around the square footage for each room, the scope of what this project has set as a goal, initial fit testing of the program into an idealized space, and an initial conceptual cost estimate.

The next steps will be to set up a meeting with all parties, which includes GSA, ACBH Building Facility manager, Office of Ethnic Services and the Wellness HUB Team to discuss the project short-term and long-term goals.

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 19/20

a. **Number of clients served:** 23

How Well Did We Do?

II. Please describe ways that the program strives to:

a. **Reduce mental health stigma:** Refuge aims to reduce mental health stigma by providing education around each individual mental illness, normalizing their experience through peer to peer interactions and staff support, and providing ways to better manage symptoms of mental illness.

b. **Create a welcoming environment:** We come from a home setting that is used as a platform for the "family" environment. Thus, allowing the participants to make relationships that they can take with them for the rest of their lives.

III. Language Capacity for this program: English

IV. FY19/20 Challenges: We had difficulty with client participating in the day treatment portion of the program. As a result, the entire program was revamped making it easier and more accessible to the age group that we serve.

Is Anyone Better Off?

V. FY 19/20 Client Impact: I believe all clients are better off whether the impact is experienced immediately or later o down the line. Our goal is to teach practical information while dually planting seeds so that they have the opportunity to grow in positive ways.

VI. FY 19/20 Additional Information: Clients take sometime to aclimate to the program we see more crisis in the beginning of placement and then it tapers off they gain employment, schieve educational goals and become medication compliant.

VII. FY 20/21 Projections of Clients to be Served: 30

VIII. FY 20/21 Program or Service Changes: As of October 1, 2020, we will change our model per state mandate to a reevaluation of care every 7-21days.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 24

PROVIDER NAME: Alameda County Behavioral Health

PROGRAM NAME: Schreiber Center

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

Target Population: The Schreiber Center serves the mental health care needs of adults (ages 18-59) and older adults (60+) with intellectual and developmental disabilities. The Schreiber Center also serves residents of Alameda County, ages 18 and up, who are clients of the Regional Center of the East Bay (RCEB). Clients must also meet the specialty mental health criteria and have a covered behavioral health care plan to be considered eligible for services.

How Much Did We Do?

I. FY 19/20

a. **Number of clients served:** 75

How Well Did We Do?

II. Please describe ways that the program strives to:

a. **Reduce mental health stigma:** At Schreiber Center we are committed to normalizing mental health concerns for our clients, their caregivers, and families. We use person-centered, strength-based language to help eliminate potential negative labels that can often surround mental health diagnosis. We make certain from intake to discharge, that our clients are able to seek our care and treatment without fearing judgment. Schreiber clinicians offer our clients opportunities to practice discussing their mental health conditions in an informed way. We offer supportive, relevant resources to our client's and their families and listen carefully to their fears and concerns. Schreiber's client base is culturally diverse. The MD and clinicians are dedicated to cultural competency which allows for individualized and flexible responses to the varying culturally specific stigmas that can arise during the course of treatment.

b. **Create a welcoming environment:** Schreiber staff understands that many times the life of people with disabilities is difficult. We understand that society doesn't always accommodates the complex needs of our clients. We make sure consumers feel seen and are respected for their unique struggle. Schreiber Center staff are dedicated to trying to accommodate the needs of our clients. Schreiber's front desk staff offer warmth and acceptance and regularly help coordinate rides and accessibility issues for our clients. Our clinicians, clinic managers, and psychiatrist alike are consistently committed to approaching each of our clients with a sense of warmth, empathy, and hope. Schreiber aims to

accommodate people, no matter what they are struggling with by welcoming them to our office's culture of acceptance. Our staff culture provides a solid safe platform for Schreiber clients to return to week after week with confidence that they are welcome to receive help in a way that honors their humanity and dignity.

III. 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.

IV. FY 20/21 Challenges: Schreiber Center is impacted by COVID-19 in that clients are receiving telehealth. Also, there remains high demand for mental health services offered by Schreiber Center, increased staff would mitigate long wait lists for services.

Is Anyone Better Off?

V. FY 20/21 Client Impact: Schreiber Center's clients reap individual benefits measured both 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 report benefitting from our services. Schreiber clients report developing personal insight into their diagnosis and often improve relational and life skills. Our interventions also increase feelings of hope.

VI. FY 20/21 Additional Information: As mentioned previousely in this report, Schreiber Center is impacted by COVID-19 in that clients are receiving telehealth.

VII. FY 20/21 Projections of Clients to be Served: Due to the facts that Schreiber Center staff have been on leave this fiscal year as well as providing services during the COVID-19 pandemic, the center will strive towards maintain the clients severed to 75.

VIII. FY 20/21 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/Tri-City Health Care

PROGRAM NAME: Behavioral Health - Primary Care Integration Project

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

Target Population: PATH services are offered to all adults (18-59) and older adults (60+) assigned to the service team at the support center.

How Much Did We Do?

I. FY 19/20

a. **Number of clients served:** 99

How Well Did We Do?

II. Please describe ways that the program strives to:

b. **Reduce mental health stigma:** The reduction of mental health stigma occurs naturally in our setting. PATH patients do not need to be reminded of their mental health diagnosis or to even address the fact at primary care visits as the provider has been informed of current status before the patient even arrives. The nurse and care coordinator are available to help with scheduling specialty referrals, which is standard for our patients, whereas at other clinics this service might only be available to “qualifying” patients.

c. **Create a welcoming environment:** We have strived to make our waiting room a comfortable and welcoming environment. We make sure to have healthy snacks and interesting, educational videos available. We have personal artwork posted on the walls that is provided by patients. They are invited to submit a picture that is drawn, colored, or photocopied; we then frame and hang the art in the waiting room. It gives our patients joy to see their submissions hanging and they come in with anticipation and curiosity to see what others may have submitted.

III. Language Capacity for this program: PATH provides services in English, Spanish, Punjabi, Hindi and Tagalog.

IV. FY19/20 Challenges: COVID19 pandemic. We have adjusted our appointments to telemedicine starting in March 2020. Patients were reluctant to schedule a phone appointment in the beginning but have become more willing over time. We are not collecting blood draws as regularly as we did before the

shelter-in-place mandate as our nurse care coordinator is not on site daily and patients do not want to leave their homes to come in.

Is Anyone Better Off?

V. FY 19/20 Client Impact: We have multiple clients that are better off having been involved with the PATH clinic. Many clients did not have Primary Care opportunities before joining PATH, the combination of BH case management and PATH care coordination greatly affects these clients' physical health as they are surrounded by support and encouragement which makes them much more likely to follow through with attending to their physical health conditions.

VI. FY 19/20 Additional Information:

VII. FY 20/21 Projections of Clients to be Served: It is our goal to open our Tuesday afternoon clinic up to a full day. We aim to have 14 patients scheduled per clinic.

VIII. FY 20/21 Program or Service Changes: Provider, Anita Galhotra, NP, continues to be our Thursday clinic provider. We now have Napoleon Nazareno, NP, providing a half day of clinic on Tuesday afternoons.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 25

PROVIDER NAME: Oakland-PATH/LifeLong Medical Care and Fremont-PATH/Tri-City Health Care

PROGRAM NAME: Behavioral Health - Primary Care Integration Project

Program Description: LifeLong Medical Care operates a Federally Qualified Health Center (FQHC) to provide co-located services at the Oakland and Eden Adult Community Support Centers (OCSC and ECSC) 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 19/20

a. **Number of clients served:** 13 clients enrolled and active

How Well Did We Do?

II. Please describe ways that the program strives to:

a. **Reduce mental health stigma:** We began services at the Eden Path site when the pandemic started. Our clinic is located in the building where clients are familiar because of their Case Management services are located in the same area. Our staff are compassionate and thoughtful about language used in communication with our clients.
b. **Create a welcoming environment:** Because of the pandemic, we closed our physical site but we welcomed our Eden clients to come to our opened site that is less than 3 miles away when a in person appointment was required.

III. Language Capacity for this program: We currently have one clinician who speaks Spanish and we use an Interpretation Service for other languages. We use Purple Communication for sign language interpretation that must be done in person. We are also working with the Interpretation service to negotiate video visits for our patients who are hearing impaired.

IV. FY19/20 Challenges: There has been significant challenges during this Pandemic. Our clients are experiencing increased feeling of isolation due to social distancing. We have initiated our telehealth appointments to our Eden PATH clients while using innovative ways to do a three-way call with the case manager when needed.

Is Anyone Better Off?

V. FY 19/20 Client Impact: We opened our Eden Path clinic less than a month before the pandemic started. Despite the crisis, LifeLong enrolled and established care for 13 patients. LifeLong will continue to work to improve our telehealth and video appointments for our patients that can be utilized even when

the crisis has ended. Additionally, we are working on starting a virtual group as a way to continually engage with our clients.

VI. FY 19/20 Additional Information:

VII. FY 20/21 Projections of Clients to be Served: We project that we will increase our panel by 20 additional patients.

VIII. FY 20/21 Program or Service Changes: We are unsure of when we will be back to normal or when we can safely open all of our clinics at full capacity. However, we will continue to provide telehealth appointments and in-clinic appointments as warranted.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 25

PROVIDER NAME: Oakland-PATH/LifeLong Medical Care and Fremont-PATH/Tri-City Health Care

PROGRAM NAME: Behavioral Health - Primary Care Integration Project

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

Target Population: PATH services are offered to all adults (18-59) and older adults (60+) assigned to the service team at the support center.

I. FY 2019-20 Outcomes

a. **Clients Served:** There are 318 clients enrolled in PATH East Oakland

II. Please describe ways that the program strives to:

a. **Reduce mental health stigma:** Our patients are seen in a clinic with their peers, in an environment that they have become accustom to. Our staff are compassionate and thoughtful about language used in communication with our clients. Additionally, we work together with a Peer Health Educator to develop. During the COVID-19 pandemic, we attempted to continue patients over the phone and in-person when required.
b. **Create a welcoming environment:**
We welcome patients who are scheduled on a given day to see a provider whenever they show up. We understand that locating our clients can be challenging so we accommodate the patient if they show up earlier or later for their scheduled appointments. The PATH program also offers group visits where patients contribute to the group while learning about basic health topics, mental health tools and group communication. During the pandemic, we opened the PATH clinic for patients who are in need of an in-clinic appointment to accommodate their needs in a familiar and accessible environment and reduce traveling to another site. We initiated telehealth appointments to PATH clients while using innovative ways to do a three-way call with the case manager when needed.

III. Language Capacity for this program: We currently have two clinicians who speak Spanish. We use the Language line for interpretation for patients. We are also exploring an interpretation service to negotiate video visits for our patients who are hearing impaired.

IV. FY2019/2020 Challenges: The usual challenges around transportation and quality housing continue to exist. Additionally, the pandemic has interrupted the normalcy of health care. Majority of patients are now seen via telehealth and offer in-clinic appointments to patients for issues that cannot be resolved in a telehealth visit. It is challenging for our patients to receive care over the phone and we continue to work on innovative ideas around engaging with them during the pandemic.

V. FY 2019/20 Impact: We are uncertain how the pandemic will continue to impact our patients, and will continue to adjust programming and accessibility. LifeLong is working on improving our telehealth and video appointments to increase effectiveness and future use past the COVID-19 crisis. Additionally, we are working on starting a virtual group to continue engagement with our clients.

VI. FY2019-20 Additional Information: We implemented a new EHR system and we are learning all the fascinating features and capabilities of the system. Thus far, the new system has been helpful in locating clients outside medical records and also receiving diagnostic results in a timelier fashion.

VII. FY 2020/2021 Projections of Clients: We project 35 more clients added to the PATH program depending on the state of the pandemic. During this time, we increased our outreach to clients who may have been lost to follow-up.

VIII. FY 2020/2021 Program or Services Changes: We are unsure of when we will be back to normal or when we can safely open all of our clinics at full capacity. However, we will continue to provide telehealth appointments and in-clinic appointments as warranted.

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

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 19/20

a. **Number of clients served:** The Trust Clinic served 1,766 people in FY19-20 (a 26% increase over the previous year).

How Well Did We Do?

II. Please describe ways that the program strives to:

a. **Reduce mental health stigma:** The Trust Clinic reduces mental health stigma by having a service delivery model that integrates behavioral health care in a primary care setting. Clinic services are trauma informed, and all staff, from the waiting room to the nurses, receive annual training to maintain best practices in integrated care. Behavioral health clinicians and psychiatrist, are available daily for both walk-in and scheduled care. The Trust Clinic also have a very active consumer advisory board, who provide ongoing feedback and work collaboratively with the clinic leadership to continually evaluate services and patient experience.

b. **Create a welcoming environment:** The Trust Clinic provides a welcoming environment through a number of ways:

- Accessible location, near public transit
- Walk-in appointment availability
- Welcoming waiting room (e.g., coffee or tea, computer use)
- Health coaches available to support patients with non-medical needs, e.g., case management, food assistance
- Showers on-site
- Behavioral health clinicians available in the primary care setting

III. Language Capacity for this program: English and Spanish speaking staff and language line services for other language needs.

IV. FY19/20 Challenges: In mid-March, LifeLong Medical care adjusted services at the Trust Clinic in response to Alameda County's COVID-19 Shelter-In-Place policy. All LifeLong sites shut down except for the Trust Clinic, which remained open thanks to a reduced core team of LifeLong providers and staff.

Some adjustments were made at the Trust Clinic due to COVID-19 precautions. The Trust waiting room was closed off and the showers, which are normally busy, had to be closed off. A drastically reduced number of people are now permitted inside the clinic. Instead, a LifeLong team consisting of a Health Coach, Medical Assistant (MA), and a medical provider on duty screen patients greeted patients at the door and screened patients for COVID symptoms.

LifeLong is primarily a walk-in clinic. In the last few months of FY2019-20, the LifeLong revised protocol so that the Trust Clinic worked with patients who do not have a working phone to room them in the clinic, and provide assistance to use a clinic phone to visit with their behavioral health provider. Patients who needed to be seen for services (such as injections) were seen in person with appropriate droplet precaution.

Intakes continued, with ongoing discussion between PCPs and behavioral health clinicians on how best to take care of patients given the risk of COVID-19 transmission and social distancing guidelines. PCPs continued to prescribe psych meds.

Most BH team members were instructed to work remotely and serve patients via telephone visits using standardized telemedicine documentation guidelines. LifeLong made additional arrangements for staff including procuring work cell phones (for staff without a data plan, etc.), and set-up with a HIPAA-compliant Zoom chat app to support staff communication regarding patient info.

Is Anyone Better Off?

V. FY 19/20 Client Impact: More than 1,700 people who are homeless and at-risk of homelessness were served by the TrustClinic in FY 2019-20.

The Trust Clinic service model emphasizes a welcoming, non-judgmental environment with support provided by health coaches. In FY 2019-20, approximately half of the 1,700 patients served by the Trust Clinic received case management and enabling support services.

In FY 2019-20, one in two patients at the Trust clinic needed mental health services and were able to access mental health services on average 4-5 times at Trust during the year.

a. **As part of this section please also provide a case study or personal client/family story:** LL is a 50-year-old man who I met doing outreach with our ACHCH Street Health team about two years ago. At the time, he was living in a large homeless encampment under the BART tracks, and was struggling with chronic pain, severe depression and PTSD, for which he was self-medicating by using methamphetamines. We met several times at his encampment, and he eventually agreed to meet with me for a psychiatric evaluation in the field and did very well on an antidepressant. As his symptoms of depression and PTSD slowly resolved, he agreed to establish care at the TRUST Clinic for more wrap around services. He was embarrassed to come to clinic as he had very limited access to a shower. We arranged for him to take a shower at the clinic before he met with his primary care provider for an intake. While at TRUST, he has established care with a therapist whom he meets with weekly, has worked closely with one of our case managers and was recently housed, has part time employment, and has not used methamphetamines for over a year. We continue to meet every 1-2 months to check in, and he always shares how the Street Health team and TRUST "saved his life".

VI. FY 19/20 Additional Information: We want to share another story related to what our patients are experiencing under the COVID-19 pandemic:

TP is a 24-year-old woman who lives alone in a van and was referred to the ACHCH Street Health team by Punks with Lunch for the evaluation and treatment of Opioid Use Disorder. I met TP in January 2020 for a intake appointment near her van. After our discussion, she decided that she was not quite ready to start treatment, and we decided to meet every month to discuss her recovery and readiness for treatment and explore establishing care at TRUST. Soon after shelter in place started in mid-March, I received a call from TP- who was now ready to start treatment as she did not want to try to obtain heroin during a pandemic She has been stable on Buprenorphine since and last used heroin in late March. In June, she had symptom of COVID-19 and was tested for the virus at the TRUST Clinic, which came back negative. She had a very positive experience at the TRUST Clinic, and has since established care there after not being seen by a primary care provider in years.

In March, the Trust Clinic, became the first COVID-19 testing site designed to provide low barrier testing for our patient population. Unhoused individual are able to walk, or drive, up and receive testing, and referrals to Project Roomkey Operation Comfort as clinical indicated. Of note, the first referral to Operation Comfort in Alameda County was referred by the Trust Clinic, a testament to their responsiveness to the COVID-19 pandemic. Since opening the testing test, they have expanded to support field based testing to proactively respond and decrease outbreaks in our community. To date, LifeLong Trust providers have tested 708 patients; 51 of whom were positive for COVID-19.

VII. FY 20/21 Projections of Clients to be Served: LifeLong Medical Care projects a similar patient population, 1,700 patients in FY2019-20 and more than 15,000 visits. Of note, given the overwhelming demand for high qua primary care and behavioral health services for our homeless population, the Trust Clinic is approaching capacit their current clinic space. ACHCH and LifeLong Medical Care are discussing what can be done to address capacit issues.

VIII. FY 20/21 Program or Service Changes: No project changes are currently anticipated.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 26A

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

PROGRAM NAME: Training and Technical Assistance on Accurate Diagnosis and Appropriate Medication Treatment and Healing Practices for African Americans

Program Description: Hiawatha Harris, M.D., Inc./Pathways to Wellness Medication Clinic designs and delivers culturally responsive services and technical assistance support to help psychiatric prescribers who provide medication assessment and support to African American adults (18-59) living with mental health issues. The culturally responsive curriculum was developed to address the topics of: 1. Stigma around mental health problems in the African American community that can lead to delays in or termination of treatment; 2. Medication issues such as over/under prescribing, incorrect dosage and side effects; 3. Historical trauma of African Americans; 4. Health disparities impacting African American communities; 5. Bias and racial stereotypes; 6. Understanding barriers to accessing mental health services; 7. Knowledge of community holistic interventions such as spiritual, family, and community support; and 8. Strategies for provision of more culturally responsive and congruent services.

Target Population: Alameda County psychiatric prescribers who are identified by ACBH who provide services to adults who identify as African American, ages 18-59 who have moderate to severe mental illness impairments resulting in at least one significant impairment in an important area of life functioning.

I. FY 19/20

a. **Number of clients served:** There was a total of _134_ unique persons in attendance for our six scheduled trainings in FY19-20. However, we had a total of _173_ persons who were registered for the trainings in for a variety of reasons were unable to attend.

   We had a total of (8) agencies that attended four or more of the 6 trainings offered this fiscal year. [this reflects an increase from (5) agencies that attended two or more of the training sessions in FY18-19, which was our first year of this contract]. This fiscal year we are seeing that the agencies are now in a position to begin to implement the information from the various trainings offered by our AATA trainers.

II. Please describe ways that the program strives to:

a. **Reduce mental health stigma:** The program offered the following trainings to help reduce mental health stigma. There was a full day training that offered ways to reduce stigma in the African-American community and also the training explored the historical reasons for stigma and how it was related to racism and inappropriate behavioral health treatment of African-Americans. This training offered particular emphasis on how stigma develops and what providers can do to begin

to decrease the amount of stigma in working with their African-American clients. The training also discussed ways to increase trust when working with African-American clients. One of the key emphasis in this training was avoiding the use of stereotypes and actually asking clients what would make them feel more comfortable in treatment. In addition, it emphasized the importance of therapists who are of a different ethnic group to set the stage to allow their African-American clients to ask them questions regarding race and racism. This will give the therapist an opportunity to discuss the racial issue and increase trusts with their African-American clients. The feedback from our participant surveys showed that they saw this as a key learning and found it extremely helpful.

b. Create a welcoming environment:
Variety of Training Topics Provided by Pathways AATA Team in Fiscal Year 19-20

February 22, 2019 | Introduction to the African American Training and Technical Assistance Program *(Discussion around the purpose of our training contract and best practices when going back and incorporate key learnings into everyday client care)*

March 26, 2019 | Cultural Skill: *A component of Cultural Competence in the Delivery of Mental Health Services*

April 26, 2019 | Clinical Pearls Regarding Diagnosing and Prescribing for the African American Population for Healthcare Providers who are Not Prescribers

May 31, 2019 | Clinical Pearls Regarding Diagnosing and Prescribing for the African American Population for Healthcare Providers who Are Prescribers

June 10, 2019 | Healthcare Re-envisioned - *The MIS-labeling of Our Children and Targeted Nutrient Therapy*

September 20, 2019 | The African American community's view of behavioral health—*How these ideas were formed and what can be done to decreases the stigma*

October 25, 2019 | How to Heal Trauma with These 3 Steps

February 28, 2020 | The Journey Towards Cultural Competence in the Delivery of Behavioral Health Care Services Culturally Conscious Model of Care

March 20, 2020 | Eight Stories Up and Thirteen Reasons: *Choosing Hope Over Suicide*

March 25, 2020 | Intersection of Race, Psychiatry, Medicine and Pharmacology

JUNE 26, 2020 | Trauma and its Impact on Black Communities: *Preparing Patients & Families for Mental Health Treatment*

III. Language Capacity for this program: N/A

IV. FY19/20 Challenges: This year our primary challenge has been responding to the issues related to COVID-19 virus.

In March 2020, at the beginning of our third-quarter we received information regarding *shelter in place* and within a two-week. We were required to change our scheduled in person training and transform it to a webinar. In that two-week period of time we were tasked with contacting the 40 persons who had registered for the in-person training, to give them all of the needed information in order to be able to attend the webinar.

In using this new web-based platform we were able to submit appropriate information that enabled all of the registered attendees to participate in the training. Fortunately, this particular provider was familiar with offering trainings via a web-based platform. We were able to make the transition without significant difficult. However, we did find that we had some participants who were not familiar with utilizing this format and who experienced some difficulty attending this conference.

We now find that more people have experience in utilizing web-based trainings platform across the entire county. In fact, our last training of this fiscal year we were able to provide services to 106 participants.

Is Anyone Better Off?

V. FY 19/20 Client Impact: The trainings were presented in such a way that the participants and agencies as a whole shared that they were able to develop new ways to gather information in order to complete client intake questionnaires. Basically, participants took information provided by our trainers and added it to their existing tools to make them more culturally competent. The trainings were also utilized to assist providers in understanding the issues regarding other techniques of healing trauma for their African-American clients.

We also provided a training regarding the overall Trauma in the African American community and how behavioral health agencies can utilize this information in offering more appropriate services to their African-American client.

VI. FY 19/20 Additional Information:

About 85% of participants of the AATA attendees are net promotors and would recommend the event to a friend or colleague. Overall, attendees enjoyed the content and expertise of speakers and appreciated the detailed history of the information provided. Attendees have stated that the presenters provided scientific evidence of inequities, practical solutions, and a good discussion of the historical implications of current events.

In the earlier trainings of the year, attendees enjoyed the engagement and interaction between trainer and trainee. It provided an opportunity to share information and network with others in the community. As trainings shifted into remote teleconferencing, participants have stated they would have loved to have attended in person, but understand given the circumstances. In summary, participants felt appreciative of the speakers and felt the sessions were Informative, inclusive, culturally humble, and extensive. Feedback specifically for the AATA staff members: “Keep up the good work in educating providers.”

VII. FY 20/21 Projections of Clients to be Served: For fiscal year 2020-2021 we will continue to project 120 to 150 participants in attendance. We have noticed an increase in the number of persons attending our trainings as we are now offering all trainings via web base and we are now able to offer Continuing Education Units for our

trainings. Webinars make it easier for clinicians to attend the training and CEUs allow them to stay current with their ongoing education requirements for licensed healthcare professionals with BBSE.

VIII. FY 20/21 Program or Service Changes: As a direct result of COVID-19 we are currently projecting that all of our trainings for this upcoming fiscal year will be virtual trainings and we have shared this information with all of our proposed speakers for the planning for the next 12 months.

In addition, we plan to offer an increase number of the (4) hour trainings as we believe shorter trainings will be more effective for webinars versus longer trainings that we have done *in-person* prior to COVID-19. Also, we find the shorter trainings to have been more appropriate for our provider groups especially psychiatrists and nurse practitioners due to their need to be more accessible to their work locations during business hours.

Our AATA team has been responding to community groups and behavioral health providers requesting technical assistance for family groups who are dealing with behavioral health and the COVID-19 issues that is directly impacting African American clients.

We believe these requests will continue and increase as the behavioral health community deals with the pandemic COVID-19 and the new awareness of racial discrimination and police violence across the country. The pandemic has highlighted the issue of health disparities particularly for the African-American community both in physical and behavioral health care.

Finally, our AATA team continues to explore ways to build a more appropriate behavioral health response for our provider network by increasing our individual trainings and to offer additional technical assistance for some of the Alameda County behavioral health organizations.

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 19/20 Number of clients served: 26 unduplicated clients.

How Well Did We Do?

II. Please describe ways that the program strives to:

a. Reduce mental health stigma: The Afiya Care staff is made up of two behavioral health clinicians, one male clinician and one female, and two care navigators, one male and one female. All of our staff identify as African American and are trained to be culturally competent and trauma informed. The makeup of our staff offers Afiya Care clients the opportunity to have a preference for a certain gender. All of our current Afiya Care clients identify as African American which has helped shape our program to be culturally responsive and culturally congruent and thus had a positive impact on our client's satisfaction with the program.

   Our program and staff have strived to reduce mental health stigma by normalizing the process of seeking mental health through education. We educate clients on how their total wellness is interconnected between health, mind, body and spirit. This approach has been helpful for client's realize that the symptoms they are experiencing can be decreased, managed, or eradicated if we use a holistic approach.

b. Create a welcoming environment: In the patient's initial sessions, our behavioral health clinicians assume the position of student and allow the client to educate them on their experiences and what brought them to therapy. We recognize each client will share their story if they feel accepted, heard, and in a space where they are free of judgment. We practice non-judgmental, non-verbal communication because we believe this is just as important as what we say. People make decisions based on the information they have available to them at the time and this pedagogy is welcoming and sets up the environment for joint exploration of new actions that can achieve wellness.

III. **Language Capacity for this program:** The only language that our program had to utilize is English due to all of our clients first and the main language spoken was English. If we had encountered a client that spoke another language, we would've utilized the Language Line Solution services.

IV. **FY19/20 Challenges:** The challenges and barriers we faced this year during program implementation included difficulties reaching clients, engaging clients, and completing necessary documentation. The population served in the Afiya care program encounter several barriers to engagement such as 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.

During COVID, we moved to offering telehealth services but we found that clients were hard to reach due to either the phone numbers provided were not connected, the client didn't have access to a reliable phone, their voicemail box stayed full, and/or they never called us back after many attempts to reach them. For some clients who have free cell phone service, many do not have phones that are compatible with receiving therapy through a video platform.

Is Anyone Better Off?

V. **FY 19/20 Client Impact:** This fiscal year 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.

The client story shared was given by our behavioral health clinician, Cecil Devers, LCSW, 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. A sought mental health therapy after moving out of a residential religious community. He was homeless; however, he had secured bed in a shelter. He described the religious organization as a cult. He was raised by an African, refugee immigrant, (Munchausen Syndrome by Proxy) single mother and his older brother. He had a history of gang association, selling illegal substances, abusing substances, and incarceration.

After engaging in Afiya Care services, Mr. A has recently opened an LLC small business and stated that he has been feeling more confident with managing his finances to move into a permanent residence. He has been working on shifting his interpersonal relationships so that he continues to keep positive people in his life. He is engaged to be married and has become closer to his father and extended family members. His mother and older brother are struggling with adapting to him since he started setting personal boundaries but Mr. A understands this is part of his growth process and is excited to continue moving forward in his life.

VI. **FY 19/20 Additional Information:** None noted at this time.

VII. **FY 20/21 Projections of Clients to be Served:** We project and hope to serve a total of 40 unduplicated clients. We strive to always maintain a minimum panel of ten unique clients annually.

VIII. **FY 20/21 Program or Service Changes:** Due to the complexities of COVID-19, we will continue providing behavioral health and care navigation services virtually via phone or video conferencing on a HIPAA compliant telehealth platform. This upcoming year we plan to mitigate some of the challenges we faced this previous year by implementing an outreach specialist who can do targeted outreach to people who meet the criteria for Afiya Care.

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 19/20

a. **Number of clients served**: 81 unduplicated clients served, which is ***62%*** more than the contracted 50 unduplicated client target.

How Well Did We Do?

II. Please describe ways that the program strives to:

a. **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.

b. **Create a welcoming environment:** Empathic, strong use of Motivational Interviewing, collaboration with natural supports.

III. 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.

IV. FY19/20 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?

V. FY 19/20 Client Impact: At least 38% 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.

VI. FY 19/20 Additional Information: A 0.2 PTE clinician wil begin working in August 2020.

VII. FY 20/21 Projections of Clients to be Served: We expect to meet the following 2020/2021 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

VIII. FY 20/21 Program or Service Changes: Cleo Thompson became the Director of Program November 2019

Client story: * For confidentiality purposes pseudo initials area used in story below.

TT is 29 year old African American male with a history chronic homelessness, suicide attempts, and history of aggression towards others that has resulted in an extensive history of mental health encounters starting at a young age. IHOT received a referral for TT. The referring party, a level 1 service team reported that the client had been difficult to engage and to locate for regular services. They reported his symptoms had increased over the years and believed he needed a higher level of care. They said he had been MIA for months and was unable to be reached to complete appropriate assessments and treatment plans to maintain services. IHOT Staff began outreaching TT at his encampment and places he was known to frequent. IHOT was able to locate client and build rapport. Using peer support as a road map to help TT better understand and express his needs, IHOT supported TT 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 TT 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 and be aware of TT's potential triggers as well as supporting TT with expressing himself to providers appropriately while maintaining boundaries and supporting his connection to mental health treatment. IHOT provided continued support until TT was fully and successfully linked to care. He completed his assessment and signed consent for services. According to FSP, TT worked collaboratively with FSP to identify achievable goals and objectives and created a treatment plan he signed. Upon closing him to IHOT services, it was noted 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 was connecting with a psychiatrist via tele-health due to Covid-19. Most importantly, TT expressed he was happy with the services with the FSP that he was connected to and looked forward to working with them.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 27

PROVIDER NAME: ABODE Services

PROGRAM NAME: In-Home Outreach Team (IHOT)

Program Description: The In-Home Outreach Team (IHOT) provides outreach and engagement services to adults with untreated mental illness, with the intention of connecting them with psychiatric care and other community supports. Each IHOT team consists of: a clinical lead, a licensed eligible clinician, two peer advocates, and one family advocate enabling them to have multiple and varied perspectives with which to relate to the participants and their families. This unique factor helps with finding new ways to engage folks otherwise considered resistant or reluctant to 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 19/20

a. **Number of clients served:** 99 Participants for June 30, 2019 – July 1, 2020. Of those 99 participants we were still serving 20 at the time of the report.

How Well Did We Do?

II. Please describe ways that the program strives to:

a. **Reduce mental health stigma:** The staffing design of the IHOT Team (2 Peer Advocates, 1 Family Advocate, 1 Mental Health Clinician and 1 Licensed Program Manager) enables us to provide services that reduce mental health stigma. The Family Advocate offers families support, psychoeducation, and advocacy from a family perspective. She shares her own experience with her family member who suffers from mental health issues. Our Peer Advocates assist participants to access mental health and other resources. Their lived experience and education enable them to meet our participants where they are and to model mental wellness through their own stories.

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. Our team deliberately does not use mental health verbiage, labeling, or assumption making about participants, but choose to focus on the participant as an individual.

We meet participants in their community setting. During our challenges due to COVID19, 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.

b. **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 other basics. 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.

III. 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 not encountered any language barriers at this time.

The Elevate HOPE team had to adjust the way they provide services during the Covid 19 pandemic. Staff worked from home and contacted Participants and family members via phone and also met with participants in the community. The Elevate HOPE team has managed to meet participant's and family members in their homes if safe, in their backyards, 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 Advocate has provided monthly Zoom Support Group to include former and current participant families. The last meeting was attended virtually by 18 family members.

The Elevate HOPE Team is now fully staffed. It was a struggle to hire a second Peer Advocate who would be a good fit for the team and was able and willing to work with participants in the field. This may have been due to a reduction in the pool of possible employees and the salary we can offer in relation to the cost of living in the Bay Area.

Is Anyone Better Off?

IV. FY 19/20 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 COVID19) 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 99 participants, at least 50 percent were linked to Mental Health, Social Services, Case Management, drug/substance abuse and Inpatient Psychiatric Programs. Seven participants were referred to AOT.

- **Contract Deliverables/Requirements DHCS Section IV. (C) of IHOT Contract Objective:**

  Percent of engaged clients who successfully link to outpatient mental health services or rehabilitation and recovery services within the first twelve months of referral.

  Percent of engaged clients with a decrease in crisis stabilization, psychiatric health facility (PHF), or psychiatric hospitalization admissions within the first 12 months of referral to the program as compared to the 12 months prior to their entry into the program.

  Case Example of Contract Deliverables Met from Section IV. (C) IHOT Contract 7/1/19-6/30/20:

  ViIb was referred to the IHOT Program in 2018 and then again in 2020. The referral was made to IHOT by the brother who reported that the family is feeling unsafe in their home because of the participant's erratic behavior. The family unit consists of the brother, ViIb, the brother's partner, their 2 school age children and the father/grandfather who is ill and in his 70's. IHOT engaged with the family offering support and information about how the family could protect themselves. The IHOT team engaged with ViIb to work with him to engage in mental health services and to deescalate his behaviors. The IHOT Team also contacted the Crisis Team and Police Departments for a 5150 due to ViIb's escalating behavior. He was admitted to PES at John George 2/20. The IHOT team continued to work with the family and with ViIB and referred him to a level 1 case management team. He was connected to that team in April 2020. IHOT continued to check in with the family and with Vi until we were sure he was accessing services with the level 1 team and receiving case management and psychiatric services.

  We discharged ViIb from the IHOT program in June 2020. At that time, he was residing in the family home with no threatening behavior. He was accessing services including medication management and case management. Since 2/20, Vi has not been in PES services in Alameda County.

V. FY 19/20 Additional Information: The Abode IHOT Program is continuing to add checks and balances to our program documentation and Risk Assessment. As of August, 2020 we are using a written Engagement Plan to better map how we will provide our services and to include the goals/desires of the participants. Since 4/20, we have been completing a formal Risk Assessment with all new referrals to assess any safety/risk concerns.

VII. FY 20/21 Projections of Clients to be Served: We would like to serve at least 50 referred participants and to serve at least 25-30 participants at any given point in time.

VIII. FY 20/21 Program or Service Changes: For this upcoming year, 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 would like to see the Peer Advocates and Clinician trained in WRAP (Wellness, Recovery, Action Plan) and utilize these skills when engaging and working with participants.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 27

PROVIDER NAME: La Familia Counseling Services

PROGRAM NAME: In-Home Outreach Team (IHOT)

Program Description: The In-Home Outreach Team (IHOT) provides outreach and engagement services to adults with untreated mental illness, with the intention of connecting them with psychiatric care and other community supports. Each IHOT team consists of: a clinical lead, a licensed eligible clinician, two peer advocates, and one family advocate enabling them to have multiple and varied perspectives with which to relate to the participants and their families. This unique factor helps with finding new ways to engage folks otherwise considered resistant or reluctant to 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 19/20

a. **Number of clients served:** Ninety (90) clients served.

How Well Did We Do?

II. Please describe ways that the program strives to:

a. **Reduce mental health stigma:** One of the goals of La Familia IHOT is to reduce mental health stigma amongst clients themselves and their families. IHOT allows clients to verbalize their delusions and hallucinations without judgement, often engaging them in a conversation about such matters without pathologizing their inner experiences. One of the

incentives we provide to clients is that they will have the opportunity to share these same thoughts and feelings to the providers to whom will eventually link them. One of the most painful challenges families face is the loss of healthy functioning on the part their loved one. The families tend to focus on the cultural standards of their adult children instead of their mental health. IHOT provides psycho-education to families to better understand the mental health challenges of their loved ones. In this way, families begin to understand their loved one is not being defiant or oppositional, but experiencing a mental health crisis or challenge.

b. **Create a welcoming environment:** La Familia IHOT displays respect and dignity to all clients by continuing to interact with them despite their problematic behaviors. This respect and dignity is tantamount as many homeless and actively psychotic clients we serve experience hostile interactions from community members who may be scared of clients due to their behavior. Staff meet clients where they express would be a most comfortable environment for them, such as their home, their homeless encampment, a restaurant, or park. La Familia IHOT begins services by introducing themselves and inquiring with the clients as to what type of immediate support would be helpful to them. By listening to clients, acknowledging their struggles, and providing emotional support, IHOT staff prioritize building rapport with clients as a primary means to ensure their interest in the services to which IHOT will link them.

III. 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. Although IHOT staff has the capacity to serve Spanish-speaking clients, IHOT encounters working with clients and families who speak other languages. La Familia IHOT was able to successfully work with a family who was monolingual Mandarin-speaking using the Alameda County Language Line and interpreter service. IHOT services were eventually discontinued and the case was closed because the client declined mental health services. However, the family requested La Familia IHOT again when the client was more agreeable to mental health services. This indicated the family felt heard and comfortable with La Familia IHOT even utilizing the Alameda County Language Line and interpreter service.

IV. FY19/20 Challenges: In the latter portion FY 19-20, two (2) clients passed away within a period of a few months. IHOT Family Coach, Quiana Broussard, was the primary staff working with both clients along with a secondary staff. The first client suddenly passed away unexpectedly for reasons not made aware to IHOT. The second client passed away due to medical self-neglect even after the client was recently medically hospitalized and discharged from an emergency room. Program Supervisor, Ramon Rios-Parada, submitted an Unusual Occurrence & Reporting Form to the Quality Assurance Department of Alameda County Behavioral Health Care services in both instances of these client deaths.

The partner of the first client who passed away was referred by Broussard to herself (Broussard) due to suffering from alcohol dependence and whom no longer received the financial support from the client who passed away and whose housing was now in jeopardy. Broussard provided intense

emotional support to this partner who now became a client of Broussard through the grieving process. Broussard is now closing this case after several months of supporting this client with securing housing. In regards to the second client that passed way, Broussard supported the mother and father of the deceased client to cope with the grieving process as well logistical support with the death of the client. These two client deaths that occurred within a short amount of time greatly impacted Broussard and the rest of IHOT staff. Program Supervisor, Ramon Rios-Parada provided individual support to staff involved directly with the case. Senior Director of Adult Behavioral Programs, Wajeeha Khan, and Rios-Parada also facilitated a special session of group supervision to process the death of these clients.

Another significant challenge of FY 19-20 has been the impact of COVID-19 and Shelter-in-Place on the accessibility of specialty mental health services available within Alameda County Behavioral Health and local emergency housing shelters. Although efforts to make available telehealth have been very effective by service providers, the majority of IHOT clientele who are homeless do not possess a computer or cell phone to access telehealth. Other clients may possess some means of technology, but they are psychiatrically disabled which impairs their capacity to utilize such means of technology for which in-person and face-to-face services were already difficult before COVID-19. Under these circumstances, La Familia IHOT staff have enhanced the collaboration with various providers and advocated for providers to make themselves available for in-person and face-to-face services as much as possible which some providers have executed. COVID-19 has also impacted the lack of accessibility of emergency shelters for homeless clients. Many homeless shelters have temporarily closed new admissions into their facilities due to concerns of COVID-19 or have decreased the availability of beds. However, IHOT has been persistent in finding emergency housing placement for clients on as-needed basis.

Is Anyone Better Off?

V. FY 19/20 Client Impact: La Familia IHOT has successfully connected 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). The profile of IHOT clientele are individuals who are dual diagnosed, homeless or at-risk of homeless, and have disengaged from their previous treatment provider. IHOT has successfully improved the well-being of a significant percentage of clients in regards to these areas of need, such as linking clients back to their treatment provider, securing their housing, and providing supplemental economic resources. IHOT has also provided basic needs to clients, such as food and clothes to clients during COVID-19 who were otherwise without the financial means and transportation to seek such basic needs on their own. IHOT has also provided clients with gift cards to purchase food as well as bus passes for transportation. Lastly, IHOT also supported clients to connect with resources specific to COVID-19, such as Operation Safer Ground and economic relief due to COVID-19, such as the Family Support Funds.

VI. FY 19/20 Additional Information: IHOT has benefited from the addition of a Clinician to IHOT staff during FY 19-20. IHOT staff have been able to consult with this new Clinician in matters relating to more specialized knowledge of mental health which has enhanced IHOT staff's knowledge of menta health in general. One client's family specifically requested to work with a Clinician to which

the IHOT Clinician was able to make themselves available to the family. This family has appreciated this more specialized support this Clinician has provided since being requested by the family.

Three (3) staff of La Familia IHOT, including Program Supervisor, Ramon Rios-Parada, Famiy Coach, Quiana Broussard, and Lead Case Manager, Ana Ochoa, were chosen by Alameda County to be a part of a pilot program of a new online tool to ehnahce care coordination with various service providers, the Community Health Record (CHR). Chief Program Officer, Carolynn, Langsdale was the executive officer who also coordinated this pilot program on behalf of IHOT. These three IHOT staff participated in a six (6) month training program which consisted of weekly and bi-monthly meetings about a vareity of topics related to the Community Health Record. IHOT successfully completed this training pilot program and will continue to utilize the CHR to ehnance client services in the future.

VII. FY 20/21 Projections of Clients to be Served: Ninety (90) clients projected to be served in FY 20/21.

VIII. FY 20/21 Program or Service Changes: La Familia IHOT will continue to provide client services in a manner consistent with health and safety protocols of Shelter-in-Place and that fulfills contractual obligations with Alameda County Behavioral Health Care 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 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 19/20

a. **Number of clients served:** 56

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 at 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 at 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 Turkish and Punjabi.

IV. FY19/20 Challenges: The current biggest challenge impacting the program at this time is the global pandemic we are facing. It makes connecting with clients in hospitals extremely difficult and it is harder for the team to utilize the resources that they normally 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 been able to utilize more collateral supports lately 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. It has not had a good outcome in general.

Is Anyone Better Off?

V. FY 19/20 Client Impact: 8 clients who were not linked anywhere were linked. 17 clients linked back to previous provider or IHOT bridged to a new provider. 2 decided to stay with private insurance.

VI. FY 19/20 Additional Information: 2 went to jail long term and could not be linked in jail. 1 went to Villa Fairmont long term. 1 became deceased. 1 was under 18 and the parent did not want to participate. 8 moved out of county, state or country. 1 aged to adult IHOT. 8 simply would not link and could not be found.

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 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 19/20

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. FY19/20 Challenges: COVID-19. We were on track to reach our full census of 400 clients when COVID-19 became a pandemic. 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 sxs. 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 clients access were (and some still are) not taking new clients.

Is Anyone Better Off?

V. FY 19/20 Client Impact: We really aim to meet clients where there are and use a trauma informed lens. In our program we know that supporting a client's mental health (identifying barriers, solutions to the barriers, and support along the way) does not always look the same. All of our clients are individuals and we strive to learn who they are and how they manage their sxs. We have many stories about how we help clients to identify and work to reduce their mental health sxs. This can be by identifying core needs not being met (food, shelter, feeling of safety) We have been able to house people, supported clients in regaining partial custody of their children, and built up personal supports to reduce isolation. One story, as told by a staff, is "When I first started working with my client her symptoms of PTSD and anxiety were uncontrollable. She was timid, scared, and anxious during our meetings. But with consistent intervention and support, and a safe environment, she was able to open up and strive to learn how to manage her symptoms and work on improving her life over all. By listening to what her interests were and incorporating therapeutic interventions such as a calming hike to normalize her anxiety and creating vision boards to aspire a positive view of life, we were able to support her so that she is now able to utilize her interests and hobbies to positively cope with her PTSD and anxiety."

VI. FY 19/20 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: Family Service Agency of San Francisco (FSA)

PROGRAM NAME: Older Adult Service Team

Program Description: The Older Adult Service Team supports client recovery through a holistic and strength-based approach that considers the overall bio-psycho-social needs of older adult clients. Over 12% of the consumers are 60 years or older. With a significant number of older adults needing this level or service, creating a team to focus on the unique needs of the older adult population was a priority. Service Teams are multi-disciplinary and coordinate community-based services to provide individually customized mental health care for people experiencing frequent setbacks or persistent challenges 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 19/20

a. **Number of clients served:** 91

How Well Did We Do?

II. Please describe ways that the program strives to:

a. **Reduce mental health stigma:** All OAST providers are trained and supported to utilize frameworks and methods that reduce stigma and provide opportunity for clients to connect meaningfully with providers and people in the community. We are often in a place where we need to advocate to every person in OAST clients' lives, particularly housing and medical providers. Documentation/acknowledging legacy of OAST clients w/in the system of care.

b. **Create a welcoming environment:** 99% of OAST work is field based and much of it occurs in congregate housing settings. Our providers foster welcoming environments through the development of strong relationships with clients, their families, housing providers and all other supports. We continuously work to evolve our environment to ensure that all clients feel a strong connection to their providers and our team. As our program has evolved we have determined that each client benefits from working with a team of providers and have adjusted our caseload distribution to ensure that collaboration between OAST providers and clients occurs and that clients, their families and supports can call anyone on our team and connect.

III. Language Capacity for this program: OAST providers are proficient in Spanish, Chinese, Vietnamese and French.

IV. FY19/20 Challenges: OAST, now in its third year, has evolved to be at a place where expansion and development was approved by ACBH and then rescinded, presumably due to the financial and logistical impacts of the COVID-19 pandemic and crisis. We have adjusted our treatment model to incorporate telehealth and are no-contact site visits. Our billing has clearly been impacted but our connection to clients has continued. We have supported multiple clients and their families as they have navigated through COVID-19.

We shifted from working in the community to providing care remotely from March 13 on, with exceptions for crisis and medication management support and some on-site, no contact visits. The impact of COVID-19 and the SIP has profoundly impacted our care and connection. Clients who were accustomed to seeing their providers once a week have had to trust in our process of connection.

Is Anyone Better Off?

V. FY 19/20 Client Impact: While it can be challenging to look beyond the pandemic, we have been able to measure the impact of our program in the context of its original objective - to support clients to age in place with dignity. We have been able to connect clients with resources that improve their quality of life. For clients who frequently receive emergency psychiatric services we have been able to work with them and their families, and supports to provide the rehabilitative and therapeutic care to reduce incidents of crisis.

Deliverables:

Quality Objectives - 80% of clients receive two or more visits within 30 days of their EOD and four or more visits within 60 days of their EOD.

OAST providers have connected with the majority of the clients (97%) twice within the first 30 days of their EOD and 4 visits across the first 60 days of their opening to OAST. Our caseload distribution and strategy ensure that clients are connected with multiple provides (typically 3 or 4 depending on the client's care needs). Our clients know that our team operates like a family - at times they will visit with our Clinical Case Managers, other times our Nurse Practitioner, Support Staff and Program Management. Due to the unique needs of the older adults we serve, we have strategized and modified a traditional case management structure to meet the needs of the community.

Impact Objectives - Percent of eligible clients who had a decrease in CS, PHF, or psychiatric hospital admissions within the program as compared to the 12 months prior to their entry into the program.

Within OAST, 94% of our clients who entered our program experienced a decrease in CS, PHF or psychiatric hospital admissions in their most recent 12 months in the program as compared to the 12 months prior to their entry into OAST. To be more specific, while 65% of the clients entering OAST did not have a recent history of hospitalization, those who did, with little exception, experienced a decrease in hospitalizations.

Case Study

Joseph (names/identifying information has been changed to protect the individual's identity) is a 73-year-old African American man who has been connected with ongoing Case Management and Psychiatric Care for the past 28 years. He currently lives in a congregate residence, an independent living home in

Hayward. Diagnosed with Schizophrenia, he sporadically takes medication to treat ongoing, persistent symptoms of paranoia and delusional thinking that can exacerbate into AH. Persecutory thoughts and hallucinations at times cause him to experience suicidal and self-harming thoughts, that at times develop into a crisis. He has no contact with family for decades and not much about his history outside of his involvement with the mental health care system is known.

Upon entering OAST's services, Joseph was understandably wary of new providers - he had been working with the same case manager for 20 years and rapport developed slowly with our staff. Eventually he welcomed our visits and collaboration. Our providers accompanied him to PCP visits where he reported feeling support with managing multiple chronic health conditions and an increased capacity to self-advocate with primary care providers. Approximately 8 months in to the program, Joseph contacted our staff to report that he was feeling that the voices were returning and that he was feeling suicidal, identifying a specific plan and means. We inquired whether he wanted to go to a CRT or JGPP and he asked for support to get to JGPP. We accompanied him to JGPP and in the waiting area, talked with the staff as we explored his increased acuity of symptoms and their possible origins. Upon learning that he had stopped taking medication as prescribed and consulting with our psychiatric care team, Joseph was able to return home rather than being placed in PES. From that point, what seemed to be an anomaly for him, Joseph took greater initiative in his self-care, managing his medication and health issues, and in the coming months, other domains in his life. He personally coordinated a move from one residence to another and self-enrolled in a day program, contacting the OAST staff requesting support with the application. He has not reported any deviation from his current state of wellness and our providers have remarked on his new-found capacity to invest in his own wellbeing and quality of life.

Since Joseph lives in a residence with other OAST clients, we have now begun the process of relying on him to share his experience, in the hopes of creating increased peer support within the home. While the Shelter in place order has significantly limited our ability to reach him in person, he has willingly participated in telehealth focused connection - video conferencing with his OAST providers each week.

VI. FY 19/20 Additional Information: OAST management has developed a qualitative and quantitative research project, aimed at gathering information about the needs of this unique community. We have presented our findings to ACBH, providing evidence for particular restructuring and expansion of OAST. While the SIP order and subsequent impacts to the State's budget have resulted in that expansion being rescinded, we hope to renew the dialog and share our most current data and refinements to our project. OAST, being a niche program, provides significant opportunity to gather information to clearly outline and anticipate the needs of a community.

VII. FY 20/21 Projections of Clients to be Served: 90-110

VIII. FY 20/21 Program or Service Changes: Increasing focus on psychiatric care and the co-morbid needs of the clientele.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 30

PROVIDER NAME: La Familia Counseling Services

PROGRAM NAME: Sally's Place Peer Respite

Program Description: Sally's Place is a Peer Respite Home and is the first and only of its kind in Alameda County. It is staffed by peers, in alignment with the objectives of our local agencies- Pool of Consumer Champions (POCC) and the Alameda County Accelerated Peer Specialist Program (ACAPS). Guests receive support from compassionate peer staff and can stay for up to 14 days. Sally's Place Peer Respite is a voluntary, short-term program that provides non-clinical crisis support to help people find new understanding and ways to move forward with their recovery. It operates 24 hours per day in a homelike environment.

Target Population: Sally's Place serves adults, 18 years of age or older, who are experiencing mental health concerns or distress, have an identified place to stay in Alameda County at the time of intake (which could include a shelter), are able to manage medical needs independently and who voluntarily agree to engage in services.

I. FY 2018-19 Outcomes

a. **Number of unique consumers/clients served:** Sally's Place Peer Respite open house was on January 9, 2019 and we opened for services on January 21, 2019 during FY2019 Sally's Place has provided Peer support Services to 70 unduplicated new guests and re-admitted 6 guests that had returned who required more support either with referrals or respite services.

b. **FY 2018/19 Impact:** During FY2019/19 Sally's Place impacted 40 African Americans, 26 Caucasian, 4 Mexican/Mexican Americans, 2 Vietnamese, 1 Filipino, 1 Native American, 1 Asian, 1 Other Asian, 1 Other Southeast Asian, 1 Other Pacific Islander, 6 Other Non –Caucasian community members. Having only 6 guest's return for services at Sally's Place may mean that they are getting better or are connected to supportive services.

   Data shows that Sally's Place have served and supported 23 Females, 53 males and two 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.

II. Please describe ways that the program strives to:

a. **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.

b. **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.

III. 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.

IV. FY 2018-19 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 21yrs. old and the oldest guest was 72 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), 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.

V. FY2018/19 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 an 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.

VI. FY 2019/20 Projections of Clients to be served: Our goal for FY2019/20 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 FY2019/20.

VII. FY2019-20 Program or Service Changes: Sally's Place Peer Respite is a brand 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: Early Psychosis Programs (EPP)

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 19/20

a. **Number of clients served:** The Felton Early Psychosis Programs (re)MIND® and BEAM Alameda served a total 88 unduplicated program participants from July 1, 2019 to June 30, 2020. We have served 71 individuals in (re)MIND® and 17 individuals in BEAM. During this period, we have successfully increased program referrals. It is important to note that many individuals pre-screened were not eligible for services on the basis of insurance (commercial insurance) and were linked to other services.

How Well Did We Do?

II. Please describe ways that the program strives to:

a. **Reduce mental health stigma:** To reduce mental health stigma, staff continues to provide psychoeducation to program participants and families to normalize the experience of mental health challenges, and address the stigma associated with psychosis. In addition, staff uses various strategies that are non-stigmatizing and non-discriminatory with the individuals and families we serve.

b. **Create a welcoming environment:** In the office, we have created a space that is TAY friendly where program participants are able to engage in activities, socialize with other peers, play games, and access computers and information about other community resources. Staff is responsive to the cultural needs of individuals and families, encourage cultural expressions, and use client-centered and non-discriminatory language. We have created an environment that reflects ethnic and cultural diversity which is also reflected in our program materials. Staff attends mandatory cultural responsiveness trainings on creating a welcoming environment for LGBTQIA+ youth and SOGIE. However, due to COVID-19 and in compliance with Public Health guidelines, during the last quarter of FY 19-20 we implemented changes to our office space to promote health and safety during the pandemic. Although these changes made our environment less welcoming (temporarily discontinued snacks, games, and rearranged furniture in common areas), we have approached them from a community-safety perspective, and use every opportunity to educate our program participants and caregivers on COVID-19 symptoms, use of face covering, proper hand washing, social distancing guidelines, and instructions to avoid physical contact.

III. Language Capacity for this program: Currently, our staffing language capacity includes English, Spanish, Hindi, and Gujarati. In addition, we have prompt access to interpreter services as needed for other threshold languages.

IV. FY19/20 Challenges: During Q1 and Q2 of FY19/20, we faced challenges that impacted service delivery: low referrals; lengthy staff vacancies (including administrative support); a challenging Medi-Cal site certification process following recent relocation; and increased efforts to train and monitor staff to meet required Medi-Cal documentation standards. To address these challenges, we increased community outreach, held a successful open house event, created new program materials to facilitate referrals, started wellness groups on site, partnered with PEERS to provide additional peer support groups, created standards and tools for documentation, and continued to streamline processes to improve contract efficiency. During Q3 and Q4 of FY19/20, the biggest challenge was adapting operations in response to the COVID-19 pandemic and Public Health guidelines. We created an electronic filing system and transferred all documents into HIPAA/HITECH compliant cloud storage platform. We continued our efforts to provide outreach presentations remotely and adjusted our referral process. Moreover, we created accessibility for staff to be able to provide telehealth through Zoom for Healthcare and for faxes to be sent and received electronically. 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. Another 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).

Is Anyone Better Off?

V. FY 19/20 Client Impact: During this reporting period, 9 out of 88 individuals engaged in services for 12 months or longer had at least one admission to CS, PHF, or psychiatric hospital in the previous 12 months before enrollment. 7 out of the 9 participants (77.78%) showed reduction in the total number of crisis stabilization or inpatient services episodes. In addition, there was an additional 56% reduction of the total number of days in inpatient settings (length of hospitalization) for this group, from a total of 180 days

during the 12-month period prior to enrollment to a total of 79 days while engaged in services for 12 months or longer. Also, during this period, 44 individuals received supported employment and education services. 10 out of 44 individuals successfully engaged in competitive employment, resulting in a job placement of 23%, with a placement rate of 0.53 placements per month per Employment and Education Specialist (EES) FTE (average of 1.5 FTE during FY19/20. 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 goals during a time of business closures and alarming unemployment rates.

One of our success stories involves a high school student experiencing psychosis. Like many of the young people we serve, they had experienced multiple psychiatric hospitalizations when they enrolled in the Early Psychosis program in Alameda County. This young person's first hospitalization was due to being at-risk for self-harm and experiencing distressing auditory hallucinations and disorganized thinking and behavior. In addition to their increased psychiatric symptoms they also experienced other life stressors including loss of a close relative. Due to stressors and increased psychosis, they continued to experience multiple hospitalizations and needed support to regain stability in the community. Luckily, this young person had a supportive adoptive mother who sought services and helped them connect with specialized treatment. Over the course of several months this young person worked with our staff therapist and learned skills to identify triggers to symptoms and coping strategies to minimize delusions, hallucinations and thoughts of suicide. Through the course of treatment, they were able to gain insight into their symptoms, practice learned skills and coping strategies, and their symptoms stabilized. This young person graduated high school this year and is attending junior college.

VI. FY 19/20 Additional Information: During FY19/20, we provided 11 community outreach presentations, ranging between 1-2 hours in length. Provider agencies include Crisis Support Services of Alameda County, ACCESS, PEERS, Fairmont PHP, JGP, Woordroe Place, La Clinica, UC Berkeley Counseling Center, Laney College, Berkeley City College, and First Five, engaging a total of 166 attendees. During the first few months since the beginning of COVID-19 pandemic and shelter-in-place, we addressed how the public health emergency could impact our participants' ability to access community resources and services by creating a COVID-19 resource guide where families could access resources for additional food, shelter, remote social groups, safe leisure activities during shelter-in-place, and COVID test sites. We also provided virtual support groups (one Youth Group and two Family Groups - in Spanish and in English) to provide social support, coping strategies, and activities for participants during the public health emergency.

VII. FY 20/21 Projections of Clients to be Served: We are expecting to serve 100 unduplicated individuals in FY20/21.

VIII. FY 20/21 Program or Service Changes: For FY20/21, we will optimize our intake and assessment processes to establish medical necessity and start providing clients with planned services more quickly.

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 19/20

a. Number of clients served: 7,919 Clients

ACTIVITY	PROCESS OBJECTIVE	COUNT	OBJ. MET?
Crisis Line and Lifeline Services	36,000 duplicated calls	42,114 duplicated calls	Yes
Crisis Line and Lifeline Services	6,400 Direct Staff Hours	11,852 direct staff hours	Yes
Crisis Line and Lifeline Services	At least 550 calls with suicide risk 3 -5 (ie, high risk calls)	714 calls	Yes
After-hours ACCESS Line	3,400 duplicated calls	4,052 duplicated calls	Yes
After-hours ACCESS Line	200 direct hours	541 direct hours	Yes
After-hours SUD Helpline	860 duplicated calls	1,422 duplicated calls	Yes
Community Volunteer Training	150 volunteers and interns	186 volunteers and interns	Yes

How Well Did We Do?

II. Please describe ways that the program strives to:

a. **Reduce mental health stigma:** The crisis line program fosters a sense of community where mental health lived experience is seen as valuable experiences that enhances the counselor's ability to support our clients. All leaders in the crisis program are skilled at sharing their lived experience stories and these stories are woven throughout the initial crisis line training program. We work to show that mental health challenges not only impact our clients, they impact the people on our team and our families.

   Mental health training is provided in onboarding training, and stigma reduction interventions are woven into one-on-one supervision and group supervision.

   The CSS Call Database is being re-built and all forms are being evaluated to ensure that documentation is strength based and client's goals, strengths, and resiliency are highlighted in their charts.

b. **Create a welcoming environment:** In Q4, CSS made the commitment towards becoming a more anti-racist and multicultural agency. Through this work, our teams conducted self-evaluation and nearly all staff members participated in small group cultural humility 101 training, that covered topics including: micro aggressions in a clinical setting, white fragility, mitigating power imbalance in a therapeutic relationship, understanding racism and it's impacts on our community and examining and responding to counselor implicit bias. White Ally, and POC and BIPOC groups were formed for additional education and process. We also restructured staff meeting times to intentionally do anti-racism work as a team on a weekly basis. We hope these strategies will result in our counselors providing services that are non-stigmatizing and non-discriminatory.

   Currently, the CSS Website, social media presence, and physical space is being evaluated by team members from all levels of the organization and an action plan is being written to make the environment more welcoming.

   In the upcoming fiscal year, the small group Cultural Humility training will be offered to our volunteers.

   Staff shift supervisors, who work 8-40 hours/week on the crisis lines, are provided one-on-one supervision, as well as a confidential counter-transference process group where staff can safely discharge vicarious traumatization related to providing care to clients. In the group, shift supervisors build skills and resilience tools to support their work, including staying patient and welcoming when clients are most symptomatic.

III. Language Capacity for this program: The program utilizes LanguageLine Solutions for on-demand language needs.

IV. FY19/20 Challenges: COVID-19 and shelter in place orders created challenges related to remote crisis line work. This created additional needs for technology and training and impacted our ability to complete silent monitoring and training functions. We put a hold on on-shift training between April 2020 and August

2020. During that time, we experienced the usual rates of attrition. The combination of not being able to graduate crisis line counselors and the natural volunteer turn-over led to a shortage of volunteers. This required more paid staff hours to be utilized to respond to the crisis lines clients. We now have a plan to train and graduate 50-50 volunteers by December 31, 2020, and will be at our usual capacity at that time.

Is Anyone Better Off?

V. FY 19/20 Client Impact:

IMPACT MEASURES	IMPACT OBJECTIVES	ACTUAL IMPACT	OBJ. MET?
The percent of crisis line consumers with a risk level of 2 or higher who self-report a reduction in suicide intent from the initiation of the call to the end of the call among those who report suicide intent at the start and end of the call.	At least 20%	38.3%	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	602 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%	77.4%	No

The program set the goal that 80% of our medium to high risk calls would be stabilized by the end of the call without the use of law enforcement. Our actual impact was 77.4%. It is important to note that for people who call the crisis line during a suicide attempt in progress necessitates intervention from law enforcement because immediate medical needs must be evaluated. 54 of the 176 law enforcement calls were for a suicide attempt in progress. It's also important to note that after business hours, including overnight hours, law enforcement agencies are the only resources that can respond to a mental health emergency. Because the crisis line program functions as afterhours service for the ACCESS and SUD Line, we are likely to get more emergency procedures calls during that time. 68% of all of our calls to law enforcement occurred during afterhours time.

QUALITY MEASURES	QUALITY OBJECTIVE	QUALITY MEASUREMENT RESULTS	OBJ. MET?
The percentage of duplicated crisis callers that completed the satisfaction survey.	A representative sample of at least 10% of unduplicated callers.	24 completed surveys	No
The percentage of survey respondents that reported that they are likely, very likely, or extremely likely to call again if they found themselves in another crisis situation.	At least 75%	79%	Yes
The percentage of respondents that reported they felt connected, very connected, or extremely connected to the counselor they spoke with on the call.	At least 75%	79%	Yes

Caller Satisfaction surveys provide information on the effectiveness of a call and a caller's experience with the services received. From June 1 to July 15, callers in Alameda County were given the option to answer a satisfaction survey via text message or via phone. Most callers consented to taking the survey via text message, therefore receiving the 3 questions via an automated text platform. 107 callers consented to taking the survey, and 24 completed the survey. This generated a conversion rate of 22% between caller consent to survey completion. The three survey questions and overall results can be found below. Partially completed surveys (total of 4) where callers didn't answer all 3 questions were not included in the data analysis.

This fiscal year, the program selected a 6 week period as the survey period and though the responses received suggest overall strong rapport and likeliness to utilize services again, the number of surveys received is lower than the 10% goal set in the quality objectives. The program plans to address this in a number of ways in the 20-21 fiscal year. The first is to have additional survey seasons to capture more respondents and responses. Another is to reach out directly to callers the line has existing rapport with as a way to get their feedback. We acknowledge that one

drawback of that approach is that this group of callers are likely to have a more positive experience with the line since they see it as a regular part of their support system. Another approach is to incorporate the surveys into follow up calls and ensure that follow up supervisors are using the tool as part of their calls. The team is also brainstorming ways to increase the conversion rate as another strategy to increase the number of completed surveys.

VI. FY 19/20 Additional Information:

VII. FY 20/21 Projections of Clients to be Served: 8,000 Clients

VIII. FY 20/21 Program or Service Changes: None at this time.

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 2019/20

a. Number of clients served: The following demonstrates total numbers/ages of clients served at each location/RU:

- Fremont office: RU 01KL1, 15 Adults; RU 01KL2, 7 Youth
- Berkeley office: RU 01N41, 11 Adults; RU 01N42, 5 Youth
- Combined Adults/Youth served by private insurance sector (ie. Kaiser, UHC, Humana): 25
- Uninsured: 2 Adult

How Well Did We Do?:

II. Describe ways the program strives to:

a. Reduce mental health stigma:

- Provide a welcoming environment; All Staff attend cultural competency trainings.
- Offices in Fremont, Berkeley have on-site waiting rooms with receptionist or security support.

b. Create a welcoming environment:

- During COVID pandemic, staff provide Telehealth for continuity of service, otherwise practice safety protocols and wear PPE gear when meeting clients in person.
- Fremont office: Client enters office and there is a comfortable waiting room with chairs and a couch; There is a doorbell the client rings to notify staff that client is in the waiting room;

- Berkeley office: Client enters the Ed Roberts Campus and there is on-site receptionist and security. Client is greeted and announced to staff that he/she is here for services. Staff comes to the reception area to greet client and bring him/her to the office.
- All staff in this program have a VP phone number for accessibility to assist deaf clients.

III. **Language Capacity:** The majority of direct services are conducted in American Sign Language (ASL) by staff; Medication support services conducted with hearing psychiatrist and ASL interpreter is available for accessibility; Previous Program Director, Joni Teague, conducted services and communication with staff in ASL through February, 2020. Interim Program Director, since March 2020, Lynn O'Leary, is hearing staff and all communication to staff is in English, with professional ASL interpreter as needed for deaf staff.

IV. **FY 2019/20 Challenges:** We had to resolve issues around IT support and accessible equipment for staff trainings, finding the appropriate tools to use for staff to get proper training; initial lack of knowledge of accessibility and understanding of specific needs of deaf and hard of hearing staff, ie. More frequent breaks were needed, appropriate turn taking behavior, pauses to elicit communication between hearing staff and deaf staff; Further education for agencies and other providers about intricacies and complications of running a deaf program.

Is Anyone Better Off?:

V. **FY 2019/20 Impact:** Staff clinicians report that clients show decrease in behavioral impairments and mental health symptoms that have a negative impact on their social-emotional-relational functioning, which in turn affect the family and larger deaf community. By providing mental health and rehabilitative services using interventions such as CBT-based behavior modification and Motivational Interviewing with therapeutic skill building like Parent Education, individual client symptoms and impairments decrease when their pro-social skills and behaviors increase, which positively impacts adult individuals, family systems and the larger community.

Early into FY'19-20, an adult single male, father of 4, began services with DCCS. He reported suffering depression and substance use following his arrest for DV and was court ordered client for services as he was at risk of having children removed from the home. At the start of treatment, the client felt alone and anxious, did not feel confident in his parenting, had polysubstance use, and anger issues (domestic violence). He was diagnosed with Major Depression, affecting all areas of his functioning. After several months of CBT-based interventions including thought-analysis and anger management tools for tracking triggers, the therapist assigned client-specific Parent Education videos in ASL for cultural-linguistic appropriate services to support his parenting skill building. The client recently celebrated one year in treatment, attending nearly weekly, and has requested continuing services, reporting that they have significantly diminished his depression and greatly improved relationships with his children, who are no longer at risk of out-of-home placement through Family Court.

VI. **FY 2019/20 Additional Information:** There are minimal Alameda County Medi-Cal clients being referred to DCCS. Majority of referrals come from the private insurance sector such as, Kaiser, UHC, Humana, Blue Cross, etc. These systems are also very complicated, as each client must get a referral from their PCP which must then be approved by the insurance carrier, (for very limited services), and then each service must enter a single case agreement between the insurance carrier and Felton Institute, DCCS program.

VII. **FY 2020/21 Projections of Clients:** The DCCS program hopes to serve up to 70 clients and expand staffing structure. The current staff structure includes 2 Clinical Case Managers (licensed and registered LPHA), 1 Case Manager (Mental Health Rehab Specialist), Program Director, and Admin Support staff. Through critical review, observations, and study of this program by staff in this program, the program acknowledges the need for additional Case Managers and Peer Support staff to enhance the level of direct services in order to provide more Targeted Case Management needs, mental health services, and provide supportive groups for the deaf community.

VIII. **FY 2020/21 Program or Services Changes:** Joni Teague, Program Director who is deaf and conducted services and communication with clients, staff and agency, and other providers in the community in ASL and by reading lips, resigned from Felton Institute on February 28, 2020; Lynn O'Leary, hearing staff stepped in as Interim Program Director to ensure fiduciary and equity responsibilities of the program to the funders; Kimberly Cohn, MFT, RDT-BCT recently joined DCCS on August 24, 2020 as the new Program Director. She is licensed, hearing staff who also signs ASL.

During this time of change, COVID-19, SIP was set in place, and program deliverables were adjusted and changed to fit the regulations of COVID; Program management and majority of deliverables were shifted to remote services and meetings were held by Zoom. Several clients require staff to conduct home visits because they are not equipped with assisted devices such as a smartphones and computers and any video relay systems device. All staff practice safety protocols when out in the field. Outreach was not conducted in person, but all were done by meetings in Zoom. A DCCS event, "My Mind Matters" was cancelled. DCCS staff completed a video-log that was posted on FaceBook, Instagram, and Twitter. This v-log sends the message that DCCS is open and ready to support anyone or people in the Deaf Community during COVID-19 that need support or simply to talk to one of staff members of DCCS. Additionally, the video briefly shared with the deaf community general COVID-19 safety measures. This v-log was widely received by the community, and there have been potential clients reaching out to DCCS for services in multiple counties.

Each site/clinic will have specific protocols written up and placed in the office location. For DCCS, there are 3 office locations: 1) Fremont office-serving Alameda County Clients 2) Berkeley office-serving Alameda County/if necessary. PPE Gears for clear masks have been delivered for staff use and to share with clients. Since DCCS is a specialized program, clear masks were ordered to assist staff and clients in communication of reading lips and facial communication integral to ASL grammar and meaning. Property Manager from office site locations have responded and on-site staff are working to collaborate with property management to develop a protocol for safely shared common space at the building.

Continued outreach efforts are being made by the staff during COVID-19, -especially with Ohlone College. DCCS staff continues discussions with the school, as to how staff can become additional resources during this time to provide DCCS services to deaf students.

Deaf Counseling Advocacy & Referral Agency (DCARA) completed their unity video to share with the community with message of mindfulness and being kind to each other, especially to the Asian Community on their website. DCCS program was a part of this event and message.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 34

PROVIDER NAME: EBAC

PROGRAM NAME: Castlemont CE classroom

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 19/20

a. **Number of clients served:** 29 unduplicated

How Well Did We Do?

II. Please describe ways that the program strives to:

a. Reduce mental health stigma: We provide psychoeducation to school staff and families of the students. We provide ongoing collateral meetings with the school administration to reduce stigma by ensuring the language used and planning for mainstream support is inclusive an unbiased. We work with teachers to ensure that mainstream classroom integration is safe and inclusive of the student and their supports.

b. Create a welcoming environment: We have a therapy room that is decorated by the student/client and the clinical team. We ensure we have comfortable furniture and supplies that soothe the students such as musical instruments, fidgets, punching bags, art supplies and snacks. We utilize a trauma informed approach which means we consider the personal and cultural needs of each family in the space and during other interactions.

III. Language Capacity for this program: As a staff we speak primarily English in the program.

IV. FY19/20 Challenges: We do have some students whose parents are monolingual. To manage this, we use the language line. School attendance is a challenge as many students have sporadic attendance and at times if they are on campus they are hanging out socially with peers. We had a teacher that was not an appropriate cultural fit. This teacher has since been liberated from the space. A parent had safety concerns for her student due to community conflict/violence. We were able to work with the parent to increase attendance and mitigate concerns. COVID-19 pandemic and distance learning in the final

semester of the year. We also lost DeAndre Green, a long-time staff and friend, that had a positive relationship and impact on the students.

Is Anyone Better Off?

V. FY 19/20 Client Impact: We offered approximately 600 hours of family and caregiver support, really creating the opportunity for the families of the student to understand the students needs as well as learn the skills to continue to meet those needs. We also offered over 1,000 hours of direct client support and 156 hours of teacher and admin consultation. 3 of the 4 seniors graduated with our support and 1 is attending college.

VI. FY 19/20 Additional Information: During the COVID-19 Pandemic we were able to continue offering case management services including linking to technology to participate in remote learning as well as some basic needs such as food pantry bags and in person wellness checks on the most high needs.

VII. FY 20/21 Projections of Clients to be Served: 30 minimum to include I-CE students and their families.

VIII. FY 20/21 Program or Service Changes: None.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 34

PROVIDER NAME: EBAC

PROGRAM NAME: Roosevelt CE classroom

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 19/20

a. **Number of clients served:** 55

How Well Did We Do?

II. Please describe ways that the program strives to:

a. **Reduce mental health stigma:** We provided psychoeducation to school staff and families of the students. We provide ongoing collateral meetings with the school administration to reduce stigma by ensuring the language used and planning for mainstream support is inclusive an unbiased. We work with teachers to ensure that mainstream classroom integration is safe and inclusive of the student and their supports. We included all significant support persons in the decision-making process.

b. **Create a welcoming environment:** We used language that reflected the culture of the students served and ensured it was strength based. We have the right size furniture in the therapeutic space, allow the students to help with decoration and stock with activities that meet a variety of needs including dolls representing various cultures.

III. Language Capacity for this program: English and Spanish. We used our agency case managers for language support as well as the language line when needed.

IV. FY19/20 Challenges: Some student behaviors where more severe than the coverage arranged for the classroom. COVID-19 and the immediate shift to distant learning.

Is Anyone Better Off?

V. FY 19/20 Client Impact: We served not only the students but their siblings and families as well. We provided approximately 300 hours of family support. We spent a minimum of 140 hours with the teachers and school administration updating and educating them on how to best meet the specific needs of the CE students, in addition the 14 specific training hours we provided to ensure skill level was consistent. Additionally, we were able to successfully offer 160 hours of direct client specific services.

VI. FY 19/20 Additional Information: One of the CE students made the schools honor roll and gave the promotion ceremony speech via zoom.

VII. FY 20/21 Projections of Clients to be Served: 30 (given the pandemic)

VIII. FY 20/21 Program or Service Changes: Remote services due to the pandemic.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 34

PROVIDER NAME: Fred Finch Youth & Family Services

PROGRAM NAME: School-based Behavioral Health

Program Description: MHSA Braided funding for Expansion of School-Based Behavioral Health in the Oakland Unified School District (OUSD). MHSA funding is being braided with Educationally Related Mental Health Services (ERMHS) and Early Periodic Screening Diagnosis and Treatment (EPSDT) funds to provide enhanced (non Medi-Cal billable) mental health services and supports to children in Counseling-Enriched Special Day Classes (CESDC) and two of its School Based Behavioral Health (SBBH) programs in OUSD in order to assist these children and their families in becoming successful in school and at home.

Target Population: Youth attending Counseling-Enriched Special Day Classes (CESDC) and/or two of its School Based Behavioral Health (SBBH) programs in OUSD.

How Much Did We Do?

I. FY 19/20

a. **Number of clients served:** 42 youth and their families

How Well Did We Do?

II. Please describe ways that the program strives to:

a. **Reduce mental health stigma:** We addressed student needs by partnering with educational staff to create trauma-informed classrooms with structured environments, use of positive behavioral systems, and a wide variety of psychosocial supports to develop life skills. Clinicians use a strength-based philosophy to empower youth and families which looks at the unique strengths and needs across various life domains. We are grounded in a wraparound approach using school, family, and community to collaborate and support the client to address obstacles and challenges they may have to accessing their education.

b. **Create a welcoming environment:** As a program we strive to provide trauma-informed and culturally/linguistically responsive services in the school, family home, and community. We focus on nurturing healthy and secure attachments within the family and within the school. We support youth with developing skills to advocate for themselves within school and to feel successful with their education. Clinicians are strength-based and client-centered, supporting families to feel respected, informed about their treatment, and connected to positive supports within the school system and community.

III. Language Capacity for this program: We provide all services in English and conversational Spanish. All threshold languages are available via Alameda County Behavioral Health Language Phone Line when needed. Printed materials are available in English and Spanish.

IV. FY19/20 Challenges: Challenges within the program have been related to some of the implementation of the new MHSA funding stream. Clinical staff often found it challenging to switch to two separate and distinct funding streams when it came to thinking about the documentation of the services they provided. Eventually the clinicians were able to get more creative about the MHSA services they provided and came to appreciate the opportunities that the MHSA funding provided. One of our sites was less open to the idea of providing opportunities to support a positive school culture so most of the focus was in collaborating with the administration. In March 2020, schools went into distant learning due to COVID-19 pandemic. This had a huge impact in our ability to support school community and culture. As a program we put more focus on engagement and wellness checks for clients and families during distant learning time.

Is Anyone Better Off?

V. FY 19/20 Client Impact: With MHSA funding for the program we have been able to add a Family Partner position to support families of the students within the program. Our Family Partner has been able to support parents' engagement in their student's education, support parents with understanding mental health and how this impacts their students' access to education, and assistance accessing resources for basic living. The Parent Partner also helped to build community with parents, allowing them to share about their lived experiences of having a child of their own with a mental health diagnosis which has been impacted by the educational system. Our clinical team has been able to support students within the program to integrate into the larger school community, building a stronger school culture for all. We have been able to provide training and consultation for school staff on positive behavior interventions, building trauma-informed classrooms, and increasing awareness of mental health symptoms in the school setting.

Client Story- AB is in middle school and was new to the program this school year. AB has experienced homelessness in the past, witnessed community violence, and experienced bullying in school. AB was often absent from school, so his therapist referred his family to our Family Partner to engage them in assessing barriers for AB with coming to school. The Family Partner was able to build rapport and a trusting relationship with caregiver. From this relationship Family Partner and caregiver identified needs the family had that were impacting AB's school attendance. Family Partner was able to support caregiver with applying for housing and apply for financial supports that the caregiver identified as needs for the family. When primary needs were addressed, the Family Partner staff was able to support parent with engagement with the school community to support AB with coming to school. When schools closed due to COVID-19 pandemic, Family Partner was able to support and train the parent and caregiver to use the learning platforms so that AB could complete assignments.

VI. FY 19/20 Additional Information: None

VII. FY 20/21 Projections of Clients to be Served: 36 students plus their families.

VIII. FY 20/21 Program or Service Changes: Services will be provided at 3 school sites (Westlake Middle school closed their CESDC classroom) starting the 20/21 school year. Oakland Unified has moved the program from Oakland High to Life Academy for the 20/21 school year. Oakland Unified is starting in distance learning due to COVID-19 with no clear date of when students will be allowed to return for in person instruction. We will continue to provide services via video, phone and in person as needed.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 35

PROVIDER NAME: Mental Health Association of Alameda County (Family Education and Resource Center)

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 19/20

a. **Number of clients served:** The FREC program served 1,948 clients in FY 2019-20 inclusive of Warm Line calls and walk-ins.

How Well Did We Do?

II. Please describe ways that the program strives to:

a. **Reduce mental health stigma:** The intent to reduce mental health stigma is foundational to all aspects of FERC's program design:
   - The first step in this effort is to employ staff with lived experience as caregivers of loved ones living with mental health illness and challenges. Throughout the fiscal year the program adhered to this precept: FERC staff are caregivers and all program volunteers are caregivers and sometimes consumers.
   - Each staff person is supported to develop the ability to speak openly about their lived experience, to tell their story. The intent is that openly sharing stories about mental health challenges in families will model a different perspective on mental health, one in which shame and secrecy have no place. Staff with lived experience are fundamental to mitigating the mental health stigma.
   - The program provides families with support groups in which they can learn to speak openly about the challenges they face as they care for their loved ones. These groups also facilitate the sharing of information and insights and allow families to develop leadership skills as they become resources for one another.
   - The program provides culturally syntonic supports for Spanish speaking families; the Oakland and Fremont sites are safe places (now online) where people can receive support from bi-lingual and bi-cultural advocates. This aspect of the program helps normalize mental health challenges and reduces the stigma for these families.
   - The program provides fun social gatherings (such as Bingo Fridays) for caregivers and their loved ones where family fun time is shared in a group setting. In this environment (currently virtual) the

behavior of loved ones is not judged and families are relieved of the social anxiety they often carry due to mental health stigma.

- The program provides the CIT training for police officers from police departments across the greater bay area and this training is pivotal to reducing the mental health stigma existent within police departments. The powerful stories presented by mental health consumers and family members provide the officers with expanded perspectives and understanding. This shifts their responses from stigma-based assumptions to compassionate understanding for those living with mental health challenges.
- In fiscal Year 2019-20, the program provided mental health education for the community by holding a presentation at the Oakland Rotary Club in December 2019 on the topic of MH Stigma. The program also provided a Mental Health Resources workshop to Heritage Homes in February 2020. In March 2020, prior to the COVID-19 SIP order, the program provided a Mental Health Stigma Presentation for the Union City Family Center. Finally, the program worked with a volunteer in the months of April, May and June 2020 to develop a monthly mental health Lunchtime Presentation series on the topics of DSM V diagnoses and common medications and their side effects. This series will be provided in fiscal year 2020-21 starting in July 2020.
- Throughout the fiscal year the program provided 5 Presentations to organizations on MH:
  July 2019 – Organization**:** Alameda Family Services. Presentation topic: FERC and Family Resources; **September 2019** - Organization: Gladman Memorial. Presentation topic: Collaborating with Providers to Reduce Stigma. **October 2019** - Organization: Willow Rock Presentation topic: Mental Health Stigma Workshop; **October 2019 -** Organization: BestNow. Presentation topic: Working with Families. **November 2019 -** Organization: IHSS. Presentation topic: Self Care and Mental Health Stigma Inservice.

b. Create a welcoming environment: Throughout the fiscal year, until COVID-19, the program created three welcoming environments across the county. These resource center locations in Oakland, Fremont and Livermore are comfortable, inviting and culturally syntonic spaces where caregivers can come for support and social connection. Each space maintains a resource lending library with books on a wide variety of topics relevant to mental health, including books in the county's threshold languages. Each space has signage and resources printed in threshold languages and the program provides family advocate services in Spanish and Vietnamese. The Fremont site is located in the Fremont Family Resource Center hub, a one stop location where program families can receive support services for a wide array of basic needs, on site. The collaboration between providers located at the FRC provides families with warm hand off linkages which enhances the sense of being welcome within the environment.

With the advent of COVID-19 and the resultant shifts of working from home and providing virtual support services, the goal became one of creating a welcoming virtual environment. Some of the strategies the program adopted (and continues to use) are:

- Starting client support groups and client meetings with a brief relaxation practice and inviting participants to set their intentions for their time together
- Ending support groups and client one on ones with a grounding practice
- Including a self-care component in the service design for each virtual gathering
- Acknowledging to clients in the virtual environment the stress of the pandemic and ongoing health care disparities for families of color
- Increasing Spanish speaking support groups to once a week to assure that families have a safe and supportive place to connect with each other

- Creating a fun social environment where families can relax together and have fun
- In partnership with ACBH OFE, the program implemented the Parent Café model to provide caregivers and parents the opportunity to virtually meet each other to discuss a variety of topic questions based in the Protective Factors. Families were welcomed by parent leaders with experiences in common.

III. Language Capacity for this program:

County Language	FERC Staff Language
English Only 57%	English 50%
Spanish 16%	Spanish 42%
Asian Languages 19%	Vietnamese 8%

IV. FY19/20 Challenges:

The program experienced two major challenges in FY 2019-20:

1) Staffing: FERC struggled with staffing. FERC staffing rates across the fiscal year were as follows:
   - July 2019 through January 2020 staffing was at 50%
   - February 2020 staffing increased to 57%
   - April 2020 staffing increased to 71%
   - May through June 2020, staffing was at 86%
   - At the end of the fiscal year, the program had 2 unfilled positions: the Outreach Coordinator and a bilingual Family Advocate. As of this writing, the Outreach Coordinator will be onboarded on 8/31/2020 and the hiring process for the final bilingual Family Advocate is ongoing.

2) COVID-19: The second major challenge was the advent of the COVID-19 pandemic. Forty three percent of the program's staff started work during COVID-19 shelter in place, including the onboarding of the new program director. In this unprecedented challenge with all staff working from home, new staff were trained in virtual platforms (Zoom and Google Meets). The outcome of this type of training has been the need for an extended training period for the four new Family Advocates and Warmline Operator. By the end of the fiscal year all 4 new hires were still in training and all staff remain working remotely from home.

   The majority of program services also were shifted from in person to virtual platforms; this shift included FERC caregiver support groups, one-on-one client meetings, program social support groups, program outreach and community partnership work such as NAMI Support Group co-facilitation and Parent Cafés. The program was quickly responsive to this shift and by April 2020, much of the shift to virtual platform services had been implemented and 100% of the virtual shift was completed by the beginning of May 2020. To respond to family needs during the COVID crisis, the FERC program increased the number of monthly support groups offered by 50% for the Support groups in English and by 75% for the Support Groups in Spanish.

   The program's Warmline, a phone service, was not disrupted by the pandemic, however, the process of shifting Warmline calls from the desk phone system to staff cell phones (outside the agency phone system) was complicated and took the months of April and May to iron out. However, the program

ended the fiscal year with Warmline calls successfully going directly to staff cells. Warmline hours were extended from 5:00PM – 8:00PM.

Is Anyone Better Off?

V. FY 19/20 Client Impact:

- **Deliverable**: Contractor shall provide a total of 5,756 hours of outreach and engagement, services and supports, and training to families.
  Report: The Program provided 10,750 hours of outreach and engagement, services and supports and training to families in the fiscal year.

- **Deliverable**: Contractor shall make 500 outreach contacts to various individuals and organizations.
  Report: The Program provided 485 outreach contacts to various individuals and organizations in the fiscal year.

- **Deliverable**: Contractor shall make at least 400 follow-up contacts to these sources. These follow-up contacts shall result in Contractor becoming involved in projects with at least two organizations.
  Report: The program made over 400 follow-up contacts which resulted in the following two projects:
  San Lorenzo Unified School District – December 2019 MH Workshop and committee to design the FY 2020-21 school district project: Parents' Monthly Support Group.
  County Office of Family Empowerment – May 2020 Collaborative Parent Café project: the program in partnership with the OFE provided 3 Parent Cafés throughout May.

- **Deliverable**: Contractor shall hold six outreach and engagement activities throughout the County.
  Report:
  August 2019 – Allen Temple Church Health Fair
  August 2019 - Acts Full Gospel Church Health Fair
  March 2020 – Union City Youth and Families Services Event
  May 2020 - The program held three virtual Parent Café Events in May 2020 to outreach to the community during the COVID-19 Shelter in Place orders. Attendees were from North, Central and South County.

- **Deliverable**: Contractor shall establish five resource displays for family members in the four Alameda County threshold languages.
  Report:
  The program provided resource displays in the county threshold languages at the following locations in the fiscal year: Newark Display to Pastor Jones; Fremont Police Department; Fremont Hospital; Heritage Homes in Livermore; Fremont Family Resource Center.

- **Deliverable**: Contractor shall hold a minimum of 10 peer and social support groups throughout the County.
  Report: The program held 8 peer and social support groups on-line during the COVID shelter-in-place order:
  Family Fun and Art: May 5th and 12th
  Caregiver Friday Bingo: May 22nd, 29th; June 5th, 12th, 19th and 26th

- **Deliverable**: Contractor shall respond to at least 900 new Warm Line contacts.

Report: The program responded to 614 Warm Line contacts. The program is actively promoting the Warm Line and the new Outreach Coordinator to be onboarded in FY 20 -21 will also actively promote the Warm Line.

- **Deliverable**: Contractor shall recruit, train, and coordinate activities for two to four volunteers and report on the subject areas for which the volunteers were recruited.
  Report: The program recruited and trained two volunteers in the fiscal year. The first volunteer is a caregiver who identifies as a bi-lingual, bi-cultural East Indian medical student. He was trained to provide a FERC Lunchtime Education Series on mental health diagnoses, common medications and their side effects. This FERC education series was developed for the virtual platform zoom.
  The second volunteer is a mental health consumer who identifies as a white transsexual woman. She was trained to partner with FERC staff to provide the weekly Friday Bingo for Caregivers programming held on zoom.

- **Deliverable**: Contractor shall provide at least 800 Assembly Bill (AB) 1424 consultations. Contractor shall refer family members to websites and assist them in accessing relevant documents.
  Report: The program provided 1,948 with consultation on AB 1424 including referrals to appropriate resources.

- **Deliverable**: Contractor shall conduct at least one full-day provider education training that focuses on engaging family members in the treatment plan; culturally-competent family engagement; confidentiality procedures; addressing AB 1424 requirements; expanding support systems beyond family members; and family issues and resources. These trainings shall offer Continuing Education Units (CEUs).
  Report: The program did not conduct a full day education training that offered CEU units in the fiscal year. It should be noted that the Program Director left in December 2019 and this position was filled on March 23, 2020. By the end of the fiscal year, the opportunity to conduct this type of event was complicated by the advent of COVID-19.

- **Deliverable**: Contractor shall conduct a modified part-day version of this training on a quarterly basis.
  Report: The program did not conduct a quarterly modified part-day version of the above education training that offered CEU units in the fiscal year. It should be noted that the Program Director left in December 2019 and this position was filled on March 23, 2020.

- **Deliverable**: Contractor shall hold monthly family support groups, one meeting in each of the four regions, with 10 to 20 family members attending each group. At least one cohort of at least five to seven family leaders shall be trained with participants recruited from the monthly family support groups. Five to eight family members shall perform leadership functions within various County committees, task forces, and commissions.
  Report: From July 1, 2019 – March 30, 2020 the program provided (4) monthly family support groups and attend (2) as a community resource partner.
    - 2/4 family support groups are in Oakland
    - 1/4 Spanish support group is held in San Leandro
    - 1/4 support group is held in Livermore
    - 1/2 we partner with NAMI Tri-Valley, hosted in Pleasanton
    - 1/2 we partner with NAMI Tri-Valley, hosted in Livermore

In prior fiscal years, the program had a strong Family Leadership group comprised of 5-7 family members who regularly participated in county budget meetings, ACBH task force committees, etc. There have been significant changes in ACBH leadership over the years; most of the committees that welcomed community consumer and family voice have been suspended and dismantled.

Throughout the fiscal year, the program had a cohort of three Family Leaders who provided leadership until the March 2020 COVID Shelter in Place orders. The program had a Family Leader who Co-Facilitated a support group and taught the Family to Family class; the program also had a Family Leader who facilitated a support group and taught Family to Family. Finally, finally, the program had a Family Leader who regularly attended County Board of Supervisors meetings.

Starting in April 2020, in response to the COVID-19 pandemic the program increased support groups from 6 to 11 per month:

- Oakland Caregiver Support Groups via Zoom - 5:00pm – 6:30pm – 1st and 3rd Thursday of the month (June 4th and 18th 2020)
- Fremont Caregiver Support Groups via Google Meets - 4:00pm – 5:30pm – 2nd Tuesday and 3rd Thursday of the month (June 9th and 18th 2020)
- Oakland Borderline Support Group – On hold due to facilitator hiatus
- African American Family Outreach Project Support Group via Conference Call – 5:30pm – 7:30pm 4th Tuesday of the month (June 23rd 2020)
- Spanish Caregivers Support Groups via Zoom - 5:30pm – 7:00pm – Weekly each Wednesday (June 3rd, 9th, 16th, 23rd, 30th 2020)
- In Co-facilitation Partnership with NAMI Tri-Valley:
  Family Caregiver Support Group (Livermore) via Zoom – 7:00pm – 8:30pm – 2nd Monday of the month (June 8, 2020)
  Family Caregiver Support Group (Pleasanton) via Zoom – 7:15pm – 9:00pm - 4th Monday of the month (June 22, 2020)
  CIT for Law Enforcement

- **Deliverable**: Contractor shall provide a consumer / family member panel for the CIT trainings delivered by OPD. Contractor shall ensure that there are two to four consumers or family members participating on each panel.
  Report: This deliverable was met in 5 of the 6 CIT presentations in the fiscal year. The 6th CIT training was held in person at the Oakland Police Department OPD during the COVID-19 pandemic and 2 of the panel participants were not able to participate in person.
  - July 24, 2019 — 3 total: 2 consumers; 1 family member
  - August 28, 2019 — 3 total: 2 consumers; 1 family member
  - October 30, 2019 — 3 total: 2 consumers; 1 family member
  - January 27, 2020 — 3 total: 2 consumers; 1 family member
  - February 24, 2020 — 2 total: 1 consumer; 1 family member
  - June 22, 2020 — 1 total: 1 family member

A. Quality Objectives:

CIT for Law Enforcement **Deliverable**:

Quality Measures	Quality Objectives
Percent of officers who respond "strongly agree" on the CIT training evaluation to the statement: "I expect to use some of the information learned today."	95%

Report:

Date	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
July 24, 2019	78%	11%	6%	0%	5%
August 28, 2019	58%	26%	11%	5%	5%
October 30, 2019	77%	23%	0%	0%	0%
January 27, 2020	81%	19%	0%	0%	0%
February 24, 2020	71%	29%	0%	0%	0%
June 22, 2020	36%	64%	0%	0%	0%

B. Impact Objectives

Deliverable: Contractor shall provide services toward achieving the following impact objective:

CIT for Law Enforcement

Impact Measures	Impact Objectives
Percent of officers who respond "strongly agree" on the CIT training evaluation to the statement: "this information will improve my effectiveness in interacting with consumers and family members."	95%

Report:

Date	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
July 24, 2019	67%	22%	6%	0%	5%
August 28, 2019	58%	37%	11%	5%	5%
October 30, 2019	77%	23%	5%	0%	0%
January 27, 2020	69%	31%	0%	0%	0%
February 24, 2020	71%	24%	5%	0%	0%
June 22, 2020	50%	50%	0%	0%	0%

Report:

VI. FY 19/20 Additional Information: Compelling Vignette: In the beginning of March 2020, a family was referred to FERC for support. This single mother, fictitiously named Luz, idenitifies as Latinx and is a monolingual Spanish speaker. Luz parents her two sons and reside in an apartment in Central County. In June 2020, Luz's youngest son graduated 7th grade and her eldest son graduated middle shcool. Both of her sons live with diagnosed SMI and concurent developmental disabilities. Both sons are Regional Center Clients. On the surface this family appeared to have support services in place although the family's older son had been discharged from Eden Center services mid year. As the Family Advocate (FA) developed a

relationship with Luz she observed significant strengths. Luz's commitment to her sons' well being was passionate and tenacious. She put her children above all else in her life. She wanted a high quality education for her boys and gave them as much school-realted support as she could. Although struggling with unemployment, Luz provided her sons with a stable living environment, and was usually able to met her family's basic needs. Luz also had a friend who she could rely on for some of her transportation needs and for help with English translation. Luz had great stgrengths.

However it soon became clear to Luz's FA that Luz and her family had some significan needs that were going unmet. Soon after coming to FERC, Luz's friend returned to her job and was no longer available for translation support. As Luz's bilingual FA stepped in to provide the needed translation, she noticed that Luz struggled with literacy in addition to her language barrier. Luz also struggled with organization and with memory issues. The FA ascertained that Luz had not been evaluated for literacy needs and had not been evaluated for her challenges with organization and memory. Luz also had significant challenges around technology. When the shelter in place order came into effect mid March 2020, and she had to suddenly provide support to her two sons for their online schooling, Luz was at a loss. Luz did not have the skills to support navigating the Zoom classroom and, she was not able to access her own email. She related that her firend had done this for her. Luz's memory issues were a barrier to her developing the computer skills she needed.

By the end of the school year, Luz felt that her sons' IEPs were not in place. She felt that each of her sons' IEPs were not complete and were not in accordance with the School Psychologist assessments. Neither of her sons' schools were responsive to Luz. Neither school was willing to send Luz information through the postal service. Each school insisted on communicating in English through email, and the schools were not responsive to Luz's requests for IEP Amendment meetings. Luz became distraught.

FERC became very concerned that Luz could be experiencing disparities due her race, her language and literacy barriers and her disabilities. FERC assigned two FA staff to support Luz. One FA, fictitiously named Gina, focused on Luz's sons' educational issues. FA Gina advocated for IEP meetings, contacted DREDF and attended the end of the year IEP meetings that were finally scheduled. The second FA who is bilingual/ bicultural, fictitiously named Elena, worked directly with Luz to help her with her emails and her daily organizing/calendaring tasks. FA Elena also began to talk to Luz about her own self-care and her challenges with memory and literacy. FA Elena worked with Luz to help her step away from the stigma of these issues. This work is ongoing. Luz relates that she wants to put her children first and her needs secondary. It is challenging for her to recognize the importance of her own well-being relative to that of her sons. But she is shifting in her perspecitve. She is starting to be curious about self-care and is listening to FA Elena's suggestions. By the end of the fiscal year, Luz was not yet ready to attend a FERC support group for Spanish speaking families lead by her FA, however, she said she is thinking about it. FA Gina is working hard to get IEP meetings set for the Addendums that were not in place at the end of the 2019-20 school year – both boys need to start the school year with an accurate IEP in place. FA Gina has worked with DREDF to file a complaint against the school district for both sons. Luz had started to attend therapy.

It is hoped that with the continued support provided by FERC, Luz and her sons will enter into the new school year (her oldest son starting high school!) with technological supports in place for distance learning, and for access to Luz's computer emails. It is hoped that as Luz works with her therapist, her literacy, memory and organizational challenges will be assessed. It is the goal of both FA Elena and FA Gina that with their intensive support Luz will be able to move forward and access the ongoing supports she needs for herself and her family.

VII. FY 20/21 Projections of Clients to be Served: 2,824 (5-year average)

VIII. FY 20/21 Program or Service Changes: The program anticipates the following changes in the upcoming fiscal year (2020-21): By the end of August 2020, the program anticipates onboarding the new FERC Outreach Coordinator position. The candidate is an African American woman who will develop and implement a social media outreach campaign and provide ongoing relationship development and collaboration with community partners via a variety of virtual methodologies.

In the new fiscal year, the FERC program will host the African American Family Outreach Project (AAFOP), which has traditionally been hosted by the agency. This shift will result in a joining of two funding streams (AAFOP and FERC) and will allow the hiring of an AAFOP outreach worker/Family Advocate position. This unique position will be a .50 FTE AAFOP Outreach Worker and a .50 FTE FERC Family Advocate. The intent is to extend culturally syntonic Family Advocate service provision to African American families in Alameda County.

In mid-July 2020, the program will pilot an extension of FERC Warm Line services from 5:00PM – 8:00PM. The data from this two-month extension of Warm Line hours will be analyzed and a determination will be made as to the efficacy of the program's Warmline Hours Extension.

Finally, the program plans to increase virtual programming designed to reduce social isolation in the new fiscal year, building upon the program's success with the weekly Friday Bingo program and the program's Parent Café collaboration with the OFE during the COVID Shelter in Place orders.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 36

PROVIDER NAME: CalMHSA

PROGRAM NAME: Presumptive Transfer Project

Program Description: Funding to be transferred for the support of providing services to Alameda County foster youth being served outside of Alameda County.

Target Population: Foster youth receiving mental health services outside of Alameda County

This is a current mandate for all California Counties.

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

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1 Proposition 63: Mental Health Services Act 2004

2 MHSOAC PEI Fact Sheet, December 2017

STATE DEFINED PREVENTION AND EARLY INTERVENTION PROGRAMS

PREVENTION

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

EARLY INTERVENTION

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

OUTREACH

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

STIGMA & DISCRIMINATION REDUCTION

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

ACCESS & LINKAGE TO TX

- Related activities to connect children, adults, and seniors with severe mental illness to medically necessary care and treatment as early in the onset as possible.
- Examples include screening, assessment, referral, telephone help lines, & mobile response.
- Includes targeted access and linkage activities for cultural populations.

SUICIDE PREVENTION

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

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

Program Outcomes & Impact: PEI Data Report FY 19/20

PERFORMANCE INDICATORS: How Much Did We Do?

	Total		PEI		UELP	
Program Totals	**#**	**%**	**#**	**%**	**#**	**%**
TOTAL SERVED	**82,812**	**100**	**36,884**	**45**	**45,928**	**55**

	Total		PEI		UELP	
AGE CATEGORIES	**#**	**%**	**#**	**%**	**#**	**%**
Children/Youth (0-15 yrs.)	16,327	19%	10,231	25%	6,096	13%
Transition Age Youth (16-25 yrs.)	11,696	14%	2,706	7%	8,988	20%
Adult (26-59 yrs.)	23,095	27%	3,678	9%	19,417	43%
Older Adult (60+ yrs.)	8,896	10%	1,267	3%	7,629	17%
Declined to Answer	1,130	1%	1,009	2%	121	0%
Unknown	24,784	29%	21,661	53%	3,123	7%
TOTAL	**85,928**	**100%**	**40,554**	**100%**	**45,374**	**100%**

	Total		PEI		UELP	
PRIMARY LANGUAGE	**#**	**%**	**#**	**%**	**#**	**%**
English	21,161	28	8,704	27	12,457	29
Spanish	18,585	25	2,135	7	16,450	38
Cantonese	1,165	2	282	1	883	2
Chinese	42	0	40	0	2	0
Vietnamese	672	1	52	0	620	1
Farsi	539	1	85	0	454	1
Arabic	646	1	38	0	608	1
Tagalog	217	0	63	0	154	0
Declined to Answer	4,985	7	4,985	16	0	0
Unknown	15,393	20	15,379	48	14	0
Another language not listed	12,295	16	323	1	11,972	27
TOTAL	**75,700**	**100**	**32,086**	**100**	**43,614**	**100**

	Total		PEI		UELP	
RACE	**#**	**%**	**#**	**%**	**#**	**%**
American Indian or Alaska Native	314	0	81	0	233	1
Asian	22,616	27	3,804	10	18,812	43
Black or African American	7,250	9	5,587	14	1,663	4
Native Hawaiian or other Pacific Islander	501	1	312	1	189	0
White	5,344	6	3,768	9	1,576	4
Other Race	28,036	34	8,244	21	19,792	45
Declined to Answer	4,100	5	4,048	10	52	0
Unknown	15,503	19	13,840	35	1,663	4
TOTAL	**83,664**	**100%**	**39,684**	**100%**	**43,980**	**100%**

	Total		PEI		UELP	
ETHNICITY/CULTURAL HERITAGE	**#**	**%**	**#**	**%**	**#**	**%**
Hispanic or Latino						
Caribbean	54	0	26	0	28	0
Central American	3,089	5	176	1	2,913	8
Mexican/Mexican American/Chicano	8,764	13	1,134	4	7,630	20
Puerto Rican	40	0	18	0	22	0
South American	172	0	32	0	140	0
Another Hispanic/Latino ethnicity not listed	8,398	12	635	2	7,763	21
Hispanic or Latino Subtotal	20,517	31	2,021	7	18,496	49
Non-Hispanic and Non-Latino						
African	210	0	210	1	0	0
African American	2,646	4	2,646	9	0	0
Asian Indian/South Asian	1,698	3	703	2	995	3
Cambodian	4,636	7	25	0	4,611	12
Chinese	2,419	4	543	2	1,876	5
Eastern European	103	0	103	0	0	0
European	477	1	477	0	0	0
Filipino	1,919	3	600	2	2	4
Japanese	30	0	30	0	0	0
Korean	1,420	2	171	1	1,249	3
Middle Eastern	167	0	167	1	0	0
Vietnamese	789	1	120	0	669	2
Other Non-Hispanic or Non-Latino ethnicity not listed	8,714	13	447	2	8,267	22

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

	Total		PEI		UELP	
	#	%	#	%	#	%
Non-Hispanic and Non-Latino Subtotal	25,228	38	6,242	21	18,986	51
More than one ethnicity	1,053	2	968	3	85	0
Unknown ethnicity	14,802	22	14,802	50	0	0
Declined to answer	5,625	8	5,625	19	0	0
TOTAL	**83,664**	**100%**	**29,658**	**100%**	**37,567**	**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 19/20

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
	x	Cultural and Linguistic
		Older Adults
		Early Identification of Mental Health Illness

Box A: Please provide a brief program description (character limit 1,000).

Blue Skies works to provider brief therapy and clinical case management services to families focusing on Early Childhood Mental Health stabilization and providing resources to support mothers/fathers and families with young children ages 0-5 where mental health issues and complex psycho-social needs have been identified. We provider prevention services to families referred from ACPHD/MPCAH-Starting out Strong System of Care. The home visiting programs that refer to our services receive consultation, MH counseling, short to longer term case management, brief therapy, developmental screening, and referral resources linking clients to MH treatment options in AC. All program efforts encourage multi-disciplinary collaboration with referring home visiting programs to provide shared interventions efforts for mental wellness strategies to benefit families for stabilization, growth, improved parenting, and enhanced personal development.

Box B: Please provide the total number of individuals served to date July 1, 2019 through June 30, 2020 through MHSA funding.

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	2
Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	5
Number of unduplicated individual family members served indirectly by your program:	0
Grand total of unduplicated individuals served:	**7**

Box C: 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.

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	**0**

SEXUAL ORIENTATION	
Gay/Lesbian	
Heterosexual/Straight	
Bisexual	
Questioning/Unsure	
Queer	
Declined to answer	
Unknown	
Another group not listed	
TOTAL	**0**
If another group is counted, please specify:	

VETERAN STATUS	
Yes	
No	
Declined to answer	
Unknown	
TOTAL	**0**

CURRENT GENDER IDENTITY	
Female	
Male	
Transgender	
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	
Another identity not listed	
TOTAL	**0**
If another identity is counted, please specify:	

PRIMARY LANGUAGE	
English	34
Spanish	18
Cantonese	
Chinese	
Vietnamese	
Farsi	
Arabic	
Tagalog	
Declined to answer	
Unknown	85
Another language not listed	
TOTAL	**137**
If another language is counted, please specify:	

SEX ASSIGNED AT BIRTH	
Male	
Female	
Declined to answer	
Unknown	
TOTAL	**0**

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.

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	2
Black or African American	46
Native Hawaiian or Other Pacific Islander	
White	2
Other Race	
Declined to answer	2
Unknown	39
TOTAL	91
If another race is counted, please specify:	

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	
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	
Total Hispanic or Latino	**0**

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

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	0

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.

The challenges of supporting the Blue Skies Mental Wellness Team during this fiscal year surrounded the ever-changing case-loads and inconsistency of client contact. Our program averaged 8-10 referrals per month from the home visiting programs. However due to the demographics and trauma indexes of the clients it was difficult to maintain consistent contact with many of the clients.

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.

It was very supportive to have a finally received a full-time specialist clerk for our program. This recent person hired has been able to assist me with the many organizational projects to support the BSMWT that were overdue and difficult to manage alone. Additionally, the team has continued to come together and grow in reflection.

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 BSMWT has been able to continue to accept and receive and uptake in referrals from the ACPHD-MPCAH Starting Out Strong System of Care. We have continued to provide a consultation model. We offer consultation feedback to referring home visitors and Public Health Nurses, along with being able to provide a Consultation Case Review Team meeting to 4 home visiting programs, offering our BSMWT model on a monthly basis. We are preparing to offer this resource to an additional home visiting program and are expanding to bring on 2 additional half time mental health consultants due to an Alameda County Healthy Start Initiative grant option. Our team has continued to work effectively with multidisciplinary staff in the ACPHD, presenting a mental wellness/prevention model which has been well received.

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

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, including:

- 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. The following information is about the 2019/2020 administration.

The health assessment and satisfaction surveys were disseminated to the UELP community in 23 different languages including English, Spanish, Vietnamese, Chinese, Dari, Hindi, Khmer, Nepali, Korean, Thai, and Burmese and covered the following outcomes:

- Forming and strengthening identity;
- Changing knowledge and perception of mental health;
- Building community and wellness;
- Connecting individual and family with their culture;
- Improving access to services and resources;
- Transforming mental health services; and
- Increasing workforce and leadership development.

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

In FY 19/20, the data shows that UELP providers in total produced:

- 7,472 *Prevention* events, which is a 5% decrease from last year;
- 46,538 people were served at these *Prevention* events (duplicated count); and
- 1,092 unique clients were served through *PC* services, which is an 22% increase in the number of clients served in FY 18/19.

In FY 19/20, both tools assessed the impact of the three core strategies (Outreach and Engagement; Mental Health Consultation; and Early Intervention services) across the following outcomes:

- <u>Forming and Strengthening Identity</u>

  Prevention services enhance self-efficacy. Eighty-three percent of participants receiving *Prevention* services reported that they were better able to deal with crisis. 89% felt better about themselves.

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

- Changing Individual Knowledge and Perception of Mental Health Services
  UELP programs are meant to raise awareness and understanding of mental health services and, in turn, decrease internalized stigma. This data shows that respondents have a firm understanding of how different types of moods can impact their mental, emotional, and overall health. The data also show a shift in the perception of mental health in both *Prevention* and *PC* services, further suggesting a reduction in internalized stigma. 96% of respondents receiving Prevention services reported a better understanding that stress, worries, and level of happiness can impact their mental or emotional health, and talking to people can improve their wellbeing.

- Building Community and Its Wellness
  UELP providers continue to create opportunities for clients to build new friendships and support systems within their programs. The data shows that clients have established relationships with people in their community and have people they can rely on for support. This suggests a reduction of stigma in the community around having and talking about mental health challenges. 97% of respondents that received Prevention services reported having people who will listen and support them when they need to talk. 93% have people with whom they can do enjoyable things.

- Connecting Individual and Family with Their Culture
  UELP services aim to bolster the connection clients have with their culture by utilizing their cultural norms as a bridge to provide services, which can be achieved in many ways. Some examples include using cultural practices, celebrations, and validations in program activities. The data shown below demonstrates that UELP services are facilitating a connection between clients, their culture, and communities. 86% of Prevention respondents reported that they felt more connected to their culture and community.

- Improving Access to Services and Resources
  Monolingual or LEP (Limited English Proficiency) populations may experience challenges navigating the behavioral health care system and accessing services or resources, particularly when they are in need or in crisis. This is extremely important because barriers to access can lead to increased stress, anxiety, isolation, depression, and other mental health concerns. With the assistance of UELP services, the majority of participants are more successful at navigating the system in order to obtain the services and resources they need. 88% of Prevention and 78% of Preventive Counseling respondents feel that they have become more effective in getting resources they or their family needs.

- Transforming Mental Health Services
  UELP service agencies are determined to provide transformative mental health services. The idea is to move away from the "one size fits all" approach to mental health, emphasizing the use of culturally congruent mental health methods with marginalized populations. The data below shows that respondents are satisfied with the services they receive in UELP. Participants continue to report that they are treated well and would recommend these services to friends or family members. 98% of respondents reported that program staff treated them with dignity and respect. 95% reported that staff were sensitive to their cultural background.

- Increase Workforce and Leadership Development

  This outcome is still a new area of exploration for the UELP evaluation**.** However, data from the focus groups/interview indicates that UELP programs are creating opportunities with their clients for *community leadership.*

ADDITIONAL FINDINGS

As a direct result of their participation in UELP services respondents were asked to provide areas of improvement. Mental health was the largest area of improvement for *Prevention* survey respondents. This is consistent with the responses to the open-ended questions. Emotional support was the largest area of improvement for *PC* respondents, which is also reflected in the open-ended questions. Emotional support, mental health, and stress were high ranking areas of improvement for both *PC* and *Prevention*. Employment (76%) was also highly ranked as an area of improvement for *PC* respondents.

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

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 19/20

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. Most UIY come primarily from Guatemala, El Salvador, Honduras, and Mexico. Alameda County is recipient of highest numbers of UIY in California, and in the country. Outreach to participants and families, stabilization, identification of early signs of mental illness, linkages to various resources and supports, are the key objectives of UIY program. The intent of UIY Care team is to provide linguistically and culturally responsive trauma-informed services, via one-to-one support, psychoeducational workshops, support groups, linkages to community resources and specialty mental health programs, to a population sensitive to acculturation and challenges navigating new systems.

Box B: Please provide the total number of individuals served to date July 1, 2019 through June 30, 2020 through MHSA funding.

Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	7146

Number of unduplicated individual family members served indirectly by your program:	
Grand total of unduplicated individuals served:	**7259**

Box C: 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.

AGE CATEGORIES	
Children/Youth (0-15 yrs)	502
Transition Age Youth (16-25 yrs)	2229
Adult (26-59 yrs)	2925
Older Adult (60+ yrs)	180
Declined to answer	
Unknown	1310
TOTAL	**7146**

SEXUAL ORIENTATION	
Gay/Lesbian	76
Heterosexual/Straight	4245
Bisexual	25
Questioning/Unsure	
Queer	
Declined to answer	
Unknown	2800
Another group not listed	
TOTAL	**7146**

VETERAN STATUS	
Yes	1
No	5743
Declined to answer	1402
Unknown	
TOTAL	**7146**

CURRENT GENDER IDENTITY	
Female	3677
Male	2028
Transgender	
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	1441
Another identity not listed	
TOTAL	**7146**
If another identity is counted, please specify:	

PRIMARY LANGUAGE	
English	2534
Spanish	4437
Cantonese	
Chinese	
Vietnamese	
Farsi	
Arabic	
Tagalog	
Declined to answer	
TOTAL	**6973**

SEX ASSIGNED AT BIRTH	
Male	2028
Female	3677
Declined to answer	
Unknown	1441
TOTAL	**7146**

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

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.

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	2
Chronic health condition	1
Disability Subtotal	**3**
None	5591
Declined to answer	
Unknown	585
Another disability not listed	
TOTAL	**6179**

RACE	
American Indian or Alaska Native	2
Asian	64
Black or African American	150
Native Hawaiian or Other Pacific Islander	
White	449
Other Race	5648
Declined to answer	
Unknown	833
TOTAL	7146

Latino (5074), Multiracial (384), Other (190),

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	1
Central American	1887
Mexican/Mexican American/Chicano	775
Puerto Rican	9
South American	38
Another Hispanic/Latino ethnicity not listed	2360
Total Hispanic or Latino	**5070**

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	5070

South American: Argentinian (8), Braziian (1), Colombian (12) Peruvian (1); Ecuadorian (2), Uraguay (1), Venezuelan (9), Guyanese (4); Central American: Guatemalan (826), Honduran (347), Nicaraguan (57), Salvadoran (657); Other (2360);

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.

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

An accomplishment UIY team is excited to share, is the participation in "Cena Caliente", which was created as a response to the needs of the UIY population living in the Hayward community, who were facing a shortage of food during Shelter-in-place ordinance. UIY staff not only helped plan this event, but also played a vital role in finding the physical space and volunteers to be able to provide fresh food to families in need. These services happened several days a week, over the course of several weeks. UIY staff saw this as an opportunity to assess for needs, and connect families to many other meaningful resources. What is more, upon noting that some families were impacted by COVID-19 and needed to quarantine, UIY staff (along with partners who supported this cause), ensured that access to food was not interrupted, by delivering it personally. Brief images of this event can be found in the following video https://vimeo.com/445325188/92f39dcbf3 (at 00:46, 00:56, 2:24- 2:29)

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.

Though we recognize that the onset of COVID did not affect FY 2019-2020 in full, the impact has been of such dimension (and continues to be), that it is worth focusing on the challenges that stemmed from it. The most salient implementation challenge was that online based virtual services were not an effective model for service delivery and outreach to the UIY/CMF population. Coordination of care, follow through, obtaining participant feedback, and difficulty accessing basic need supports, were highly impacted due to the lack of "in-person" services. Part of the reason for this, is that the tools available for the UIY team to reach participants were part of the same larger system that participants need assistance navigating. The way UIY has mitigated this challenge, was by respecting participants' engagement comfort levels, and offering creative solutions, along with more participatory practices of UIY Care Team staff.

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.

Despite the incredible amount of limitations, faced by both UIY team as a service provider, and participants, the experience continues to suggest that the UIY Care Team's core values stay true over time, and that are the main reason for the successes of the program. UIY team learned that trust is key for change to occur, to build resilience, and that trust takes time and effort. UIY learned that to overcome systemic barriers, we need to sustain our presence over time, which is not only our one to one work and outreach efforts, but also participation in community meetings to establish, develop new partnerships, advocate for our underserved populations, and come up with creative solutions from a community stance.

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):	12

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:	8
G.5: Average duration of untreated mental illness in weeks:	14.5 Weeks (Date of 1st visit with UIY Staff to Date start Specialty Mental health treatment
G.6: Average number of days between referral and first participation in referred treatment program:	7.47 Weeks, 52 days approximately

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:	UIY does not have ability to report on amount of paper referrals received.
H.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	At least 129 individuals participated in PEI - UIY program
H.4: Average number of days between referral and first participation in referred PEI program:	1.16 days between referral and participation in PEI - UIY program
H.5: Describe how your program encouraged access to services and follow through on above referrals (500 Characters):	UIY team advocates for UIY needs, and obtains referrals through regular COST (Coordination of Services Team) meetings. Additionally, as a result of the team staff outreach efforts to provide one to one support sessions, workshops, parent/caregiver engagement, and support groups. Engagement and follow through are often a result achieved by developing a strong bond and rapport with participants.

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

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:	**3000**
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 19/20

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
		Cultural and Linguistic
		Older Adults
		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: Please provide the total number of individuals served to date July 1, 2019 through June 30, 2020 through MHSA funding.

Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	14643
Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	313
Number of unduplicated individual family members served indirectly by your program:	NA

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

Grand total of unduplicated individuals served:	**14956**

Box C: 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.

AGE CATEGORIES	
Children/Youth (0-15 yrs)	3261
Transition Age Youth (16-25 yrs)	2032
Adult (26-59 yrs)	6316
Older Adult (60+ yrs)	1885
Declined to answer	
Unknown	1149
TOTAL	**14643**

SEXUAL ORIENTATION	
Gay/Lesbian	53
Heterosexual/Straight	7037
Bisexual	10
Questioning/Unsure	1
Queer	
Declined to answer	
Unknown	7529
Another group not listed	9
TOTAL	**14639**
If another group is counted, please specify:	

VETERAN STATUS	
Yes	32
No	7143
Declined to answer	
Unknown	7468
TOTAL	**14643**

CURRENT GENDER IDENTITY	
Female	9916
Male	4348
Transgender	2
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	375
Another identity not listed	
TOTAL	**14641**
If another identity is counted, please specify:	

PRIMARY LANGUAGE	
English	2803
Spanish	11770
Cantonese	
Chinese	
Vietnamese	
Farsi	
Arabic	
Tagalog	
Declined to answer	
Unknown	
Another language not listed	68
TOTAL	**14641**
If another language is counted, please specify:	

SEX ASSIGNED AT BIRTH	
Male	4348
Female	9916
Declined to answer	
Unknown	377
TOTAL	**14641**

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.

DISABILITY*** STATUS	
Communication Domain	
Vision	27
Hearing/Speech	58
Another type not listed	6
Communication Domain Subtotal	**91**
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	13
Physical/mobility	81
Chronic health condition	514
Disability Subtotal	**608**
None	4713
Declined to answer	
Unknown	9227
Another disability not listed	
TOTAL	**14639**
If another disability is counted, please specify:	

RACE	
American Indian or Alaska Native	1
Asian	319
Black or African American	255
Native Hawaiian or Other Pacific Islander	
White	280
Other Race	13098
Declined to answer	
Unknown	218
TOTAL	14171
If another race is counted, please specify: Latino (13030), Other (68).	

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	27
Central American	958
Mexican/Mexican American/Chicano	6803
Puerto Rican	13
South American	102
Another Hispanic/Latino ethnicity not listed	4952
Total Hispanic or Latino	**12855**
If Non-Hispanic or Non-Latino, please specify:	
African	

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

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	319
Total Non-Hispanic or Non-Latino	**319**
More than one ethnicity	
Unknown Ethnicity	
Declined to answer	
EHTNICITY TOTAL	13174
If another ethnicity is counted, please specify: API (319)	

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.

CyB services included group and individual education and counseling in Spanish and English as well as referrals to services and traditional healing events. The COVID19 emergency defined much of our program's accomplishments this year. We successfully transitioned into mostly online based services across the collaborative, which included teaching clients, how to use devices and applications to communicate remotely. Collaborative agencies in the Tri-City and Hayward areas, quickly shifted to provide food pantry, support groups, workshops and other resources.

A woman in her 30s came to CyB for services. She had been assaulted 2 weeks prior to reaching out for help. After the first session the client reported feeling very grateful for the service. The client continued to educate herself on the physiological/psychological effects of trauma and by the end of the 6 sessions she reported no longer experiencing the initial fear.

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.

Staff transitions including program manager, program assistant and a lead health educator leaving and a new health educator and mental health specialist coming in within a short period of time. Program Director and MH Supervisor teamed up to ensure continuity in managerial infrastructure while new Program Manager was being recruited. COVID19 emergency forced us all to close-down and move our services online. The sudden change caused a brief disruption in services while we all adapted to use applications, technology and created protocol and materials for social distancing and for online-based services. Thus far this transition has been successful and continuity of services has now resumed. Some collaborative partners added emergency support services to meet the needs of the community during these difficult times, including food and financial support services as well as support groups and workshops and teaching participant how to use technology to communicate with service providers.

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.

Teamwork and coordination were essential to meet the challenge presented by the COVID19 pandemic both in terms of the programmatic and the emotional impacts for staff and clients. The collaborative showed resiliency and adaptability to quickly transform and resume services. Community and our clients continued to be at the center of our effort and mission and despite the significant challenges presented by leadership and staff transitions and the COVID19 pandemic, CyB never interrupted communication and services to families in our community. In some instances, our partners even stepped up the effort and added services and resources to their clients. The community itself was quick to regroup and adapt quickly to the new reality and to learn how to continue to support each other and their service providers in the mist of this adversity. The big lesson this year was: We are on this together and together we shall overcome the challenges ahead of us and even pass the crisis we face today.

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

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):	0
G.3: Types of treatment individuals were referred to (list types) (500-character limit):	Casa del Sol
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):	NA
H.2: Number of paper referrals to an ACBH PEI-funded program:	NA
H.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	NA
H.4: Average number of days between referral and first participation in referred PEI program:	NA

H.5: Describe how your program encouraged access to services and follow through on above referrals (500 Characters):	NA

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):
	148 Workshops/Support Groups Child/youth
	81 Workshops/Support Groups 16-25
	213 Workshop/Support Groups for adults
	114 Workshops/Supports Groups for seniors
	935 One to One Prevention Visits
	427 Early Intervention Visits
	20 CBO Trainings
	102 Consultation with Natural Leaders/Professional Leaders
	44 Presentations to Community Groups

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

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 19/20

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 AHS Prevention & Wellness Program (also referred to as the "Prevention Program") addresses the mental health and other needs of underserved and emerging API communities. Our goals are to improve access to culturally competent prevention and early intervention services; reduce stigma attached to mental health services; and strengthen API communities' knowledge of wellness practices and resources. Our services include community outreach events, workshops and education, mental health consultation, short term preventative counseling with an option of family consultation, case management, and support group. All services are free. Our prevention program was contracted to serve the following communities: Cantonese-speaking Chinese, Mandarin-speaking Chinese, Korean, Japanese, and Mongolian.

Box B: Please provide the total number of individuals served to date July 1, 2019 through June 30, 2020 through MHSA funding.

Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	1142
Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	19

Number of unduplicated individual family members served indirectly by your program:	NA
Grand total of unduplicated individuals served:	**1161**

Box C: 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.

AGE CATEGORIES	
Children/Youth (0-15 yrs)	171
Transition Age Youth (16-25 yrs)	175
Adult (26-59 yrs)	612
Older Adult (60+ yrs)	473
Declined to answer	
Unknown	10
TOTAL	**1441**

SEXUAL ORIENTATION	
Gay/Lesbian	
Heterosexual/Straight	571
Bisexual	5
Questioning/Unsure	
Queer	
Declined to answer	
Unknown	866
Another group not listed	
TOTAL	**1442**
If another group is counted, please specify:	

VETERAN STATUS	
Yes	
No	645
Declined to answer	
Unknown	737
TOTAL	**1382**

CURRENT GENDER IDENTITY	
Female	1091
Male	349
Transgender	
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	
Another identity not listed	
TOTAL	**1440**
If another identity is counted, please specify:	

PRIMARY LANGUAGE	
English	312
Spanish	
Cantonese	692
Chinese	
Vietnamese	28
Farsi	
Arabic	
Tagalog	
Declined to answer	
Unknown	8
Another language not listed	384
TOTAL	**1424**

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

SEX ASSIGNED AT BIRTH	
Male	349
Female	1091
Declined to answer	
Unknown	
TOTAL	**1440**

If another language is counted, please specify:
Mandarin (82), Mien (269), Cambodian (10), Hmong (1), Japanese (3), Korean (19)

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.

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	3
Chronic health condition	
Disability Subtotal	**4**
None	609
Declined to answer	
Unknown	829
Another disability not listed	
TOTAL	**1442**

If another disability is counted, please specify:

RACE	
American Indian or Alaska Native	
Asian	1345
Black or African American	8
Native Hawaiian or Other Pacific Islander	1
White	19
Other Race	5
Declined to answer	
Unknown	64
TOTAL	1442

If another race is counted, please specify:

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	
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	5
Total Hispanic or Latino	**5**
If Non-Hispanic or Non-Latino, please specify:	
African	
African American	
Asian Indian/South Asian	3
Cambodian	1
Chinese	990
Eastern European	
European	
Filipino	9
Japanese	
Korean	19
Middle Eastern	
Vietnamese	28
Other Non-Hispanic or Non-Latino ethnicity not listed	400
Total Non-Hispanic or Non-Latino	**1450**
More than one ethnicity	
Unknown Ethnicity	
Declined to answer	
EHTNICITY TOTAL	1455

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.

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

We successfully conducted mental health wellness event that engaged 92 children, youth, and families at AHS Health Center in Oakland. During a separated collaborative mental health presentation, a total of 265 Asian students were engaged and showed interest in mental health. We also collaborated on other events that allowed us to engage 65 youth and created support groups with students at libraries and schools. A client came to us with severe distress due to a history of family conflict, a medical insurance, immigration, and current living arrangement concerns. Our counselor applied culturally sensitive psychoeducation approach and empathic communication techniques. The client was able to develop rapport with the counselor and implemented newly acquired skills and be able to connect with community resources. After several weeks of services, the client reported a significant reduction in mental distress and improved outlook on life.

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.

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.

Given the circumstances of COVID-19, our program learned the urgency in listening, strengthening and developing collaborations, and innovating services. Listening and understanding the vulnerability of East Asian older adults during this time, we reached out to senior centers who mainly serve our East Asian language populations. We offered to serve and provide support where we could. One of the high needs reported were PPE (masks), toilet paper, self-care information, mental health resources, and activities in language. As of today, we were able to gather resources and send care packages to 82 seniors from various centers. Our Prevention team was able to successfully network with local groups that provided free masks and many other materials donated. We continue to collaborate and innovate our services to further meet the community 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):	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):	Both are now with mental health outpatient treatment programs.
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:	NA
G.6: Average number of days between referral and first participation in referred treatment program:	NA

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:	45
H.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	30
H.4: Average number of days between referral and first participation in referred PEI program:	14 days
H.5: Describe how your program encouraged access to services and follow through on above referrals (500 Characters):	Our team outreached to East Asian communities/providers/schools sharing mental health education resources in language and sharing no cost for services. Counselors provided engagement services in client preferred language and clients were scheduled for once a week sessions to further rapport and initial engagement. Provided Telehealth services to interested clients.

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):
SMH outpatient clinic and other community offices	*12 youth at libraries; 12 youth at youth program; 14 Mein speaking housewives; 10 Chinese speaking*
AHS Health Center in Oakland	*92 children, youth and family members as AHS patients*
Students from middle and high school in Oakland, Hayward and community- based event	*400 youth*

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

WeChat group	*259 Chinese reading viewers*
Delivering caring packets to senior centers and community members	*82 Chinese speaking seniors; 30 community members*
Psychoeducation to bring awareness of emotional wellness to senior center and rehab center	*26 Chinese speaking seniors; 21 care givers of adult consumers*
Instagram	*281 Instagram viewers total*

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 19/20

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
		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).

Center for Empowering Refugees and Immigrants' (CERI) is a trauma-informed non-profit with a mission "to improve the social, psychological, and economic health of refugee families in which one or more individuals have been affected by war trauma, genocide, torture or another form of extreme trauma." Core services include: individual, family, and group counseling; care management, advocacy, and referrals; a range of wellness and enrichment activities; and culturally-grounded community gatherings, projects, and events, on-site and in the local community. Through its UELP program, ROYAA, CERI provides services designed to address the intergenerational impact of war trauma and empower people from the CERI community including youth who are at risk for becoming involved in crime, drugs, violence, and sexual exploitation. Our work for this funding is for serving Southeast Asians and includes 10 groups with 5 cultural groups, 3 languages and cohorts for youth, adults, women, men and elders.

Box B: Please provide the total number of individuals served to date July 1, 2019 through June 30, 2020 through MHSA funding.

Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	6198

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	33
Number of unduplicated individual family members served indirectly by your program:	NA
Grand total of unduplicated individuals served:	**6231**

Box C: 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.

AGE CATEGORIES	
Children/Youth (0-15 yrs)	378
Transition Age Youth (16-25 yrs)	687
Adult (26-59 yrs)	2862
Older Adult (60+ yrs)	1881
Declined to answer	121
Unknown	269
TOTAL	**6198**

SEXUAL ORIENTATION	
Gay/Lesbian	46
Heterosexual/Straight	4251
Bisexual	3
Questioning/Unsure	2
Queer	355
Declined to answer	
Unknown	1499
Another group not listed	42
TOTAL	**6198**
If another group is counted, please specify:	

VETERAN STATUS	
Yes	43
No	5251
Declined to answer	
Unknown	904
TOTAL	**6198**

CURRENT GENDER IDENTITY	
Female	4290
Male	1359
Transgender	71
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	305
Another identity not listed	
TOTAL	**6025**
If another identity is counted, please specify:	

PRIMARY LANGUAGE	
English	1597
Spanish	22
Cantonese	
Chinese	
Vietnamese	578
Farsi	4
Arabic	
Tagalog	
Declined to answer	
Unknown	6
Another language not listed	3989
TOTAL	**6196**

SEX ASSIGNED AT BIRTH	
Male	1359
Female	4290
Declined to answer	
Unknown	376
TOTAL	**6025**

If another language is counted, please specify: Korean (1), Cambodian/Khmer (3842), Persian (7), Burmese (85), Punjabi (1)

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.

DISABILITY*** STATUS	
Communication Domain	
Vision	14
Hearing/Speech	26
Another type not listed	147
Communication Domain Subtotal	**187**
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	2258
Physical/mobility	120
Chronic health condition	30
Disability Subtotal	**2408**
None	2013
Declined to answer	
Unknown	1589
Another disability not listed	1
TOTAL	**6198**
If another disability is counted, please specify:	

RACE	
American Indian or Alaska Native	8
Asian	5722
Black or African American	40
Native Hawaiian or Other Pacific Islander	14
White	166
Other Race	130
Declined to answer	3
Unknown	115
TOTAL	6198

If another race is counted, please specify: Latino (159), Multiracial (85),

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.

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

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	159
Total Hispanic or Latino	**159**
If Non-Hispanic or Non-Latino, please specify:	
African	
African American	
Asian Indian/South Asian	38
Cambodian	4560
Chinese	74
Eastern European	
European	
Filipino	11
Japanese	
Korean	7
Middle Eastern	
Vietnamese	594
Other Non-Hispanic or Non-Latino ethnicity not listed	414
Total Non-Hispanic or Non-Latino	**5698**
More than one ethnicity	85
Unknown Ethnicity	
Declined to answer	
EHTNICITY TOTAL	5942
If another ethnicity is counted, please specify: Hmong (16), Indonesian (22), Japanese (5), Lao (12), Nepalese (59), Pakistani (2), Persian (82), Tongan (1), Other Asian (101), Other Southeast Asian (5), Samoan (1), Other Pacific Islander (4), Afghan (7), Blangadeshi (2), Bhutanese (66), Karen (1), Karenni (4), Rakhin (24)	

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.

CERI established strong partnerships with non-profit and community organizations. We provided 1400 meals per week which has made our site a neighborhood center, building community and giving us outreach opportunities. Our program expanded to serve new communities (Burmese, Vietnamese, Mien, Lao, Indonesian, and Thai). We addressed barriers to accessing services by getting funding to meet many needs created by COVID. We also initiated conversations on racial justice, addressing anti-black and anti-Asian racism.
Case study: K entered our program in 2019 with her husband who faced deportation. K and her children receive preventive counseling and with our advocacy her husband was released and is involved in our food distribution program. We created the Impacted Families program, with CERI providing counseling and referrals for deportation defense. K has been hired to support other families and started a group for Khmer mothers. K started a mask-making program and is active with our youth.

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.

COVID created challenges for our program. Meetings with clients needed to be moved online. Clients face social isolation, especially elders, which can aggravate mental health issues. Many do not have computers, reliable internet access, phones, and computer/internet literacy. Many need case management for visits with SSA and doctors. Youth struggled with COVID limitations. COVID also presented our communities with the real rise in anti-Asian racism. Program expansion and community engagement in COVID were also challenging.
Mitigation. Staff we hired are from new communities we serve and had community connections. We implemented groups on Zoom. We had 10 active groups (5 cultural, 3 language and youth, adult, women, men and elder groups). We have changed our service model to follow all CDC guidelines. All of our clients receive regular calls from staff. We have supported conversations about Black Lives Matter, the anti-black and anti-Asian racism many face on a daily basis.

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 the wake of George Floyd's murder and the movement for an end to police brutality, we have been more intentional about integrating racial justice into our model. We trained clients, supported them in their experiences of race/racism, and made progress in building allies for black lives.Southeast Asian youth are overrepresented in the juvenile justice system. Issues of police harassment and profiling are lived experiences for our youth. Adults and older adults often carry negative stereotypes of youth, and youth often don't understand older adults or know much about their history and cultures due to not speaking the primary language of older community members and because adults don't share their experiences due to trauma. This year, we created settings for youth and adults/elders to interact. We also hired staff who are in the middle in terms of age as they have an understanding of both generations and can serve as mediators, mentors and interpreters of these varying perspectives.

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

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):	4
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):	10
G.3: Types of treatment individuals were referred to (list types) (500-character limit):	Outpatient Treatment Centers - Pacific Center, West Coast Children's Center, BACS, AHS, CERI non-medical outpatient treatment PES
G.4: Unduplicated number of individuals who participated in referred program at least one time:	13
G.5: Average duration of untreated mental illness in weeks:	2.5
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):	Southeast Asian (youth, TAY, older adults, families, LQBTQ, women, men)
H.2: Number of paper referrals to an ACBH PEI-funded program:	Not tracked- verbal referrals only
H.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	Not tracked
H.4: Average number of days between referral and first participation in referred PEI program:	Not tracked
H.5: Describe how your program encouraged access to services and follow through on above referrals (500 Characters):	CERI makes direct calls to providers and facilitates a meeting between client and new provider and at times, accompanying them to services. CERI participates in collaborative meetings with other UELP providers and has strong relationships with these providers so referrals are seamless.

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):
Buddhist Temples	*8 Monks, Burmese and Cambodian*
Legal Services- ALC, HAC, BALA	*9 lawyers, 3 community organizers*
CBO- Asian Prisoner Support Committee	*7 Re-entry Coordinators*
Interfaith Movement	*3 Religious Organizers*
Schools- OUSD	*2 teachers, 2 Wellness Coordinators, 2 Administrator*
Non-profit- ARTogether	*3 Poets, 1 Executive Director, 5 artists*
Refugee Agencies- BFRN, VACCEB, Devata Giving Circle, AYPAL,	*15 Outreach Workers*

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

MHSA Program #: PEI 6

PROVIDER NAME: Bay Area Community Health (formerly Tri-City Health Center)

PROGRAM NAME: Outreach, Education & Consultation for East Asian Community

Program Outcomes & Impact: UELP Data Report FY 19/20

Program Name:	Arise: Asian Wellness Project	
Organization:	Bay Area Community Health (formerly Tri-City Health Center)	
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.

Box B: Please provide the total number of individuals served to date July 1, 2019 through June 30, 2020 through MHSA funding.

Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	881
Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	59
Number of unduplicated individual family members served indirectly by your program:	NA

Grand total of unduplicated individuals served:	**940**

Box C: 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.

AGE CATEGORIES	
Children/Youth (0-15 yrs)	111
Transition Age Youth (16-25 yrs)	147
Adult (26-59 yrs)	163
Older Adult (60+ yrs)	460
Declined to answer	
Unknown	
TOTAL	**881**

VETERAN STATUS	
Yes	
No	592
Declined to answer	
Unknown	289
TOTAL	**881**

CURRENT GENDER IDENTITY	
Female	25
Male	11
Transgender	
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	
Another identity not listed	
TOTAL	**36**
If another identity is counted, please specify:	

SEX ASSIGNED AT BIRTH	
Male	307
Female	574
Declined to answer	
Unknown	
TOTAL	**881**

SEXUAL ORIENTATION	
Gay/Lesbian	838
Heterosexual/Straight	41
Bisexual	
Questioning/Unsure	
Queer	
Declined to answer	
Unknown	2
Another group not listed	
TOTAL	**881**
If another group is counted, please specify:	

PRIMARY LANGUAGE	
English	307
Spanish	
Cantonese	105
Chinese	454
Vietnamese	
Farsi	
Arabic	
Tagalog	
Declined to answer	
Unknown	
Another language not listed	15
TOTAL	**881**
If another language is counted, please specify: Chinese above is Mandarin, Korean (15),	

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

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.

DISABILITY*** STATUS	
Communication Domain	
Vision	
Hearing/Speech	6
Another type not listed	
Communication Domain Subtotal	**6**
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	
Physical/mobility	1
Chronic health condition	1
Disability Subtotal	**2**
None	413
Declined to answer	
Unknown	457
Another disability not listed	
TOTAL	**878**
If another disability is counted, please specify:	

RACE	
American Indian or Alaska Native	
Asian	765
Black or African American	
Native Hawaiian or Other Pacific Islander	
White	3
Other Race	113
Declined to answer	
Unknown	
TOTAL	881
If another race is counted, please specify: Latino (2), Multi-racial (1)	

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	
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	2
Total Hispanic or Latino	**2**

If Non-Hispanic or Non-Latino, please specify:	
African	
African American	
Asian Indian/South Asian	
Cambodian	
Chinese	650
Eastern European	
European	
Filipino	
Japanese	1
Korean	27
Middle Eastern	
Vietnamese	
Other Non-Hispanic or Non-Latino ethnicity not listed	86
Total Non-Hispanic or Non-Latino	**764**
More than one ethnicity	
Unknown Ethnicity	
Declined to answer	
EHTNICITY TOTAL	766
If another ethnicity is counted, please specify: Taiwanese (2), Other East Asian (84)	

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.

This year, we have increased the number of school partnerships and on-site services. This has reduced barriers to access mental health prevention services for students and increased services for those who would not have received them otherwise. We also signed an MOU with Fremont Unified School District. One of our successes this year was a referral made by a school social worker for a 12-year-old boy. His family (mom, dad, sister) recently moved to the US from China and are all monolingual Mandarin speakers. Our Outreach worker provided information on health insurance for the kids, and worked with BACH's Outreach Department to help the kids apply for Medi-Cal and CalFresh. Additionally, we provided the mother with information for adult schools because she wanted to learn English. She is really thankful to our team for providing helpful resources to them, especially during this pandemic. The boy is also being seen for individual counseling.

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

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.
Adjusting to remote services during the Covid-19 pandemic posed a challenge. We did not receive as many referrals from school staff once school instruction moved off-site. Thus, we were a few clients short of our 40 individual prevention counseling clients deliverable. Previously, counselors would send us referrals when they noticed issues with students. Since students started virtual learning from home, we did not have the same on-site administrative support. There were also struggles to move senior support groups to virtual settings since seniors are not familiar with new technologies. Our team spent time setting up Zoom on their phones so they could join the support group virtually. Our Mental Health Specialist also left in April, so we were not able to provide prevention counseling in May and June. Additionally, we had to cancel in-person cooking/nutrition and yoga workshops due to the Covid-19 pandemic.

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.
We learned that high school aged students seem more receptive to services when there is school staff support. Moving forward, we will work on connecting with parents as well as coordinating with school staff, and find additional creative ways to motivate adolescents to participate in mental health prevention 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):	0
G.3: Types of treatment individuals were referred to (list types) (500-character limit):	ACCESS, individual therapy
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:	2.5
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):	East Asians: high school aged, middle school aged, seniors
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:	4
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):	Provided contact info and PEI programs info to clients. Informed clients of appropriate services based on their language and cultural needs that PEI programs can provide. Learned about PEI programs referrals process.

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):
Back-to-School Night @ Mission San Jose High School	*parents, counselors, vice principal, principal*
Ohlone Community College Fair	*college students, counselors*
High School Seniors' Night	*students, parents, counselors, admin*
Food for Love event: Delivering meals to people's homes	*50 seniors and adults with mental health issues*
Facebook and Instagram Digital Ads	*Community members*
Educational Workshops: Nutrition, Acupuncture/Chinese Medicine, Yoga, Vaping	*Community members: adolescents, adults, and seniors*
Mental Health Consultations: elementary, junior high, high school, and local coding school	*1 nurse, 7 counselors, 1 principal, 1 vice principal, 2 senior staff members*

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

American High School Parents Mtg (school)	*parents, school staff*
Sound of Hope: Chinese radio talk show and Radio Interview	*Chinese community members*

MHSA Program #: PEI 6

PROVIDER NAME: RAMS Pacific Islander Wellness Initiative

PROGRAM NAME: Outreach, Education & Consultation for Asian Pacific Islander Community

Program Outcomes & Impact: UELP Data Report FY 19/20

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
		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).

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. PIWI staff include licensed therapists, program manager, program/data coordinator, health navigators, and community leaders who identify as Pacific Islanders. Since March 2020, all services are provided via online platforms (Zoom, social media channels, among others).

Box B: Please provide the total number of individuals served to date July 1, 2019 through June 30, 2020 through MHSA funding.

Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	291

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	26
Number of unduplicated individual family members served indirectly by your program:	NA
Grand total of unduplicated individuals served:	**317**

Box C: 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.

AGE CATEGORIES	
Children/Youth (0-15 yrs)	9
Transition Age Youth (16-25 yrs)	132
Adult (26-59 yrs)	132
Older Adult (60+ yrs)	18
Declined to answer	
Unknown	
TOTAL	**291**

VETERAN STATUS	
Yes	7
No	277
Declined to answer	
Unknown	7
TOTAL	**291**

SEXUAL ORIENTATION	
Gay/Lesbian	14
Heterosexual/Straight	274
Bisexual	
Questioning/Unsure	
Queer	1
Declined to answer	
Unknown	2
Another group not listed	
TOTAL	**291**
If another group is counted, please specify:	

CURRENT GENDER IDENTITY	
Female	172
Male	119
Transgender	
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	
Another identity not listed	
TOTAL	**291**
If another identity is counted, please specify:	

PRIMARY LANGUAGE	
English	16
Spanish	12
Cantonese	
Chinese	2
Vietnamese	4
Farsi	
Arabic	
Tagalog	11
Declined to answer	
Unknown	
Another language not listed	233
TOTAL	**278**

SEX ASSIGNED AT BIRTH	
Male	119
Female	172
Declined to answer	
Unknown	
TOTAL	**291**

If another language is counted, please specify: Hawaiian (14), Native American Dialect (6), Samoan (80), Tongan (123), Chamorro Guamanian (5), Marhsallese (2), Other (3)

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.

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	2
Disability Subtotal	**4**
None	282
Declined to answer	
Unknown	5
Another disability not listed	
TOTAL	**291**
If another disability is counted, please specify:	

RACE	
American Indian or Alaska Native	
Asian	89
Black or African American	2
Native Hawaiian or Other Pacific Islander	167
White	15
Other Race	18
Declined to answer	
Unknown	
TOTAL	291
If another race is counted, please specify: Latino (18)	

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

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	11
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	6
Total Hispanic or Latino	**17**
If Non-Hispanic or Non-Latino, please specify:	
African	
African American	
Asian Indian/South Asian	
Cambodian	
Chinese	2
Eastern European	
European	
Filipino	11
Japanese	
Korean	
Middle Eastern	
Vietnamese	4
Other Non-Hispanic or Non-Latino ethnicity not listed	248
Total Non-Hispanic or Non-Latino	**265**
More than one ethnicity	
Unknown Ethnicity	
Declined to answer	
EHTNICITY TOTAL	282
If another ethnicity is counted, please specify: Guamanian (7), Native Hawaiian (14), Samoan (81), Tongan (124), Other Pacific Islander (4), Belaun Palauan (13), Marshalese (3), Other Southeast Asian (1)	

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.
Our accomplishments are: 1) filled all positions with bilingual/bicultural staff; 2) strengthened the capacity of health navigators (training and mentoring) to screen/assess clients showing early signs of mental illness, to facilitate psycho-education curriculum, to facilitate non-clinical groups, and to gain confidence in speaking about mental health; 3) created social media channels; 4) developed social media contents to engage, educate, and reduce stigma; 5) provided preventive counseling to 31 clients; 6) successfully referred and linked 6 clients to needs identified in care plan; 7) expanded collaboration with faith leaders, service providers, colleges, and schools; 8) reached over 10K individuals through social media and community events; 9) quick adjustment to COVID-19 directives; 10) convened Pacific Islander clinician's group.

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.
Challenges are: 1) Navigation pathways: navigating existing and available linkages to services and resources for whole health care; 2) Establishing partnerships with providers to ensure “warm” hand-off; 3) Understanding and familiarizing with Alameda County system; 4) ISL process is burdensome, time consuming, and archaic.

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.
Lessons learned are: 1) Routine operations and quality implementation require ongoing adjustment and scaling; 2) Finding the rhythm of the program so that everyone is in-sync; 4) Adjusting to the pandemic; 5) Funding and resources to sustain lasting change; 6) Community work expands outside working hours; and, 7) Staff hiring and retention.

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):	4
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):	Medication support, long-term counseling, primary care provider
G.4: Unduplicated number of individuals who participated in referred program at least one time:	6

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

G.5: Average duration of untreated mental illness in weeks:	up to 4 weeks
G.6: Average number of days between referral and first participation in referred treatment program:	30-45 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):	Youth, TAY, parents, elders, all Pacific Islanders
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:	NA
H.5: Describe how your program encouraged access to services and follow through on above referrals (500 Characters):	Community members are encouraged to seek and use help to address mental health concerns early. Our small team work shoulder-to-shoulder to develop a client referral plan, including follow-up contact and providing resources for/to meet basic needs (housing, food, shelter).

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):
Schools	*5 teachers at schools*
Cultural affinity groups	*3 mentors*
Colleges	*5 college professors at college*
Churches	*20 clergy members at church gathering*

Community centers	*10 providers and 30 parents*
Event centers	*100 parents at event center*
Festival	*5 police officers*
Conference	*3 police officers*
Convening	*20 mental health providers*

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

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 19/20

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: Please provide the total number of individuals served to date July 1, 2019 through June 30, 2020 through MHSA funding.

Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	2228
Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	39

Number of unduplicated individual family members served indirectly by your program:	
Grand total of unduplicated individuals served:	**2267**

Box C: 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.

AGE CATEGORIES	
Children/Youth (0-15 yrs)	35
Transition Age Youth (16-25 yrs)	149
Adult (26-59 yrs)	179
Older Adult (60+ yrs)	1864
Declined to answer	
Unknown	1
TOTAL	**2228**

SEXUAL ORIENTATION	
Gay/Lesbian	
Heterosexual/Straight	1887
Bisexual	
Questioning/Unsure	
Queer	1
Declined to answer	
Unknown	340
Another group not listed	
TOTAL	**2228**
If another group is counted, please specify:	

VETERAN STATUS	
Yes	
No	718
Declined to answer	
Unknown	1510
TOTAL	**2228**

CURRENT GENDER IDENTITY	
Female	1546
Male	649
Transgender	
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	32
Another identity not listed	
TOTAL	**2227**
If another identity is counted, please specify:	

PRIMARY LANGUAGE	
English	283
Spanish	29
Cantonese	189
Chinese	
Vietnamese	10
Farsi	
Arabic	
Tagalog	16
Declined to answer	
TOTAL	**2035**
If another language is counted, please specify: Bhuanese/Dzongkhas (4), Cambodian/Khmer (48), Mandarin (428), Genepali (6), Korean (1022)	

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

SEX ASSIGNED AT BIRTH	
Male	649
Female	1546
Declined to answer	
Unknown	32
TOTAL	**2227**

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.

DISABILITY*** STATUS	
Communication Domain	
Vision	
Hearing/Speech	6
Another type not listed	30
Communication Domain Subtotal	**36**
Disability Domain	

RACE	
American Indian or Alaska Native	9
Asian	2128
Black or African American	3
Native Hawaiian or Other Pacific Islander	
White	28
Other Race	60

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	
South American	
Another Hispanic/Latino ethnicity not listed	47
Total Hispanic or Latino	**49**
If Non-Hispanic or Non-Latino, please specify:	
African	
African American	
Asian Indian/South Asian	
Cambodian	50
Chinese	739

Eastern European	
European	
Filipino	48
Japanese	
Korean	1219
Middle Eastern	
Vietnamese	17
Other Non-Hispanic or Non-Latino ethnicity not listed	53
Total Non-Hispanic or Non-Latino	**2126**
More than one ethnicity	
Unknown Ethnicity	
Declined to answer	
EHTNICITY TOTAL	2175
If another ethnicity is counted, please specify: Bhutanese (4), Burman (1), Mien (1), Nepalese (6), Taiwanese (21). Other South East Asian (2); Other Asian (17), Mongolian (1)	

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.

1) ACWP engaged many Korean elders in building leadership to promote mental health awareness in order to reduce stigmas in the API community. The "Jikimees" leaders, also known as Community Protectors, came together to learn about MH signs & symptoms, leadership building, community engagement, and social support. 2) KCCEB mobilization of the Korean community members during COVID-19 pandemic and shelter in place. When COVID-19 hit the Korean community, the Korean elders were impacted the hardest. They were the most vulnerable population. KCCEB came together and organized with multiple community-based organizations in the bay area to form the Korean Bay Area Task Force to address the following issues: 1) Food insecurity, 2) Legal (unemployment, immigration, etc.) 3) Public benefit needs, 4) Health access/navigation, and 5) mental health support.

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.

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

1) Meeting the overwhelming increased needs and demands of the community. Throughout the COVID-19 Pandemic and Shelter-in-place (SIP), Korean community members were facing an array of crisis (i.e. stressors on unemployment, paying rent, losing their small business, access their public benefits, unable to make medical appointments, and trauma triggers, etc.). Because of the emerging crisis and needs of the Korean community, KCCEB implemented new wellness project, in collaborations with our Bay Area Korean community-based organizations, to address the urgent need of the most vulnerable population such as food insecurity, legal, employment, and health and mental health needs of the community. 2) shifting from in-person to remote services due to COVID-19 & SIP. We adapted our programs to be delivered via telehealth model (via video and phone calls) so we can continue to offer services and our clients do not experience disruption of service.

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.

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. 2) The importance and value of having a strong warm handoff in helping our preventive counseling clients to navigate and access the mental health treatment systems. It's vital to ensure our clients be able to access & receive continuation of care in MH Tx programs, which requires more direct handholding, advocacy, and after-care support even after accessing services. Knowing the importance and value of such warm handoff and community members' trust, KCCEB has been committed to supporting our clients to successfully access mental health treatment programs in the private and public systems and ensure their continuation of care.

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):	5
G.3: Types of treatment individuals were referred to (list types) (500-character limit):	Clients received individual therapy to address major depressive disorders, PTSD, anxiety (social anxiety, phobias, etc.), obsessive compulsive disorders, schizo-affective disorder, etc. Individuals are being seen by LCSW, MFT, and Licensed Psychologist with psychiatric support for medication maintenance when necessary. Individual therapy was conducted weekly or biweekly basis to address the mental symptoms of each client receiving therapy services.

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:	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 (Vietnamese, mix-Asians, Middle Eastern, African, African American, Filipino, and White). ACWP mainly service youth, TAY, and adults.
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):	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):
Cultural & Wellness Events (6): trips, festivals, leadership, covid-19, elders outreach & Assessment	*community members and leaders, children, youth, TAY, families and adults and older adults, CBO staff*
MH Workshops (19): Understand MH, leadership, engagement, communication, stress mgmt, MH access	*community members and leaders, youth, TAY and adults and older adults*

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

MH Trainings (12): understanding MH, compassion fatigue, burnout, trauma, impact of MH in API comm	*community based professionals (school-based staff, community-based worker staff, caregivers)*
Mental Health Consultation (17): MH among youth, access MH Tx, MH Stigma in API comm, MH ref & svc	*CBO's, professionals (school-based staff, community-based worker staff, caregivers), family members*
Newsletters (7): Loneliness, Anxiety, Trauma, Healthy Relationships, Dep & Menopause, Selfcare	*general community members and CBO's professionals*
Tabling/Distributing materials (5): school fairs, resource fair, parenting nights, meals delivery	*community members and leaders, children, youth, TAY and adults and older adults*
Wellness Support Group (3): TaiJi for wellness, Jikimee leadership, Youth wellness support	*Korean elders community members, API community elders, and East Asian Youth*
PV Home Visits (13): MH screening, referral, and community resource support	*community members and family members*
MH Video (youtube/facebook): 1) https://youtu.be/zy7xST7vbVw, 2)	*youth and family members*
MH Video: 2) https://www.dropbox.com/s/1v2ssnizni5wck6/JOURNEY%20TO%20HEALING_081920.mp4?dl=0	*youth and family members*

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 19/20

Program Name:	Afghan Wellness Project	
Organization:	Afghan Coalition	
PEI Program # and Name:	PEI 7 Outreach, Education & Consultation (Afghan) Afghan Coaliti	
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
		Early Identification of Mental Health Illness

Box A: Please provide a brief program description (character limit 1,000).

Afghan Wellness Project provides culturally and linguistically responsive services to support individuals and families who are at risk for serious mental health issues, decreases stigma through education and awareness, increases access to culturally responsive programs, and prevents mental illness from becoming severe and disabling. We provide services to clients in Southern Alameda County. AC serves over 1,000 community members per year, particularly immigrant women and their families. Our staff is bilingual/bicultural advocates who bridge the language and cultural gaps between community members and mental health and social services. The Afghan Wellness Projects works with individuals that are isolated and/or trauma exposed, immigrants, families under stress, at risk youth as well as any individual at risk of early onset of a serious mental health issue by providing prevention and early intervention services in Dari, Pashto and English.

Box B: Please provide the total number of individuals served to date July 1, 2019 through June 30, 2020 through MHSA funding.

Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	1645

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

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:	**1688**

Box C: 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.

AGE CATEGORIES	
Children/Youth (0-15 yrs)	342
Transition Age Youth (16-25 yrs)	235
Adult (26-59 yrs)	275
Older Adult (60+ yrs)	764
Declined to answer	
Unknown	7
TOTAL	**1623**

SEXUAL ORIENTATION	
Gay/Lesbian	
Heterosexual/Straight	265
Bisexual	
Questioning/Unsure	
Queer	
Declined to answer	
Unknown	1380
Another group not listed	
TOTAL	**1645**
If another group is counted, please specify:	

VETERAN STATUS	
Yes	0
No	368
Declined to answer	
Unknown	1277
TOTAL	**1645**

CURRENT GENDER IDENTITY	
Female	1005
Male	589
Transgender	
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	51
Another identity not listed	
TOTAL	**1645**
If another identity is counted, please specify:	

PRIMARY LANGUAGE	
English	359
Spanish	
Cantonese	
Chinese	
Vietnamese	
Farsi	197
Arabic	
Tagalog	
Declined to answer	
Unknown	
Another language not listed	1089
TOTAL	**1645**
If another language is counted, please specify: Dari (908), Pashto (180),	

SEX ASSIGNED AT BIRTH	
Male	589
Female	1005
Declined to answer	
Unknown	51
TOTAL	**1645**

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.

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	3
Disability Subtotal	**8**
None	167
Declined to answer	
Unknown	942
Another disability not listed	1
TOTAL	**1118**
If another disability is counted, please specify:	

RACE	
American Indian or Alaska Native	
Asian	1326
Black or African American	24
Native Hawaiian or Other Pacific Islander	
White	29
Other Race	
Declined to answer	49
Unknown	233
TOTAL	1661
If another race is counted, please specify: Latino (13), Other (36),	

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.

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

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	13
Total Hispanic or Latino	**13**
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	1326
Total Non-Hispanic or Non-Latino	**1326**
More than one ethnicity	
Unknown Ethnicity	
Declined to answer	
EHTNICITY TOTAL	1339
If another ethnicity is counted, please specify: Afghan (1289), Other Asian (37)	

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.

AWP's Consortium Meetings provides training to Alameda County Mental Health Professionals. In June, the Consortium meeting hosted over 70 participants. AWP's Mental Health Specialist presented on Cultural Consideration for Afghans during Covid-19. During the Pandemic we reached out individually to our clients to offer assistance and support to be a reassuring presence during all the uncertainty. A Prevention Client in their 30's with special-need children felt very overwhelmed by life events. We started working with this client and the family to help them cope with life stressors and other challenges. The client shared that counseling was very helpful for him and family and offered them an opportunity to talk to a professional. The Client and their family also started organizing activities and events they all could do together as a family. "I am grateful that I and my family are able to have this counseling and learn how deal with our children who need more attention ".

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.

Covid-19 compounded the anxiety that clients were already experiencing due to past traumas from war-torn Afghanistan and relocating to a new country. When SIP went into effect, staff called all clients to assess their needs, provide resources, and offered support. Many clients were now also very isolated, especially the elderly, and did not have the technology to join online events. We were rapidly translating information regarding MH issues, Covid, and resources but many clients were not able to access AC social media sites due to lack of technology. AC developed a Strategic Plan to address this. We hired a temporary Elderly Outreach Navigator who provides training on Apps such as Zoom /WhatsApp after downloading on their phones. Clients are overjoyed to be connected to family and friends and attend virtual events. AWP had a goal of reaching a larger youth population at FUSD prior to SIP. Now youth social media content will be expanded to many platforms

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.

Youth Tutoring went well until Covid-19 when it became harder to stay in touch as technology became a challenge for families. As we pivoted to virtual programs, we learned that youth workshops participants prefer to use the chat function as opposed to using a mic/video on Zoom. Future youth programs should have more interactive aspects. Surveys and/or breakout rooms will be used where participants are comfortable discussing issues in smaller groups. The Prevention Counselor shared the following, COVID has affected millions of people, including the clients who attend prevention counseling sessions. While usually many people prefer face-to-face sessions rather than connected via technology, I learned that many of my clients are comfortable with the Telehealth sessions. Even if they would have had a chance to meet in person, many of them say they would rather do Telehealth. Meeting the clients' needs where they are at, is crucial to their mental health and health in general.

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):	4

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

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):	These individuals were referred to psychiatrists (using ACCESS), psychologist, and primary care physicians for their presenting mental health issues
G.4: Unduplicated number of individuals who participated in referred program at least one time:	6
G.5: Average duration of untreated mental illness in weeks:	The duration for clients' untreated mental health issues varied. Some of the clients started having mental health issues approximately 8-week prior to them being referred out, while others stated they were having their mental health issues for months.
G.6: Average number of days between referral and first participation in referred treatment program:	5-7 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:	25 to IRC, Tri-City & Health Start
H.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	20
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):	Every effort is made to find culturally-competent health providers for clients so that they can communicate with them and open up about their mental health issues. Clients were explained the seriousness of their mental health issues and also the need for them to be referred to a higher level of care. Possible benefits and gains were also explained as well as the limited services the prevention counselor could provide them with.

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:	**5094**
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):
Consortium Meetings 3 in-person/ 1 virtual	*Health Care providers, Community Leaders, Community members*
Community Events -Tri-City Health Care, SAVE Women's Day Event	*Health Care providers, Community members, other agencies*
Community Events -Presentation at Danish's Soccer Night/Tabling Maple Sq. Apartments (2)	*Young adult men, Community Leaders*
Annual Community Meeting	*Community members, Faith and Community Leaders*
Community Kitchen -Baking Bread, Cooking Together	*Community Leaders & members*
Presentation at the 4th Annual South Asian Mental Health Conference -Table & Presentation	*Health Care Providers, Community Leaders.*
DV 8-week class, ESL Classes, Youth Tutoring/Mentoring	*Community members, parents, youth*
Workshops -Women's group-several, 1-Book Cultural event, 2 Eid Events., Panel with NAMI	*Community member, Faith Leaders, Community Leaders*
Support groups- women's art, youth group, DV group, occasional men's group	*Community members*
Elderly Outreach Navigator	*Elderly Community Members, New Arrivals*
Social Media Sites	*Facebook Pages/Instagram*
Aggregate Outreach Numbers breakdown	*Outreach - 1,676, Social Media reached 3,418*

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

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 19/20

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. Activities will focus on helping community members understand the twin impacts of colonial/post- colonial trauma and the marginalization of immigrants in the US on help-seeking behaviors. Services will be concentrated on Filipinos in the central and southern regions of Alameda County.

Box B: Please provide the total number of individuals served to date July 1, 2019 through June 30, 2020 through MHSA funding.

Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	1364
Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	22

Number of unduplicated individual family members served indirectly by your program:	
Grand total of unduplicated individuals served:	**1386**

Box C: 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.

AGE CATEGORIES	
Children/Youth (0-15 yrs)	146
Transition Age Youth (16-25 yrs)	958
Adult (26-59 yrs)	189
Older Adult (60+ yrs)	65
Declined to answer	
Unknown	6
TOTAL	**1364**

VETERAN STATUS	
Yes	0
No	152
Declined to answer	
Unknown	1210
TOTAL	**1362**

SEXUAL ORIENTATION	
Gay/Lesbian	45
Heterosexual/Straight	659
Bisexual	1
Questioning/Unsure	37
Queer	179
Declined to answer	
Unknown	471
Another group not listed	
TOTAL	**1392**
If another group is counted, please specify:	

CURRENT GENDER IDENTITY	
Female	918
Male	340
Transgender	5
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	18
Another identity not listed	
TOTAL	**1281**
If another identity is counted, please specify:	

PRIMARY LANGUAGE	
English	1238
Spanish	
Cantonese	
Chinese	
Vietnamese	
Farsi	
Arabic	
Tagalog	126
Declined to answer	
Unknown	
Another language not listed	
TOTAL	**1364**
If another language is counted, please specify:	

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

SEX ASSIGNED AT BIRTH	
Male	340
Female	918
Declined to answer	
Unknown	23
TOTAL	**1281**

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.

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	3
Chronic health condition	1
Disability Subtotal	**4**
None	83
Declined to answer	
Unknown	1277
Another disability not listed	
TOTAL	**1364**
If another disability is counted, please specify:	

RACE	
American Indian or Alaska Native	
Asian	1312
Black or African American	7
Native Hawaiian or Other Pacific Islander	1
White	11
Other Race	16
Declined to answer	
Unknown	17
TOTAL	1364
If another race is counted, please specify: Latino (7), multiracial (5), Other (3)	

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	
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	7
Total Hispanic or Latino	**7**
If Non-Hispanic or Non-Latino, please specify:	
African	
African American	
Asian Indian/South Asian	
Cambodian	
Chinese	17
Eastern European	
European	
Filipino	1189
Japanese	
Korean	
Middle Eastern	
Vietnamese	24
Other Non-Hispanic or Non-Latino ethnicity not listed	75
Total Non-Hispanic or Non-Latino	**1305**
More than one ethnicity	
Unknown Ethnicity	
Declined to answer	
EHTNICITY TOTAL	1312
If another ethnicity is counted, please specify: Other Asian (75), Other Pacific Islander (1)	

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

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.

Youth leaders were successfully developed from participant base. Cohort has expanded to include youth from Oakland, Berkeley and Castro Valley. They were able to connect ideas of emotional stability, peer support, mental health into indigenous Filipino values of kapwa, bayanihan spirit, intersectional liberation/self-determination, and decolonization.
Open mic event showcasing art, music, poetry and dance was successful in bringing new youth and TAY to participant base.
New cohort of LGBTQ+ TAY began meeting this year.
Peer support was successfully developed among elder caregiver cohort who are otherwise extremely isolated.
Providing a linkage for a challenging preventative counseling client with a high level of need took strong collaboration between the MH specialist and the new provider to prevent abandonment and increased anxiety for the client. The healthy termination and transition was ensured.

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.

The COVID-19 pandemic and shelter-in-place orders were a great disruption to all programming. Meeting clients' immediate needs was prioritized and referrals were made to FAJ's COVID relief program which provided financial assistance to our most vulnerable community members, particularly those who did not qualify for government benefits. Services transitioned to online platforms such as Zoom, Instagram and Discord. Challenges retaining participants on virtual platforms remain. An online community server was created to keep track of youth and TAY participants, consistently keeping them in the loop of FAJ programming. Still, digital-divide issues remain in efforts to engage new and existing clients. Experimentation with various outreach methods and practices to ensure comfort and confidentiality will continue to maximize participation.

Our TAY coordinator maintained consistent presence in many local TAY-oriented community spaces this year. In the future we will increase leverage of relationships with community stakeholders to expand our client base. We will also increase collaboration with other FAJ programs to give clients a more meaningful relationship to the organization. Flexibility, patience and experimentation is key in developing best practices for virtual programming and telehealth to increase client engagement and decrease the unique client fatigue associated with virtual 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):	0
G.3: Types of treatment individuals were referred to (list types) (500-character limit):	High levels of anxiety with PTSD.
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:	60

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 youth, LGBTQ+, TAY and elder caregivers.
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:	1
H.4: Average number of days between referral and first participation in referred PEI program:	30
H.5: Describe how your program encouraged access to services and follow through on above referrals (500 Characters):	Programs being offered by our organization were explored and discussed during group and individual preventative sessions. Program participation seemed conducive to client goals to expand capacity to become more involved in advocacy to help expand a sense of purpose and connection to the community at large.

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

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):
High School site	*High School aged youth, school staff, service providers.*
Organization offices	*Youth, TAY, LGBTQ+, Elder Caregivers, Community-at-large.*
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 19/20

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: Please provide the total number of individuals served to date July 1, 2019 through June 30, 2020 through MHSA funding.

Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	1060
Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	63
Number of unduplicated individual family members served indirectly by your program:	NA

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

Grand total of unduplicated individuals served:	**1123**

Box C: 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.

AGE CATEGORIES	
Children/Youth (0-15 yrs)	251
Transition Age Youth (16-25 yrs)	175
Adult (26-59 yrs)	613
Older Adult (60+ yrs)	21
Declined to answer	
Unknown	
TOTAL	**1060**

VETERAN STATUS	
Yes	
No	1060
Declined to answer	
Unknown	
TOTAL	**1060**

SEXUAL ORIENTATION	
Gay/Lesbian	
Heterosexual/Straight	658
Bisexual	
Questioning/Unsure	
Queer	
Declined to answer	
Unknown	402
Another group not listed	
TOTAL	**1060**
If another group is counted, please specify:	

CURRENT GENDER IDENTITY	
Female	671
Male	389
Transgender	
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	
Another identity not listed	
TOTAL	**1060**
If another identity is counted, please specify:	

PRIMARY LANGUAGE	
English	
Spanish	97
Cantonese	
Chinese	
Vietnamese	
Farsi	60
Arabic	21
Tagalog	
Declined to answer	
Unknown	
Another language not listed	882
TOTAL	**1060**
If another language is counted, please specify: Dari (549), Karen (55), Other (123), Burmese (65), Pashto (90),	

SEX ASSIGNED AT BIRTH	
Male	389
Female	671
Declined to answer	
Unknown	
TOTAL	**1060**

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.

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	1060
Declined to answer	
Unknown	
Another disability not listed	
TOTAL	**1060**
If another disability is counted, please specify:	

RACE	
American Indian or Alaska Native	
Asian	826
Black or African American	
Native Hawaiian or Other Pacific Islander	
White	
Other Race	234
Declined to answer	
Unknown	
TOTAL	1060
If another race is counted, please specify: Latino (75), Other (159),	

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.

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

Ethnicity/Cultural Heritage (Please choose only one per individual)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	38
Mexican/Mexican American/Chicano	37
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	
Total Hispanic or Latino	**75**
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	826
Total Non-Hispanic or Non-Latino	**826**
More than one ethnicity	
Unknown Ethnicity	
Declined to answer	
EHTNICITY TOTAL	901
If another ethnicity is counted, please specify: Afghan (699), Karen (35), Burman (85), Other Asian (7)	

Box D: In the boxes below please provide a brief response to the following question. What were the <u>successes/accomplishments</u> 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.

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 example of a client who has significantly benefited from APTW's wraparound services is a recently widowed mother who was referred to our preventative counseling from a partner UELP provider due to her mental health concerns. The preventative counselor met regularly with this client and discussed stress coping techniques. The preventative counselor also helped the client access rental assistance and connect to a culturally and linguistically appropriate counselor, and primary care providers.

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.

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: 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 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. This led to internal referrals from IRC's Immigration, Employment, English Classes and Reception and Placement Program. The APTW team also participates in IRC's biweekly Case Consultation meetings to inquire about potential referrals, offer support, and suggest potential external referrals if APTW is not an appropriate fit. This IRC cross-program collaboration ensures that any immigrant who was enrolled in other IRC programming and exhibiting signs of emotional stress would be referred to the H&W team and then to appropriate services, including strong partner UELP providers. APTW has collaborated with PTR, DHTI and Afghan Coalition on referrals and community resources.

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

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):	3
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:	14

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:	5
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:	10

H.5: Describe how your program encouraged access to services and follow through on above referrals (500 Characters):	The APTW strategies for successful linkage to other PEI programs revolve around one-on-one coaching on resources, and education around myths of the risks of seeking mental health support. If and when a client is willing to be referred to another PEI program, the APTW offers to support with transportation, registration, and other logistical stressors that can be barriers. The APTW team also follows up directly with the PEI provider 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):

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

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 19/20

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
		Older Adults
	x	Early Identification of Mental Health Illness

Box A: Please provide a brief program description (character limit 1,000).

Every person experiences challenges at different stages in their life, such as college, marriage, divorce, parenting, aging and retirement. Other types of challenges can be unpredictable, such as accidents and sickness. Working with the South Asian population has shown us that these challenges increase remarkably if you are an immigrant. When life becomes too overwhelming, that result can bring changes in how an individual thinks, feels and acts. The South Asian Community Health Promotion Services program offers Prevention and Early Intervention services for individuals, couples, or families in distress. These short-term, culturally sensitive and language specific services offer support aimed at developing knowledge and skills to work through those challenges effectively. These services are not only provided at our clinic but we have the flexibility of providing home visits and offering services at schools, religious establishments, and other community locations.

Box B: Please provide the total number of individuals served to date July 1, 2019 through June 30, 2020 through MHSA funding.	
Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	6945
Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	63
Number of unduplicated individual family members served indirectly by your program:	NA
Grand total of unduplicated individuals served:	**7008**

Box C: 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.

AGE CATEGORIES	
Children/Youth (0-15 yrs)	683
Transition Age Youth (16-25 yrs)	1520
Adult (26-59 yrs)	4458
Older Adult (60+ yrs)	271
Declined to answer	
Unknown	13
TOTAL	**6945**

VETERAN STATUS	
Yes	3
No	2730
Declined to answer	
Unknown	3964
TOTAL	**6697**

SEXUAL ORIENTATION	
Gay/Lesbian	8
Heterosexual/Straight	2533
Bisexual	8
Questioning/Unsure	1
Queer	
Declined to answer	
Unknown	4129
Another group not listed	22
TOTAL	**6701**
If another group is counted, please specify:	

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

CURRENT GENDER IDENTITY	
Female	2918
Male	3318
Transgender	
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	19
Another identity not listed	
TOTAL	**6255**
If another identity is counted, please specify:	

SEX ASSIGNED AT BIRTH	
Male	3318
Female	2918
Declined to answer	
Unknown	19
TOTAL	**6255**

PRIMARY LANGUAGE	
English	2445
Spanish	1
Cantonese	
Chinese	
Vietnamese	
Farsi	186
Arabic	
Tagalog	
Declined to answer	
Unknown	
Another language not listed	2944
TOTAL	**5576**
If another language is counted, please specify: Genpali (2557), Hindi (102), Punjabi (155), Urdu (3), Other (1246), Pashto (1)	

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.

DISABILITY*** STATUS	
Communication Domain	
Vision	
Hearing/Speech	
Another type not listed	3
Communication Domain Subtotal	**3**
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	
Physical/mobility	3
Chronic health condition	1
Disability Subtotal	**4**
None	1909
Declined to answer	
Unknown	2667
Another disability not listed	
TOTAL	**4583**

RACE	
American Indian or Alaska Native	48
Asian	5630
Black or African American	12
Native Hawaiian or Other Pacific Islander	6
White	363
Other Race	
Declined to answer	
Unknown	129
TOTAL	6188
If another race is counted, please specify: Latino (83), Other (75),	

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	
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	83
Total Hispanic or Latino	**83**
If Non-Hispanic or Non-Latino, please specify:	
African	
African American	
Asian Indian/South Asian	942
Cambodian	
Chinese	54
Eastern European	
European	
Filipino	50
Japanese	
Korean	4
Middle Eastern	
Vietnamese	2
Other Non-Hispanic or Non-Latino ethnicity not listed	4317
Total Non-Hispanic or Non-Latino	**5369**
More than one ethnicity	
Unknown Ethnicity	
Declined to answer	
EHTNICITY TOTAL	5452
If another ethnicity is counted, please specify: Bhutanese (1406), Nepalese (2445), Pakisatani (40), Other Asian (186), Persian (117), Afghan (62), Bangladeshi (1)	

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

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.

It has been a year full of uncertainty and unprecedented change. The biggest success this year has been a smooth transition to telehealth in the midst of all of the confusion around the pandemic. Telehealth allowed us to reach out to even more unserved community members by allowing us to eliminate certain stigmas and barriers to care within the South Asian community. Participants did not need to come into the clinic where other community members may see them receiving services, participants did not need to arrange for transportation, participants did not need to arrange for childcare, and participants were able to attend more regularly. We were able to provide more support groups and workshops on a telehealth platform that also allowed participants to stay anonymous if they chose to, eliminating some barriers associated with shame and guilt for engaging in services. Hardships due to the pandemic allowed community members to engage more openly in conversations around wellness.

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.

The biggest challenges this year was our inability to work in the community. A lot of our work is boots on the ground, however due to the shelter in place orders as a response to the pandemic we were unable to send outreach workers into the community. The number of outreach events where we could table were limited, which prevented us from engaging directly with community members and leaders. There were some limitations to how much outreach we could do via telehealth because some community members didn't have access to technology or struggled with technology. As we began to get accustomed to the new reality we were able to begin reaching out to community leaders via telehealth and supporting them in providing information on our services to community members. We also began allowing our outreach workers to start engaging in limited community work while protecting their safety and the safety of community members.

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.

Some lessons learned were: a) Importance of using non-stigmatizing language b) Helped strengthen our beliefs around how important Prevention is and how it helps during times of crisis. Many of our participants had increased resilience during the pandemic since they had been engaging in services prior to the pandemic c) Telehealth needs to continue to be offered for these communities d) Groups can work if there is room for anonymity for participants in the group. e) Engaging in community work can continue through virtual spaces.

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):	15
G.3: Types of treatment individuals were referred to (list types) (500-character limit):	Alameda County Outpatient Services at The Hume Center, Contra Costa County Outpatient Services at The Hume Center, Tri City Health, EAP (Employee Assistance Programs), and Private Insurance Providers.
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:	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. We focus 50 percent of our services on supporting youth. We also provide support to adults, older adults, families and couples.
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:	2
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):	There is a PEI School Based Program at the Hume Center. So, the referrals were made internally so the student could be seen under PEI School Based rather than the SACHPS program.

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.)***

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

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	*24 counselors, 3 social workers, 1 police officer, 3 nurses, 10 principals, 35 admin/teachers*
Faith Based Establishments (Gurdwaras, Mandirs, Masjids)	*5 faith leaders*
Community Leaders	*50+ leaders in Nepalese, Bhutanese, Punjabi and Persian communities*
Community Centers	*100+ community members, 20+ community leaders*
Health Fairs	*100+ community members, 15+ other Community Based Organizations*
Community Events (cultural holiday festivals, cultural picnics, religious holiday celebrations, etc.)	*100 + community members, 20+ community leaders*
Local CBOs	*mental health providers, doctors, social workers, DV counselors, resource specialists*
Colleges & Universities	*professors, administration, counselors, students*
Local Libraries	*librarians, community members*
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 19/20

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).

Outreach: at cultural/seasonal events at NAHC and other agency events: pyscho-education at NAHC community space talking circles, parenting, Elders, relapse prevention and other cultural activities; mental health consultation: cultural competence training for new hires, clinical staff and at other agencies and schools; preventive counseling: screening, assessment, counseling and referrals. Community health workers serve as system navigators building peer support and networks for youth & adults and mental health specialists. Community events create outreach opportunities, social connection with each other and opportunities to get to know providers and options. Stigma is reduced by getting services in a non-traditional setting. Community become partners in planning, execution and evaluation of services.

Box B: Please provide the total number of individuals served to date July 1, 2019 through June 30, 2020 through MHSA funding.

Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	484

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	34
Number of unduplicated individual family members served indirectly by your program:	NA
Grand total of unduplicated individuals served:	**518**

Box C: 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.

AGE CATEGORIES	
Children/Youth (0-15 yrs)	110
Transition Age Youth (16-25 yrs)	26
Adult (26-59 yrs)	69
Older Adult (60+ yrs)	91
Declined to answer	
Unknown	188
TOTAL	**484**

SEXUAL ORIENTATION	
Gay/Lesbian	7
Heterosexual/Straight	151
Bisexual	
Questioning/Unsure	
Queer	
Declined to answer	
Unknown	326
Another group not listed	
TOTAL	**484**
If another group is counted, please specify:	

VETERAN STATUS	
Yes	11
No	271
Declined to answer	
Unknown	202
TOTAL	**484**

CURRENT GENDER IDENTITY	
Female	138
Male	154
Transgender	
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	192
Another identity not listed	
TOTAL	**484**
If another identity is counted, please specify:	

PRIMARY LANGUAGE	
English	484
Spanish	
Cantonese	
Chinese	
Vietnamese	
Farsi	
Arabic	
Tagalog	
Declined to answer	
Unknown	
Another language not listed	
TOTAL	**484**
If another language is counted, please specify:	

SEX ASSIGNED AT BIRTH	
Male	154
Female	138
Declined to answer	
Unknown	192
TOTAL	**484**

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.

DISABILITY*** STATUS	
Communication Domain	
Vision	
Hearing/Speech	1
Another type not listed	
Communication Domain Subtotal	**1**
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	
Physical/mobility	3
Chronic health condition	
Disability Subtotal	**3**
None	215
Declined to answer	
Unknown	265
Another disability not listed	
TOTAL	**484**
If another disability is counted, please specify:	

RACE	
American Indian or Alaska Native	165
Asian	18
Black or African American	20
Native Hawaiian or Other Pacific Islander	
White	2
Other Race	93
Declined to answer	
Unknown	
TOTAL	298
If another race is counted, please specify: Latino (89), other (4)	

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.

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

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	83
Total Hispanic or Latino	**83**
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	18
Total Non-Hispanic or Non-Latino	**18**
More than one ethnicity	
Unknown Ethnicity	
Declined to answer	
EHTNICITY TOTAL	101
If another ethnicity is counted, please specify: (other API 18)	

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.

NAHC was able to complete most of the goals & deliverable outlined in our scope of work. Some of the highlights included the Annual Youth GONA, Gathering of the Lodges, Seasonal Cultural celebrations which included mental health workshops (ex: Keeping mentally safe, Dealing with Holiday Stress). Due to the COVID-19 pandemic, NAHC successfully continued a majority of PEI services on a virtual platform. We converted our Beading & Drumming prevention/cultural groups to an online venue hosted via RingCentral. We also were able to continue our two-day monthly visits with a traditional healer trough telehealth phone calls. This was especially meaningful for our Elders who are suffering from isolation. We were able to get Elders on the same phone call with the traditional healer so they can visit with each other while getting spiritual support.

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.

Some of our major events had to be cancelled because of the risk of Covid spread. This was a big loss for our community as gatherings help heal from the separation that we all experience being a small population and often times the only Native American in a school or work place or neighborhood. Our Elders especially suffered with isolation because our weekly Elders group was not able to meet. We mitigated these challenges by going virtual where we could.

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 lessons learned over the past year are that: 1) there is a value in seeing each other (staff and community members) which is more precious than we realized. Our mental health is greatly improved when we get to be with each other. We saw the damaging effects of isolation from each other as staff, with our community members and community members with each other. We realize now how important our gatherings are to foster wellness in our community. 2) We also learn that we can use virtual space to maintain wellness. Some people need more help to get the technology tools or training to stay in touch this way but we have met those challenges. We saw our resilience rise up with these challenges and realize the virtual world can also increase participation in some cases. We have had less no-shows for one-on-one counseling appointments with the barriers of transportation removed.

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
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):	NA

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

G.3: Types of treatment individuals were referred to (list types) (500-character limit):	NA
G.4: Unduplicated number of individuals who participated in referred program at least one time:	NA
G.5: Average duration of untreated mental illness in weeks:	NA
G.6: . Average number of days between referral and first participation in referred treatment program:	NA

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:	34
H.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	34
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):	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 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):

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

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 19/20

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 and case management support for those who have fled violence and persecution in their home countries and seek refuge in the Bay Area. When entire societies are affected by large-scale violence such as war and genocide, collective trauma can result. Thus, mental health concerns caused by exposure to trauma are chief among the mental health needs for the priority population, and are PTR's primary focus. Intervening early and effectively once refugees and asylum-seekers reach the U.S. is key to preventing the deleterious effects of trauma from deeply impacting the lives of future generations.

Box B: Please provide the total number of individuals served to date July 1, 2019 through June 30, 2020 through MHSA funding.	
Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	1201
Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	35

Number of unduplicated individual family members served indirectly by your program:	NA
Grand total of unduplicated individuals served:	**1236**

Box C: 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.

AGE CATEGORIES	
Children/Youth (0-15 yrs)	123
Transition Age Youth (16-25 yrs)	332
Adult (26-59 yrs)	487
Older Adult (60+ yrs)	105
Declined to answer	
Unknown	154
TOTAL	**1201**

VETERAN STATUS	
Yes	
No	241
Declined to answer	
Unknown	960
TOTAL	**1201**

SEXUAL ORIENTATION	
Gay/Lesbian	
Heterosexual/Straight	294
Bisexual	
Questioning/Unsure	
Queer	
Declined to answer	
Unknown	907
Another group not listed	
TOTAL	**1201**
If another group is counted, please specify:	

CURRENT GENDER IDENTITY	
Female	137
Male	93
Transgender	
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	
Another identity not listed	
TOTAL	**230**
If another identity is counted, please specify:	

PRIMARY LANGUAGE	
English	365
Spanish	2
Cantonese	
Chinese	
Vietnamese	
Farsi	
Arabic	
Tagalog	
Declined to answer	
Unknown	
Another language not listed	834
TOTAL	**1201**
If another language is counted, please specify: Other (765), Amharic (34), Tigrinya (33). Arabic (2)	

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

SEX ASSIGNED AT BIRTH	
Male	547
Female	499
Declined to answer	
Unknown	155
TOTAL	**1201**

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.

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	2
Chronic health condition	
Disability Subtotal	**2**
None	331
Declined to answer	
Unknown	1042
Another disability not listed	
TOTAL	**1375**
If another disability is counted, please specify:	

RACE	
American Indian or Alaska Native	
Asian	8
Black or African American	1132
Native Hawaiian or Other Pacific Islander	
White	32
Other Race	10
Declined to answer	
Unknown	1
TOTAL	1183
If another race is counted, please specify: Latino (8).	

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	
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	
Cambodian	
Chinese	
Eastern European	
European	
Filipino	
Japanese	
Korean	
Middle Eastern	
Vietnamese	
Other Non-Hispanic or Non-Latino ethnicity not listed	87
Total Non-Hispanic or Non-Latino	**87**
More than one ethnicity	
Unknown Ethnicity	
Declined to answer	
EHTNICITY TOTAL	95
If another ethnicity is counted, please specify: Eritrean (27), African (60)	

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

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.

PTR's UELP PEI program provided counseling to 35 unique clients, facilitated 12 monthly psychoeducational workshops, 3 educational workshops, and 3 support groups; participated in 5 community events; and distributed program materials on 5 local listservs that reach individuals/CBOs throughout the Bay Area. One success we are particularly proud of is facilitating a series of conversations and engagements with community leaders from several different African communities that enabled us to identify mental health issues present within different communities and contextualize the content of psychoeducational workshops and outreach events to best serve community members. Integrating different topics related to mental health, stress, and overall wellbeing allowed us to normalize and destigmatize mental health issues. We also supported African newcomer students at a local high school to establish an African student club to help address issues of isolation and racism experienced by the students.

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.

PTR's primary challenge continued to be the requirement to enter personal 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. We created a unique consent form for UELP clients that clearly indicates the information that is shared in InSyst and the level of protection guaranteed by Alameda County to maintain confidentiality of all PHI. This consent allows each client to choose to consent to have their information entered in InSyst; 10 clients did not consent to reporting their personal information in InSyst. We continued to provide preventive counseling services for these clients, despite our ability to report these clients in our total clients served. Another challenge was managing community expectations of service provision.

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.

One lesson learned was the importance of engaging community, faith, and CBO leaders throughout the development and implementation of psychoeducational workshops and outreach events. Community leaders provide an entry point to engaging with community members and their active involvement helped us to identify needs and contextualize the content of our workshops and events to meet the needs of the communities. The success of our program was due to our ability to provide general information on mental health and wellness for all African communities, as well as topics tailored to reach specific cultural and linguistic communities. We also learned the value in having a diverse staff who represent different African communities, as this allowed us to build strong relationships and trust with community members from several different African countries. Lastly, maintaining a structured curriculum for the youth support group provided a safe, trusting environment for newly arrived African students.

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):	5
G.3: Types of treatment individuals were referred to (list types) (500-character limit):	When deemed appropriate, PTR referred clients to our in-house pro-bono psychiatrists for medication evaluations and management and provided internal referrals for mental health treatment with our staff clinicians and clinical interns. During this fiscal year, 1 client was referred to an external Mental Health Treatment Program, Alameda STRIDES.
G.4: Unduplicated number of individuals who participated in referred program at least one time:	6
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:	14

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
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

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

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):
High School	*students, school counselors, school staff, teachers, parents*
Community Centers	*community leaders*
Places of worship (churches, mosques, etc.)	*religious/faith leaders*
Community-based organizations	*community leaders*
Park (Umoja Festival, AAN Annual Event)	*community and CBO leaders, immigration attorney, artist, general community*

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 19/20

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. We offer preventive counseling, support groups, educational and cultural workshops, community events, and referrals and linkages to promote and support community wellness. We also offer consultations to local organizations, providers and community leaders about how to be culturally responsive and supportive when working with Middle Eastern and North African communities.

Box B: Please provide the total number of individuals served to date July 1, 2019 through June 30, 2020 through MHSA funding.

Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	750
Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	28

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

Number of unduplicated individual family members served indirectly by your program:	NA
Grand total of unduplicated individuals served:	**778**

Box C: 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.

AGE CATEGORIES	
Children/Youth (0-15 yrs)	85
Transition Age Youth (16-25 yrs)	338
Adult (26-59 yrs)	300
Older Adult (60+ yrs)	11
Declined to answer	
Unknown	16
TOTAL	**750**

VETERAN STATUS	
Yes	
No	617
Declined to answer	
Unknown	133
TOTAL	**750**

SEXUAL ORIENTATION	
Gay/Lesbian	
Heterosexual/Straight	206
Bisexual	1
Questioning/Unsure	
Queer	5
Declined to answer	
Unknown	537
Another group not listed	
TOTAL	**749**
If another group is counted, please specify:	

CURRENT GENDER IDENTITY	
Female	419
Male	304
Transgender	
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	27
Another identity not listed	
TOTAL	**750**
If another identity is counted, please specify:	

PRIMARY LANGUAGE	
English	21
Spanish	80
Cantonese	2
Chinese	
Vietnamese	
Farsi	7
Arabic	587
Tagalog	1
Declined to answer	
Unknown	
Another language not listed	39
TOTAL	**737**
If another language is counted, please specify: Bangali (1), Sri Lankan Tamil (1), Urdu (1), Dari (1)	

SEX ASSIGNED AT BIRTH	
Male	304
Female	419
Declined to answer	2
Unknown	25
TOTAL	**750**

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.

DISABILITY*** STATUS	
Communication Domain	
Vision	
Hearing/Speech	
Another type not listed	1
Communication Domain Subtotal	**1**
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	2
Physical/mobility	1
Chronic health condition	3
Disability Subtotal	**6**
None	131
Declined to answer	
Unknown	612
Another disability not listed	
TOTAL	**750**
If another disability is counted, please specify:	

RACE	
American Indian or Alaska Native	
Asian	25
Black or African American	10
Native Hawaiian or Other Pacific Islander	
White	182
Other Race	480
Declined to answer	
Unknown	53
TOTAL	750
If another race is counted, please specify: Other Race includes: Multiracial (3), Latino (72) and Middle Eastern individual who did not choose "White."	

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

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	30
Mexican/Mexican American/Chicano	2
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	40
Total Hispanic or Latino	**72**
If Non-Hispanic or Non-Latino, please specify:	
African	
African American	
Asian Indian/South Asian	12
Cambodian	
Chinese	
Eastern European	
European	
Filipino	1
Japanese	
Korean	
Middle Eastern	
Vietnamese	
Other Non-Hispanic or Non-Latino ethnicity not listed	184
Total Non-Hispanic or Non-Latino	**197**
More than one ethnicity	
Unknown Ethnicity	
Declined to answer	
EHTNICITY TOTAL	269
If another ethnicity is counted, please specify: Arab (52), Middle Eastern/North African (114), Pakistani (10, Sri Lankan (1), Other East Asian (7)	

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.

We are proud of our Outreach/Engagement and Psycho-Education in our first year. We had online community events offering resources during COVID-19, space to engage in conversations about Spirituality & Ramadan, a fun and meaningful competition to honor Ramadan, and a celebration to Break the Fast with MENA mothers. We did mental health consultations with staff at Oakland International High School (OIHS) and students at institutes of higher education studying therapy and addiction studies. We held drop in and ongoing support groups with OIHS students and MENA mothers as well as educational workshops to de-stigmatize therapy, address issues of belonging, connect wellness to SDOH, and explore storytelling. We became a visible resource for preventive counseling. One success was with a MENA mother who received support from our MHS to explain a health issue to her husband in a culturally appropriate way. Since that time the mother shared that her husband has changed and been more supportive.

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.

We faced quite a few challenges this year. Given that it was our launch year, we had the typical challenges of setting up the program with creating systems and documentation, hiring and growing a team, developing partnerships, and building trust in the community as a new program. As we were beginning to build momentum and visibility, the COVID-19 pandemic hit, so we had to let go of in-person community and cultural events and began offering services online. While we were successful at reaching our goals through creative online offerings, the sudden shift to remote service delivery meant the loss of connection with many community members, particularly our youth clients at Oakland International High School. We did not give up though and through strengthening partnerships with organizations and leveraging digital media and online platforms, we have continued to build trust and connection in the MENA community.

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.

We learned that trust takes time. MENA communities often do not trust social service systems, which we know firsthand are not set up to support newcomers. With mental health and wellness there is also deep stigma about asking for support and counseling. We found that in order to gain trust we need to go to the heart of the community, which is often the women and mothers in the MENA community. We saw that by building strong relationships with mothers, doors opened to young women and men, fathers, and grandparents, all of whom also need tailored support to face many complex concerns from isolation, especially during COVID-19, to trauma from fleeing war and making a life in a new country/culture to the stress of supporting transnational families, and more. Finally, in the difficulties we faced with hiring and with the gap in Arabic-speaking MH providers to refer to, we learned about the critical need for workforce development with MENA communities in mental health.

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

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):	0
G.3: Types of treatment individuals were referred to (list types) (500-character limit):	Despite extensive efforts to identify networks of support for our clients, we were unable to refer clients to further treatment due to the lack of local therapy providers with relevant linguistic and cultural competencies. In cases where we could identify appropriate providers, they were not accepting new clients or there was a long wait.
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 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:	1
H.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	1
H.4: Average number of days between referral and first participation in referred PEI program:	10

H.5: Describe how your program encouraged access to services and follow through on above referrals (500 Characters):	We first met with the agency to understand their processes and services to see if it could be a match for our client. We then completed the referral form and sent it to the agency. Then we did a warm handoff and we continued to follow up with the client and with the agency.

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):
Breaking the Fast Celebration (online)	*Arab/MENA mothers*
Ramadan Competition (online)	*Arab/MENA community members and youth*
Digital Storytelling Screening (online)	*Arab/MENA youth women*
Spirituality and Ramadan Online Event (online)	*Arab/MENA community members*
Community Resource Event (online)	*Arab/MENA community members and diverse immigrant communities*
Garden of Belonging Psycho-Education workshops	*Youth/students at Oakland International High School, including Arab/MENA youth*
What is Therapy? Psycho-Education Workshops	*Arab/MENA youth and students at Oakland International High School*
What is Wellness? Psycho-Education Workshops	*Arab/MENA youth and students at Oakland International High School*
Drop in support group for Arab/MENA students at Oakland International High School	*Arab/MENA youth and students at Oakland International High School*
Arab/MENA Young Men's Group at Oakland International High School	*Arab/MENA youth men at Oakland International High School*
Arab/MENA Mother's Group held at West Oakland Middle School then online	*Arab/MENA mothers*
Digital storytelling cultural education workshops (online)	*Arab/MENA youth women*
Mental health consultation with Oakland International High School	*School teachers and staff at Oakland International High School*

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

Mental health consultation with local institutions of higher educations (CIIS, CSM, JFK)	*therapy and addiction studies students*

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 19/20

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 some type of 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 referred individuals. PEI funds currently aid in the implementation of the COST strategy in 268 schools across 14 school districts in Alameda County.

Box B: Please provide the total number of individuals served to date July 1, 2019 through June 30, 2020 through MHSA funding.

Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	5,189
Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	5,748

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

Number of unduplicated individual family members served indirectly by your program:	0
Grand total of unduplicated individuals served:	**10937**

Box C: 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.

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	17585
TOTAL	**17585**

SEXUAL ORIENTATION	
Gay/Lesbian	8
Heterosexual/Straight	136
Bisexual	5
Questioning/Unsure	1
Queer	0
Declined to answer	0
Unknown	0
Another group not listed	8080
TOTAL	**8230**
If another group is counted, please specify:	

VETERAN STATUS	
Yes	
No	
Declined to answer	
Unknown	
TOTAL	**0**

CURRENT GENDER IDENTITY	
Female	1723
Male	1524
Transgender	10
Genderqueer	0
Questioning/unsure of gender identity	6
Declined to answer	4996
Unknown	0
Another identity not listed	0
TOTAL	**8259**
If another identity is counted, please specify:	

PRIMARY LANGUAGE	
English	3037
Spanish	1194
Cantonese	104
Chinese	0
Vietnamese	17
Farsi	24
Arabic	24
Tagalog	35
Declined to answer	4453
Unknown	0
Another language not listed	77
TOTAL	**8965**
If another language is counted, please specify: If another language is counted, please specify: Mandarin, Other Chinese Dialects, Other Filipino Dialect, Laotian, Cambodian, Samoan, Russian, German, Italian, Hebrew, French, Portuguese, Armenian, Arabic, Sign ASL, Other	

SEX ASSIGNED AT BIRTH	
Male	2635
Female	2312
Declined to answer	4139
Unknown	0
TOTAL	**9086**

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.

DISABILITY*** STATUS	
Communication Domain	
Vision	8
Hearing/Speech	39
Another type not listed	0
Communication Domain Subtotal	**47**
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	56
Physical/mobility	6
Chronic health condition	16
Disability Subtotal	**78**
None	
Declined to answer	5179
Unknown	147
Another disability not listed	
TOTAL	**5451**
If another disability is counted, please specify:	

RACE	
American Indian or Alaska Native	12
Asian	1,923
Black or African American	2867
Native Hawaiian or Other Pacific Islander	243
White	1849
Other Race	6813
Declined to answer	3291
Unknown	
TOTAL	16998
If another race is counted, please specify:	

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

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	2
Central American	58
Mexican/Mexican American/Chicano	465
Puerto Rican	5
South American	6
Another Hispanic/Latino ethnicity not listed	11
Total Hispanic or Latino	**547**
If Non-Hispanic or Non-Latino, please specify:	
African	14
African American	679
Asian Indian/South Asian	384
Cambodian	12
Chinese	271
Eastern European	4
European	32
Filipino	353
Japanese	19
Korean	85
Middle Eastern	69
Vietnamese	66
Other Non-Hispanic or Non-Latino ethnicity not listed	175
Total Non-Hispanic or Non-Latino	**2163**
More than one ethnicity	346
Unknown Ethnicity	
Declined to answer	4391
EHTNICITY TOTAL	7447
If another ethnicity is counted, please specify:	

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.

Continuation of COST during Shelter in Place has been a success. For example, the COST team received a referral for a senior whose father had died in China in the fall, and he had been living with his mother in a small studio. His mother passed away during the shelter-in-place due to a battle with cancer, and he was fending for himself. His teacher referred him to the COST meeting and the team immediately went into action to get him food, gift cards, telehealth support and connection with an older sibling in the Bay Area. This young man stayed connected with his same-language social worker on the COST team and we were able to check in with him regularly and met him at his diploma pick up to make sure he received a graduation picture and felt celebrated. His guidance counselor also connected him with the Student Health Center at the University where he will be attending in the Fall. If we hadn't had a clear referral process, this student would have fallen through the cracks for sure.

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.

The biggest challenge across all 14 school districts that CHSC supports, as well as for CHSC itself, has been reacting to impact of the global Coronavirus pandemic. CHSC quickly adapted to meet needs of students and their families as schools, school health centers, and service providers closed due to the shelter-in-place mandate. This included food and technology distribution as well as resource navigation and obtaining HIPPA approved licenses to provide services virtually. As a part of the Alameda County Behavioral Health Care Services and Alameda County Public Health Department, CHSC staff began helping with COVID response such as contact tracing and planning how to safely re-open schools. CHSC also worked with providers to strategize how to continue services and also held trainings for staff across the county on self-care while also responding to their needs of students and their families.

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.

Shelter-in-place has brought to light the importance of self-care as well as trying to bring together communities Also, relational trust, especially with ongoing turnover in staff, continues to be important to the in implementation and uptake of mental health services. CHSC continuously strives to establish and maintain positive relationships with school districts as well as to foster positive relationships between schools and service providers.

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

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):	3170
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):	NA
G.3: Types of treatment individuals were referred to (list types) (500-character limit):	Mental health treatment programs that individuals were referred to primarily consisted of the following school-based health services: individual counseling or therapy, group counseling, crisis intervention, individualized behavior support, family counseling and parent workshops. Additionally, linkages to other services outside of school-based health resources were made when needed.
G.4: Unduplicated number of individuals who participated in referred program at least one time:	3170
G.5: Average duration of untreated mental illness in weeks:	NA
G.6: Average number of days between referral and first participation in referred treatment program:	The average time in weeks between when a paper referral was given to an individual and when that individual had their first appointment with a mental health treatment provider varied across the 14 school districts receiving MHSA funding support. 57% of referrals were connected to services within 1-14 days of referral and 43% of referrals were connected to services within 14-28 days of receiving a paper referral.

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 youth, 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 prorgram:	NA

H.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	NA
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):	Alameda County School Districts are implementing a Coordination of Services Team (COST) strategy to increase early identification of students who may need support services as well as access and linkage to behavioral and mental health care. Through COST implementation teachers, staff, students (self-referral) and families may submit referrals for students they are concerned about and a multidisciplinary group of staff and internal/external service providers (i.e. COST Team) meets weekly or biweekly to triage student needs. During COST team meetings, members take responsibility for following up with the student and their guardian to ensure linkage to care is offered. Furthermore, the COST coordinator documents when follow-up occurred, if linkage to care was accepted, and the initiation date of the care that the student received.

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):

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

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 19/20

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):	510-704-7475	
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
		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. Two 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. Linkages are made for children and parents needing additional resources. Consultation is provided according to the ACBH developed Standards of Practice.

Box B: Please provide the total number of individuals served to date July 1, 2019 through June 30, 2020 through MHSA funding.

Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	230

Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	NA
Grand total of unduplicated individuals served:	**230**

Box C: 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.

AGE CATEGORIES	
Children/Youth (0-15 yrs)	122
Transition Age Youth (16-25 yrs)	2
Adult (26-59 yrs)	101
Older Adult (60+ yrs)	5
Declined to answer	
Unknown	
TOTAL	**230**

VETERAN STATUS	
Yes	0
No	230
Declined to answer	
Unknown	
TOTAL	**230**

SEXUAL ORIENTATION	
Gay/Lesbian	2
Heterosexual/Straight	102
Bisexual	
Questioning/Unsure	
Queer	
Declined to answer	
Unknown	126
Another group not listed	
TOTAL	**230**
If another group is counted, please specify:	

CURRENT GENDER IDENTITY	
Female	141
Male	89
Transgender	
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	
Another identity not listed	
TOTAL	**230**
If another identity is counted, please specify:	

PRIMARY LANGUAGE	
English	118
Spanish	56
Cantonese	0
Chinese	13
Vietnamese	14
Farsi	1
Arabic	1
Tagalog	0
Declined to answer	0
Unknown	0
Another language not listed	27
TOTAL	**230**

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

SEX ASSIGNED AT BIRTH	
Male	89
Female	141
Declined to answer	
Unknown	
TOTAL	**230**

Communication Domain	
Vision	
Hearing/Speech	11
Another type not listed	
Communication Domain Subtotal	**11**
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	9
Physical/mobility	
Chronic health condition	
Disability Subtotal	**9**
None	
Declined to answer	
Unknown	
Another disability not listed	
TOTAL	**20**
If another disability is counted, please specify:	

American Indian or Alaska Native	0
Asian	16
Black or African American	64
Native Hawaiian or Other Pacific Islander	1
White	2
Other Race	50
Declined to answer	
Unknown	97
TOTAL	230
If another race is counted, please specify: African	

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	1
Central American	17
Mexican/Mexican American/Chicano	39
Puerto Rican	
South American	1
Another Hispanic/Latino ethnicity not listed	
Total Hispanic or Latino	**58**
If Non-Hispanic or Non-Latino, please specify:	
African	35
African American	64
Asian Indian/South Asian	2
Cambodian	1
Chinese	13
Eastern European	
European	
Filipino	
Japanese	
Korean	
Middle Eastern	1
Vietnamese	14
Other Non-Hispanic or Non-Latino ethnicity not listed	
Total Non-Hispanic or Non-Latino	**130**
More than one ethnicity	
Unknown Ethnicity	42
Declined to answer	
EHTNICITY TOTAL	230
If another ethnicity is counted, please specify:	

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

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.

This past year my program is proud of the way the consultant and other teachers and community providers provided multidisciplinary support to children and families. For example, one student in particular who has an IEP was bussed to one program and returned to her main preschool (where consultant supports teachers). For a couple of school years there was no communication between the two sites. The consultant was able to encourage, build, and support communication between both sites. This communication resulted in preschool teachers learning new interventions to use in the classroom, smoother transitions, and wrap around support for the student. The parents reported feeling supported and cared for. This type of care also extended to student's younger sibling where his teachers and parents felt confident to provide and inquire about appropriate resources for him. These services are vital in mitigating further behavioral, cognitive, and mental health challenges.

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.

The biggest challenge that our program faced was COVID19. Shelter in Place quickly changed the way we communicate, teach, learn, and overall provide services that were designed to be in person. Sites and consultant did their best to adapt and adjust by providing virtual services. Consultants supported families with linkages to resources for basic needs and supported teachers by thinking together how to create quality distant learning. Consultants supported sites with finding alternative ways to end the school year and honor graduates as well as provide virtual circle times and curriculum. Consultants worked closely with Directors to think of safe ways to shift policies and procedures.

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.

This school year emphasized the need to collaborate, practice teamwork, be flexible, step out of comfort zones, and that mental health and relationships are a priority. These lessons were apparent during the course of the school year but became even more so during the pandemic. The disparities and inequities for our low-income children of color also became much more apparent. In spite of the challenges, including high staff turnover, we also learned that we could creatively continue to serve our teachers, children, and families 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):	6
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):	Family and individual therapy and support groups
G.4: Unduplicated number of individuals who participated in referred program at least one time:	6
G.5: Average duration of untreated mental illness in weeks:	NA
G.6: Average number of days between referral and first participation in referred treatment program:	20

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):	Latin X and African American families
H.2: Number of paper referrals to an ACBH PEI-funded program:	NA
H.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	NA
H.4: Average number of days between referral and first participation in referred PEI program:	N

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

H.5: Describe how your program encouraged access to services and follow through on above referrals (500 Characters):	When students demonstrated severe symptoms of trauma, dysregulation, and other behavioral challenges the consultant would work with the teachers and families to make a referral to parent-child therapy or a therapeutic preschool setting. Our preschool children are not mentally ill and these referrals will mitigate further symptoms with the hope of preventing sever mental illness. Similarly, when parents are symptomatic, referrals are also made for treatment. This may include substance abuse treatment and treatment for mental illness.

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):
3 Child Development Centers/ Preschools	*3 center directors, 33 teachers, 2 mental health consultants, 1 mental health coordinator*

MHSA Program #: PEI 1E

PROVIDER NAME: Alameda Family Services

PROGRAM NAME: School-Based Mental Health Outreach

Program Outcomes & Impact: PEI Data Report FY 19/20

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: Please provide the total number of individuals served to date July 1, 2019 through June 30, 2020 through MHSA funding.

Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	191
Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	0

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

Number of unduplicated individual family members served indirectly by your program:	1662
Grand total of unduplicated individuals served:	**1853**

Box C: 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.

AGE CATEGORIES	
Children/Youth (0-15 yrs)	380
Transition Age Youth (16-25 yrs)	1140
Adult (26-59 yrs)	333
Older Adult (60+ yrs)	
Declined to answer	
Unknown	
TOTAL	**1853**

VETERAN STATUS	
Yes	
No	1520
Declined to answer	
Unknown	333
TOTAL	**1853**

SEXUAL ORIENTATION	
Gay/Lesbian	4
Heterosexual/Straight	71
Bisexual	15
Questioning/Unsure	3
Queer	3
Declined to answer	
Unknown	1756
Another group not listed	1
TOTAL	**1853**
If another group is counted, please specify:	

CURRENT GENDER IDENTITY	
Female	57
Male	134
Transgender	1
Genderqueer	3
Questioning/unsure of gender identity	
Declined to answer	
Unknown	1658
Another identity not listed	
TOTAL	**1853**
If another identity is counted, please specify:	

PRIMARY LANGUAGE	
English	
Spanish	
Cantonese	
Chinese	
Vietnamese	
Farsi	
Arabic	
Tagalog	
Declined to answer	
Unknown	1853
Another language not listed	
TOTAL	**1853**
If another language is counted, please specify:	

SEX ASSIGNED AT BIRTH	
Male	
Female	
Declined to answer	
Unknown	1853
TOTAL	**1853**

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.

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	1853
Another disability not listed	
TOTAL	**1853**
If another disability is counted, please specify:	

RACE	
American Indian or Alaska Native	2
Asian	487
Black or African American	114
Native Hawaiian or Other Pacific Islander	2
White	440
Other Race	426
Declined to answer	
Unknown	382
TOTAL	1853
If another race is counted, please specify:	

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

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	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	2
African American	1
Asian Indian/South Asian	
Cambodian	2
Chinese	2
Eastern European	1
European	2
Filipino	40
Japanese	
Korean	4
Middle Eastern	2
Vietnamese	3
Other Non-Hispanic or Non-Latino ethnicity not listed	4
Total Non-Hispanic or Non-Latino	**63**
More than one ethnicity	168
Unknown Ethnicity	1617
Declined to answer	
EHTNICITY TOTAL	1853
If another ethnicity is counted, please specify:	

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.

Mentor on Discharge ® - Post Crisis Peer Mentoring

We have continued to improve our outreach efforts and referral process. In addition to our on-campus campaigns/events, we have reached hundreds of students through school orientations and classroom presentations. We've adjusted to the limited conditions under shelter-in-place [SIP] and school closures, by utilizing social media and virtual platforms such as Zoom. Despite being limited to telehealth and without warm hand-offs, we're still able to follow through on referrals. For example, referrals from our medical team have led to students starting MH services during SIP. For one case in particular, a patient finally agreed to start individual therapy during their telehealth medical appointment after months of being hesitant to start the MH referral process. The clinician assigned to the student obtained parent consent, which had been a source of reluctance for the student. Even through remote services our team continues to provide wraparound support whenever possible.

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.

Our biggest challenges this year had to do with access. At the start of the year, access to our health centers was an issue. At Alameda High, the new school wing created physical distance between us and most of the students. At Encinal, campus renovation caused physical barriers and construction hazards that moved foot traffic away from our health center. At Island, our center was moved to a different classroom that was shared with the school support /afterschool program. In the latter half of the school year access and connection with students was a challenge across sites due to SIP and sudden school closures. Throughout the year our team's ability to problem-solve and go the extra mile along with collaborating with students mitigated these challenges. We increased our in-person and social media outreach based on individual school needs/culture and student feedback. This also led to the creation of our student internship program in order to continue outreach during the summer.

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.

This year it was very clear how significant it is to meet youth where they're at when it comes to outreach. Without in-person interactions through our health centers, classroom workshops, and on-campus activities we immediately felt disconnected from the students and school community. With SIP and school closures, the value of an active internet presence, especially through social media, became immediately apparent. In addition to being accessible through social media, namely Instagram, it is just as important to provide content most relevant to youth that is presented in a youth-friendly and engaging manner. For this we have been grateful for our Youth Advisory Board members' contributions to our outreach efforts through social media. We are in the process of improving our outreach and marketing not just as the school-based department but as a whole agency. This includes presence across various social media platforms, website redesign, and a quarterly newsletter.

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

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):	36
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):	64
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:	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 that identify as LGBTQ, first generation immigrants, Black, Muslim, Latin-x, Asian, and Filipino. The School-Based Mental Health Outreach program helps improve access to mental health services to a diverse population of youth across multiple schools that would otherwise be unaware and in some cases unable to obtain mental health support. By conducting outreach efforts on-campus, we provide information and resources directly to youth in a non-judgmental and easily accessible manner.
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:	**1853**
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):
Suicide Prevention Awareness Events, Presentations, & Workshops	*Students, Teachers, District Staff 585 youth and 35 adults)*
City of Alameda Mental Health Initiative	*City, District, and County Staff; Students; City Council (2 youth, 14 adults)*
District LGBTQ Roundtable	*Students, District Staff, Teachers, Community Members (6 youth, 4 adults)*
City Collaborative	*District Staff, Superintendent, County Sup., City Staff, Non-profit Program Directors (20 adults)*
District MH Steering Committee	*District Staff, Outside Non-profits, School Board (9 adults)*
School Tours, Orientations, and Presentations	*Students, Faculty, Parents (1,680 students, 90 adults) **not counted in unduplicated*
Youth Development/Youth Advisory Board	*Students (25 youth)*
School campaigns (mental health, harm reduction, stress awareness, coping, relationship abuse)	*Students, Teachers, School Counselors (642 students, 54 adults)*
Meeting with Kaiser MH Staff	*Behavioral Health Therapist (1 adult)*
Alameda Welfare Council Presentation	*Community members (3 adults)*
Bay Area Physicians for Human Rights Presentation	*Medical doctors (18 adults)*
AFS Board of Directors Meeting	*Board Members in the community (14 adults)*
Alameda City Rotary Presentation	*Community members, Parents (30 adults)*
Postvention Parent Group	*Parents (4 adults)*

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

Meeting with Alameda Police Department (MH intervention)	*APD Commanding Officers (5 adults)*
City Council Town Halls on MH (COVID-19)	*City Staff, District Staff, Parents, Community Members (80 adults)*
AUSD Redesign Task Force	*District Staff, Teachers, School Staff, Students, Community Members (2 youth, 30 adults)*
MH Awareness Social Media Outreach	*Students, Teachers, School Staff, Community Members (258 youth, 12 adults)*

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.

Client Success: 74 yr old man referred to GART by SLPD due to concerns about hoarding and potential mental health sx. Ct has not been able to access or reside in his house for many years due to increased clutter and reported feeling anxious, depressed, and stressed regarding circumstances. While ct was initially resistant to services, after multiple attempts of engagement by GART clinician, ct accepted services and began psychotherapy to address his mood sx and made improvements in engagement and expressing himself. Over the course of treatment, ct was able to feel comfortable enough to engage in additional services to support his housing needs. The GART team continues to be a resource for individuals, families, and other community providers for consultation, support, and treatment for older adults. The GART team has successfully been able to strategize and implement telehealth options to safely continue to provide services to both new and current clients during COVID-19 pandemic.

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.

The GART RN transferred to ACPH in July 2019, which has impacted the team, it's productivity, and service provision. Having an RN on the team is critical for many reasons, including older adults frequently have co-occurring medical conditions. However, we have found it to be equally important when establishing rapport and engagement as many clients experience an increased level of comfort discussing with an RN the impact of health conditions on their mental health. Multiple rounds of interviews for a replacement have been conducted without success. Beginning in February 2020, GART was able to utilize a contract RN to support the team part time, which provided some help in supporting the needs of our clients until a permanent RN is hired. However, at the end of June 2020, the contract RN did not elect to extend his contract, leaving the GART team without an RN once again.

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 the process of community outreach and fielding consultation calls, the team continues to notice there is at times confusion regarding the role of GART, as well as ACBH has determined that productivity is lower than desired. Part of the confusion and low use of the program may be due to staff turnover at other provider sites. In addition, through fielding referral calls, clinicians have noticed increased calls and potential service gaps for older adults that symptoms may be better explained by dementia as well as individuals experiencing homelessness.

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

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 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):	0
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, field-based case management, peer support groups, friendly visitors, cultural and language specific providers, substance abuse providers, housing and 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

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

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 19/20

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: Please provide the total number of individuals served to date July 1, 2019 through June 30, 2020 through MHSA funding.

Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	732
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:	**732**

Box C: 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.

AGE CATEGORIES	
Children/Youth (0-15 yrs)	
Transition Age Youth (16-25 yrs)	23
Adult (26-59 yrs)	109
Older Adult (60+ yrs)	34
Declined to answer	82
Unknown	484
TOTAL	**732**

VETERAN STATUS	
Yes	2
No	81
Declined to answer	165
Unknown	484
TOTAL	**732**

CURRENT GENDER IDENTITY	
Female	117
Male	61
Transgender	
Genderqueer	
Questioning/unsure of gender identity	2
Declined to answer	63
Unknown	484
Another identity not listed	5
TOTAL	**732**
If another identity is counted, please specify: Nonbinary	

SEXUAL ORIENTATION	
Gay/Lesbian	3
Heterosexual/Straight	55
Bisexual	2
Questioning/Unsure	4
Queer	6
Declined to answer	173
Unknown	484
Another group not listed	5
TOTAL	**732**
If another group is counted, please specify: Pansexual, poly	

PRIMARY LANGUAGE	
English	78
Spanish	5
Cantonese	
Chinese	1
Vietnamese	1
Farsi	
Arabic	
Tagalog	
Declined to answer	159
Unknown	484
Another language not listed	4
TOTAL	**732**

If another language is counted, please specify: Russian, ASL, Punjabi

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

SEX ASSIGNED AT BIRTH	
Male	
Female	
Declined to answer	
Unknown	732
TOTAL	**732**

DISABILITY*** STATUS	
Communication Domain	
Vision	1
Hearing/Speech	1
Another type not listed	
Communication Domain Subtotal	**2**
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	2
Physical/mobility	15
Chronic health condition	2
Disability Subtotal	**19**
None	24
Declined to answer	203
Unknown	484
Another disability not listed	
TOTAL	**732**
If another disability is counted, please specify: Depression, PTSD, schizophrenia, bipolar	

RACE	
American Indian or Alaska Native	4
Asian	9
Black or African American	76
Native Hawaiian or Other Pacific Islander	
White	47
Other Race	49
Declined to answer	63
Unknown	484
TOTAL	732
If another race is counted, please specify: More than one race, Latino	

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	6
Puerto Rican	
South American	

Another Hispanic/Latino ethnicity not listed	
Total Hispanic or Latino	**6**
If Non-Hispanic or Non-Latino, please specify:	
African	1
African American	
Asian Indian/South Asian	1
Cambodian	
Chinese	2
Eastern European	1
European	3
Filipino	3
Japanese	
Korean	
Middle Eastern	
Vietnamese	
Other Non-Hispanic or Non-Latino ethnicity not listed	4
Total Non-Hispanic or Non-Latino	**15**
More than one ethnicity	1
Unknown Ethnicity	484
Declined to answer	226
EHTNICITY TOTAL	732
If another ethnicity is counted, please specify: Hong Kong, Jewish	

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.

A highlight from earlier in the year was the anti-stigma support group for African American elders held at Sylvester Rutledge Manor. The elders were highly engaged in the group. The experience of reflecting on the ways in which others' negative perceptions of them had harmed their mental health, and collectively generating tools for strengthening their own self-esteem, was profound for many members. As is often the case, participants wanted more engagement and more peer support services. Dr. Lawrence Yang, Associate Professor of Global Public Health in the Department of Social and Behavioral Sciences at New York University, who has evaluated the all three recent ECC campaigns, concluded that the "elder group members after participating in the group curriculum experienced decreased awareness of mental health stereotypes, increased social support from others, and significantly increased positive beliefs about recovery."

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

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.

The greatest challenge to our participants this past year came with the isolation of sheltering in place and the disruption of in-person PEERS' in-person programming, which is a key part of maintaining wellness for many of our participants. This was a particularly significant challenge for our most active participants – members of our Lift Every Voice and Speak speakers' bureau (LEVS). Disconnection from regular sources of support, fears about the pandemic, financial hardship, and housing insecurity or homelessness were among the most common challenges our participants reported. However, with the support of PEERS, LEVS members continued to provide mutual support and build community during these past months of sheltering in place. A variety of remote activities for LEVS members drew an average of 14 participants each, from mid-March through the end of June. They also were able to complete their final speaking engagement remotely.

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.

One important lesson we learned this past year was how a crisis can be an opportunity to advance our mission. For example, in an effort to increase engagement and offer encouragement and solace to our community while we are sheltering in place, we increased PEERS' online presence. We released more than 30 staff-authored posts related to WRAP, ranging from wellness tools to previews of upcoming topics in PEERS' WRAP-based remote groups. We also launched our PEERS Perspectives series, which began in mid-April and had included more than 10 posts by the end of June. The first post was quoted in the Mercury News, in a story about how people who have experience living with mental health challenges have much to offer others who are struggling with isolation and anxiety during the pandemic. This enabled us to reach a far broader audience with a profoundly destigmatizing message about the strengths and gifts that people with lived experience of mental health challenges can offer everyone.

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
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):	NA
G.3: Types of treatment individuals were referred to (list types) (500-character limit):	

G.4: Unduplicated number of individuals who participated in referred program at least one time:	NA
G.5: Average duration of untreated mental illness in weeks:	NA
G.6: . Average number of days between referral and first participation in referred treatment program:	NA

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:	
H.4: Average number of days between referral and first participation in referred PEI program:	
H.5: Describe how your program encouraged access to services and follow through on above referrals (500 Characters):	Staff members make warm, personal connections with participants and, when encouraging a participant to engage with another PEERS program, they personally introduce the participant to the staff responsible for that program, when possible.

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):
Church	*28 members of the African American faith community*
Community festivals and fairs	*161 West Oaklanders, 135 seniors*

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

MHSA Program #: PEI 12

PROVIDER NAME: Crisis Support Services of Alameda County

PROGRAM NAME: Text Line

Program Outcomes & Impact: PEI Data Report FY 19/20

Program Name:	Text Line Program	
Organization:	Crisis Support Services of Alameda County	
PEI Program # and Name:	PEI 22 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: Please provide the total number of individuals served to date July 1, 2019 through June 30, 2020 through MHSA funding.	
Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	358
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:	4
Grand total of unduplicated individuals served:	**362**

Box C: 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.

AGE CATEGORIES	
Children/Youth (0-15 yrs)	25
Transition Age Youth (16-25 yrs)	24
Adult (26-59 yrs)	10
Older Adult (60+ yrs)	2
Declined to answer	301
Unknown	
TOTAL	**362**

VETERAN STATUS	
Yes	
No	
Declined to answer	
Unknown	**362**
TOTAL	**362**

CURRENT GENDER IDENTITY	
Female	57
Male	9
Transgender	1
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	294
Another identity not listed	1
TOTAL	**362**
If another identity is counted, please specify:	

SEX ASSIGNED AT BIRTH	
Male	
Female	
Declined to answer	
Unknown	362
TOTAL	**362**

SEXUAL ORIENTATION	
Gay/Lesbian	3
Heterosexual/Straight	8
Bisexual	2
Questioning/Unsure	
Queer	
Declined to answer	
Unknown	349
Another group not listed	
TOTAL	**362**
If another group is counted, please specify:	

PRIMARY LANGUAGE	
English	362
Spanish	
Cantonese	
Chinese	
Vietnamese	
Farsi	
Arabic	
Tagalog	
Declined to answer	
Unknown	
Another language not listed	
TOTAL	**362**
If another language is counted, please specify:	

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

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.

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	2
Black or African American	
Native Hawaiian or Other Pacific Islander	1
White	
Other Race	
Declined to answer	2
Unknown	
TOTAL	5
If another race is counted, please specify:	

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	
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	3
Total Hispanic or Latino	**3**

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	257
Declined to answer	2
EHTNICITY TOTAL	262
If another ethnicity is counted, please specify: 1 Iranian, 1 Russian	

MHSA Program #: PEI 12

PROVIDER NAME: Crisis Support Services of Alameda County

PROGRAM NAME: Community Education Program

Program Outcomes & Impact: PEI Data Report FY 19/20

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
	x	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. Through providing education and training on suicide prevention we work to increase knowledge of suicide warning signs, risk and protective factors, and how to help. .

Box B: Please provide the total number of individuals served to date July 1, 2019 through June 30, 2020 through MHSA funding.	
Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	12,818
Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	0

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

Number of unduplicated individual family members served indirectly by your program:	6
Grand total of unduplicated individuals served:	**12824**

Box C: 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.

AGE CATEGORIES	
Children/Youth (0-15 yrs)	9,167
Transition Age Youth (16-25 yrs)	479
Adult (26-59 yrs)	827
Older Adult (60+ yrs)	95
Declined to answer	194
Unknown	2062
TOTAL	**12824**

SEXUAL ORIENTATION	
Gay/Lesbian	40
Heterosexual/Straight	832
Bisexual	29
Questioning/Unsure	7
Queer	32
Declined to answer	286
Unknown	11593
Another group not listed	5
TOTAL	**12824**
If another group is counted, please specify:	

VETERAN STATUS	
Yes	47
No	941
Declined to answer	243
Unknown	2426
TOTAL	**3657**

CURRENT GENDER IDENTITY	
Female	662
Male	288
Transgender	1
Genderqueer	12
Declined to answer	261
Unknown	11594
Another identity not listed	4
TOTAL	**12824**
If another identity is counted, please specify:	

PRIMARY LANGUAGE	
English	896
Spanish	40
Cantonese	2
Chinese	3
Farsi	0
Arabic	1
Tagalog	6
Declined to answer	203
Unknown	11630
Another language not listed	42
TOTAL	**12824**
If another language is counted, please specify: Mandarin, Korean, Other Filipino dialect, Japanese, Cambodian, Mien, Hmong, Russian, Polish, Italian, French, Portuguese, Armenian, Arabic	

SEX ASSIGNED AT BIRTH	
Male	299
Female	722
Declined to answer	209
Unknown	11594
TOTAL	**12824**

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.

DISABILITY*** STATUS	
Communication Domain	
Vision	20
Hearing/Speech	12
Another type not listed	8
Communication Domain Subtotal	**40**
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	29
Physical/mobility	23
Chronic health condition	45
Disability Subtotal	**97**
None	816
Declined to answer	301
Unknown	11557
Another disability not listed	13
TOTAL	**12824**
If another disability is counted, please specify: "More than one"	

RACE	
American Indian or Alaska Native	27
Asian	592
Black or African American	157
Native Hawaiian or Other Pacific Islander	40
White	740
Other Race	138
Declined to answer	213
Unknown	10917
TOTAL	12824
If another race is counted, please specify: " More than one"	

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

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	7
Central American	26
Mexican/Mexican American/Chicano	155
Puerto Rican	6
South American	13
Another Hispanic/Latino ethnicity not listed	402
Total Hispanic or Latino	**609**
If Non-Hispanic or Non-Latino, please specify:	
African	13
African American	232
Asian Indian/South Asian	33
Cambodian	6
Chinese	34
Eastern European	42
European	174
Filipino	143
Japanese	3
Korean	7
Middle Eastern	53
Vietnamese	8
Other Non-Hispanic or Non-Latino ethnicity not listed	42
Total Non-Hispanic or Non-Latino	**790**
More than one ethnicity	373
Unknown Ethnicity	10625
Declined to answer	427
EHTNICITY TOTAL	12824
If another ethnicity is counted, please specify:	

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.

Virtual Workshops - Teens for Life Program - Video Series
While schools were shut down, distance learning was still occurring as the school year had not yet officially ended. From 3/20-5/20, we cancelled 10 schools that were scheduled on our calendar and missed seeing an estimated 1,800 students in classroom presentations. As a way to still reach students, our Teens for Life Program spent 4-5 weeks creating a video series of our curriculum to distribute to our teacher contacts. Our teachers and our team recognized the need to continue to support our youth in this current public health crisis. The video series features the topics that emulate the core content of our youth curriculum. Before the school year officially ended we were able to send out the video series through our YouTube channel to 77 contacts from 50 schools to utilize as they saw fit as part of their learning curriculum along with Hayward USD's google classroom as part of their Health & Wellness series for students.

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.

1) TFL Program: Due to 2 staff members moving on to other opportunities, we went through a hiring and training process during summer/fall 2019. Training takes time and limits the amount of presentations that can be scheduled. In late Fall 2019, we experienced the sudden death of one of our newly hired staff. We were grateful to have support to take our time as a team to grieve and process this loss. At the start of 2020, we began the process of hiring a new TFL Health Educator for the Spring semester. 2) Covid19 Impact: Our program cancelled scheduled presentations for our schools and with our community partners. As part of their training as educators/trainers, our staff had the skillset to provide support to our Crisis line programming 3) Technology: As the long-term nature of the pandemic settled in, our program adjusted to providing live webinars. Our staff has to learn how to use new technology, and adjust to a new way of engaging with an online audience.

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.

Application of the cultural lens in suicide prevention: In our efforts to provide universal information to strengthen the safety net of our community as whole, there are gaps that we are actively working to address in our curriculums to better serve our community. In early Spring 2020, we connected with the suicide prevention coordinator of Santa Clara County Behavioral Health to learn more about the adjustments being made to their suicide prevention and mental health curricula to better reflect their diverse community. Using research by Palo Alto University's Dr. Joyce Chu, Santa Clara County was able to apply cultural standards to suicide

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

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):	0
G.3: Types of treatment individuals were referred to (list types) (500-character limit):	All who receive a presentation and those we interact with at Health fairs receive information on our 24-Hour Crisis line and TextLine and other agency services. 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:	0
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:	0

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 (10-17); Transition-Age Youth (16-24); Older Adults (55+)
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):	All who receive a presentation and those we interact with at Health fairs receive information on our 24-Hour Crisis line and TextLine and other agency services. Adults also receive a resource sheet that lists information on agency services, ACBH, and other local community resources.

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:	**12824**
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 Classrooms	*9,280 youth*
Districts and School Sites	*642 teachers, Mental Health staff & Parents*
Community Organizations	*798 Adult community members & MH professionals*
Higher Education Settings	*370 students & faculty*
Justice System	*564 LE officers, Dispatchers, Deputies, Civilian Jail Staff,*
Health Care Setting	*311 staff*
School Health Fairs	*352 youth*
Community Health Fairs	*492 community members*
Faith Community	*49 adults*
Senior Housing	*42 older adult residents*

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

MHSA Program #: PEI 12

PROVIDER NAME: Crisis Support Services of Alameda County

PROGRAM NAME: Clinical Program

Program Outcomes & Impact: PEI Data Report FY 19/20

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
		Early Identification of Mental Health Illness

Box A: Please provide a brief program description (character limit 1,000).
Our program has three main components: Older Adults, Grief, and School Based. We provide individual and family therapy in all programs. We also offer a variety of groups that support community members with grief and loss along with support for older adults.

Box B: Please provide the total number of individuals served to date July 1, 2019 through June 30, 2020 through MHSA funding.	
Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	323
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:	**323**

Box C: 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.

AGE CATEGORIES	
Children/Youth (0-15 yrs)	96
Transition Age Youth (16-25 yrs)	
Adult (26-59 yrs)	104
Older Adult (60+ yrs)	123
Declined to answer	
Unknown	
TOTAL	**323**

VETERAN STATUS	
Yes	
No	
Declined to answer	
Unknown	323
TOTAL	**323**

CURRENT GENDER IDENTITY	
Female	167
Male	122
Transgender	
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	34
Another identity not listed	
TOTAL	**323**
If another identity is counted, please specify:	

SEX ASSIGNED AT BIRTH	
Male	122
Female	167
Declined to answer	
Unknown	34
TOTAL	**323**

SEXUAL ORIENTATION	
Gay/Lesbian	5
Heterosexual/Straight	201
Bisexual	7
Questioning/Unsure	
Queer	
Declined to answer	110
Unknown	
Another group not listed	
TOTAL	**323**
If another group is counted, please specify:	

PRIMARY LANGUAGE	
English	
Spanish	
Cantonese	
Chinese	
Vietnamese	
Farsi	
Arabic	
Tagalog	
Declined to answer	
Unknown	323
Another language not listed	
TOTAL	**323**
If another language is counted, please specify:	

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

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.

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	323
Another disability not listed	
TOTAL	**323**
If another disability is counted, please specify:	

RACE	
American Indian or Alaska Native	
Asian	19
Black or African American	88
Native Hawaiian or Other Pacific Islander	3
White	
Other Race	78
Declined to answer	30
Unknown	105
TOTAL	323
If another race is counted, please specify:	

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	78
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	
Total Hispanic or Latino	**78**
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	78
If another ethnicity is counted, please specify:	

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 the shelter in place order was issued on March 17th, the clinical program collaborated with the entire agency to meet the anticipated needs of isolated seniors in Alameda County. Following the lead of other outreach programs that had been established by agencies throughout California, CSS reached out to partners who served seniors to offer free check in calls. Announcements and fliers were sent to all senior centers in Alameda County

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

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.

As the program transitioned to telemedicine and the worked to respond to the needs of the community, the program paused intakes for several months. Several schools communicated with us that they put COST meetings on hold and set a focus on assisting their academic staff in reaching their clients. Our clinical coordinator continued to respond to calls and shared resources with referrals, identifying that the program anticipated a considerable wait. Several clients agreed to stay on our waitlist and others were referred to various community programs. Due to this decision, we did not meet our planned goal of 80 student clients, although we anticipate meeting this goal this upcoming year. We have transitioned to a telemedicine platform and are starting the year by meeting individually with all school providers to develop a more integrated plan of services

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.

We have learned about how to provide services via telemedicine and how to create documentation strategies that can be cloud based. We're all increasing our understanding of how to provide high quality therapy and risk assessment via telemedicine and what platforms are most conducive to running group therapy.

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
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):	NA
G.3: Types of treatment individuals were referred to (list types) (500-character limit):	NA
G.4: Unduplicated number of individuals who participated in referred program at least one time:	NA
G.5: Average duration of untreated mental illness in weeks:	NA

G.6: Average number of days between referral and first participation in referred treatment program:	NA

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):	NA
H.2: Number of paper referrals to an ACBH PEI-funded program:	NA
H.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	NA
H.4: Average number of days between referral and first participation in referred PEI program:	NA
H.5: Describe how your program encouraged access to services and follow through on above referrals (500 Characters):	NA

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:	**22**
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 licensed mental health professionals (Clinical Director and Clinical Coordinator)
	20 clinical interns and trainees in schools, community centers
	20 clinical interns and trainees providing in home and outpatient services
	any of the above individuals when doing a critical incident response in the community

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

MHSA Program #: PEI 13

PROVIDER NAME: Peers Envisioning and Engaging in Recovery Services (PEERS)

PROGRAM NAME: WRAP®

Program Outcomes & Impact: PEI Data Report FY 19/20

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).
TAY Wellness Program offers ongoing wellness support and leadership development through bimonthly TAY Leadership Club meetings and one-time TAY wellness workshops for young people ages 18-25, all aligned with the TAYSOC 5 Pillars of Care.

Box B: Please provide the total number of individuals served to date July 1, 2019 through June 30, 2020 through MHSA funding.	
Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	514
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:	**514**

Box C: 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.

AGE CATEGORIES	
Children/Youth (0-15 yrs)	12
Transition Age Youth (16-25 yrs)	97
Adult (26-59 yrs)	210
Older Adult (60+ yrs)	49
Declined to answer	146
Unknown	
TOTAL	**514**

VETERAN STATUS	
Yes	12
No	298
Declined to answer	204
Unknown	
TOTAL	**514**

CURRENT GENDER IDENTITY	
Female	214
Male	229
Transgender	
Genderqueer	1
Questioning/unsure of gender identity	1
Declined to answer	65
Unknown	
Another identity not listed	4
TOTAL	**514**
If another identity is counted, please specify: Nonbinary	

SEX ASSIGNED AT BIRTH	
Male	
Female	
Declined to answer	
Unknown	514
TOTAL	**514**

SEXUAL ORIENTATION	
Gay/Lesbian	19
Heterosexual/Straight	223
Bisexual	13
Questioning/Unsure	3
Queer	6
Declined to answer	241
Unknown	
Another group not listed	9
TOTAL	**514**
If another group is counted, please specify: Pansexual, Male, Female	

PRIMARY LANGUAGE	
English	292
Spanish	47
Cantonese	
Chinese	1
Vietnamese	6
Farsi	1
Arabic	
Tagalog	2
Declined to answer	159
Another language not listed	6
TOTAL	**514**
If another language is counted, please specify: Hebrew, Korean, Malay, Polish, Rak/Burmese	

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

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.

DISABILITY*** STATUS	
Communication Domain	
Vision	5
Hearing/Speech	2
Another type not listed	
Communication Domain Subtotal	**7**
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	44
Physical/mobility	19
Chronic health condition	12
Disability Subtotal	**75**
None	142
Declined to answer	207
Unknown	
Another disability not listed	97
TOTAL	**528**
If another disability is counted, please specify: Autism, PTSD, anxiety, bipolar disorder, scoliosis, cerebral palsy	

RACE	
American Indian or Alaska Native	7
Asian	20
Black or African American	185
Native Hawaiian or Other Pacific Islander	2
White	73
Other Race	152
Declined to answer	75
Unknown	
TOTAL	514
If another race is counted, please specify: More than one race, Latino, Moor, Arab	

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	1
Mexican/Mexican American/Chicano	9
Puerto Rican	1
South American	
Another Hispanic/Latino ethnicity not listed	1
Total Hispanic or Latino	**12**

If Non-Hispanic or Non-Latino, please specify:	
African	1
African American	185
Asian Indian/South Asian	
Cambodian	
Chinese	4
Eastern European	1
European	2
Filipino	3
Japanese	1
Korean	1
Middle Eastern	2
Vietnamese	6
Other Non-Hispanic or Non-Latino ethnicity not listed	6
Total Non-Hispanic or Non-Latino	**212**
More than one ethnicity	8
Unknown Ethnicity	
Declined to answer	282
EHTNICITY TOTAL	514
If another ethnicity is counted, please specify: Afghan, Jewish, Malay - Kendayan, Moorish, Hawaiian	

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.

The TAY Leadership Club (TLC) saw increased membership after the groups moved from in-person to remote after the shelter-in-place order. To meet this increased desire for connection and support, we moved from holding TLC meetings biweekly to holding them weekly. These remote meetings addressed multiple pillars of the TAY System of Care, and included both guest presenters, facilitated discussions, and peer support.

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

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.

Our immediate focus during the fourth quarter was to provide support to the participants who most relied on our programs to support their wellness (our most active participants). After that, we prioritized reaching out to offer peer support to the broader community of Alameda County residents we have served in this fiscal year and last -- participants who came to one or two PEERS activities 2019-20 and 2018-19. We are pleased with our success in these efforts. However, with the exception of new TAY participants, we were not able to reach the many new participants who likely would have attended our activities had they not moved from in-person to remote. For example, the Jay Mahler Recovery Center often would bring a group of residents to the Friday WRAP group at PEERS, and this connection has not happened during sheltering in place. We will continue to experiment to see what works, including trying new forms of partnership.

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.

As the COVID-19 crisis escalated, PEERS pivoted quickly to providing WRAP-based wellness support remotely. We held our first remote WRAP® Facilitator Mentoring meeting on March 19, and our first remote WRAP-based groups on March 25. Both the Spanish group at La Familia and the group for residents of South County Homeless Project (where residents are sheltering together) have met consistently and provided critical support to participants during this isolating and often traumatic time. While the predictable challenges related to the digital divide have been evident, we were surprised to uncover benefits of providing remote services. Many of our participants have barriers to participating in in-person activities, including difficulties with transportation, challenges with physical mobility, and mental health challenges that make it difficult to leave home. For some, joining a remote group is more accessible than coming to PEERS or another location in order to access peer support.

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):	0
G.3: Types of treatment individuals were referred to (list types) (500-character limit):	0

G.4: Unduplicated number of individuals who participated in referred program at least one time:	0
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:	0

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:	0
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 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):
Community festivals and fairs	*50 LGBTQIA+ community members, 38 young adults, 62 other*
PACT events at Parole Office	*28 returning citizens*
Library	*43 library patrons, particularly homeless patrons*
Youth conference	*80 youth*
Community college	*56 college students with disabilities*

MHSA Program #: PEI 3

PROVIDER NAME: Alameda County Behavioral Health

PROGRAM NAME: Geriatric Assessment and Response Team

Program Outcomes & Impact: PEI Data Report FY 19/20

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: Please provide the total number of individuals served to date July 1, 2019 through June 30, 2020 through MHSA funding.

Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	291
Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	40

Number of unduplicated individual family members served indirectly by your program:	0
Grand total of unduplicated individuals served:	**331**

Box C: 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.

AGE CATEGORIES	
Children/Youth (0-15 yrs)	
Transition Age Youth (16-25 yrs)	
Adult (26-59 yrs)	
Older Adult (60+ yrs)	40
Declined to answer	
Unknown	
TOTAL	**40**

VETERAN STATUS	
Yes	
No	
Declined to answer	
Unknown	
TOTAL	**0**

CURRENT GENDER IDENTITY	
Female	22
Male	18
Transgender	
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	
Another identity not listed	
TOTAL	**40**
If another identity is counted, please specify:	

SEXUAL ORIENTATION	
Gay/Lesbian	1
Heterosexual/Straight	30
Bisexual	
Questioning/Unsure	
Queer	
Declined to answer	
Unknown	9
Another group not listed	
TOTAL	**40**
If another group is counted, please specify:	

PRIMARY LANGUAGE	
English	37
Spanish	
Cantonese	
Chinese	
Vietnamese	
Farsi	
Arabic	
Tagalog	
Declined to answer	
Unknown	
Another language not listed	3
TOTAL	**40**
Korean, Russian and Other	

SEX ASSIGNED AT BIRTH	
Male	18
Female	22
Declined to answer	
Unknown	
TOTAL	**40**

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.

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	13
Chronic health condition	
Disability Subtotal	**13**
None	
Declined to answer	
Unknown	27
Another disability not listed	
TOTAL	**40**
If another disability is counted, please specify:	

RACE	
American Indian or Alaska Native	
Asian	2
Black or African American	16
Native Hawaiian or Other Pacific Islander	
White	12
Other Race	8
Declined to answer	
Unknown	2
TOTAL	40
If another race is counted, please specify:	

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	
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	1
Total Hispanic or Latino	**1**
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	1
If another ethnicity is counted, please specify:	

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):
N/A	N/A

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

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.

A texter opted in and said he was having thoughts of suicide and the plan he was considering was to jump in front of a train or take pills. The texter agreed to not attempt to get the pills that night – they were in the parent's bathroom – and if any thought of jumping in front of the train got stronger the texter would call the Lifeline.
During the session, the counselor coached texter input the Lifeline phone number in to his phone as well as complete an online, youth-oriented safety plan template: Your Life Your Voice.
He reported that no one knows that he identifies as male and that this session was the first time he had admitted it. He also reported feeling anxious at school because of academic stress as well social stress.
During the session the texter came up with an immediate safety plan for the night and next day – call the lifeline if it gets worse over the course of the night. He also planned with the counselor to reach out the next morning to his parent and ask for a therapist again as was provided him in the past. He also made a plan to talk to his first period teacher and ask help with setting up a contact with the school therapist.
He said he was feeling a bit better after talking and that he was going to listen to music, read and go to bed. During the session the counselor not only worked on safety planning with the texter, but also highlighted the texter's strengths and empathized with the texter's emotions. At the end her wrote: "I might check in again tomorrow, but I'll definitely if it starts getting kinda bad and I get overwhelmed and stuff".

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.

Challenge #1: Marketing the service to more youth. COVID19 impacted the community education schedule, so there were less opportunities for the community to hear about the text line service.
Solution #1: Create a series of social media marketing materials and collaborated with Community Education Department to regularly post on CSS Facebook, Twitter and Instagram page. The team is currently exploring TikTok as an option as well.

Challenge #2: We would like to see more consistent on-site consultation, support, and training for Text Line Volunteers.
Solution #2: We prioritized funding to have a paid shift supervisor on every text line shift. The role of the shift supervisor is to answer text sessions, provide training, oversight, and mentoring to crisis line volunteers. One shift supervisor is a mental health trainee collecting hours. The shift supervisors receive one-on-one supervision with the crisis line coordinator and provide group supervision to the volunteers.

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 Text Line Program is constantly inspired by the resilience and courage we witness in our youth. The text program has worked to build connections with the entire Alameda County Crisis Continuum and has successfully made warm handoffs to Berkeley Mental Health and ACBH Access for further assessment and referrals. The program understands there are many barriers to accessing mental health support for our youth, and works to provide a warm and supportive service to build trust and confidence in the mental health system for our consumers.

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):	NA
G.3: Types of treatment individuals were referred to (list types) (500-character limit):	NA
G.4: Unduplicated number of individuals who participated in referred program at least one time:	NA
G.5: Average duration of untreated mental illness in weeks:	NA
G.6: Average number of days between referral and first participation in referred treatment program:	NA

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:	0
H.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	0

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

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):	For medium to high risk consumers, we offer an outreach text session to confirm if the texter completed the referral.

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:	**40**
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	*40 text line counselors*

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

MHSA Program #: PEI 17A

PROVIDER NAME: Youth Uprising

PROGRAM NAME: Early Intervention

Program Outcomes & Impact: PEI Data Report FY 19/20

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).
Provide 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); Help TAY develop skills that instill independence, self-sufficiency, and resilience; Increase the diversity of TAY clients receiving access and linkage to mental health, prevention, and wellness supports; Reduce stigma associated with mental illness; and Improve the integration of physical and mental well-being of TAY.

Box B: Please provide the total number of individuals served to date July 1, 2019 through June 30, 2020 through MHSA funding.	
Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	1
Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	1

Number of unduplicated individual family members served indirectly by your program:	NA
Grand total of unduplicated individuals served:	**165**

Box C: 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.

AGE CATEGORIES	
Children/Youth (0-15 yrs)	37
Transition Age Youth (16-25 yrs)	128
Adult (26-59 yrs)	
Older Adult (60+ yrs)	
Declined to answer	
Unknown	
TOTAL	**165**

SEXUAL ORIENTATION	
Gay/Lesbian	4
Heterosexual/Straight	119
Bisexual	10
Questioning/Unsure	
Queer	1
Declined to answer	11
Unknown	19
Another group not listed	1
TOTAL	**165**
If another group is counted, please specify:	

VETERAN STATUS	
Yes	
No	165
Declined to answer	
Unknown	
TOTAL	**165**

CURRENT GENDER IDENTITY	
Female	72
Male	91
Transgender	
Genderqueer	2
Questioning/unsure of gender identity	
Declined to answer	
Unknown	
Another identity not listed	
TOTAL	**165**
If another identity is counted, please specify:	

PRIMARY LANGUAGE	
English	161
Spanish	4
Cantonese	
Chinese	
Vietnamese	
Farsi	
Arabic	
Tagalog	
Declined to answer	
Another language not listed	
TOTAL	**165**
If another language is counted, please specify:	

SEX ASSIGNED AT BIRTH	
Male	93
Female	71
Declined to answer	
Unknown	1
TOTAL	**165**

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

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.

DISABILITY*** STATUS	
Communication Domain	
Vision	
Hearing/Speech	1
Another type not listed	
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	7
Physical/mobility	6
Chronic health condition	
Disability Subtotal	**13**
None	134
Declined to answer	16
Unknown	
Another disability not listed	1
TOTAL	**165**
If another disability is counted, please specify:	

RACE	
American Indian or Alaska Native	1
Asian	
Black or African American	129
Native Hawaiian or Other Pacific Islander	1
Other Race	26
Declined to answer	7
Unknown	
TOTAL	165
If another race is counted, please specify:	

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	10
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	23
Total Hispanic or Latino	**33**
If Non-Hispanic or Non-Latino, please specify:	

African	105
African American	22
Asian Indian/South Asian	
Cambodian	
Chinese	
Eastern European	
European	1
Filipino	
Japanese	
Korean	
Middle Eastern	
Vietnamese	
Other Non-Hispanic or Non-Latino ethnicity not listed	3
Total Non-Hispanic or Non-Latino	**131**
More than one ethnicity	
Unknown Ethnicity	
Declined to answer	1
EHTNICITY TOTAL	165
If another ethnicity is counted, please specify:	

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.

Having staff trained in Crisis Intervention and Restorative Justice circles. Every member of the agency must be connected to one youth in the agency to ensure relationships are being built with
the young people to sustain the success of our clients. Having staff trained in Restorative Justice circles. Now Youth UpRising is holding at least 3
community-building circles We were able to hire a H&W Director who is now able to hire and provide
clinical supervision to clinicians. We are hopeful to have clinicians hired by June and can start offering our full scope of services. We are also proud of how resilient and resourceful our staff have been when there was no H&W department. We are excited that we were able to successfully pivot, with very short notice, to offering all of our Health and Wellness offerings, including counseling and case management, via phone and virtually.

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

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.

One of the most difficult challenges of the entire year was the staff transition. In the Fall of 2019, all of the Health and Wellness staff and interns transitioned out of the agency. We were not able to hire another H&W Director until February. Once the new H&W Director started, we were then impacted greatly byt COVID-19 and needed to shelter in place. Unfortunately, the new H&W Director was unable to build partnerships with referring agencies and build rapport with as many youth due to the shelter in place occurring less than a month after she started. During the shelter in place, our Intake Case Manager unexpectedly passed away and staff have been grieving that loss since her passing. Another challenge was being able to hire new clinicians.

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.

One of the hardest lessons for us to learn was that we need processes and contingency plans in place. With the passing of our case manager, we lost the data she had for Q4 as she didn't get the chance to input it in our system before her passing. We were also greatly impacted by the shelter in place due to COVID and had to find creative ways to engage our youth.

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):	NA
G.3: Types of treatment individuals were referred to (list types) (500-character limit):	John George Psychiatric Hospital
G.4: Unduplicated number of individuals who participated in referred program at least one time:	NA
G.5: Average duration of untreated mental illness in weeks:	<1 once referred to YU
G.6: Average number of days between referral and first participation in referred treatment program:	2

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:	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):	NA

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):

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

MHSA Program #: PEI 17B

PROVIDER NAME: REACH Ashland Youth Center

PROGRAM NAME: Early Intervention

Program Outcomes & Impact: PEI Data Report FY 19/20

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):	X	Childhood Trauma
	X	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).

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.
As a program of the Center for Health Schools and Communities (CHCS) a division of the Alameda County Health Care Services Agency. We collaborate with a variety of the county and public agencies, as well as the local school district and community providers. Together, we weave health and wellness, social justice, and youth leadership into all of REACH's programs and services.

Box B: Please provide the total number of individuals served to date July 1, 2019 through June 30, 2020 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:	78
Number of unduplicated individual family members served indirectly by your program:	74
Grand total of unduplicated individuals served:	**186**

Box C: 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.

AGE CATEGORIES	
Children/Youth (0-15 yrs)	45
Transition Age Youth (16-25 yrs)	67
Adult (26-59 yrs)	0
Older Adult (60+ yrs)	0
Declined to answer	0
Unknown	0
TOTAL	**112**

VETERAN STATUS	
Yes	
No	
Declined to answer	
Unknown	
TOTAL	**0**

SEXUAL ORIENTATION	
Gay/Lesbian	
Heterosexual/Straight	
Bisexual	
Questioning/Unsure	
Queer	1
Declined to answer	
Unknown	111
Another group not listed	
TOTAL	**112**
If another group is counted, please specify:	

CURRENT GENDER IDENTITY	
Female	50
Male	59
Transgender	
Genderqueer	1
Questioning/unsure of gender identity	
Declined to answer	
Unknown	2
Another identity not listed	
TOTAL	**112**
If another identity is counted, please specify:	

PRIMARY LANGUAGE	
English	63
Spanish	20
Cantonese	
Chinese	
Vietnamese	
Farsi	
Arabic	
Tagalog	2
Declined to answer	
Unknown	27
Another language not listed	
TOTAL	**112**

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

SEX ASSIGNED AT BIRTH	
Male	
Female	
Declined to answer	
Unknown	112
TOTAL	**112**

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.

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	112
Another disability not listed	
TOTAL	**112**
If another disability is counted, please specify:	

RACE	
American Indian or Alaska Native	0
Asian	5
Black or African American	48
Native Hawaiian or Other Pacific Islander	3
White	3
Other Race	52
Declined to answer	0
Unknown	1
TOTAL	112
If another race is counted, please specify:	

Latinx
Multi-racial

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	3
Mexican/Mexican American/Chicano	24
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	28
Total Hispanic or Latino	**55**
If Non-Hispanic or Non-Latino, please specify:	
African	1
African American	46
Asian Indian/South Asian	1
Cambodian	1
Chinese	
Eastern European	
European	
Filipino	1
Japanese	
Korean	
Middle Eastern	
Vietnamese	
Other Non-Hispanic or Non-Latino ethnicity not listed	3
Total Non-Hispanic or Non-Latino	**53**
More than one ethnicity	2
Unknown Ethnicity	1
Declined to answer	1
EHTNICITY TOTAL	112
If another ethnicity is counted, please specify: Latinx without specified ethnicity/region	

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.

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

When Shelter in Place (SIP) was issued on March 17, 2020, a list of active REACH members was generated to provide guidance to the staff to make outreach calls to make youth and their families to clarify the order and offer support to families impacted by SIP. Although we could not see the youth and families in-person we wanted to ensure the families that we were still working and available to support them. The list generated resulted in over 550+ families to be contacted. The Health and Wellness Clinical supervisor assigned a call to each clinician including school-based consultants to make initial outreach calls to families (3 REACH Clinical Case Managers and 6 School-based Consultants. Each clinician received approximately 50 names and supervisor also made the call to make sure that all youth and families were contacted. Through this coordinated effort were able to contact all of the youth and families on the call list and identify the families that needed services.

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.

The challenges over the past year dealt more with the service delivery and having to move services from in-person to tele-health and utilizing the various virtual platforms. Although these platforms have been readily available for staff it was used sparingly by staff in the pre-COVID framework. Shelter in Place (SIP) and COVID-19 really forced providers to be creative and adjust these platforms and tele-health with the current restrictions and parameters. Staff (clinicians and non-clinicians) had to rapidly acquaint themselves with these platforms and adapt additional skillsets to effectively provide support to the youth and families. REACH staff were able to do this with bumps along the way and staff learning to used Zoom and Microsoft Teams to communicate with the youth.

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 most valuable lesson learned this year was the importance of pivoting service delivery to the youth and families in the midst of a pandemic. It required creativity and ingenuity to meet youth and families in the current situation and to work within public health protocols. We were still able to maintain contact and make adjustment with tele-health and using different video platforms engage youth, families and community partners. In addition, we were able to prioritize needs in the community and provide relief for families dealing with food security, academic challenges (distance learning) and housing loss.

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):	55

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):	5
G.3: Types of treatment individuals were referred to (list types) (500-character limit):	In-patient hospital, crisis stabilization centers, to their primary care provider due to insurance.
G.4: Unduplicated number of individuals who participated in referred program at least one time:	61
G.5: Average duration of untreated mental illness in weeks:	0.35
G.6: Average number of days between referral and first participation in referred treatment program:	2.42

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):	NA
H.2: Number of paper referrals to an ACBH PEI-funded program:	NA
H.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	NA
H.4: Average number of days between referral and first participation in referred PEI program:	NA
H.5: Describe how your program encouraged access to services and follow through on above referrals (500 Characters):	NA

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

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 19/20

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: Please provide the total number of individuals served to date July 1, 2019 through June 30, 2020 through MHSA funding.	
Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	1448
Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	82
Number of unduplicated individual family members served indirectly by your program:	778

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

Grand total of unduplicated individuals served:	**2308**

Box C: 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.

AGE CATEGORIES	
Children/Youth (0-15 yrs)	8
Transition Age Youth (16-25 yrs)	52
Adult (26-59 yrs)	566
Older Adult (60+ yrs)	487
Declined to answer	0
Unknown	417
TOTAL	**1530**

VETERAN STATUS	
Yes	
No	1530
Declined to answer	
Unknown	
TOTAL	**1530**

CURRENT GENDER IDENTITY	
Female	13
Male	8
Transgender	2
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	1507
Another identity not listed	
TOTAL	**1530**
If another identity is counted, please specify:	

SEX ASSIGNED AT BIRTH	
Male	368
Female	740
Declined to answer	
Unknown	422
TOTAL	**1530**

SEXUAL ORIENTATION	
Gay/Lesbian	
Heterosexual/Straight	126
Bisexual	
Questioning/Unsure	
Queer	
Declined to answer	
Unknown	1404
Another group not listed	
TOTAL	**1530**
If another group is counted, please specify:	

PRIMARY LANGUAGE	
English	376
Spanish	263
Cantonese	176
Chinese	
Vietnamese	13
Farsi	58
Arabic	3
Tagalog	7
Declined to answer	
Unknown	485
Another language not listed	149
TOTAL	**1530**
If another language is counted, please specify:	

Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	266
Physical/mobility	
Chronic health condition	
Disability Subtotal	**266**
None	566
Declined to answer	
Unknown	698
Another disability not listed	
TOTAL	**1530**
If another disability is counted, please specify:	

Declined to answer	
Unknown	503
TOTAL	1530
If another race is counted, please specify:	

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	22
Mexican/Mexican American/Chicano	167
Puerto Rican	1
South American	7
Another Hispanic/Latino ethnicity not listed	
Total Hispanic or Latino	**197**
If Non-Hispanic or Non-Latino, please specify:	
African	
African American	22
Asian Indian/South Asian	259
Cambodian	3
Chinese	184
Eastern European	
European	53
Filipino	38
Japanese	
Korean	71
Middle Eastern	19

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

Vietnamese	18
Other Non-Hispanic or Non-Latino ethnicity not listed	40
Total Non-Hispanic or Non-Latino	**707**
More than one ethnicity	
Unknown Ethnicity	626
Declined to answer	
EHTNICITY TOTAL	1530
If another ethnicity is counted, please specify:	

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.

16-year-old "Pedro" was born in the U.S. but had been living in Mexico until 8 months ago, when his parents sent him to live with his aunt. When COVID-19 began, Pedro became depressed, began hitting his head, and refused to eat. The aunt called one of our staff for help and shared that she had advised Pedro to "suck it up, you are here now and you have to deal with it". Staff explained that this reaction was counterproductive and that Pedro needed support and someone to listen. She informed the aunt of the signs and symptoms of possible mental health issues and, with the aunt's permission, referred him to EBAC's Behavioral Health Services. After a one-hour conversation with the aunt, the EBAC counselor began sessions with Pedro via phone. The aunt reported that while Pedro is still worried about COVID-19 and his family, he has a better disposition and is even working at a fast food restaurant. He has a good appetite and has stopped hitting his head.

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.

An ongoing challenge is that even with our attempts at cultural inclusivity, many families are just not able to talk about mental health issues and some staff struggle to do what can be uncomfortable. This is a continual area of quality improvement effort for us. Another area of great difficulty was the shelter-in-place. Some families had no or limited privacy at home, which made it difficult to discuss sensitive and personal topics freely. Conversations had to be adapted to a sort of coded language in some cases. Many families reported being so highly impacted by financial and COVID-related stressors that it was difficult for them to focus on anything other than their very basic needs. Staff had to quickly learn new systems at a local and federal level to assist their clients in accessing newly available resources. To address this concern, EBAC developed a communication plan and staff participated in multiple webinars concerning this issue to keep informed and up-to-date.

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. We learned to give staff some structure about how to spend their time each day during the "shelter-in-place" 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):	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):	0
G.3: Types of treatment individuals were referred to (list types) (500-character limit):	NA
G.4: Unduplicated number of individuals who participated in referred program at least one time:	NA
G.5: Average duration of untreated mental illness in weeks:	NA
G.6: Average number of days between referral and first participation in referred treatment program:	NA

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):	NA
H.2: Number of paper referrals to an ACBH PEI-funded program:	NA

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

H.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	NA
H.4: Average number of days between referral and first participation in referred PEI program:	NA
H.5: Describe how your program encouraged access to services and follow through on above referrals (500 Characters):	NA

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:	**1113**
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):
parent, caregivers, general community members	*Fremont Healthy Start*
parent, caregivers, general community members	*Fremont Family Resource Center*
school staff, teachers, parent, caregivers	*School*
parent, caregivers, general community members	*Client Homes*

MHSA Program #: PEI 20A

PROVIDER NAME: Beats, Rhymes, and Life

PROGRAM NAME: Beats, Rhymes, and Life

Program Outcomes & Impact: PEI Data Report FY 19/20

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
		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, Inc. provides supplemental mental health supports for youth of color in culturally congruent modalities of Hip-Hop since 2004.

Box B: Please provide the total number of individuals served to date July 1, 2019 through June 30, 2020 through MHSA funding.

Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	70
Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	
Number of unduplicated individual family members served indirectly by your program:	2

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

AGE CATEGORIES	
Children/Youth (0-15 yrs)	14
Transition Age Youth (16-25 yrs)	51
Adult (26-59 yrs)	
Older Adult (60+ yrs)	
Declined to answer	7
Unknown	
TOTAL	**72**

VETERAN STATUS	
Yes	
No	72
Declined to answer	
Unknown	
TOTAL	**72**

CURRENT GENDER IDENTITY	
Female	19
Male	53
Transgender	
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	
Another identity not listed	
TOTAL	**72**
If another identity is counted, please specify:	

SEX ASSIGNED AT BIRTH	
Male	52
Female	20
Declined to answer	
Unknown	
TOTAL	**72**

SEXUAL ORIENTATION	
Gay/Lesbian	
Heterosexual/Straight	34
Bisexual	
Questioning/Unsure	2
Queer	
Declined to answer	36
Unknown	
Another group not listed	
TOTAL	**72**
If another group is counted, please specify:	

PRIMARY LANGUAGE	
English	67
Spanish	4
Cantonese	
Chinese	
Vietnamese	
Farsi	
Arabic	
Tagalog	
Declined to answer	
Unknown	
Another language not listed	
TOTAL	**71**
If another language is counted, please specify:	

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.

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.)	1
Physical/mobility	
Chronic health condition	
Disability Subtotal	**1**
None	21
Declined to answer	
Unknown	
Another disability not listed	46
TOTAL	**72**
If another disability is counted, please specify:	

RACE	
American Indian or Alaska Native	
Asian	3
Black or African American	53
Native Hawaiian or Other Pacific Islander	
White	2
Other Race	5
Declined to answer	9
Unknown	
TOTAL	72
mixed 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	4
Mexican/Mexican American/Chicano	2
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	
Total Hispanic or Latino	**6**
If Non-Hispanic or Non-Latino, please specify:	
African	
African American	52

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

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	4
Total Non-Hispanic or Non-Latino	**58**
More than one ethnicity	6
Unknown Ethnicity	
Declined to answer	2
EHTNICITY TOTAL	72
If another ethnicity is counted, please specify:	

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.

Three youth form our first cohort of 15 youth WISE program were hired to become part intern/peer mentor staff. They have developed their leadership at our agency. They created an ran our current outreach team that presented to conferences and panels as well as outreach engagement opportunities in which they performed original music. They were original panelists for the ACBH first 'Tay Talks', and are currently applying for the County Youth Advisory Board.

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.

A major challenge we faced during the end of semester was the COVID 19 Virus. It came in the final third of the semester. There was an incredible major shift and a transition period of 1-2 months in which we had to take care of our organization and staff and then create new ways to engage youth and launch telehealth programming over zoom.

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.

Reexamining the impact of programming including collaterals and realizing that there are more youth and families that are being served by programs than we realized.

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):	Typically, youth are referred from COST wellness departments from high schools and mental health orgs' clinicians and collaboration with community organizations we haven't had to refer to higher level of care
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):	none
G.3: Types of treatment individuals were referred to (list types) (500-character limit):	none
G.4: Unduplicated number of individuals who participated in referred program at least one time:	none
G.5: Average duration of untreated mental illness in weeks:	none
G.6: Average number of days between referral and first participation in referred treatment program:	none

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:	none
H.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	none

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

H.4: Average number of days between referral and first participation in referred PEI program:	none
H.5: Describe how your program encouraged access to services and follow through on above referrals (500 Characters):	Mental health awareness events throughout the county and fiscal year; and our community showcases twice a year.

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 20B

PROVIDER NAME: Black Men Speak

PROGRAM NAME: Culturally Responsive Programs for African Americans – Black Men Speak

Program Outcomes & Impact: PEI Data Report FY 19/20

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: Please provide the total number of individuals served to date July 1, 2019 through June 30, 2020 through MHSA funding.	
Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	2436
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:	**2436**

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

Box C: 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.

AGE CATEGORIES	
Children/Youth (0-15 yrs)	1
Transition Age Youth (16-25 yrs)	2
Adult (26-59 yrs)	31
Older Adult (60+ yrs)	16
Declined to answer	16
Unknown	672
TOTAL	**738**

VETERAN STATUS	
Yes	
No	
Declined to answer	
Unknown	721
TOTAL	**721**

CURRENT GENDER IDENTITY	
Female	29
Male	21
Transgender	
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	671
Another identity not listed	
TOTAL	**721**
If another identity is counted, please specify:	

SEX ASSIGNED AT BIRTH	
Male	
Female	
Declined to answer	
Unknown	721
TOTAL	**721**

SEXUAL ORIENTATION	
Gay/Lesbian	
Heterosexual/Straight	
Bisexual	
Questioning/Unsure	
Queer	
Declined to answer	
Unknown	
Another group not listed	
TOTAL	**0**
If another group is counted, please specify:	

PRIMARY LANGUAGE	
English	600
Spanish	100
Cantonese	
Chinese	21
Vietnamese	
Farsi	
Arabic	
Tagalog	
Declined to answer	
Unknown	0
Another language not listed	
TOTAL	**721**
If another language is counted, please specify:	

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.

Japanese	
Korean	
Middle Eastern	
Vietnamese	
Other Non-Hispanic or Non-Latino ethnicity not listed	3
Total Non-Hispanic or Non-Latino	**51**
More than one ethnicity	
Unknown Ethnicity	670
Declined to answer	
EHTNICITY TOTAL	721
If another ethnicity is counted, please specify:	

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.

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. One of our most noted successful outreach events was participation in the Annual Oscar Grant Remembrance program, where we were able to give out information to educate participants about Black Men Speaks and its goal to empower members.

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.**

BMS (Black Men Speaks) would have completed all of our deliverables by the end of March, 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 an engagement planned at Santa Rita, but it has been postponed. When we are able, we will do outreach at both Santa Rita and the Juvenile Justice Center. We also plan to conduct virtual meetings where speakers will share the life experiences and stories of resilience, as well as short videos shared on social media.

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

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.

We have learned to adapt to a new way of doing our deliverables, and that 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 like organizations such as; All of Us or None, BOP, and BOSS we have continued to increase visibility of BMS and empowerment in target population 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):	NA
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):	NA
G.3: Types of treatment individuals were referred to (list types) (500-character limit):	NA
G.4: Unduplicated number of individuals who participated in referred program at least one time:	NA
G.5: Average duration of untreated mental illness in weeks:	NA
G.6: Average number of days between referral and first participation in referred treatment program:	NA

Box H: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:

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:	NA
H.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	NA

H.4: Average number of days between referral and first participation in referred PEI program:	NA
H.5: Describe how your program encouraged access to services and follow through on above referrals (500 Characters):	By passing out resource information and referrals to Mental Health Agencies and service organizations; such as Roots. We follow through with follow-up calls and warm hand offs.

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:	**75**
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	50 parents, adults and 25 young black adults

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

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 19/20

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 action oriented and problem-solving workshops for African American families throughout the year. The workshops are designed to engage family members and provide professional and peer support around helping their loved ones. During the workshops (and breakout sessions) family members 1) receive information about mental health and specific mental health disorders; 2) informed about services available throughout Alameda county for individuals with mental health and/or substance use disorders; and 3) made aware of the importance of self-care as a means of stress reduction.

Box B: Please provide the total number of individuals served to date July 1, 2019 through June 30, 2020 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:	151
Grand total of unduplicated individuals served:	**151**

Box C: 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.

AGE CATEGORIES	
Children/Youth (0-15 yrs)	1
Transition Age Youth (16-25 yrs)	
Adult (26-59 yrs)	21
Older Adult (60+ yrs)	17
Declined to answer	19
Unknown	
TOTAL	**58**

SEXUAL ORIENTATION	
Gay/Lesbian	
Heterosexual/Straight	
Bisexual	
Questioning/Unsure	
Queer	
Declined to answer	
Unknown	58
Another group not listed	
TOTAL	**58**
If another group is counted, please specify:	

VETERAN STATUS	
Yes	
No	
Declined to answer	
Unknown	58
TOTAL	**58**

CURRENT GENDER IDENTITY	
Female	
Male	
Transgender	
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	58
Another identity not listed	
TOTAL	**58**
If another identity is counted, please specify:	

PRIMARY LANGUAGE	
English	
Spanish	
Cantonese	
Chinese	
Vietnamese	
Farsi	
Arabic	
Tagalog	
Declined to answer	
TOTAL	**58**
If another language is counted, please specify:	

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

SEX ASSIGNED AT BIRTH	
Male	12
Female	27
Declined to answer	19
Unknown	
TOTAL	**58**

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.

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	58
Another disability not listed	
TOTAL	**58**
If another disability is counted, please specify:	

RACE	
American Indian or Alaska Native	
Asian	1
Black or African American	35
Native Hawaiian or Other Pacific Islander	
White	2
Other Race	2
Declined to answer	
Unknown	18
TOTAL	58
If another race is counted, please specify:	

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	1
Central American	
Mexican/Mexican American/Chicano	1
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	
Total Hispanic or Latino	**2**
If Non-Hispanic or Non-Latino, please specify:	
African	
African American	36
Asian Indian/South Asian	
Cambodian	
Chinese	
Eastern European	
European	
Filipino	
Japanese	
Korean	
Middle Eastern	
Vietnamese	
Other Non-Hispanic or Non-Latino ethnicity not listed	2
Total Non-Hispanic or Non-Latino	**38**
More than one ethnicity	
Unknown Ethnicity	18
Declined to answer	
EHTNICITY TOTAL	58
If another ethnicity is counted, please specify:	

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.

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

During FY 19-20 MHAAC conducted four outreach workshops for African American families. A fifth workshop was planned, but cancelled due to the Covid-19 Shelter in Place Order. Two workshops were conducted in person and two were held virtually. Creating virtual workshops was a major accomplishment that involved learning a new technology skillset in the creation of a PowerPoint program, increased communication with workshop registrants both before and after the workshop to provide an overview of Zoom controls and to give them access to a newly created Google Drive folder containing PDF copies of over 150 brochures, flyers and pamphlets related to mental illness. We also expanded our group of speakers and break-out session leaders. Finally, in response to the significant amount of societal turmoil (Covid-19, BLM, economic instability, political campaigns and wild fires), we emphasized the importance of self-care as a means of reducing stress.

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.

Our most significant challenge was the conversion of workshops from an in-person event to an online event. We overcame this challenge without any reduction in workshop participation. Workshop planning committee members are very sensitive to the potential danger of calling the police to handle mental health crises - particularly those involving black men. During our workshops we strongly encourage family members to request Crisis Intervention Trained (CIT) police officers when dialing 911, as these officers have been trained in de-escalation techniques. We also encourage family members to meet police officers before they enter the premises and to provide a quick overview of the current situation, a summary of past behavior, hospitalizations and medications and most importantly - whether or not there are any weapons in the house.

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.

An important lesson learned this year involved the use of a virtual format. Specifically, new participants attended our virtual program since transportation and caregiving issues were consequently less of a concern. In the future, post Coid-19, we plan to provide both in-person and virtual events.

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
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):	NA

G.3: Types of treatment individuals were referred to (list types) (500-character limit):	NA
G.4: Unduplicated number of individuals who participated in referred program at least one time:	NA
G.5: Average duration of untreated mental illness in weeks:	NA
G.6: Average number of days between referral and first participation in referred treatment program:	NA

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):	NA
H.2: Number of paper referrals to an ACBH PEI-funded program:	NA
H.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	NA
H.4: Average number of days between referral and first participation in referred PEI program:	NA
H.5: Describe how your program encouraged access to services and follow through on above referrals (500 Characters):	NA

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):

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

Senior Center	*Administrative Manager, Executive Director, Lead PRA, FERC Program Supervisor, Presenters*
Recreation Center	*Administrative Manager, Executive Director, Lead PRA, 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 19/20

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
	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).

RJOY's Africentric Healing Circles Program provides culturally responsive mental health support for Alameda County's African-American community. RJOY uses a tailored restorative justice model to support healing at the individual and community level. The circles foster and utilize deep interpersonal relationships among circle members, as well as RJOY staff who work with them. This methodology draws on indigenous and Africentric healing practices in combination with the ACBH MHSA Prevention and Early Intervention (PEI) plan. Over the course of the grant period, we have run over 300 circles focused on a range of topics, including incarcerated youth, LGBTQIA people of color, teen girls, elders and others. We served 729 unduplicated participants, by quarter. In addition, we held six events for 821 individuals to introduce them to restorative justice-based healing practices. Of the 1,550 total who participated in our programs, 1,384 provided intake data that forms the basis for this report.

Box B: Please provide the total number of individuals served to date July 1, 2019 through June 30, 2020 through MHSA funding.

Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	34

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	1250
Number of unduplicated individual family members served indirectly by your program:	100
Grand total of unduplicated individuals served:	**1384**

Box C: 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.

AGE CATEGORIES	
Children/Youth (0-15 yrs)	302
Transition Age Youth (16-25 yrs)	389
Adult (26-59 yrs)	456
Older Adult (60+ yrs)	72
Declined to answer	165
Unknown	
TOTAL	**1384**

VETERAN STATUS	
Yes	57
No	470
Declined to answer	857
Unknown	
TOTAL	**1384**

SEXUAL ORIENTATION	
Gay/Lesbian	47
Heterosexual/Straight	733
Bisexual	57
Questioning/Unsure	
Queer	23
Declined to answer	484
Unknown	
Another group not listed	40
TOTAL	**1384**
If another group is counted, please specify: This includes respondents with more than one answer and/or answers that represent an idiosyncratic expression of identity.	

CURRENT GENDER IDENTITY	
Female	760
Male	596
Transgender	9
Genderqueer	13
Questioning/unsure of gender identity	0
Declined to answer	6
Unknown	0
Another identity not listed	0
TOTAL	**1384**
If another identity is counted, please specify:	

PRIMARY LANGUAGE	
English	1013
Spanish	337
Cantonese	
Chinese	
Vietnamese	
Farsi	1
Arabic	9
Tagalog	10
Declined to answer	1
Unknown	
Another language not listed	13
TOTAL	**1384**
If another language is counted, please specify:	

SEX ASSIGNED AT BIRTH	
Male	766
Female	598
Declined to answer	0
Unknown	20
TOTAL	**1384**

DISABILITY*** STATUS	
Communication Domain	
Vision	3
Hearing/Speech	2
Another type not listed	
Communication Domain Subtotal	**5**
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	1
Physical/mobility	4
Chronic health condition	2
Disability Subtotal	**7**
None	444
Declined to answer	855
Unknown	
Another disability not listed	73
TOTAL	**1384**
If another disability is counted, please specify:	

RACE	
American Indian or Alaska Native	13
Asian	29
Black or African American	966
Native Hawaiian or Other Pacific Islander	5
White	69
Other Race	0
Declined to answer	282
Unknown	20
TOTAL	1384

If another race is counted, please specify: Of the 282 who declined to answer, we observed that many appear to be people of African descent. This likely reflects suspicion rooted in discrimination in general and in the history of harms done to African-American research subjects in particular. Though we did not gather observational data, we estimate that at least 80% of those who declined are people of African descent.

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	10
Central American	33
Mexican/Mexican American/Chicano	72
Puerto Rican	1
South American	0
Another Hispanic/Latino ethnicity not listed	160
Total Hispanic or Latino	**276**

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

If Non-Hispanic or Non-Latino, please specify:	
African	30
African American	916
Asian Indian/South Asian	5
Cambodian	
Chinese	4
Eastern European	
European	20
Filipino	5
Japanese	3
Korean	1
Middle Eastern	3
Vietnamese	1
Other Non-Hispanic or Non-Latino ethnicity not listed	50
Total Non-Hispanic or Non-Latino	**1038**
More than one ethnicity	11
Unknown Ethnicity	
Declined to answer	59
EHTNICITY TOTAL	1384

If another ethnicity is counted, please specify: It is worth noting the effect of ethnicity data on the interpretation of our demographic data. We have a number of participants who are both Latino and of African descent, including some from Central America and elsewhere. These individuals show up as "other race not listed" in the race category, and while many may be Afro-Caribbean, we were not able to capture specific data in this regard.

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.

RJOY's healing circles enhanced the health and wellness of more than 1,300 people of African descent, with over 300 individual circle meetings over the course of the year. One participant in our teen circle ("MM") is an RJOY intern who has always guarded her feelings carefully. During the circle, she spoke about the abuse her biological father inflicted on her mother and siblings, and explored the impact of this trauma on who she has become. She talked of how this situation required her to play a protective, mother role with her siblings, and their peers, and the impact it had on her in terms of her own ability to be a child. MM said that she had never talked about these experiences, even with her foster parents or other family. The fact that she was able to open up – where over ¾ of participants have said that they feel it is a place where they can be honest – reflects how this restorative justice approach can provide the support that people need to both speak out and to heal.

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.

The arrival of Covid-19 in the Bay Area late in the third quarter was a significant challenge for the Africentric Healing Circles, leading to a significant reduction in attendance in the final quarter, where we had a total of 81 participants. Some of our circles adapted relatively easily to a virtual environment, while others had a more difficult time maintaining the level of dialogue and honesty that participants especially appreciate in the program. We were particularly saddened by the impact of the pandemic on the work we have been doing with incarcerated youth; detention centers - and also Oakland Tech High School, libraries, group homes and other public locations where we held circles - have been closed to outside visitors, making it impossible to hold drop-in circles for these youth. Our events have had a much larger turn out during the pandemic which suggests to us that it is easier to access one-time events rather than weekly meetings for our clients during this time.

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.

We learned that the demand for our circles is growing, and we added several new circles, including a black male circle and a teen circle, and will add more for women, biracial people, and incarcerated youth and adults. The onset of COVID-19 provided two lessons. First, we started drop-in groups, in particular in juvenile detention facilities, but these groups are impossible without the right physical spaces. At the same time, access to technology is unpredictable. We could provide computers to some participants, but many had no digital access. Six of 11 circles active in the 4th quarter readily went online.

We also learned that our programs now require more sophisticated data tools. Paper surveys make it difficult to gather uniform data about the population we serve. For example, we found it difficult to fully understand the complex racial and ethnic identities of some of our participants, for example by obscuring the African heritage of many Latinx and Caribbean participants.

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

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):	76
G.3: Types of treatment individuals were referred to (list types) (500-character limit):	We made referrals to counseling centers (mental health outpatient treatment programs), crisis mental health services/hotlines, group homes, homeless shelters, food banks. We also placed follow up phone calls and checked in with referrals sources. We practiced clinical case management services, continually assessing client needs.
G.4: Unduplicated number of individuals who participated in referred program at least one time:	12
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:	seven 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):	African Americans, including youth, elders, formerly incarcerated adults and young people, LGBTQIA individuals and others.
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):

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

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 19/20

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	
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: Please provide the total number of individuals served to date July 1, 2019 through June 30, 2020 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:	68
Number of unduplicated individual family members served indirectly by your program:	215
Grand total of unduplicated individuals served:	**293**

Box C: 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.

AGE CATEGORIES	
Children/Youth (0-15 yrs)	
Transition Age Youth (16-25 yrs)	15
Adult (26-59 yrs)	225
Older Adult (60+ yrs)	53
Declined to answer	
Unknown	
TOTAL	**293**

VETERAN STATUS	
Yes	56
No	
Declined to answer	
Unknown	
TOTAL	**56**

SEXUAL ORIENTATION	
Gay/Lesbian	
Heterosexual/Straight	275
Bisexual	
Questioning/Unsure	
Queer	
Declined to answer	18
Unknown	
Another group not listed	
TOTAL	**293**
If another group is counted, please specify:	

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

CURRENT GENDER IDENTITY	
Female	170
Male	123
Transgender	
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	
Another identity not listed	
TOTAL	**293**
If another identity is counted, please specify:	

PRIMARY LANGUAGE	
English	293
Spanish	
Cantonese	
Chinese	
Vietnamese	
Farsi	
Arabic	
Tagalog	
Declined to answer	
Unknown	
Another language not listed	
TOTAL	**293**
If another language is counted, please specify:	

SEX ASSIGNED AT BIRTH	
Male	170
Female	
Declined to answer	123
Unknown	
TOTAL	**293**

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.

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	293
Unknown	
Another disability not listed	
TOTAL	**293**

RACE	
American Indian or Alaska Native	
Asian	
Black or African American	293
Native Hawaiian or Other Pacific Islander	
White	
Other Race	
Declined to answer	
Unknown	
TOTAL	293
If another race is counted, please specify:	

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	
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	
Declined to answer	
EHTNICITY TOTAL	0
If another ethnicity is counted, please specify:	

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

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.

In response to the current medical/health crisis impacting our community MHFC hosted our first COVID 19 State of Emergency April 20, 2020: Due to the Countywide Shelter in Place we hosted a MHFC State of Emergency Virtual Webinar: MHFC State of Emergency COVID 19: An Intimate Compassionate & Understanding Conversation to access faith and mental health resources to support African Americans to flatten the curve and reduce the risk of infection, suffering and fatalities. Four of our participating MHFC Congregations, Friendship Christian Center (Oakland), New Covenant Evangelistic Center (Union City), In His Hands Ministries (Fremont) and Allen Temple Baptist Church (Oakland) received mini grants to fund innovative projects to improve outcomes and provide support and resources for members adjusting to COVID 19 guidelines and to respond to the mental health impacts of social distancing and isolation.

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.

Due to COVID 19 we are strategizing on how to facilitate trainings etc. virtually and prepare our faith communities to respond to the mental health needs of congregants and our community during social distancing and post COVID 19. Utilizing technology, we are training our congregations/faith communities how to maximize social media, the internet and web-based trainings to disseminate information, provide support and connection for members living with mental health needs and their families.

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.

We learned that more time is needed than we initially anticipated to meet with the faith leaders to establish a firm foundation on which to build the program. It's important to listen as much as it is to train. We dedicated more sessions with our pastors/faith leaders to troubleshoot adapt our model to address the current pandemic to give relevance to challenges they are experiencing. Congregations are limited to virtual services and programs. We are working with the Mental Wellness Ministries to stay within relational reach during a time of social distancing.

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

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):	NA
G.3: Types of treatment individuals were referred to (list types) (500-character limit):	NA
G.4: Unduplicated number of individuals who participated in referred program at least one time:	NA
G.5: Average duration of untreated mental illness in weeks:	NA
G.6: Average number of days between referral and first participation in referred treatment program:	NA

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):	NA
H.2: Number of paper referrals to an ACBH PEI-funded program:	NA
H.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	NA
H.4: Average number of days between referral and first participation in referred PEI program:	NA
H.5: Describe how your program encouraged access to services and follow through on above referrals (500 Characters):	NA

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

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):
Churches/Faith Communities	*Pastors, Deacons, Ministers, Teachers & Children, Youth, TAY and Adult ministry leaders*
Online Web Based Trainings	*Clergy Community Stakeholders, Denominational/Ecclesiastical Leaders & Community Partners*

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 19/20

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: Please provide the total number of individuals served to date July 1, 2019 through June 30, 2020 through MHSA funding.

Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	451

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

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:	**451**

Box C: 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.

AGE CATEGORIES	
Children/Youth (0-15 yrs)	
Transition Age Youth (16-25 yrs)	
Adult (26-59 yrs)	11
Older Adult (60+ yrs)	5
Declined to answer	57
Unknown	378
TOTAL	**451**

SEXUAL ORIENTATION	
Gay/Lesbian	1
Heterosexual/Straight	13
Bisexual	
Questioning/Unsure	1
Queer	
Declined to answer	21
Unknown	415
Another group not listed	
TOTAL	**451**
If another group is counted, please specify:	

VETERAN STATUS	
Yes	
No	16
Declined to answer	57
Unknown	378
TOTAL	**451**

CURRENT GENDER IDENTITY	
Female	16
Male	3
Transgender	
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	54
Another identity not listed	378
TOTAL	**451**
If another identity is counted, please specify:	

PRIMARY LANGUAGE	
English	19
Spanish	
Cantonese	
Chinese	
Vietnamese	
Farsi	
Arabic	
Tagalog	
Declined to answer	
TOTAL	**451**
If another language is counted, please specify:	

SEX ASSIGNED AT BIRTH	
Male	
Female	
Declined to answer	
Unknown	451
TOTAL	**451**

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.

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	36
Unknown	415
Another disability not listed	
TOTAL	**451**
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	
Other Race	
Declined to answer	17
Unknown	415
TOTAL	451
If another race is counted, please specify:	

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

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	
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	19
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	**19**
More than one ethnicity	
Unknown Ethnicity	415
Declined to answer	17
EHTNICITY TOTAL	451
If another ethnicity is counted, please specify:	

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.

The first mini-campaign kick-off, held at Word Assembly in late January, was a two-hour event that engaged 175 congregants. During the service, PEERS' executive director Vanetta Johnson, campaign program coordinator Ashlee Jemmott, and program assistant Dolores Blackman, as well as content expert Dr. Lakita Long, all spoke. They addressed the importance of mental health in the African American community, described the campaign, and encouraged church attendees to join the anti-stigma group. Dr. Long emphasized that faith and mental health supports are consistent with one another, and Dolores Blackman told her story of mental health recovery through faith, community, and positive peer involvement. A well-received mental health resource table focusing on PEERS services was available after the service.

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.

The major challenge was the pandemic and the necessity of postponing in-person programming to prevent the spread of COVID-19. While PEERS was able to quickly transition to providing remote services and activities to our regular participants, the shelter-in-place order came at a particularly difficult time for the Hope & Faith Campaign. One anti-stigma group at one of the churches had held its first meeting, but the other groups had not yet begun. Initially, not knowing how long the shelter-in-place order would last, Hope & Faith staff and the church leaders decided simply to postpone the groups and events. However, as time went by, we and our church partners (with consultation from ACBH) decided to hold the anti-stigma groups remotely. In the end, engagement was high, and the groups and events were well received.

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):	NA

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

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):	NA
G.3: Types of treatment individuals were referred to (list types) (500-character limit):	NA
G.4: Unduplicated number of individuals who participated in referred program at least one time:	NA
G.5: Average duration of untreated mental illness in weeks:	NA
G.6: Average number of days between referral and first participation in referred treatment program:	NA

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:	6
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:	
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*

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

MHSA Program #: PEI 22

PROVIDER NAME: Pacific Center for Human Growth

PROGRAM NAME: Older and Out

Program Outcomes & Impact: PEI Data Report FY 19/20

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. The therapy groups run for 90 minutes, welcome new members at any time and refreshments are provided (prior to SIP). Therapy groups are facilitated by either a licensed therapist or Pacific Center clinical trainee, and anchored by attending peer specialists. Group members decide what topics to cover, including subjects like: loss of friends, retreating back into the closet to survive, dating, invisibility in the LGBTQ+ community, family acceptance challenges, loneliness, resilience, and how to find other services in Alameda County.
*Due to SIP, this practice has been instead replaced with a process during which interested new group members initially meet with Older & Out therapist and/or staff via Zoom prior to attending group.

Box B: Please provide the total number of individuals served to date July 1, 2019 through June 30, 2020 through MHSA funding.

Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	57

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:	0
Grand total of unduplicated individuals served:	**75**

Box C: 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.

AGE CATEGORIES	
Children/Youth (0-15 yrs)	
Transition Age Youth (16-25 yrs)	
Adult (26-59 yrs)	6
Older Adult (60+ yrs)	66
Declined to answer	3
Unknown	
TOTAL	**75**

VETERAN STATUS	
Yes	3
No	30
Declined to answer	42
Unknown	
TOTAL	**75**

SEXUAL ORIENTATION	
Gay/Lesbian	58
Heterosexual/Straight	
Bisexual	4
Questioning/Unsure	1
Queer	2
Declined to answer	9
Unknown	
Another group not listed	1
TOTAL	**75**
If another group is counted, please specify: Asexual: 1	

CURRENT GENDER IDENTITY	
Female	17
Male	28
Transgender	2
Genderqueer	4
Questioning/unsure of gender identity	1
Declined to answer	22
Unknown	
Another identity not listed	1
TOTAL	**75**
If another identity is counted, please specify:	

PRIMARY LANGUAGE	
English	65
Spanish	
Cantonese	
Chinese	
Vietnamese	
Farsi	
Arabic	
Tagalog	
Declined to answer	10
Unknown	
Another language not listed	
TOTAL	**75**
If another language is counted, please specify:	

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

SEX ASSIGNED AT BIRTH	
Male	33
Female	18
Declined to answer	24
Unknown	
TOTAL	**75**

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.

DISABILITY*** STATUS	
Communication Domain	
Vision	1
Hearing/Speech	3
Another type not listed	
Communication Domain Subtotal	**4**
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	2
Physical/mobility	5
Chronic health condition	4
Disability Subtotal	**11**
None	20
Declined to answer	36
Unknown	
Another disability not listed	4
TOTAL	**75**
If another disability is counted, please specify: Psychiatric disability: 4	

RACE	
American Indian or Alaska Native	2
Asian	3
Black or African American	11
Native Hawaiian or Other Pacific Islander	
White	41
Other Race	4
Declined to answer	14
Unknown	
TOTAL	75
If another race is counted, please specify: Multi-racial: 4	

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.

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

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

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):	NA
G.3: Types of treatment individuals were referred to (list types) (500-character limit):	NA
G.4: Unduplicated number of individuals who participated in referred program at least one time:	NA
G.5: Average duration of untreated mental illness in weeks:	NA
G.6: Average number of days between referral and first participation in referred treatment program:	NA

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:	none
H.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	none
H.4: Average number of days between referral and first participation in referred PEI program:	NA
H.5: Describe how your program encouraged access to services and follow through on above referrals (500 Characters):	When appropriate, Older & Out therapists and Peer Specialists make suggestions to group members about various community-based services, some which are ACBHCS-funded, for example: Caregivers' Support group, Pacific Center grief group, various HIV groups, local and national LGBTQ+ help/crisis hotlines, virtual events, and housing help at BACS.

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

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 22

PROVIDER NAME: Pacific Center for Human Growth

PROGRAM NAME: Peer Mentorship Project

Program Outcomes & Impact: PEI Data Report FY 19/20

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. They are volunteer-led and are not therapy groups. Donations are requested and no one is ever turned away for lack of funds. Since mid-March peer groups have been meeting virtually on Zoom.

Box B: Please provide the total number of individuals served to date July 1, 2019 through June 30, 2020 through MHSA funding.

Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	606
Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	21

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

Number of unduplicated individual family members served indirectly by your program:	0
Grand total of unduplicated individuals served:	**627**

Box C: 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.

AGE CATEGORIES	
Children/Youth (0-15 yrs)	0
Transition Age Youth (16-25 yrs)	149
Adult (26-59 yrs)	367
Older Adult (60+ yrs)	92
Declined to answer	19
Unknown	
TOTAL	**627**

VETERAN STATUS	
Yes	19
No	606
Declined to answer	2
Unknown	
TOTAL	**627**

CURRENT GENDER IDENTITY	
Female	177
Male	72
Transgender	171
Genderqueer	60
Questioning/unsure of gender identity	26
Declined to answer	25
Unknown	
Another identity not listed	96
TOTAL	**627**
If another identity is counted, please specify: Agender: 10, Non-binary: 68, Genderfliud: 15, Bigender: 3	

SEX ASSIGNED AT BIRTH	
Male	154
Female	272
Declined to answer	39
Unknown	162
TOTAL	**627**

SEXUAL ORIENTATION	
Gay/Lesbian	151
Heterosexual/Straight	38
Bisexual	139
Questioning/Unsure	27
Queer	138
Declined to answer	26
Unknown	
Another group not listed	108
TOTAL	**627**
If another group is counted, please specify: Asexual: 10, Demisexual: 13 , Fluid: 20, Pansexual: 65	

PRIMARY LANGUAGE	
English	615
Spanish	9
Cantonese	
Chinese	
Vietnamese	
Farsi	
Arabic	
Tagalog	
Declined to answer	
Unknown	2
Another language not listed	1
TOTAL	**627**
If another language is counted, please specify: Mandarin: 1	

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.

DISABILITY*** STATUS	
Communication Domain	
Vision	13
Hearing/Speech	15
Another type not listed	2
Communication Domain Subtotal	**30**
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	34
Physical/mobility	23
Chronic health condition	29
Disability Subtotal	**86**
None	487
Declined to answer	10
Unknown	
Another disability not listed	14
TOTAL	**627**
If another disability is counted, please specify: Psychiatric diblty: 14	

RACE	
American Indian or Alaska Native	13
Asian	74
Black or African American	47
Native Hawaiian or Other Pacific Islander	3
White	375
Other Race	72
Declined to answer	43
Unknown	
TOTAL	627
If another race is counted, please specify: More than one race: 72	

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	5
Central American	11
Mexican/Mexican American/Chicano	46
Puerto Rican	3
South American	5
Another Hispanic/Latino ethnicity not listed	
Total Hispanic or Latino	**70**

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

If Non-Hispanic or Non-Latino, please specify:	
African	8
African American	30
Asian Indian/South Asian	17
Cambodian	30
Chinese	29
Eastern European	53
European	171
Filipino	12
Japanese	3
Korean	2
Middle Eastern	18
Vietnamese	4
Other Non-Hispanic or Non-Latino ethnicity not listed	
Total Non-Hispanic or Non-Latino	347
More than one ethnicity	41
Unknown Ethnicity	
Declined to answer	169
EHTNICITY TOTAL	627
If another ethnicity is counted, please specify:	

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.

We increased our peer group offerings by 6 groups: Queer Crips United; Thursday Night Men's Group; Parents/Caregivers of Trans Tweens; Parents/Caregivers of Trans Youth of all ages; Love Letter (BIPOC Women of Color) and Grupo de Apoyo Fénix (trans-masculine Spanish-speakers).

We increased our collaborations by adding three non-profits: two local organizations, The Center for Independent Living and Somos Familia and one national organization, Stand with Trans. We increased the frequency of consultation meetings after shelter-in-place (SIP) from 1X/month to 2X. We offered quarterly Diversity, Equity, Inclusion (DEI) trainings for facilitators and of those, offered our first virtual DEI training (on ability/disability with a visiting instructor). Every group but one made the transition to a virtual platform.

We are especially proud that the group Love Letter started online after SIP. At their first group they had 9 attendees and, since have averaged 10!

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.

Since SIP, we've received feedback of decreased access for some group members. To mitigate this gap we reached out facilitators referred and linking them for support as needed and encouraged them to refer group members to us for assistance.

We've received complaints from BIPOC group members, regarding their difficulty to bring their full selves to groups citing examples of microaggressions. To mitigate this lack of safety, we held listening meetings. Plans are in place to train new BIPOC facilitators, develop new required group agreements, develop new BIPOC groups, and require intersectionality trainings.

After SIP, we became concerned about facilitators and group members' food insecurity so we reached out to them regarding food gift cards and, using our food budget, sent out 53 cards (to 35 unduplicated community members).

A thank you: "Thank you so much for making sure we are all supported through this!"

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.

Two big lessons of this last year are related to change. The first one is that we were able to shift to offering all of our peer groups online with the exception of one, a big feat. The second lesson is that we are able to listen to the BIPOC community members and respond by continuing and adding to our DEI initiatives to make systemic cultural changes to our peer group program to better serve our BIPOC members.

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
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):	NA
G.3: Types of treatment individuals were referred to (list types) (500-character limit):	NA
G.4: Unduplicated number of individuals who participated in referred program at least one time:	NA
G.5: Average duration of untreated mental illness in weeks:	NA

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

G.6: Average number of days between referral and first participation in referred treatment program:	NA

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:	NA
H.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	NA
H.4: Average number of days between referral and first participation in referred PEI program:	NA
H.5: Describe how your program encouraged access to services and follow through on above referrals (500 Characters):	We encourage our peer group facilitators to refer group members to relevant services. We changed our data collection form for the groups to improve record-keeping regarding the referrals. Additionally, particularly during shelter-in-place (SIP), we send weekly resources via email to our peer group facilitators.

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 22

PROVIDER NAME: Pacific Center for Human Growth

PROGRAM NAME: Technical Assistance Program

Program Outcomes & Impact: PEI Data Report FY 19/20

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: Please provide the total number of individuals served to date July 1, 2019 through June 30, 2020 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

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

Number of unduplicated individual family members served indirectly by your program:	NA
Grand total of unduplicated individuals served:	**0**

Box C: 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.

AGE CATEGORIES	
Children/Youth (0-15 yrs)	
Transition Age Youth (16-25 yrs)	
Adult (26-59 yrs)	29
Older Adult (60+ yrs)	
Declined to answer	
Unknown	15
TOTAL	**44**

SEXUAL ORIENTATION	
Gay/Lesbian	
Heterosexual/Straight	
Bisexual	
Questioning/Unsure	
Queer	
Declined to answer	
Unknown	44
Another group not listed	
TOTAL	**44**
If another group is counted, please specify:	

VETERAN STATUS	
Yes	
No	
Declined to answer	
Unknown	44
TOTAL	**44**

CURRENT GENDER IDENTITY	
Female	3
Male	
Transgender	1
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	40
Another identity not listed	
TOTAL	**44**
If another identity is counted, please specify:	

PRIMARY LANGUAGE	
English	40
Spanish	
Cantonese	
Chinese	
Vietnamese	
Farsi	
Arabic	
Tagalog	
Declined to answer	
Unknown	
Another language not listed	
TOTAL	**40**
If another language is counted, please specify:	

SEX ASSIGNED AT BIRTH	
Male	1
Female	3
Declined to answer	
Unknown	40

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.

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.)	
Physical/mobility	
Chronic health condition	
Disability Subtotal	**0**
None	
Declined to answer	
Unknown	44
Another disability not listed	
TOTAL	**44**
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	19
Other Race	
Declined to answer	
Unknown	19
TOTAL	44
If another race is counted, please specify:	

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	
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	
Total Hispanic or Latino	**0**

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

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	44
Declined to answer	
EHTNICITY TOTAL	44
If another ethnicity is counted, please specify:	

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.

Pacific Center trainings were well attended and well received. Post-training evaluations indicated that workshop participants left with increased knowledge about the LGBTQ+ community (e.g. – terminology, life stressors, etc.) and concrete tools for engaging LGBTQ+ clients with more sensitivity. Qualitative feedback from workshop participants indicates that Pacific Center trainings have a positive impact on the ways in which members of the LGBTQ+ community are viewed, included, and serviced.
A former participant in the grief group recently returned to Pacific Center as a Board Member. In her application and interview, she spoke about her experience receiving support from PC in the past. “"I was fortunate to find the Pacific Center's peer grief group at the crux of my grieving process. My experience with the group was incredibly impactful."

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.

In Q1 and Q2 we continued to have some difficulty with developing and implementing trainings at the ABHCS offices in meeting our goal of 3 trainings for the remainder of the fiscal year and we therefore modified our goal to 1 for the fiscal year. Additionally, while we had more success collecting demographic data during Q2, we are modifying our creation, distribution, and collection of survey and feedback materials (surveys and evaluations) to a format that encourages broader participation, and enables more detailed program analysis.

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.

Conducting follow-up trainings and/or trainings that are longer than the standard two-hour training allows for deeper levels of participation, learning and integration of the material. Ideally, we would like to be able to provide tiered, or leveled, trainings for all of the organizations we collaborate with.

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:

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

H.1: Who is/are the underserved target population(s) your program is serving (e.g TAY, Southeast Asian) (500 Characters):	LGBTQ+ 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:	
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	*Program Director, Direct Services Support, Staff, Clinicians, Administrators*
In-Patient Acute Mental Health (Q1)	*Direct Services Support, Staff, Administrators, Social Workers*
Umbrella Social Service Agency (Q1)	*Program Directors, Direct Services Support, Staff*
Community Mental Health Agency (Q1)	*Support Group Facilitators*
Youth Services Organization (Q1)	*Program Managers, Direct Services Support, Staff*
Community Mental Health Agency (Q2)	*Peer Group Facilitators*
In-Patient Residential Program (Q2)	*Clinicians, Administrators*
Community Mental Health Agency (Q3, Q4)	*Clinicians, Administrators, Direct Service Staff*

MHSA Program #: PEI 24

PROVIDER NAME: Roots Community Health Center

PROGRAM NAME: Sobrante Park

Program Outcomes & Impact: PEI Data Report FY 19/20

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: Please provide a brief program description (character limit 1,000).

Roots in Sobrante Park mission is to address long-standing health inequities by providing culturally responsive, comprehensive physical and mental health services; education, employment and training; and wraparound services that build self-sufficiency and promote community empowerment. Roots along with partners Higher Ground, Planting Justice, and Sobrante Park RAC, provide one on one support to community members, as well as health resources, skill based training for youth, practical support (diapers, food boxes, utility bill assistance), beautification efforts (tree planting), weekly Fridays at the lot where community members receive direct access and linkage to mental health professionals, family services, dental health screenings, medical enrollment, employment resources, clothes closet, and hygiene kits.

Box B: Please provide the total number of individuals served to date July 1, 2019 through June 30, 2020 through MHSA funding.

Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	15

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	32
Number of unduplicated individual family members served indirectly by your program:	41
Grand total of unduplicated individuals served:	**88**

Box C: 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.

AGE CATEGORIES	
Children/Youth (0-15 yrs)	5
Transition Age Youth (16-25 yrs)	10
Adult (26-59 yrs)	23
Older Adult (60+ yrs)	6
Declined to answer	
Unknown	3
TOTAL	**47**

VETERAN STATUS	
Yes	0
No	47
Declined to answer	
Unknown	
TOTAL	**47**

SEXUAL ORIENTATION	
Gay/Lesbian	
Heterosexual/Straight	43
Bisexual	
Questioning/Unsure	
Queer	
Declined to answer	
Unknown	4
Another group not listed	
TOTAL	**47**
If another group is counted, please specify:	

CURRENT GENDER IDENTITY	
Female	32
Male	15
Transgender	
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	
Another identity not listed	
TOTAL	**47**
If another identity is counted, please specify:	

PRIMARY LANGUAGE	
English	47
Spanish	37
Cantonese	
Chinese	
Vietnamese	
Farsi	
Arabic	
Tagalog	
Declined to answer	
TOTAL	**84**
If another language is counted, please specify:	

SEX ASSIGNED AT BIRTH	
Male	15
Female	32
Declined to answer	
Unknown	
TOTAL	**47**

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.

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	47
Declined to answer	
Unknown	
Another disability not listed	
TOTAL	**47**
If another disability is counted, please specify:	

RACE	
American Indian or Alaska Native	
Asian	
Black or African American	11
Native Hawaiian or Other Pacific Islander	1
White	1
Other Race	33
Declined to answer	
Unknown	1
TOTAL	47
If another race is counted, please specify:	

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	

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

Mexican/Mexican American/Chicano	33
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	
Total Hispanic or Latino	**33**
If Non-Hispanic or Non-Latino, please specify:	
African	
African American	11
Asian Indian/South Asian	
Cambodian	
Chinese	
Eastern European	
European	1
Filipino	1
Japanese	
Korean	
Middle Eastern	
Vietnamese	
Other Non-Hispanic or Non-Latino ethnicity not listed	
Total Non-Hispanic or Non-Latino	**13**
More than one ethnicity	
Unknown Ethnicity	1
Declined to answer	
EHTNICITY TOTAL	47
If another ethnicity is counted, please specify:	

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.

A student, navigated by Roots, started the school year with a low gpa of 1.0 at Madison Park Academy. He was getting involved in student fights and this student also attended our Uplift meetings. Throughout the year the navigators assisted him with tutoring, access to fresh healthy foods, bus passes, and gift cards. As a result of the navigation and motivation from the navigators, he ended the school year with a GPA of 3.0. His attitude about school also changed, he was more focused and even discussed continuing his education and attending college, something he had never expressed interested in. Roots is proud to report 14 of the students were able to pass the school year. Some of those kids were able to pass with a 3.5 GPA.

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.

Covid-19 was something that Roots had to adjust quickly to continue the services Roots provide to the community and close any gaps that might arise during the course of the pandemic such as access to a COVID testing site. Many changes have been made to keep our staff and community safe while delivering food and practical support resources such as diapers and utility bill assistance to the community. We use telecommunication to continue access to mental wellness professionals and navigation at a safe distance to the community. Roots and partner, Sobrante Park RAC, decided to cancel the annual health fair and time banking for safety reasons. As a result, planning for next year we will take into consideration that COVID safety rules may still be in place. Planting Justice, Higher Ground, and RAC also adjusted to the changes by continuing to do tree and food give-aways, engage juniors and seniors through virtual skills training, and delivering food to elders in the community weekly.

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.

There is a chance that COVID safety guidelines will continue into the next fiscal year, which has challenged Roots to be more creative in how we engage families and youth in Sobrante Park from a distance, therefore we are in the process of optimizing our reach into the community by launching a community initiative called 40X40. This initiative will encourage the community to be engaged in the preservation and beautification of the Sobrante Park neighborhood. The most valuable lesson we learned is that pandemic or not Roots has a community to serve, and we are not hesitant to get creative if it means being able to continue serving the 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):	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):	2
G.3: Types of treatment individuals were referred to (list types) (500-character limit):	The individual referred to Roots was seen by NIACare and AlfiyaCare are PEI programs both funded by ACBHCS to support the community by providing culturally responsive mental health and wellness professionals. The other members were seen my Madison Park Academy and a Spanish-speaking mental wellness facility.

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

G.4: Unduplicated number of individuals who participated in referred program at least one time:	3
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:	Unknown

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):	Sobrante Park community members focusing primarily on the African-American, Latino population, and juniors and seniors in high school.
H.2: Number of paper referrals to an ACBH PEI-funded prorgam:	1
H.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	3
H.4: Average number of days between referral and first participation in referred PEI program:	unknown
H.5: Describe how your program encouraged access to services and follow through on above referrals (500 Characters):	Health navigators are trained to respond when they see sign of early onset mental health challenges or severe situations in which their panel is at risk of developing mental illness. Therefore, our navigators act quickly to provide resources to fill gaps in services and refer their panel to PEI program such as Alfiya care or NIA care. Health navigators help their panel arrange transportation, remember appointment dates, help them schedule appointments, explain medication, and follow up with them regular via phone of face to face 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:	**NA**
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	

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 19/20

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.

Box B: Please provide the total number of individuals served to date July 1, 2019 through June 30, 2020 through MHSA funding.	
Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	15
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:	**15**

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

Box C: 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.

AGE CATEGORIES	
Children/Youth (0-15 yrs)	0
Transition Age Youth (16-25 yrs)	0
Adult (26-59 yrs)	7
Older Adult (60+ yrs)	8
Declined to answer	0
Unknown	0
TOTAL	**15**

VETERAN STATUS	
Yes	0
No	0
Declined to answer	0
Unknown	15
TOTAL	**15**

CURRENT GENDER IDENTITY	
Female	10
Male	5
Transgender	0
Genderqueer	0
Questioning/unsure of gender identity	0
Declined to answer	0
Unknown	0
Another identity not listed	0
TOTAL	**15**
If another identity is counted, please specify:	

SEX ASSIGNED AT BIRTH	
Male	0
Female	0
Declined to answer	0
Unknown	15
TOTAL	**15**

SEXUAL ORIENTATION	
Gay/Lesbian	0
Heterosexual/Straight	0
Bisexual	0
Questioning/Unsure	0
Queer	0
Declined to answer	0
Unknown	15
Another group not listed	0
TOTAL	**15**
If another group is counted, please specify:	

PRIMARY LANGUAGE	
English	13
Spanish	1
Cantonese	0
Chinese	1
Vietnamese	0
Farsi	0
Arabic	0
Tagalog	0
Declined to answer	0
Unknown	0
Another language not listed	0
TOTAL	**15**
If another language is counted, please specify:	

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.

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.)	0
Physical/mobility	0
Chronic health condition	0
Disability Subtotal	**0**
None	0
Declined to answer	0
Unknown	15
Another disability not listed	0
TOTAL	**15**
If another disability is counted, please specify:	

RACE	
American Indian or Alaska Native	0
Asian	0
Black or African American	3
Native Hawaiian or Other Pacific Islander	0
White	0
Other Race	0
Declined to answer	0
Unknown	12
TOTAL	15
If another race is counted, please specify:	

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	
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	
Total Hispanic or Latino	**0**

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

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	0
If another ethnicity is counted, please specify:	

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.

The 10X10 Wellness maneuvered through personnel changes and the Covid'19 Pandemic that caused staff to Shelter-In-Place orders. Programs had to be altered and administered in an on-line format. However, through those changes we were able to 1. Hold Two Get Fit classes with a total of 12 Consumers; the 1st Cohort received their certificates at the annual HHREC Holiday party. 2. Work with the 10X10 CAB committee to develop the #MentalHealthWellness365 T-shirt Campaign on Facebook and Instagram.

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.

The challenges we faced included the turnover in the Program Manager's for the 10x10 Wellness Campaign: our first manager switched to coaching a sports team at San Francisco State; apparently it had been a lifelong dream that the manager couldn't pass on.
Changes included staff members learning the skills of working from home given the shelter in place order from the Alameda County Public Health Department learning how to use zoom platform and host zoom meetings and coordinating conference calls.
Our 10x10 manager had to adjust the Get Fit training materials to Get Fit sessions via Zoom twice per week. Four participants actually completed the class and obtained certificates of completion.

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.

Our team was able to quickly adjust as needed to using zoom and managing their programs digitally and remotely.

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
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):	NA
G.3: Types of treatment individuals were referred to (list types) (500-character limit):	NA
G.4: Unduplicated number of individuals who participated in referred program at least one time:	NA
G.5: Average duration of untreated mental illness in weeks:	NA
G.6: Average number of days between referral and first participation in referred treatment program:	NA

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

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):	NA
H.2: Number of paper referrals to an ACBH PEI-funded program:	NA
H.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	NA
H.4: Average number of days between referral and first participation in referred PEI program:	NA
H.5: Describe how your program encouraged access to services and follow through on above referrals (500 Characters):	NA

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	
City of Berkeley Asian Health Services Specialty Mental Health	
Alameda County of Network of Mental Health Clients	
Berkeley Mental Health	
Downtown TAY	
Bay Area Community Services	
Pool of Consumer Champions	
SAGA	
BestNow	
Mental Health Association for Chinese Communities	

MHSA Program #: PEI 27

PROVIDER NAME: Health and Human Resource Education Center

PROGRAM NAME: Health Through Art

Program Outcomes & Impact: PEI Data Report FY 19/20

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 create art and utilize art as a platform to express emotions, tell stories, and heal. Since 1992, HTA has hosted a biennial call for art inviting Alameda County residents to submit 2-D art illustrating what effects their mental health, including racism, discrimination, housing, socio-economic status, health disparities etc. Winners of the call for art are selected by a committee consisting of stakeholders, community health workers, and county residents. All submissions and artists are recognized in an award ceremony where 8-10 winners are awarded $500 each for their outstanding work.

Box B: Please provide the total number of individuals served to date July 1, 2019 through June 30, 2020 through MHSA funding.

Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	28
Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	91

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

Number of unduplicated individual family members served indirectly by your program:	0
Grand total of unduplicated individuals served:	**119**

Box C: 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.

AGE CATEGORIES	
Children/Youth (0-15 yrs)	16
Transition Age Youth (16-25 yrs)	24
Adult (26-59 yrs)	22
Older Adult (60+ yrs)	13
Declined to answer	
Unknown	44
TOTAL	**119**

VETERAN STATUS	
Yes	
No	
Declined to answer	
Unknown	119
TOTAL	**119**

SEXUAL ORIENTATION	
Gay/Lesbian	
Heterosexual/Straight	
Bisexual	
Questioning/Unsure	
Queer	
Declined to answer	
Unknown	119
Another group not listed	
TOTAL	**119**
If another group is counted, please specify:	

CURRENT GENDER IDENTITY	
Female	
Male	
Transgender	
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	119
Another identity not listed	
TOTAL	**119**
If another identity is counted, please specify:	

PRIMARY LANGUAGE	
English	119
Spanish	
Cantonese	
Chinese	
Vietnamese	
Farsi	
Arabic	
Tagalog	
Declined to answer	
Unknown	
Another language not listed	
TOTAL	**119**
If another language is counted, please specify:	

SEX ASSIGNED AT BIRTH	
Male	10
Female	33
Declined to answer	
Unknown	76
TOTAL	**119**

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.

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	119
Another disability not listed	
TOTAL	**119**
If another disability is counted, please specify:	

RACE	
American Indian or Alaska Native	
Asian	5
Black or African American	5
Native Hawaiian or Other Pacific Islander	1
White	5
Other Race	
Declined to answer	
Unknown	103
TOTAL	119
If another race is counted, please specify:	

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	

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

Mexican/Mexican American/Chicano	
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	5
Total Hispanic or Latino	**5**
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	108
Total Non-Hispanic or Non-Latino	**108**
More than one ethnicity	6
Unknown Ethnicity	
Declined to answer	
EHTNICITY TOTAL	119
If another ethnicity is counted, please specify:	

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.

Successfully conducted outreach and marketing of the 13th CFA to over 70 community-based organizations and businesses all over Alameda County, including but not limited to Tri-City, S.A.V.E., F.E.R.C., and the school districts of Oakland, San Leandro, Alameda, and Union City. Formed a new group of 6 committed CAB members from PEERS, Director of Villa Rehabilitation-Villa Fairmont, President of Oakland Art Murmur, P.O.C.C. affiliate, and HHREC staff. Conducted art workshops at a skilled nursing facility in Fremont and Villa Fairmont Mental Health Rehabilitation Center in San Leandro. Amid COVID-19, we were able to collect 62 art pieces to feature in the CFA and created a virtual platform selection committee and winner's announcement.

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.

Low participation in the CFA required the program to extend the deadline to submit entries. An additional 500 flyers and 250 brochures were ordered and continued outreach was conducted. An update was sent to all the organizations that we sent emails to. The HTA Program Manager personally delivered marketing material to at least 10 organizations/businesses in each city of Alameda County. The full list is on record. The biggest challenge was when COVID-19 came right before a selection party and award ceremony could be planned so everything was shifted to online platforms. We continued to accept entries and adjusted by having participants mail them in.

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.

Use online tools to conduct most of our work and stay in touch with consumers and program participants. Continue to practice using these tools after Shelter-in-place order has been lifted. Hosting CAB meetings on ZOOM versus in person saves members time from traveling to the office. We will be able to recruit more members since travel will not be a concern. Sending frequent emails and making follow up phone calls helps stay in touch with consumers and program participants. Providing more information on our website allows us to direct them there and increases the use of our website. Lastly, posting reminders and information on our social media websites will keep participants engaged in the program and agency as a whole.

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):	0
G.3: Types of treatment individuals were referred to (list types) (500-character limit):	NA
G.4: Unduplicated number of individuals who participated in referred program at least one time:	0
G.5: Average duration of untreated mental illness in weeks:	0

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

G.6: Average number of days between referral and first participation in referred treatment program:	0

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, High School Students Oakland Technology High School, James Logan High School), seniors. These groups, including young adults and adults at Villa Fairmont all expressed their challenges with mental health and substance use and how art has helped them cope.
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):	NA

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):
Rehabs center-Villa Fairmont	*1 Director, 2 MSW interns, 2 Coordinators*
HHREC Holiday Party for consumers	*1 MD of Oakland VA hospital*
Skilled Nursing Facility- Fremont Healthcare Center	*1 Activity Coordinator*

MHSA Program #: PEI 28

PROVIDER NAME: Health and Human Resource Education Center

PROGRAM NAME: Downtown TAY

Program Outcomes & Impact: PEI Data Report FY 19/20

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: Please provide the total number of individuals served to date July 1, 2019 through June 30, 2020 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

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

Number of unduplicated individual family members served indirectly by your program:	0
Grand total of unduplicated individuals served:	**50**

Box C: 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.

AGE CATEGORIES	
Children/Youth (0-15 yrs)	
Transition Age Youth (16-25 yrs)	31
Adult (26-59 yrs)	20
Older Adult (60+ yrs)	
Declined to answer	
Unknown	1
TOTAL	**52**

VETERAN STATUS	
Yes	0
No	51
Declined to answer	
Unknown	1
TOTAL	**52**

CURRENT GENDER IDENTITY	
Female	24
Male	25
Transgender	2
Genderqueer	0
Questioning/unsure of gender identity	0
Declined to answer	0
Unknown	1
Another identity not listed	
TOTAL	**52**
If another identity is counted, specify	

SEX ASSIGNED AT BIRTH	
Male	27
Female	25
Declined to answer	0
Unknown	0
TOTAL	**52**

SEXUAL ORIENTATION	
Gay/Lesbian	5
Heterosexual/Straight	18
Bisexual	7
Questioning/Unsure	2
Queer	3
Declined to answer	5
Unknown	10
Another group not listed	2
TOTAL	**52**
If another group is counted, please specify:	

PRIMARY LANGUAGE	
English	52
Spanish	
Cantonese	
Chinese	
Vietnamese	
Farsi	
Arabic	
Tagalog	
Declined to answer	
TOTAL	**52**
If another language is counted, please specify:	

Communication Domain	
Vision	0
Hearing/Speech	0
Another type not listed	0
Communication Domain Subtotal	**0**
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	0
Physical/mobility	0
Chronic health condition	0
Disability Subtotal	**0**
None	0
Declined to answer	0
Unknown	0
Another disability not listed	0
TOTAL	**0**
If another disability is counted, please specify:	

American Indian or Alaska Native	0
Asian	0
Black or African American	48
Native Hawaiian or Other Pacific Islander	0
White	0
Other Race	3
Declined to answer	0
Unknown	1
TOTAL	52
If another race is counted, please specify:	

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	1
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	
Total Hispanic or Latino	**1**
If Non-Hispanic or Non-Latino, please specify:	
African	
African American	
Asian Indian/South Asian	
Cambodian	
Chinese	
Eastern European	

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

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	2
Unknown Ethnicity	
Declined to answer	
EHTNICITY TOTAL	3
If another ethnicity is counted, please specify:	

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.

Downtown TAY transformed a Culture Broker Academy Graduate (Spring 2019) to Brother 4 Brother Facilitator October 2019 then Facilitator transition to Program Coordinator February 2020. Eleven TAY (18-24) Completed Fall 2019 and Spring 2020 Culture Broker Academy.
Having two staff members who were formal TAY has elevated the program in a short amount of time by providing more on-site support for TAY. This transition has been a great addition to the Downtown TAY staff. Downtown Town TAY Held their Fourth Annual Kwanzaa Gathering (Fostering community and a safe space) December 27, 2019
Downtown TAY Warm Hub (Wellness Bags for TAY Community) over 50 bags to the Downtown TAY Community during the FY 19-20. The Warm Hub was a segue to provide a space for five TAY (18-24) from Covenant House who have regularly attended Downtown TAY programming since the 3rd Quarter.

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.

Downtown TAY mitigated several of these issues by promoting the Program Coordinator to Lead Program Coordinator and the Brother for Brother Facilitator to a new Program Coordinator. Food Insecurities have been a large issue for the TAY during this Fiscal Year. We maintained our pantry full of snacks and a refrigerator stocked with accessible food. TAY of Downtown TAY have been facing homelessness due to the ageing out of the foster care system and expensive rents in the Bay Area. When Downtown TAY Staff receive a housing waitlist, staff send emails to TAY to complete housing applications. Not having reliable transportation support, Downtown TAY provided with Bus and/or BART Passes is paramount/necessary after standard programming. Maintaining the number of TAY participants has been a challenge. Downtown TAY staff will increase their outreach efforts to include the community agencies virtually. Programming transitioned to virtual workshops during the fourth quarter due to COVID-19.

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.

Empowering TAY participants to leadership and staff positions changed the atmosphere of the program for the positive. TAY felt their voices were being heard from peers and Downtown TAY Staff. Having multiple staff members helped provide resources to TAY during these challenging times. Monthly Theme Activate Health workshops increased TAY participation. Onsite and offsite outreach helped the program grow by fifteen percent. Downtown TAY began to adapt to the COVID-19 pandemic in program services, utilizing safe social distancing requirements and utilizing online virtual formats as much as possible.

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

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

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 Transitional Aged Youth and Adults (aged to 27) in Alameda County are the target for Downtown TAY.
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):	NA

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 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 19/20

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: Please provide the total number of individuals served to date July 1, 2019 through June 30, 2020 through MHSA funding.

Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	300
Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	NA

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

Number of unduplicated individual family members served indirectly by your program:	NA
Grand total of unduplicated individuals served:	**300**

Box C: 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.

AGE CATEGORIES	
Children/Youth (0-15 yrs)	
Transition Age Youth (16-25 yrs)	25
Adult (26-59 yrs)	200
Older Adult (60+ yrs)	75
Declined to answer	
Unknown	
TOTAL	**300**

VETERAN STATUS	
Yes	
No	
Declined to answer	
Unknown	300
TOTAL	**300**

SEXUAL ORIENTATION	
Gay/Lesbian	
Heterosexual/Straight	
Bisexual	
Questioning/Unsure	
Queer	
Declined to answer	
Unknown	300
Another group not listed	
TOTAL	**300**
If another group is counted, please specify:	

CURRENT GENDER IDENTITY	
Female	285
Male	15
Transgender	
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	
Another identity not listed	
TOTAL	**300**
If another identity is counted, please specify:	

PRIMARY LANGUAGE	
English	300
Spanish	
Cantonese	
Chinese	
Vietnamese	
Farsi	
Arabic	
Tagalog	
Declined to answer	
TOTAL	**300**
If another language is counted, please specify:	

SEX ASSIGNED AT BIRTH	
Male	
Female	
Declined to answer	
Unknown	300
TOTAL	**300**

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.

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	300
Another disability not listed	
TOTAL	**300**
If another disability is counted, please specify:	

RACE	
American Indian or Alaska Native	
Asian	
Black or African American	275
Native Hawaiian or Other Pacific Islander	
White	5
Other Race	20
Declined to answer	
Unknown	
TOTAL	300
If another race is counted, please specify:	

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.

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

Ethnicity/Cultural Heritage (Please choose only one per individual)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	
Mexican/Mexican American/Chicano	20
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	
Total Hispanic or Latino	**20**
If Non-Hispanic or Non-Latino, please specify:	
African	
African American	275
Asian Indian/South Asian	
Cambodian	
Chinese	
Eastern European	
European	5
Filipino	
Japanese	
Korean	
Middle Eastern	
Vietnamese	
Other Non-Hispanic or Non-Latino ethnicity not listed	
Total Non-Hispanic or Non-Latino	**280**
More than one ethnicity	
Unknown Ethnicity	
Declined to answer	
EHTNICITY TOTAL	300
If another ethnicity is counted, please specify:	

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.

BWMWP completed production of the magazine "Crossing the Invisible Line III: Overcoming Depression" was completed and distributed widely. A release party was held on November 14, 2019. 54 people representing contributors to the magazine, Mills College students, consumers from mental health programs and representatives from the African American Steering Committee for Health and Wellness were in attendance. 540 copies were distributed at the release party and a total of 1,500 magazines throughout the year.

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.

Prior to March 17, 2020 the BWMWP had held its usual in person Be Still Retreats. Due to the shelter in place order issued on March 17th by the Alameda County Public Health Officer hosting in-person retreats were placed on hold until further notice. the BWMWP shifted to an online format, Be-Still 2.0 using the Zoom virtual platform. 5 online workshops were offered from April to June 30, 2020. Total online attendance was 254. The following link provides a video of one of the Be-Still 2.0 workshops
https://us02web.zoom.us/rec/share/1MZcMun6805Lf53d1EXWBqM4RK_OX6a81XBN-fJZmhnZHOjNaMgJjGRmfsVuZFE7

Password: 7U!#rk97

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.

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
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):	NA
G.3: Types of treatment individuals were referred to (list types) (500-character limit):	NA
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:	NA

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

G.6: Average number of days between referral and first participation in referred treatment program:	NA

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):	Low and no income African American women and their families; TAY aged women and girls.
H.2: Number of paper referrals to an ACBH PEI-funded program:	NA
H.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	NA
H.4: Average number of days between referral and first participation in referred PEI program:	unknown
H.5: Describe how your program encouraged access to services and follow through on above referrals (500 Characters):	The format for the Be-Still retreat provides information tables with resources hosted by providers of wellness services. Some are county funded, are CBO providers, black nurses and holistic healers from the community. The "self-care" tables are always well received by the participants.

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):


INNOVATION

Innovation
"Solution Focused Activities"

Innovation (INN) Programs are intended to provide mental health systems with an opportunity to learn from innovative approaches. Innovations Programs are not designed to support existing or ongoing programs or services, but rather to provide the mental health system with innovative demonstration projects that will support system change in order to increase access to services and improve client/consumer outcomes.

An Innovations Project may introduce a novel, and/or ingenious approach to a variety of mental health practices. Innovations Projects can contribute to learning at any point across the spectrum of an individual or family's needs relating to mental health, from prevention and early intervention to recovery supports which includes supportive housing.

An Innovative Project must meet the following criteria:

1. It is new, meaning it has **not** previously been done in the mental health field; Innovation Projects must promote new approaches to mental health in one or more of the following ways:

    - Introducing a new mental health practice or approach, or
    - Adapting an existing mental health practice or approach, so that it can serve a new target population or setting, or
    - Modifying an existing practice or approach from another field, to be used for the first time in mental health.

2. It has a learning component, which will contribute to the body of knowledge about mental health.

    - The learning component is represented in the application's Learning Question.

Before INN funds can be spent on an INN project, the project idea must be vetted through a 30-day public review process, approved by the County Board of Supervisors and then approved by the Mental Health Services Oversight and Accountability Commission (MHSOAC). The first two steps may take place as part of a Three-year Plan or Plan Update or may be implemented as a stand-alone process.

Budget Summary

INNOVATION PROJECTS		
Project Name	**Fiscal Year**	**Projected Budget**
CATT	2021-2022	$3,370,847
Mobile Technology App Project	2021-2022	$345,979
Land Trust	2021-2022	$1,215,588
INN CPPP Project	2021-2022	$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	*Services/year 1*	*Services/year 2*	*Services/year 3*
San Leandro, Oakland, and Hayward	840	840	840
	70% of persons to be served who do not require emergency medical services.	**70%** of persons to be served who do not require emergency medical services.	**70%** of persons to be served who do not require emergency medical services.

Mental Health Technology: Each grantee has their own specific goals in accordance to their targeted populations. The following is a broad overview of the project's goals:

Targeted Population →	*Caregivers of SMI/SED Family Members*	*Youth/TAY Victims of Trauma by Multiple Form of Violence*	*Attempted Suicide Survivors*	*Immigrants, Asylees, and Refugees*
Identified issues to Resolve →	Outreach engagement and education for emotional support.	Early intervention after trauma; Prevention of further trauma; Promote mental health wellness in youth/TAY.	Reduce isolation, stigmatization surrounding suicidal thoughts; Prevention.	Reduce stigma; Increase access; Reduce isolation and fear.

Supportive Housing Community Land Alliance

Community	*Goals for FY21- 22*	*Goals for FY22-23*	*Goals for FY23-24*
SMI individuals whose income is 200% below federal poverty level.	Create CLT; Develop board of directors; Funding partners identified.	First consumers to be housed; Property and Housing stock investments initiated.	Additional consumers to be housed; Financing models for sustainability identified/in procurement process.

INN Program Summaries

PROJECT NAME: COMMUNITY ASSESSMENT TREATMENT TEAM (CATT)

Project Description: Alameda County's existing system for responding to behavioral health crises in the community is inefficient in terms of expense, time and connecting clients to appropriate services. A vast majority of transports for individuals on a psychiatric hold are conducted by ambulance, which is expensive and requires law enforcement to wait for an ambulance to arrive. These calls are lower priority since they are generally not life-threatening, therefore increasing the wait time. In addition, the existing system transports an individual who qualifies for a 5150 involuntary hold, but those who do not qualify are left on site without a connection to services. The goal of CATT is to improve access to services in Alameda County by Combining efforts to significantly transform the response to behavioral crises in the community:

- Develop a crisis response team that includes Behavioral Health Clinicians and an Emergency Medical Technicians (EMT) in order to provide both medical and behavioral assessments in the field, including in a medical emergency department. This team would initially be available 16 hours a day, 7 days a week, and focus on two communities that are identified as underserved. The team would be able to provide transport to the appropriate services, including psychiatric hospital, emergency department, crisis residential, sobering center or other site, for clients on 5150 holds or not requiring a hold.
- Enhance the bed availability software program (Reddinet) to show availability of psychiatric, crisis stabilization units, and sobering center beds and provide alerts when the psychiatric emergency services are reaching capacity in order to provide real time information about the availability of disposition options.
- Provide access to tele-psychiatry for the crisis response team in the field.
- Provide the crisis response team with access to a Community Health Record through AC Care Connect, which enables them to send an alert about the episode to other providers involved with the client.

By bringing together the right staffing and the right technology, this innovative crisis response team will *reduce unnecessary 5150 holds, transportation to medical facilities for medical clearance, and the many hours of waiting for clients and first responders.* In addition, it will increase access to appropriate services by connecting and transporting clients whether or not they are on a 5150 hold.

The CATT project officially began with a soft roll out July 21, 2020. There were three (3) teams that rolled out to support coverage in San Leandro, Oakland, and Hayward. Limited coverage was begun in order to focus on identifying challenges and seeking solutions to address these issues quickly before broadening team coverage.

Between the roll out date in July, 2020 and October 21, 2020, there were 364 requests for a CATT team response. A CATT team was dispatched to 214 of these requests. The following table displays the city distribution of requests to responses (this data has not verified by the CATT team's evaluator):

Name of City	Number of Requests	Number of Responses
Oakland	184	94
San Leandro	88	58
Hayward	58	44
San Lorenzo	13	8
Castro Valley	12	5
Piedmont	7	4

Of the 214 CATT responses, 33% (71) of the calls ended in transports to appropriate service facility or safe location. The remaining 64 % (137) had alternative dispositions which included cancellations prior to scene arrival or no patient located; refusal to be treated or transported; and patient treated/transfer by another EMS professional or treated/transported by private vehicle.

CATT Summary of Challenges & Resolutions

Before the CATT project was able to begin, there were a number of challenges that delayed the project's start. Several of these challenges continue to task the project managers:

Challenge	Resolution
Procurement of the CATT vehicles were delayed due to strikes at the automakers' facilities.	There was nothing to be done except wait for the strike to end. Vehicles were eventually delivered in spring 2020.
A new ambulance operating provider (EMS portion of project) was contracted in summer 2019.	Negotiations for EMS recruits in the CATT project had to start over. These negotiations included hours available to work, pay rate, and overtime pay. The pay rate negotiation continues because this was a new contract and the budget will need adjustments in funding.
Recruitment of clinicians was difficult because of a 12-hour commitment.	CATT project's community-based organization (CBO) clinician provider, Bonita House, began offering signing bonuses and offered more pay. Even with these incentives, recruitment continues to be challenging.
COVID-19 Pandemic	The pandemic brought new unknown challenges such as health safety issues for clients and responders, and safe travel in the same closed vehicle. PPE usage and ventilation issues were addressed as research confirmed what was best. To date, there has been no transference of covid from responders to clients and vice-versa.

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 will be requesting additional funding from the OAC. This funding will be for EMS, EMTs, and EMS' project administrator. Funding for the extra costs of clinicians has been covered through other county funds. However, additional funding will be required to cover the shortfalls for fiscal year 2020/2021 and the next two years of the CATT project:

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

ACBH will be working with their OAC technical advisor to present and propose the request for additional funding.

Project Name: Mental Health Technology (MH TECH 2.0)

Project Description: Technology is on the forefront of innovation for health monitoring, be it physical or mental health. Alameda County is fortunate to be located on these front lines of technology. The County's unique location in the Bay Area provides residents close proximity to not only Silicon Valley, but numerous other technology companies, big, small, and emerging. This parity provides the County with a community that tends to embrace new technology with enthusiasm.

Mobile apps that focus on mental health can be used for a variety of purposes. They show great promise in promoting healthy behavior changes, increasing adherence to treatment programs, providing immediate psychological support, facilitating self-monitoring and reducing the demand for clinician time.[1] As mobile applications grow in popularity among the general public, so does the potential to increase the quality of care and access to evidence-based treatments through this technology.

Technology also brings with it a source of anonymity. Anyone with a smartphone is able to access technology, and in most instances, able to maintain their anonymity due to encryption methods. This can give the user a feeling of less loneliness, isolation, or the feeling of being judged; a sense of empowerment; and reduction in distress, anxiety or fatigue. These are all benefits of being in a support group according to the Mayo Clinic.[2]

This two and half years (2.5) project was approved by the MHSOAC on April 25, 2019 and intends to provide a platform for individuals who reside in isolation, anonymity, or feel they have no place to go because of their situation. This project offers new opportunities for outreach, and engagement, and support to these communities by testing a technology-based delivery system for mental health solutions.

The MH Tech project began April 1, 2020. There are five (5) grantees creating mental health mobile apps for four (4) targeted populations. Of the five (5) grantees, two (2) of them are doing a single targeted population while the remaining three (3) are doing multiple populations. The targeted 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

[1] https://www.mayoclinic.org/healthy-lifestyle/stress-management/in-depth/support-groups/art-20044655

[2] Spurgeon JA, Wright JH. Computer-assisted cognitive-behavioral therapy. *Current Psychiatry Reports*, 2010; 12:547–552.

Several grantees are online and testing. Their websites are available in the chart below. The following also broadly shows the status of the grantee projects:

Grantee	Targeted Population	Status
DHTI	TAY (Youth/Transition Age Group)	Research continues for the TAY site and preparing for user evaluation period.
	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. Grantee went on a radio show and are now more
	Immigrants, Asylees, and Refugees	Population requested tangible solutions in addition to and before addressing mental health.
MHACC	Caregivers of Individuals with SMI or SED	New clickable demo with new home page layout which provides connections to mental health providers. Currently being tested by caregivers.
	Attempted Suicide Survivors	App design is in its third design after receiving input from their beta testers.
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.

One of the goals of the MH Tech project is collaboration between grantees. Currently, NAMI and Niroga Institute have begun collaboration. Niroga has been added to NAMI's website. Both of these grantees are seeking to include other grantees in a collaborative format.

MH Tech 2.0 Summary of Challenges & Resolutions

The initial challenge was completing negotiations with all grantees to finalize their agreements in the fall of 2019. Due to the board of supervisors' schedule towards the end of 2019, and beginning of 2020, it was difficult to get onto the agenda for final approval. Once agreements were signed and scheduling issues were settled for final board approval, the project began quickly in April 2020.

As the project began, so did the COVID-19 pandemic which shut down society and its infrastructure. It quickly became apparent that this project was beginning at an unprecedented time: individuals and families were being cut off from their in-person social networks, and support groups. It was agreed at the first quarterly meeting that the pandemic brought with it unforeseeable despair, and a unique opportunity to be designing a mental health application. The timing for this project to begin has placed all the grantees on an even higher alert in seeking to enhance their apps to support their targeted populations.

Although most of the grantees and their software developers have had setbacks due only to redesigning measures, one of the software developers' entire team contracted covid in December 2020. The outbreak set them back (2) months behind schedule. However, the grantee believes that they currently can get back on schedule by late spring.

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:

A Community Land Alliance (CLA), which will be based on a community land trust model, would be a nonprofit, community-based organization designed to ensure community stewardship of land. Community land trusts are often associated with conservation efforts, but there is also a significant effort to ensure affordable long-term housing through this form of ownership. The alliance will acquire land and maintain ownership of it permanently. The CLA enters into a long-term, renewable lease with residents. When the resident leaves, they earn a portion of the increased property value. The remainder is kept by the trust, preserving the affordability and purpose of the property for future households.

The proposed Innovation Project will promote interagency collaboration to create an **Alameda County Supportive Housing Land Alliance to develop and maintain supportive housing units.** ACBH will partner with Alameda County Housing and Community Development Department, housing and real estate legal and financial experts, consumer/client representatives, family member representatives, and existing nonprofit affordable housing developers to develop a land trust focused on supportive housing that incorporates unique aspects in order to address local conditions.

The Supportive Housing Land Alliance is a five (5) year project approved by the MHSOAC August 22, 2019. The Request for Proposal (RFP) process was completed in March, 2020, and the awarded bidder, Northern California Community Trust (NCLT), went to work immediately.

ACBH has contracted with a subject matter expert: Burlington Associates (BA). BA is a national consulting cooperative founded in 1993 to support community land trusts and other shared equity homeownership strategies. BA has associate offices across the United States. ACBH is fortunate that one of BA's partners is in Petaluma, CA. BA is providing technical assistance in getting the CLA started; assist with long-term planning for the stewardship, sustainability of the CLA's operations, and other aspects of the project that BA's expertise will be beneficial. BA's technical support is inclusive to NCLT and the FUSE fellow (described below).

CLA Summary of Challenges & Resolution

The Supportive Housing Land Alliance began in October, 2020 after receiving approval from the County Board of Supervisors. However, due to the pandemic, it was identified in late spring 2020 that the county's administrative and managing staff that were assigned to support the project would not be able commit a reasonable amount of time. It was agreed, and the budget supports, a fellowship would be appropriate to support the deployed project managers and staff who are unable to reasonably fulfill duties while performing COVID response team duties.

The county has collaborated with the national nonprofit FUSE Corps to create an executive fellowship. FUSE partners with local governments embedding executive fellows in cities and counties across the country to assist on issues ranging from economic and workforce development, healthcare, public safety, climate change, and education. FUSE fellows work closely with their government partners designing yearlong strategic projects, recruit experienced leaders, and provide ongoing support to help executive fellow achieve their full potential for community impact.

FUSE conducted a national search for the most qualified candidates. After candidates were selected by FUSE, ACBH staff, a Pool of Consumer Champions (POCC) member, and the county's Burlington Associates' partner conducted interviews and chose the most qualified candidate. The FUSE fellow is working closely with NCLT's project manager, BA, and ACBH staff to keep the CLA project on track, doing outreach, and moderating conversations between stakeholders. The FUSE's fellow's broad duties include:

	Duties	Completed
1)	Review current affordable housing efforts and engage with stakeholders	Identify, engage various stakeholders; synthesize information into framework for CLA
2)	Develop a comprehensive strategic plan to establish and sustain CLA	Establish timeline of CLA with support of NCLT, and the project's subject matter expert
3)	Ensure incorporation of CLA	Required document filings are in process
4)	Launch the pilot project	Will begin after all documents completed for nonprofit status
5)	Support long-term implementation	This will begin after incorporation of the CLA

Currently, the CLA project is pulling together its Advisory Committee as stated in the project's Request for Proposal (RFP) and project proposal. The Advisory Committee is comprised of a diverse membership from the community, the project management staff, POCC members, ACBH staff, consumers, and family members. The Advisory Committee's main function is to ensure meaningful stakeholder participation. The committee's duties include disseminating updates and results to their agencies and other stakeholders; updating the MHSA Stakeholders Committee, and other interested community groups.

PROJECT NAME: Community Program Planning Process

Project Description: Alameda County Behavioral Health (ACBH) continues to be fully invested in having a dynamic community process that is inclusive of all communities within the County. Community involvement from the residents of the county is essential to Innovation planning and program development. ACBH has had challenges in its outreach to many of its diverse populations. These challenges include outreach and engagement to unserved and underserved individuals in both urban and rural areas. The County is dedicated to developing a revitalized and improved approach to ensure more meaningful input from all individuals living in the county.

Alameda County requested to use INN funds for fixed annual allocation for community planning activities involving stakeholders, especially individuals in unserved and underserved communities of the county. This annual allocation will be specific in its support of design, development, and implementation of INN ideas brought forth through the community planning process. Presently, under MHSA regulations, counties may use up to 5% of their total MHSA budget to fund community program planning, and designate positions for oversight and support.

The CPPP innovation planning was done between April – May 2020. The process was accomplished in a virtual manner due to the pandemic. All focus groups were held virtually along with a large POCC webinar presentation that included voting on proposed ideas gathered from a dissemination of online submittals, surveys, and focus groups.

Even though all CPPP's outreach was done in a virtual manner, over ten times more people were reached than in the 2018-2020 CPPP. The highlights and summaries of the CPPP are:

Alameda County Three-Year Planning Process Summary

MHSA 3YR CPPP	2018-2020	2020-2023
Outreach Timeline	September-October 2017	April-May 2020
Outreach Summary	1,000+	14,069+
Survey Responses	550	627
Focus Groups	18 *138 participants*	12 *198 participants*
Public Comments	10	227

An online survey was posted to the County MHSA website in the county's seven threshold languages. There were no responses for four of these languages (Table 1) as displayed below along with first time participants (Table 2):

Table 25. Number of Survey Respondents by Survey Language (n=627)

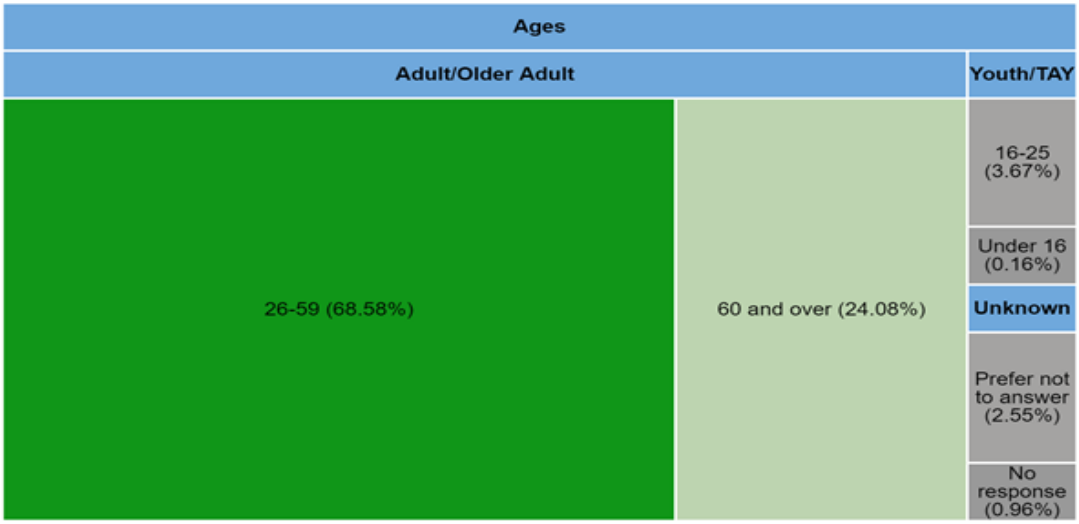
Survey Languages	Number of Responses
1. English	587
2. Chinese	31
3. Spanish	9
4. Farsi	0
5. Korean	0
6. Tagalog	0
7. Vietnamese	0
Total	**627**

Table 26. First Time Participating in MHSA Community Program Planning Process (n=627)

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

CPPP SURVEY DEMOGRAPHICS: AGE GROUPS

Figure 24. Participants' Age Groups (n=627)



CPPP SURVEY DEMOGRAPHICS: RACE AND ETHNICITY*

Figure 25. Participants' Ethnicity (n=553)
(n=612)

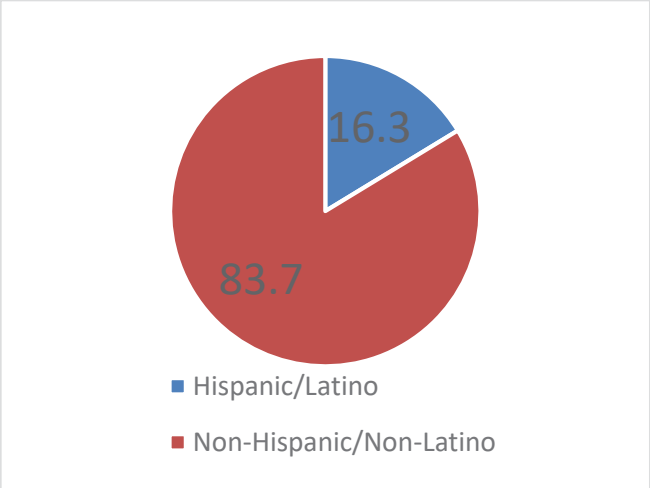
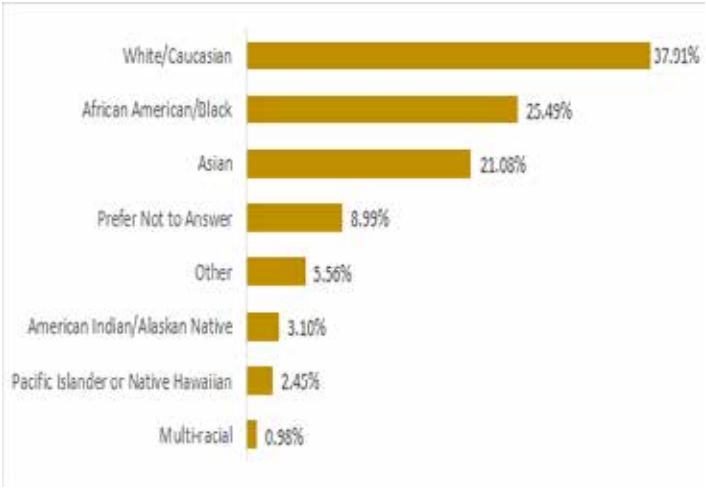


Figure 26. Participants' Race



CPPP SURVEY DEMOGRAPHICS: STAKEHOLDERS*

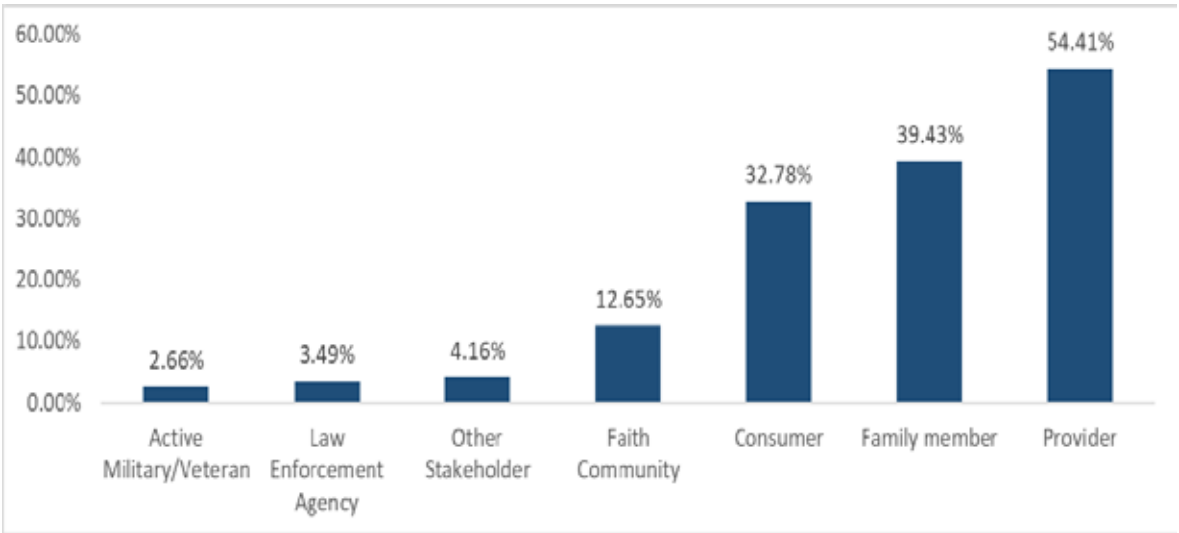


Figure 27. Participant's Stakeholder Group (n=601)

(*Participants were allowed to choose more than one category so percent total is more than 100%.)

CPPP Survey Highlights:

Figure 28: Housing and homelessness is a community priority especially among adults and older adults (see Figure 5.)

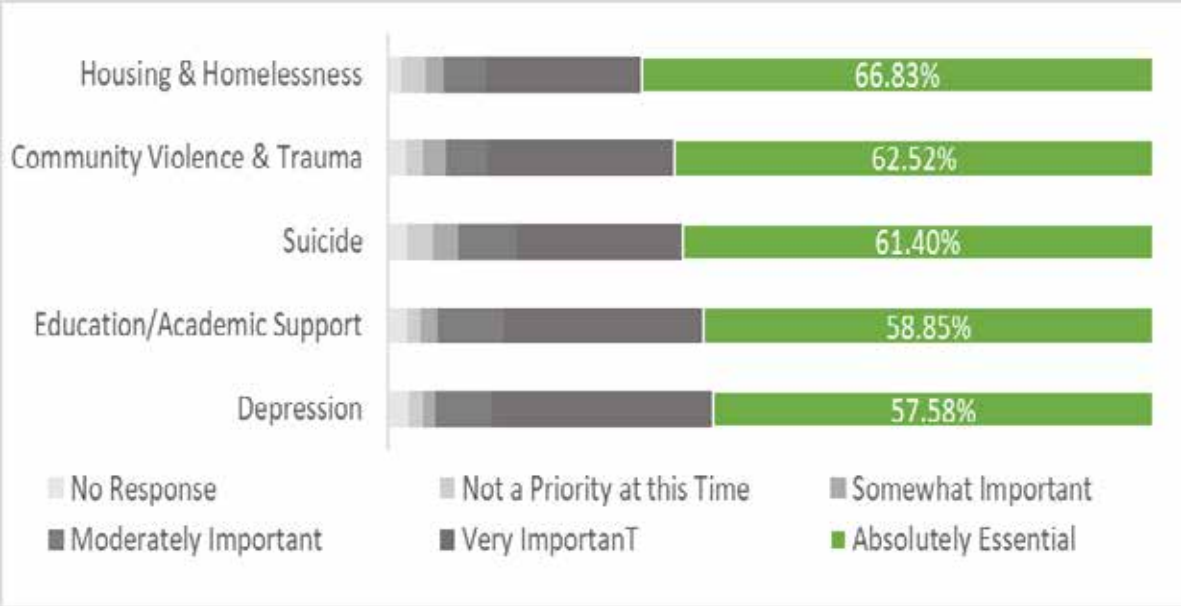


Figure 29. Top Five Priority Mental Health Needs for Adults and Older Adults (N=430)

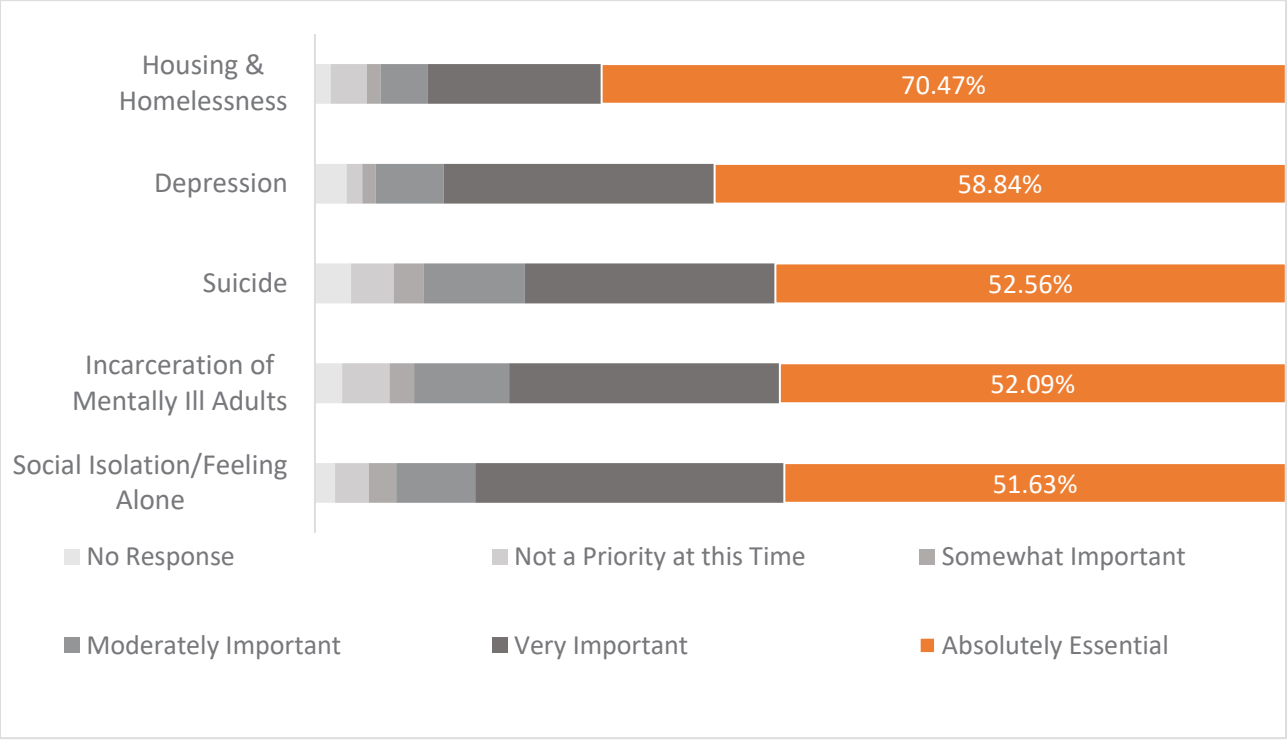


Figure 30. Populations or Groups not Adequately Served by System (n=591)

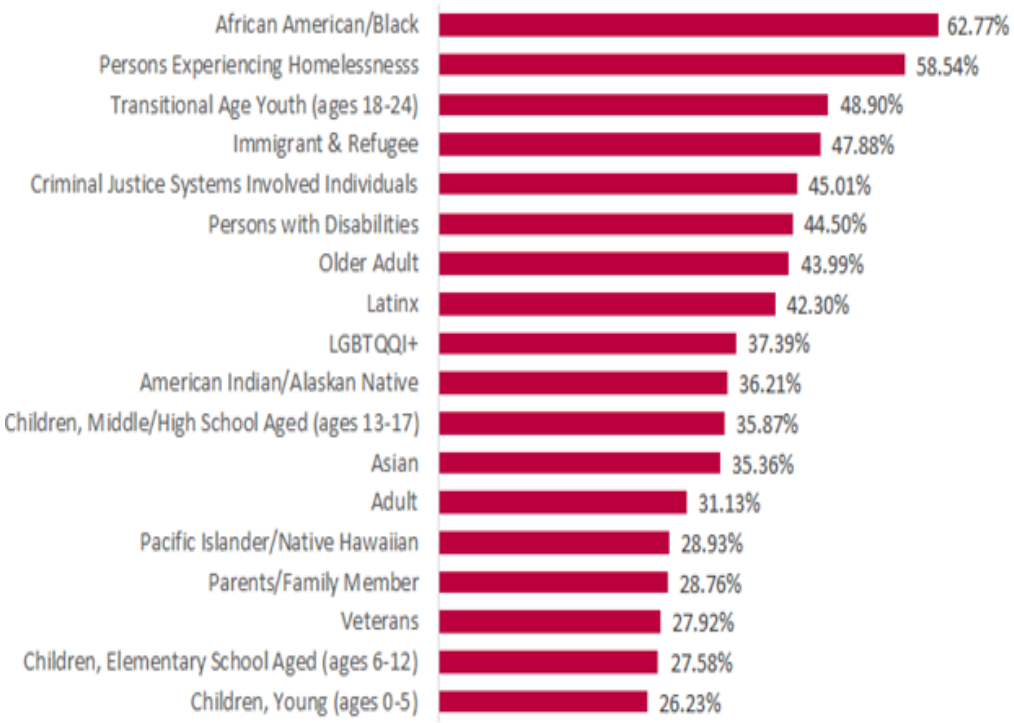
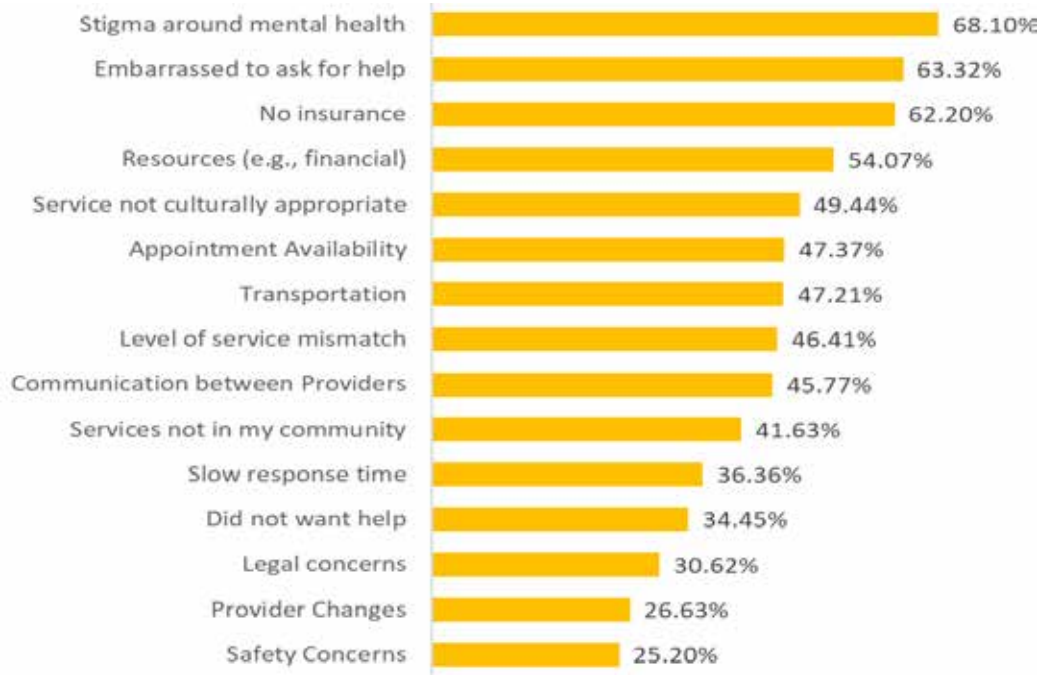


Figure 31. Barriers to Accessing Mental Health Services (n= 627)



Community Program Planning Process (CPPP) Summary of Challenges & Resolution

As noted above, CPPP innovation planning was done between April – May 2020. There are no current challenges to report.

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.

CPPP SURVEY HIGHLIGHTS: INNOVATION (INN) IDEAS

- Community and Home-base Services
- Services for Transition Age Youth (TAY)
- Outreach/Education for Stigma Reduction
- Housing Supports
- School-based Services
- Increasing Culturally Responsive Services
- Care Coordination/Provider Communication
- Telehealth – individual and group
- Creativity and recreation-based therapies
- Increasing peers in the workforce
- Supporting Families

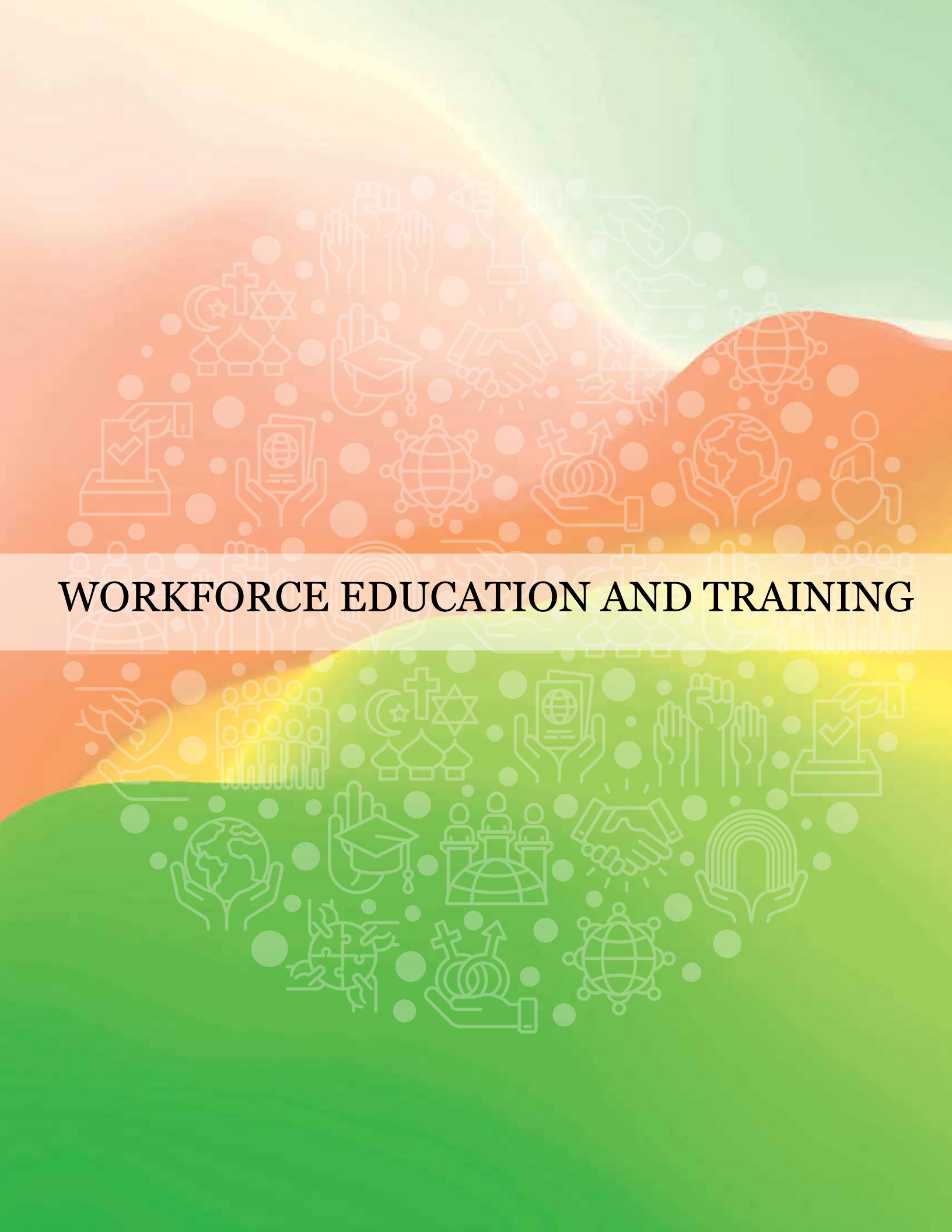
The County is currently evaluating input presented during the CPPP. These discussions have been narrowed to a number of possible new projects and are broadly represented in **Table 26:**

Table 27. New INN Programs under Development for Possible Future Procurement

INN IDEAS	Population	Problem Trying to Solve	Strategies
1. TAY Strategies for justice involved TAY	System involved TAY	There is a high percent of TAY receiving MH services in most restrictive settings (JJC/Santa Rita)	TAY peer training coupled with intensive MH services
2. Housing Supports and Advocacy	ACBH clients	Many ACBH clients are placed in housing and fail due to lack of supports. How do we keep our clients housed, supported and educated about their housing rights so that they can move from healing/stabilizing to thriving?	Housing Ombudsman team, which would include peers
3. Peer Respite for Justice Involved Individuals	ACBH clients discharged from Santa Rita Jail who need respite connection to services	Many ACBH clients discharged from Santa Rita have few resources and supports, leading to potentially high recidivism rates	Peer Respite for Justice Involved Individuals

4. Ethnic/Cultural Communities, specifically, African American and Transgender Community	African American Community	COVID-19 and the social injustice/racism/homophobia that has been experienced by African American/African American transgender community there is *increased illness, trauma and death.*	Holistic faith-based services
5. Peer-Based Strategies, Consumer Empowerment	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
6. New/Innovative Service Team Model	SMI in South County	How to better engage and treat SMI clients who qualify for ACBH services through a revamping of the service team model	Pilot a revamp of the Service Team Model

The pandemic has placed many unexpected changes on how the county's CPPP was achieved in 2020. However, a new and increased effective use of digital and online technology provided ACBH with opportunities to be explored for innovation. Alameda County looks forward to working collaboratively with the community to uncover potential ideas to move the mental health field ahead.



WORKFORCE EDUCATION 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 (Success Story)

Alameda County College Mental Health Student Navigator Pilot Program

The Alameda County College Mental Health Student Navigator Program was born from the realized need that our community college mental health services were often overwhelmed by students in need of long-term mental healthcare. Since most campuses can only operate on a short-term model (only six to eight sessions with the campus therapist) they were not equipped to further assist some students with mild to moderate symptoms. Without additional staff, many of these students were handed a resource sheet with a list of numbers who could provide them with long term care. The Navigator Program was created to bridge this gap and replace the resource sheet and interested students in "case management" to support their peers in a transition from campus-based care to community-based care.

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 four schools: Berkeley City College, Chabot College, Laney College, and Ohlone College.

Student Navigators finished eight weeks of an intensive training program, collaborated with their respective campus mental health liaisons to develop protocols and flowcharts on the "warm handoff" process and communication efforts, and connected with nine mental health community agencies through "virtual showcases" of their services. Results from pre-post tests have shown increases in knowledge in a wide range of mental health topics and self-efficacy in students' ability to communicate and support their peers. More importantly, navigator students have expressed a high level of satisfaction and engagement with the program and their ability to connect with and learn from each other.

Tyler Bennett is one of the Mental Health Navigators and is a student at Berkeley City College. He is a cisgender gay man who lives in Berkeley and is intending to pursue an Undergraduate degree (and later a Masters) in some form of Social Work and/or Public Health. He is personally aware of the needs of students due to the unique circumstances of his academic career and personal life experience:

"I am a returning college student who struggled deeply the first time I tried to go to college. I had so many things going on in my head and at home, that school could not take the priority it needed, and I dropped out. As a returning student, I am also aware of how intimidating it can be to return to a classroom at an older age while trying to juggle the initial stigma/shame of being older, the responsibilities of jobs, personal life, and academics. No matter the age of a student, our lives can have challenges that are difficult to navigate especially when we are trying to figure out what we want to do with our lives. If we also happen to have a mental illness or unresolved trauma, it makes it so much harder. Knowing just what I've gone through while recognizing the difficulties in what my peers go through is what drives my empathy to help support people and get them the help and tools they want/need to succeed."

Tyler's leadership and compassion are also shown through his desire to help make the job for the navigators easier with the inception and head development of their "navigator app". The app was made to help the navigator team resource their clients to organizations in a searchable database and map to better organize information and make real-time updates of community-based services in our evolving environment. Tyler shared:

"I have done resourcing before as a Hotline Volunteer at San Francisco Suicide Prevention and know that it can be hard to keep track of information when you're working with someone who is vulnerable and in need. Since this information is ever changing, especially when considering how COVID has changed how/when providers are operating, we needed to ensure that when we are talking to clients, we present ourselves as knowledgeable and accurate experts. Many of us have discussed how exhausting it has been to pursue help when we were in need: calling numbers given to us that did not work or we were not told the full details of how/if we qualify for services. The app seemed like the best solution to all these issues and is something that has been an absolute joy to collaborate on with this amazing group of people."

Tyler and his cohort are incredibly grateful for the opportunity to work with their Navigator cohort as they have been able to engage with a cause they all have a passion for alleviating. They feel confident that their participation and contributions have been purposeful in helping to lay the groundwork for what this program needs to continually evolve into what our current and future students need.

Client Vignette (Success Story)

<u>Wellness in Action Project, Center for Refugees and Immigrants Empowerment (CERI)</u>

Increasing diversity and inclusion of refugee and immigrant communities in the mental health field is of utmost importance if we are to meet the mental health needs of the multicultural and diverse population of Alameda County. And still, when it comes to support and representation, mental health practitioners (outreach workers, family advocates, MFTs, LCSWs, to name a few) from refugee and immigrant backgrounds find that their participation and inclusion in academic and professional settings can be rife with tokenism. It is common

to hear practitioners say that by highlighting their participation in flyers, through board meetings and welcome orientations, organizations, despite their good intentions, can easily forget the complex human being behind these gestures. It is common that there is a lack of infrastructure, critical consciousness, to manifest alliances and real solidarity in action. Thanks to Wellness in Action, this is changing for many.

Wellness in Action (WiA) is the workforce development program at the Center for Empowering Refugees and Immigrants (CERI), launched to develop career pathways in the mental health field and improve mental health access for underserved refugees and immigrants. It is funded by the Workforce Development, Education and Training (WET) unit to ensure that the Public Behavioral Mental Health workforce in Alameda County is diverse, multilingual, and culturally competent to serve the County's multicultural population better. Thanks to this support, since its inception, WiA has delivered 180 hours of training on diverse mental health practice skills, reaching over 200 participants per year for the past 4.5 years. It has offered training and support to representatives from over 20 local community-based organizations. Through its mini-grant program, it has mentored 26 grassroots leaders on community projects and in developing career paths. WiA leaders have reached over 500 people with community-based and culturally sustaining mental health promotion and wellness services.

Today we wish to highlight one of WiA's participants, Jaq Nguyen Victor, a mini-grant recipient in 2017 and 2018, whose experiences reflect the challenges that many from the refugee and immigrant diaspora face. Jaq is a queer, non-binary, trans, Vietnamese drama therapist. When speaking of their experiences working with WiA, this is what they shared:

"I owe an infinite debt of gratitude to Wellness in Action. When I received a grant back in 2017, the dream of becoming a therapist had seemed to shatter into irreparable pieces. I was struggling to survive academia for reasons that are unfortunately common for countless other first-generation college students of color who end up falling through the cracks."

Jaq, a soulful and creative individual, found out about the WiA mini-grant program and decided to apply in order to launch a healing justice program for LGBTQ+ people. Thanks to WiA's mentoring and support, Jaq developed and offered Dig & Demand - a healing justice program to radicalize mental health services for diasporic queer, trans, of color. Jaq was not only able to successfully lead this group, but they also found, as they say, the "grit and optimism to declare, I will do whatever it takes to become a healer, with or without institutional support." This is how Jaq cleared their way back to graduate school to complete a degree in Counseling Psychology. After launching Dig & Demand's pilot, it turned into an official clinical program. Post-graduation, Jaq continued at CERI as an AMFT providing groups and other clinical services to the Southeast Asian queer community. They have also continued to offer Dig & Demand at different locations. Jaq shared:

"Looking back, such success is almost unbelievable to me. I was at my lowest of lows, but then a program like Wellness in Action came along. It taught me how to imbue my pain with purpose and the importance of staying with my wounds until they could yield their blessings. I am so grateful to be an Associate MFT.

Even though the path continues to be rife with adversity and injustices, I now believe that I can meet such things with resilience."

Jaq's journey is a testimony of how life-changing and powerful it can be to participate in workforce development programs beyond the tokenism of "diversity and inclusion" towards transformation. Today, Jaq is a drama therapist and registered AMFT and has recently completed their 3000 hours of supervised practice to be eligible for a license. We can't wait to see what they will do next.

Workforce, Education & Training Program Summaries:

Alameda County Behavioral Health (ACBH), Workforce Education & Training (WET) uses multiple strategies to build and expand behavioral health workforce capacity including:

1. Workforce Staffing & Support (Staff Development, Training/Conference and Consultants)
2. Staff Development, Training/Conference and Consultants (Educational Pathways)
3. Graduate Internship Program
4. ACBH Training Institute
5. Post Graduate Certificate Program
6. Psychiatry and Integrated Behavioral Health Care
7. Graduate intern Stipend Program
8. Loan Assumption (Repayment) Program
9. PEER Training and Support (Consumer and Family Training, Education and Employment)
10. MHSA Support and Community Based Learning (CBL) Training

Action #1: Workforce Staffing & Support

FY 20-21 Progress Report:

- ACBH is committed to continue WET activities and WET is currently funded through the MHSA Community Support Services (CSS) component. WET is focusing on workforce capacity building through behavioral health career pipeline development, training opportunities, and addressing strategies to recruit and retain hard to fill positions, increasing diversity, bridging gaps in skills set and improving language capacity.

- The WET team continues to prioritize, develop and implement projects based on the 2017 workforce needs assessment survey outcomes. They also continue to evaluate WET program impact and needs based on program outcomes and informational data.

- 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 will inform our system on further developing our workforce and training programs.

- In an effort to analyze current workforce characteristics and to potentially project local Public Mental Health Services (PMHS) workforce needs across the state, in October 2020, the Office of Statewide Health Planning and Development (OSHPD) conducted a PMHS workforce demographic survey. The target audience was County civil service employees who are involved in the delivery of care in the PMHS. ACBH WET collaborated with OSHPD and in coordination with Alameda County Health Care Services (HCSA) Human Resources gathered required information to provide to OSHPD to ensure ACBH workforce participation in the survey.

Action #2: Staff Development, Training/Conference and Consultants

Program Description: MHSA WET funds are used in a variety of ways to support staff development, provide additional trainings to targeted communities and utilize consultants to implement community or school-based projects on a one-time basis.

FY 19/20 Progress Report:

- In 2019, the WET team explored ideas and strategies regarding setting up a non-licensed/license-eligible clinical supervision pilot project to help eligible clinicians gain their supervision hours. The vision of this project was to increase the number of licensed bilingual and clinicians of color to fill hard-to-fill/retain positions in the contracted community-based programs. WET team worked with the ACBH Systems of Care leaders to identify needs for each system as well as seeking input on program design, including supervision methods to build a pipeline that can potentially address the licensed-staff shortage issue. WET program intended to sponsor the provision of master's level clinical supervision to eligible agency staff at no cost to the supervisee or the agency.

- ACBH WET provided funding to the program FACES for the Future (FACES) at the Public Health Institute to provide follow up and continued engagement services to underrepresented students interested in pursuing a career in public mental and behavioral health. FACES has been working on the development and implementation of the following activities:

- **Behavioral Health Alumni Support:** FACES continue to support Behavioral Health Alumni through a variety of means -
  - Continued workshop series hosted in the evening and focused on professional development, career exposure and creating a supportive professional network. Attendance has been limited because of COVID and the holidays, but continues outreach on social media.

  - Continued the peer support series and the goal is to create a network that is both socially and professionally supportive.

  - FACES has hosted 2 additional social events that were very successful and well-received by alumni. These events included games, open-mic time and ice breakers. Many alumni express a consistent need to de-stress and create social bonds during shelter-in-place orders and new surges of COVID-19.

  - FACES has offered slots for Mental Health First Aid certification to alumni and the response was overwhelming. To meet demand, FACES added 5 reserved slots for alumni in each of the community-based trainings hosted by Cypress Resilience Project.

- **Consultation and Technical Assistance:**
  - FACES staff have maintained contact with staff at Skyline HS. Off-site learning continues during the current COVID-19 surges in the County. Teachers report that students are experiencing a lot of stress and struggle with engagement in course work.

  - Currently, FACES/Cypress Resilience Project staff are waiting to hear about virtual teaching options for Teen Mental Health First Aid training. Since the required 20% of teachers have already been trained in Youth MHFA, the staff could ostensibly move forward with training the students at Skyline if the

National Council of Behavioral Health opens Teen MHFA to a virtual format.

  - FACES reported that they expect the virtual option to be released in Feb, 2021 through the National Council. At that time, FACES can move forward with scheduling the Teen MHFA for Skyline students. The teachers and FACES staff remain in contact and check-in regularly for updates.

- FACES is working with Eden Regional Occupational Program (ROP) in Hayward to establish a vision for the Bright Young Minds event that will be held virtually at the end of April, 2021. Eden ROP serves students from across South Alameda County including San Leandro, San Lorenzo, Hayward etc. Our intention is to establish workshops with the Health Careers classes at the ROP which currently serve approximately 100 high school students. That leaves us with a significant recruitment pool for a Spring event. Right now, the team is interested in seeing if FACES can offer Bright Young Minds as a series of online workshops rather than a one-day event. This is likely a better scenario for online learning and school schedules. Likely, this will include both the morning and afternoon sessions of the Health Careers class – approximately 80 students are in each session. Right now, the FACES team is designing the workshop priorities – there will be a focus on career exposure as well as some content. Students have expressed interest in learning more about trauma and mental health during COVID-19. FACES/Cypress staff already have created student focused workshops on these topics and can offer those during the Bright Young Minds virtual event.

FY 21/21 Progress Report

- On March 5, 2020, ACBH WET organized an informational meeting on the License-Eligible Clinical Supervision Pilot Project in collaboration with the Alameda County Child and Young Adult System of Care (CYASOC). Soon after that meeting Alameda County announced a Shelter in Place order and our focus shifted how to serve clients while maintaining staff and client safety.

- ACBH WET collaborated and participated in "**A Conversation with Dr. Jei Africa: Filipino Wellness, Racial Justice, and Action"** hosted by Alameda County Behavioral Health - Filipino Mental Health Initiative, Ohlone Mental Health Navigators Program, Chabot Community College CARES program, and Filipino Advocates for Justice.

Challenges:

- The FACES for the Future Coalition continued to pivot much of its operations to online formats in response to the COVID-19 crisis. In addition, Public Health Institute has required all FACES staff to continue to work from home until at least July 1, 2021. Schools and school districts have executed varied responses for Fall/Winter instruction, and remain closed for on-site operations. Trainings, workshops for students and alumni, meetings etc. have all been converted to the online platform Zoom.

- We have temporarily stopped the clinical supervision project development process due to the impact of COVID 19 pandemic including changes in priorities as well as significant budget uncertainty. Our current plan is to obtain additional data for our needs assessment regarding this project and monitor funding availability.

Action #2: Staff Development, Training/Conference and Consultants (Educational Pathways)

Program Description: Develops a mental health career pipeline strategy in community colleges, which serve as an academic entry point for consumers, family members, ethnically and culturally diverse students, and individuals interested in human services education, and can lead to employment in the ACBH workforce.

FY 19/20 Outcomes, Impact & Challenges:

ACBH has developed 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. The WET Team, along with the organization called FACES and Oakland Unified School District planned, organized, and hosted the Bright Young Minds (BYM) conference on April 18, 2019 at the California State University East Bay. It was a ground-breaking conference with 65 high school students from diverse and under-represented communities participating to explore behavioral health care career options.

FY20/21 Progress Report

- Ohlone College completed its second 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).

- Service learning projects included workshops on suicide prevention, art therapy, a “chill and chat” session on mental health pre-finals week, and a “Stamp Out Stigma, Seek Support” social media campaign to reduce stigma associated with help-seeking behavior. Students also had an opportunity to hear from retired and active professionals in various mental health professions. This workforce development program is part of the college’s comprehensive approach to promoting student mental health and well-being and expose students to mental health related career opportunities. Students are trained using the “Wellness, Recovery and Resiliency” curriculum provided by ACBH.

- 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 the institutionalizing of the Wellness, Recovery and Resiliency curriculum.

- The WET team revised the existing mental/behavioral, 12-module curriculum, “An Introduction to Behavioral Health Care Services: Curriculum on Wellness, Recovery and Resiliency” through a contract with California Association of Social Rehabilitation Agencies (CASRA).

- The Alameda County College Mental Health Student Navigator Program has completed its first semester of a 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.

- Mental health services at community colleges throughout the state and in Alameda County operate on a short-term model where students typically can access up to six or eight sessions due to limited resources and high needs of students who need counseling 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 four schools: Berkeley City College, Chabot College, Laney College, and Ohlone College.

- Students finished eight weeks of an intensive training program, collaborated with their respective campus mental health liaisons to develop protocols and flowcharts on the "warm handoff" process and communication efforts, and connected with nine mental health community agencies through "virtual showcases" of their services.

- The group worked collaboratively in developing a "navigator app" that is a searchable database and map to better organize information and make real-time updates of community-based services in our evolving environment due partly to the pandemic. Results from pre-post tests have shown increases in knowledge in a wide range of mental health topics and self-efficacy in students' ability to communicate and support their peers. More importantly, navigator students have expressed a high level of satisfaction and engagement with the program and their ability to connect with and learn from each other.

- ACBH WET collaborated with the Department of Health Sciences Undergraduate program at California State University East Bay and participated in the Undergraduate semester long Capstone Internship Project. The focus of the Capstone Project was Problem-based Learning (PBL). Students learn about a subject by working in groups to solve an open-ended problem. Instead of learning concepts and topics and then applying them to a situation, PBL courses begin with a problem statement of practical importance. In groups, students explore what they know about the issue, determine what information is still needed, and identify where relevant topics, data, and tools can found to solve the problem. ACBH WET and two MHSA staff provided three problem statements for the PBL projects and mentored a cohort of twelve students, which was sub divided into three teams.

- 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 six mini-grant awards to support grassroots community leaders and provided technical and clinical consultation and skill building trainings for careers in community mental health.

- Nature-Based Perspectives & Approaches to Mental Health: WiA worked in partnership with Raynelle Rino of Rino Consulting Solutions on a training to dive into migration and the human connection to land to cultivate conditions for remembering and reconnecting. This training was for WiA grantees, with additional spots open for Mental Health frontline staff at local community-based organizations as well. WiA piloted this curriculum from Jan- March 2020. Nine (9) participants attended this training.

FY 21/22 Anticipated Changes:

- ACBH WET does not anticipate any significant program implementation changes during FY 21-21.

Action #3: Internship Program

Program Description: Coordinates academic internship programs across the ACBH workforce. Outreaches to educational institutions to publicize internship opportunities.

FY 19-20 Outcomes/Impacts/Challenges:

Execution of new streamlined onboarding process for Adult & Older adult Systems of Care, Adult Forensic Behavioral Health and Vocational Rehabilitation Programs

- Onboarded eight (8) student interns to the newly reorganized Adult & Older Adult System of Care program for the 1st time in two (2) years.
- Provide all programs with the Onboarding Resource Manual which was created to provide guidance, structure, and compliance for the internship program.

Thirty-one (31) students were onboarded and placed within ACBH programs and units. Nine (9) interns with the Children's and Young Adults System of Care, Eight (8) Adult & Older Adult System of Care, Nine (9) with CONREP, and Five (5) Other (1 undergrad student with WET, 3 nurse practitioners with AOASOC, 1 high school student AOASOC).

Ongoing relationship building efforts between the internship coordinator, HR, Finance and clinical teams positively *impacts* efficiency and value add of the Internship Program. The competing priorities of multiple internal and external stakeholders requires a higher level of coordination and standardization.

2019-20 ACBH Interns – Ethnicity (Number of interns= 31)

African American	5 – 16.1%
Asian Pacific Islanders	4 – 12.9%
Caucasian	9 – 29%
Hispanic/Latino	10 – 32.3%
South East Asian	3 – 9.7%

2019-20 ACBH Interns – Language (Number of interns= 31)

English	17 – 54.8%
Cantonese	0
Mandarin	2 – 6.6%
Spanish	9 – 29%
Tagalog	1 – 3.2%
Vietnamese	1 – 3.2%
Other	1 – 3.2%

Nine (9) interns were exposed to a total of 25 trainings, including:

- Working with Schools and Special Education, CBT/DBT; Expressive Arts, Healthy Nutrition and Lifestyle; Working with Latino Immigrant Families; HANDLE (Holistic Approach to Neuro Development and Learning Efficiency); Career Advancement; Working with African American Families; Asian American and Immigrant Perspective on MH; Strive Program; Strengthening Relationships Through Partnerships; Documentation Training; Transformational Coaching; Objective Arts/CANS; Play Therapy; Pediatric Psychopharmacology; Suicide Assessment and Intervention; Bullying and Suicide; Early Childhood Assessment; Autism, and Eating Disorders
- In-service training evaluations indicates a positive *impact*. Trainings and the trainers were extremely beneficial and well received by the interns;

Coordinate and facilitate annual internship fairs and internship orientations.

- Tabling at internship Fairs at bay area colleges and universities 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.
- Represented ACBH at five (5) internship and job fairs (61 students visited tables) at Cal State East Bay, USF, San Jose State; Holy Names College including for the 1st time at **HBCU's** (Historically Black Colleges & Universities) **Morehouse & Spelman** to introduce ACBH opportunities to a new, young demographic.
- 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. New this year, creation of new intern orientation resource folder which includes important documents to learning and understanding the ACBH department.

FY 20-21 Progress Report

Developing improved system to collect and manage training and program evaluation results to inform program planning, intern recruitment, placement and follow up.

- Implemented the post-internship program evaluation for interns to complete. This effort seeks to gather information from the intern perspective for continuous enhancement of internship program.
- Continuing 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

- 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.

FY 20-21 Anticipated Changes:

- Social media presence is imperative for the internship program to better communicate and promote program
- Online protocol for Internship Onboarding Process

Action #4: ACBH Training Institute

Program Description: Provides a coordinated, consistent approach to training and staff development. Develops, researches and provides a broad array of training related to mental health practice; wellness, recovery and resiliency; peer employment and supports and management development.

FY 19/20 Outcomes, Impact & Challenges:

- Provided or collaborated on a total of 87 training activities, thereby training 2,126 ACBH and contracted provider staff. Provided 353 continuing education (CE) hours to LMFTs, LCSWs, LPCCs, LEPs, Addiction Professionals, and RNs and 235 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, trainings related to Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS).

- The Trauma Informed Systems (TIS) trainers embedded in the ACBH system provided thirteen (13) TIS 101 trainings to 276 ACBH and contracted provider staff. TIS 101 training provides foundational knowledge of TIS principles and helps participants understand how trauma and stress impact developing bodies and brains, communities, organization, and systems. Provided additional six (6) trainings related to TIS to 140 ACBH and contracted provider staff including “Preventing Vicarious Trauma,” “Starting the Conversation: How to speak with families about the effects of trauma on childhood development and family systems (provided in Spanish),” and “Dynamic Mindfulness.”

- Thirteen (13) of the trainings were hosted by the Office of Ethnic Services and related to one or more of the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS). Some examples include “The African American Community's View of Behavioral Health - How These Ideas Were Formed & What Can be Done to Decrease Stigma,” “Asset-based Approaches to Working with Latinx Communities: Creating Shared Language and Understanding on the Road to Racial & Social Equity,” “Understanding Mental Health Through Indigenous Eyes,” and “Understanding Whiteness: Intent vs. Impact.”

- Provided twenty-eight (28) continuing education credits for the Community Assessment & Transport Team (CATT) Program Training; a 6-day training series of twenty (20) workshops provided to CATT team members starting in May 2020. The CATT Program is a collaboration between ACBH, FALCK ambulance services, Alameda Care Connect, and Bonita House, Inc.

- Provided four (4) trainings in Youth Mental Health First Aid (MHFA) and two (2) Adult MHFA trainings for ACBH and provider staff thereby certifying 124 staff. An additional six (6) MHFA trainings were provided to the community.

- Provided the continuing education credits for the California State University East Bay two-year post graduate Infant and Early Childhood Mental Health certificate program.

- Training outcomes are measured using self-administered evaluations. Each training proposes measurable learning objectives to be achieved by the end of the training. Following the training, attendees evaluate whether the objectives are met using a Likert scale from 1-5 (strongly disagree to strongly agree). At the end of every training, participants are asked to complete an evaluation and if they want continuing education credit, it is required. For all trainings, learning objectives are evaluated as being met on average as at least a 4 or 5 of the Likert scale, with 5 being "strongly agree."

Challenges:

- Due to the Alameda County shelter-in-place order in response to the COVID-19 pandemic, during the period of March through May 2020 seventeen (17) in person trainings had to be canceled. Many trainings were shifted to virtual platforms but doing so took time. The a five-part intensive workshop series called "Caught in the Crossfire of Cultures", which focused on the psychological problems of the Afghan population residing in Alameda County was not able to be offered virtually.

- A challenge and limitation related to the transition from in person trainings to online platforms is the change in the number of participants allowed to attend the Mental Health First Aid (MHFA) trainings. Previously, the National Council for Behavioral Health allowed thirty (30) participants per class. For the virtual version, they limit capacity to twenty (20). We have already felt the impact as we found that the two trainings scheduled for January and February were both full within two weeks of the announcement. Since ACBH funds six (6) trainings for ACBH and contracted provider staff and six (6) for the community, this results in a reduction of 120 less individuals being certified in MHFA.

- With trainings moving to online platforms we were faced with the challenge of how to confirm staff attendance since logging in and out does not verify the person's actual participation or attention throughout. To address this, the training institute implemented the requirement of achieving at least 70% passing score on a post-test for online trainings.

- The training evaluations completed by participants has been administered in paper form which makes compiling, summarizing, and analyzing data very difficult. In 2019, the County purchased a new Learning Management System (LMS) which has the capacity of offering evaluations in an online format. It is planned that evaluations will be administered electronically, which will allow for much improved data analysis and trainer feedback. It is a continued challenge however because the LMS is not yet functional.

- The Trauma Informed Systems trainings were moved to an online platform in response to the shelter-in-place however as staff and the community continued to experience stressors and trauma related to the pandemic, police brutality, and social unrest the instructors felt that the curriculum needed to be revised to better address the current issues. The TIS trainings have been put on hold while the curriculum is being revised.

- Regarding the new Learning Management System (LMS), SumTotal. Although there was a plan to "go-live" with the new system in May 2020, because of system glitches and limited training and technical support, as of January 19, 2021, the system is still not functional. We hope to be able to use the system by March 2021 even in a limited capacity if necessary.

FY 20/21 Progress Report*:*

- As of February 2nd, 2021, provided or collaborated on a total of 33 training activities, thereby training 1,033 ACBH and contracted provider staff. Provided 162 continuing education (CE) hours to LMFTs, LCSWs, LPCCs, LEPs, Addiction Professionals, and RNs and 110 CE hours to psychologists. See the addendum for a list of trainings provided.

- Training topics were provided on a variety of issues including legal and ethical issues, tobacco cessation interventions, adult and youth suicide assessment & intervention, mental health first aid, trauma informed systems related, and trainings related to responding to crisis and using a telehealth platform.
  Some examples include "Anxiety Disorders, Stress and Self Care During the Coronavirus," "Providers: Existential Despair vs. Hope and Agency During COVID-19," "Clinical Techniques and Best Practices Using a Telehealth Platform." Four (4) of the trainings were hosted by the Office of Ethnic Services and related to one or more of the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS). Trainings included *"Recovery Process of African Americans: Seeking Wellness during COVID-19 Re-opening Phases," "People Power Equals Change: Lessons from a Hyperlocal Community Assessment of Opioid Use and Community Well-Being," and "What is Wellness: An Indigenous Perspective on Healing and Connection."*

- Provided continuing education credit for the final semester of the two-year California State University East Bay post graduate Infant and Early Childhood Mental Health certificate program. Thirteen (13) students completed the program and received sixty (60) continuing education hours.

- Provided "Surviving Compassion Fatigue aka Secondary and Vicarious Trauma" to sixty-nine (69) ACBH and contracted provider staff. An overview of Trauma Informed Systems was provided for the National Alliance on Mental Illness (NAMI) East Bay Speakers' meeting and to the African American Family Outreach Project.

- Continue to maintain provider accreditation and offer required continuing education (CE) credit for Licensed Marriage and Family Therapists, Licensed Clinical Social Workers, Licensed Professional Clinical Counselors, Licensed Educational Psychologists, Licensed Clinical Psychologists, Registered Nurses, and certified Addiction Professionals.

- The Greater Bay Area Mental Health and Education Workforce Collaborative provided $4,000 toward the purchase of seats for the Mental Health First Aid virtual trainings thereby covering the fee for eight trainings equaling up to 167 participants.

- Continue the collaboration with California State University East Bay, providing the 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 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.

FY 21/22 Anticipated Changes:

- 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.

- 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 be able to offer online trainings in the future. 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. anytime, anywhere. 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, books, etc.

- The curriculum revision of the 3.5-hour Trauma Informed Systems training is a project scheduled to occur through August 2021. Both a Revision Team and Review Team participate in monthly meetings to revise the 101 slides and additional videos in the PowerPoint. We anticipate a much-improved more relevant and responsive curriculum and plan to highly encourage all ACBH staff to complete the training.

Action #5: Post Graduate Certificate Program

Program Description: MHSA WET provided funding to launch a new two-year *Infant & Early Childhood Mental Health Postgraduate Certificate Program* at Cal State University, East Bay. The overarching goal is to build capacity in a culturally diverse early childhood mental health workforce to meet the social, emotional and developmental needs of young children, ages birth to five, and families in Alameda County.

FY 19/20 Outcomes, Impact & Challenges:

- 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 (*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).

- FY 19/20 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 Progress Report*:*

Program Evaluation

- The program was evaluated by UCSF Benioff Children's Hospital Oakland under the direction of Dr. Laura Frame, Director of Research. The evaluation focused on methodological approaches used for student training. To this end, the evaluation provided ongoing feedback for managers to ensure continuous quality improvement.

- Evaluation methods used to assess the program include 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

- 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.

Administrative Process Review and Program Improvements

- 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.

Challenges

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- Students received “past due tuition” notices from Cal Sate East Bay throughout the first semester although all tuition had been subsidized and completely paid for. This situation has been resolved and should not occur moving forward.

FY 21/22 Anticipated Changes

ACBH WET does not anticipate any significant program implementation changes during FY 21-22.

Action #6: Psychiatry and Integrated Behavioral Health Care

Program Description: MHSA WET provided funding to continue its partnerships with nine Federally Qualified Health Centers (FQHCs) and the University of California, San Francisco (UCSF), School of Medicine to provide behavioral health education and clinical training.

FY 19/20 Outcomes, Impact & Challenges:

- The Office of the Medical Director (OMD) provides funding for advanced training services and opportunities for the Safety Net provider network to ensure that the workforce is always able to provide high quality and culturally responsive care management services to complex and high need patients who are high utilizers of health and social services due to multiple chronic physical and behavioral health conditions.

- OMD continued to provide clinical education and work experience to a selected UCSF School of Psychiatry Fellow at the Alameda County Health Care for the Homeless Trust Health Care Clinic.

- OMD sponsored 4 primary care providers in 2020 to the University of California, Davis, Primary Care Psychiatry Fellowship Program so that they can receive advanced training in primary care-based psychiatry. All of the Alameda County, Primary Care Fellows are from the FQHCs that serve the Alameda County residents.

- The continued funding of 12 Integrated Behavioral Health Care Coordinator (IBHCCs) positions in eight Alameda County Federally Qualified Health Centers to help improve patient tracking, treatment utilization, and accessibility to primary care and behavioral health services for Alameda County residents who use community-based Safety Net health care providers. Their duties also include ensuring timely follow-up to specialty care referrals and social services by assisting patients with scheduling appointments, and securing patient health information and data for the primary care and behavioral health appointments. In 2020, the IBHCCs provided 87,884 care coordination services to 38,471 consumers needing support to other health and social services.

FY 21/22 Anticipated Changes:

- 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. 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. In FY 2021-22, ACBH will host one fellow from UCSF to provide clinical education and training at the Alameda County Health Care for the Homeless Trust Health Care Clinic.

Action #7: Graduate Intern Stipend Program

Program Description: Offer financial incentives as workforce recruitment and retention strategies, and to increase workforce diversity. Financial Incentives are offered to individuals employed in 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.

The Graduate Intern Stipend Program is a financial incentive strategy that is included in the ACBH WET Plan. This program is designed to recruit individuals into BHCS county-operated programs and contracted, behavioral health community-based organizations (CBOs), thus creating a public mental health workforce pipeline.

FY 19/20 Outcomes, Impact & Challenges:

Executed and administered the 8th cycle of the Graduate Intern Stipend Program in August 2019.

- Awarded 20 stipends in the amount of $6,000 each for 720 internship hours. Of the 20 awardees, 90% represent the diverse communities of Alameda County.

2019-20 Graduate Intern Stipend Awardees – Ethnicity (Number of awardees =20)

African American	2 – 10%
Asian Pacific Islanders	2 – 10%
Caucasian	2 – 10%
Hispanic/Latino	13 – 65%
South East Asian	1 – 5%

2019-20 Graduate Intern Stipend Awardees – Language (Number of applicants=20)

English	6 – 30%
Cantonese	0
Mandarin	1 – 5%
Spanish	13 – 65%
Tagalog	0
Vietnamese	0
Other	0

-

FY 20-21 Progress Report

- **Launched 9th cycle of Graduate Intern Stipend Program in August 2020 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.**

FY 20-21 Anticipated Changes: The department does not anticipate any changes at this time.

Action #8: Loan Assumption (Repayment) Program

Program Description: Mental Health Loan Assumption program for individuals who complete a service obligation in public behavioral health in Alameda County.

FY 19/20 Outcomes, Impacts and Challenges

- As of April 1, 2020, ACBH WET entered into a participation agreement with the California Mental Health Services Authority (CalMHSA). The purpose of Alameda County Loan Repayment Program (ACLRP) is to provide financial incentive to hire and retain qualified, eligible employees in hard-to-fill/retain positions in the Alameda County Behavioral Health Care system, including employees of community-based organizations.

FY 20/21 Progress Report

- In July 2020, after a multi-year planning process, ACBH WET in partnership with CalMHSA, launched the local Alameda County Loan Repayment Program (ACLRP) as a workforce recruitment and retention strategy.

- 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.

- The second ACLRP application cycle will open in April 2021.

FY 20/21 Anticipated Changes:

- ACBH WET has developed a multi-year contract with CalMHSA to implement and administer the local Alameda County Loan Repayment Program (ACLRP). ACBH WET does not expect any significant program implementation changes during FY 21-22.

Action #9: Peer Training & Support (Consumer & Family Member Training, Education and Employment)

Program Description: Offers an integrated, coordinated approach to consumer and family member employment and supports consumer and family employees at all stages of the employment process, from recruitment to retention. The goal is to develop and retain authentic consumer and family member voices in leadership roles as we develop new wellness, recovery and resiliency practices across the system.

FY 19/20 Outcomes, Impact & Challenges:

- BestNow, a program with Alameda County Network of Mental Health Clients (ACNMHC), provides peer specialist training program with 6-month internships: There were 15 Class of FY19/20 trainees who have met the requirements to earn a Certificate of Completion out of 23 trainees who started the course.
- The challenges BestNow and all trainings faced were primarily due to the COVID-19 public health crisis. Having to stop the in-person classes and trainings and switch over to a virtual format created the need for additional research and planning by our system. Changing over to an online format was also quite challenging for some consumers due to their level of technological skills, as well as their lack of access to the internet and equipment that would allow them to more comfortably participate. Some BestNow students were relying on smartphones to attend online class sessions which made it more challenging to see content on the screen and did not give them the ability to see all of their classmates on the screen at the same time.
- Another major challenge related to the shelter in place was how it impacted the internships of our program participants. Almost all of BestNow trainees had to stop their internships and instead shift to the assignments and activities BestNow created for them to continue their learning and development as Peer Support Specialists.
- The Office of Consumer Empowerment (OCE) provided POCC Holiday Cultural Event and training in December 2019. 310 people participated with 15 different Pool of Consumer Champion (POCC) committees sharing their cultural norms and practices at the Holiday Cultural Event.
- In February 2020, POCC hosted a Cultural Competency Training with 75 people attending to celebrate Black History Month.
- Virtual Crisis and Peer Support Training with certificate - 22 peers participated in this evidence-based practice training learning how to work with individuals that find themselves in crisis. This training was held via zoom due to the pandemic and shelter in place orders.
- PEERS held on-going trainings for Lift Every Voice and Speak Speakers Bureau in FY 19/20. They were trained in the “Coming Out Proud” curriculum by Dr. Pat Corigan. 25 consumers were trained who are part of the Speakers Bureau. 100% of speakers reported that "This experience was empowering." 83% of audience members reported that "This presentation changed my assumptions about people with mental health experiences."
- Forensic Peer Specialist Certification Training – 20 peers received a certificate of completion for participation in a four-day evidence-based training that focused on the criminal justice system and working within it.

- Community Inclusion Training - 22 peers received a certification for participating in this best practice training focused on peers and peer providers working with individuals using resources within their own communities.

- Crisis and Peer Support Training - 22 peers participated in this evidence-based practice training learning how to work with individuals that find themselves in crisis.

- POCC African American Peer to Peer Town Hall Meetings – 79 people participated in this town hall type training that focused on the voting process and how and why it is effective.

- Peer Specialist Certification Training – 75 people participated and were educated on what it means to be a Peer Specialist.

- Pool of Consumer Champions began a weekly Support in Place (SIP) Support group for all consumers/peers who needed to connect during the COVID-19 pandemic. 6-10 people attended weekly and not always the same people needing this wellness room.

- POCC provided a training on virtual platforms for all individuals in the peer community that struggle with the digital divide during the pandemic. The POCC Public Policy committee hosted this training and had 60 people in attendance.

- POCC hosted a Hearing Voices/Special Messages support group – 5-10 people attend.

FY 21/22 Anticipated Changes:

- ACBH WET does not anticipate any significant program implementation changes during FY 21-22.

Action #10: MHSA Support and Community Based Learning (CBL) Trainings

Program Description: Community Based Learning (CBL) Trainings are free to Alameda County Behavioral Health Care Services (ACBH) systems partners, faith-based communities and non-profit organizations that want to improve health outcomes for consumers and family members in the areas of mental health and substance use disorders.
Alameda County Behavioral Health Care Services Ethnic Services Department is able to offer trainings through funding from Prop 63, the Mental Health Services Act (MHSA). For more information on these trainings please go to: https://acmhsa.org/innovation-community-based-learning/community-based- learning-trainings/

CAPITAL FACILITIES & TECHNOLOGICAL NEEDS

Capital Facilities & Technological Needs
"Bringing People and Resources Together"

The *Capital Facilities & Technological Needs (CFTN*) component of the MHSA "works towards the creation of a facility that is used for the delivery of MHSA services to mental health clients and their families or for administrative offices. Funds may also be used to support an increase in peer-support and consumer-run facilities, development of community-based settings, and the development of a technological infrastructure for the mental health system to facilitate the highest quality and cost-effective services and supports for clients and their families".

It should be noted that CFTN funding was originally a 10-year block grant, which ended on June 30, 2017. However, through Assembly Bill (AB) AB 114, ACBH was given a grace period to utilize previously reverted MHSA funding through June 30, 2020. For more information on ACBH's spending plan for AB 114 funds, please see ACBH's AB 114 Plan at https://acmhsa.org/reports-data/#mhsa-plans

In addition to the CFTN funds identified in Alameda's AB 114 Plan, ACBH 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

No new CFTN projects have been identified or allocated new funding in FY 21/22. Please see the following section for updates on ongoing CFTN programs and projects that are in various stages of implementation.

Ongoing Projects

During FY 20/21 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 Three Year Plan FY 20/21-22/23 under the ongoing section of the Plan. Several of these projects will be completed this fiscal year (FY 20/21) and others will be continued and completed in FY 21/22 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 20/21 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 through December 2020, 129 clients were admitted (60% from Alameda Health System and 40% from Street Health). 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. There have been on-going efforts to improve referral flow from Alameda Health System, including a pilot to take clients from the ED.

Due to the COVID-19 pandemic the development of additional shelter beds has been delayed, more information will be posted in the FY 22/23 Plan Update.

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 20/21 Progress: This project is currently on hold with the County Administrator's Office (CAO). At the time of release of the Plan Update there was no clear timeline for startup, more information will be included in the FY 22/23 Plan Update 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 20/21 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. In FY 20/21 ACBH is releasing its third and final payment.

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.

ACBH will report out additional progress as dates and information become available.

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 20/21 Progress: On November 11, 2020 the Alameda County Board of Supervisors approved to amend the Capital Improvement Plan (CIP) to include the African American Wellness Center Project, and award $92K for Architectural Services. ACBH is currently working with GSA to set up this architectural contract. Once in place, space planning and project development meetings can commence. It is the hope that these meetings will begin in February 2021.

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

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 20/21 progress: ACBH, through the General Services Agency (GSA), successfully purchased the land in January 2019. ACBH plans to use the lot as additional parking, providing approximately 20 additional spaces to augment the inadequate parking capacity needed to serve employees, residents, visitors and service vehicles. The grading and fencing of the space will take place once the contaminated soil is removed. The soil was to be removed in January 2020, however due to internal changes at GSA and the COVID-19 pandemic the project has been put on hold. ACBH is working with GSA on an updated timeline to restart the project. In the future this land may be augmented to expand the A Street Shelter capacity.

PROJECT NAME: TN1. MHSA Technology Project

Program Description: Purchase, installation and maintenance of a new Behavioral Health Management Information System (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 20/21 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 will begin in April 2021 for the pre-implementation planning phase. The Implementation planning phase will begin in July 2021 (FY 21/22).

Additionally, under this project ACBH has been utilizing CFTN funds for the following items that have assisted ACBH in being more efficient and effective with utilization and outcome data:

- TN1: Behavioral Health Management Contracting System (to assist with the contracting process), called Apttus (phases 1-4)
- TN1: Computer/Technology Technical Assistance
- TN1: Electronic File Storage and Document Imaging (Veeam Software)
- TN2: Web-based dashboard System, called YellowFin
- TN3: County Equipment and Software Update (includes GoToMeeting software)
- TN4: Clinician's Gateway Interface
- CFTN Administration

PERFORMANCE MANAGEMENT INITIATIVES

Performance Management Initiatives
"Data Driven Actions"

MHSA Performance Management (PM) is a process of ensuring activities and outputs meet goals in an efficient and effective manner. The process focuses on the performance of various Alameda County Behavioral Health Care services (ACBH) units that support the administration of MHSA, MHSA funded programs and services, employees, and associated tasks. The following sections provided an overarching summary of significant quality assurance and improvement activities directed towards improving the administration of MHSA components.

Alameda County Health Care Services Agency: Results-Based Accountability (RBA) Initiative

Project IMPACT began in July 2014 as an effort that supports programs throughout the Alameda County Health Care Services Agency (HCSA) to measure and report their outcomes[1]. The Project IMPACT team consists of a total of 17 program staff and managers from every Department in HSCA, including members who have worked closely with the RBA implementation efforts in their own Departments. The Agency Leadership Team (ALT), which includes the Agency Director of HCSA and the Directors, Deputy Directors and Finance Directors of each of the Agency's departments, is monitoring and guiding the development of Project IMPACT.

RBA is a program evaluation framework that is data-driven and uses a simple iterative process to help organizations assess current performance, identify strategies to improve, and facilitate rapid implementation of action plans. Since 2014, ACBH has been utilizing RBA in various capacities to monitor program performance and assess impacts on the clients who come into contact with department and/or contracted services. ACBH has integrated RBA into MHSA contracting efforts with Full-Service Partnerships (FSPs), adopted the framework as part of its Prevention & Early Intervention (PEI) services evaluation, and made strides to include it as part of the Juvenile Justice Center and Crisis Services program work.

Alameda County Behavioral Health Department Initiatives

*Reorganization Efforts***.** ACBH conducted a thorough inventory of all contractual and legal obligations for the administration and delivery of behavioral health care services[2] . ACBH leaders examined the requirements included in three contracts with the California Department of Health Care Services, and interviewed ACBH managers in an effort to understand current strengths and challenges staff face in fulfilling our obligations. At the conclusion of this process, ACBH has established or plans to establish the following new key positions:

- Two Deputy Directors: Including the **Plan Administrator** who oversees and create linkages among ACBHS's core administrative functions (e.g. MHSA, quality Improvement/Quality Management, Information Systems, and financial Services) (Hired)

[1] Project IMPACT (2016). Project IMPACT FAQ. Retrieved from http://achcsa.org/hcsa/project-impact.aspx
[2] Communication from the Office of the Agency Director (2020). ACBH Departmental Reorganization-UPDATE.

- Public Information Officer: Help to promote and raise awareness of MHSA activities including community engagement efforts, development of press releases, liaison with media groups, and supporting media campaigns. (Currently vacant, delayed hiring process due to COVD-19)

- Health Equity Officer: Partner with MHSA program in the development and implementation programs to ensure they are culturally and linguistically appropriate with elements that address inequities and promotes access to care. This individual will also support the inclusion of peers and family members in the community program planning process. (Currently vacant, delayed hiring process due to COVD-19)

- Compliance and Privacy Officer: Support the MHSA program to adhere with federal, state and local guidelines. (Currently vacant, delayed hiring process due to COVD-19)

*Future strategic planning activities***.** In light of the impact of COVID-19, the MHSA program will develop more electronic platforms like social media sites to ensure our stakeholders are engaged in the program planning. The above-mentioned new positions will also: 1) support MHSA efforts; 2) develop real time dashboards to keep the community informed on the MHSA programs in Alameda County; 3) work closely with the Finance team to ensure effective budget management; 4) continue advocacy at the State level (e.g. DHCS, MHSOAC) and 5) develop new Innovation projects to inform the delivery of mental health services in Alameda County.

Alameda County Behavioral Health: Trauma Informed Systems Initiative

ACBH's Trauma-Informed Systems (TIS) efforts have focused primarily on the training components of the *Healing Systems of Care Conceptual* framework – establishing a cohort of embedded trainers within ACBH and training staff in the TIS 101 foundational curriculum. TIS is in the beginning stages of adapting the training so that it's more responsive to the needs of staff during this period of sheltering-in-place (**see Appendix B-4**).

Over the next three years, ACBH and Trauma Transformed (T2) will shift focus towards the practice change and leadership components of the framework. In particular, T2 will support the creation of an ACBH cohort of champions and catalysts who will gather new and existing data from ACBH to determine priorities for policy and practice change within ACBH. TIS hopes to work more directly with ACBH leadership – directors, managers and supervisors – to increase their understanding of TIS principles and implement best practices for leading others in a trauma-informed way.
The goal of all these activities is to help ACBH move closer to being a healing organization. The overarching benefit of these activities will be to improve collaboration within ACBH and with their MHSA contractors, to take more proactive steps to include contractor and community voice in decision-

making, and to anticipate and work to prevent predictable stresses, harm and trauma experienced by ACBH staff, MHSA contractors, and community members**.**

Financial Services Division

The MHSA Trust Fund Account (MHSA Trust) was established to maintain the MHSA monthly allocation and interest earnings. All expenditures are charged to the County General Fund (CGF) with the related MHSA program code. Finance prepares a quarterly projection report to identify the net MHSA revenue, and then develop a journal to move funds from the MHSA Trust to the CGF to offset the expenditures.

Finance has assigned a MHSA Plan number for each plan component and its projects; and have set up 29 program codes in the County financial system to associate with the MHSA projects. For community-based organizations/providers (CBO), the Division assigns a reporting unit number (RU#) for their projects. The program codes and RU#s can be used to keep track the payment status.

In each fiscal year, the Finance Division creates what is called *The Green Sheet* to identify all MHSA projects for that year including the Plan number, total budget, MHSA budget portion, estimated Medi-Cal revenue, program code and reporting unit (RU)#. The provided data helps support the preparation of the MHSA Plan and the Annual Revenue and Expenditure Report to the Department of Health Care Services.

Communication. Finance establishes monthly meetings with the ACBH Leadership Team to provide information, discuss issues and concerns, and communicate with the MHSA Director for relevant updates.

Fiscal Accountability. The Finance Division follows a set of policies and procedures to avoid supplantation of MHSA funding. All expenditures, encumbrances and revenue are reconciled every quarter, as part of the quarterly projections process. The Division requires two signatures when signing housing assistance checks over $5,000. Each Invoice and deposit require one signature.

Procurement & Contract Compliance Activities

The ACBH Contracts Unit operates under the auspice of the Finance Division. The Contracts Unit is undergoing an organizational restructure in which all contracts will reside within this Unit. These changes are part of an overall response to federal and state health care policy changes which affect county behavioral health in California. In order to meet the demands of these changes, ACBH is proactively preparing to adapt to and thrive in the new behavioral health environment by more fully aligning ACBH's compliance with the following federal and state requirements:

- The state-county Mental Health Plan Contract, Performance Contract, and Drug Medi-Cal Contract;

- Expanded Federal Medicaid Managed Care regulations; and
- Expanded covered services and contract requirements in Drug Medi-Cal.

The Contracts Office has seven Program Contract Managers also known as Program Specialists and eight Fiscal Contract Managers. Each Contract Manager manages between three and fifteen MHSA funded programs. The Contracts Office has one Program Contract Manager who serves as the liaison between the Contracts Unit and the ACBH MHSA Division. In this role the Contract Manager reviews the MHSA plan and updates, coordinates with the MHSA staff on reporting requirements and timelines, coordination of audit requirements on behalf of the Contracts Unit and communicates emerging changes that would impact the Contracts Unit.

Roles & Responsibilities. Contract Managers are responsible for monitoring programs from various aspects; Fiscal: reviewing units of services from the electronic claiming system in comparison to the allocation. Program: technical assistance (phone calls, meetings, or emails), reviewing reports (quarterly or annually) against the contracted deliverables.

Performance Measures. Contract Managers work in collaboration with the MHSA staff, and the provider to develop process, quality, and impact objectives for each type of program. For example, Full-Service Partnerships (FSPs) are measuring the percent of providers who can achieve a 50% reduction in the following: 1. Psychiatric hospitalization admissions 2. Psychiatric hospital days and 3. Psychiatric emergency visits 12 months prior to FSP admission and 12 months post admission. Additional metrics have been implemented more recently tied to a pay for performance fiscal model.

Contract Compliance. ACBH formalized a policy in June 2018, "Contract Compliance Plan and Sanctions for ACBH Contracted Providers". This policy supports ACBH in holding providers accountable for implementing County, State, and Federal requirements. Examples may include by not limited to: lack of achievement in meeting performance standards, substantive underperformance on meeting contracted deliverables, failure to meet contractual requirements such as staffing, timelines, required certifications and/or licensure. Additionally, ACBH responded to an audit finding in 2017 which resulted in the development of the MHSA Monitoring Guidelines in 2018 to strengthen the process in which ACBH are monitoring MHSA funded programs.

MHSA Data Management Systems

ACBH 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 design and implement a new FSP outcome and impact metrics that are used in this FY 21/22 MHSA Plan Update. The newly created reporting dashboard covers hospitalizations, housing, incarcerations, primary care linkage, employment, education, cost, and data quality. The success of the dashboard has led the System of Care staff to incorporate the primary care linkage and reductions in psychiatric emergency, inpatient, and crisis stabilization utilizations into the FSP Incentive Outcomes. The incentives are helping move toward population-based program improvement payments from fee-for-service payments.

The Underserved Ethnic Language Programs (UELPs), a subset of the PEI programs, have recently expanded. A workgroup has been convened to review current evaluation processes, improve the usability of the evaluation results for providers, and include the UELP Yellowfin dashboards into the evaluation. Currently, the UELP workgroup has redesigned the logic

model and is currently working on redesigning the data collection tools. The goal is to use the updated tools in the FY 22/23 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 and hospitalizations. The goal is to work with the IHOT Program Specialists, IHOT Program Team Leads, and Data Services to create a dashboard in Yellowfin. This dashboard will then be used to update the IHOT teams on the outcomes of their clients and during the FY 22/23 MHSA plan update.

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

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Community & Faith-Based Organizations

District Attorney's Office

East Bay Agency for Children

Health Care Services Agency

Health & Human Resource Education Center

Human Resources Department

LA Jones & Associates

Mental Health Services Act (MHSA) Division

Mental Health Advisory Board

MHSA Stakeholder Group

MHSA Community Program Planning Process Steering Committee

Office of Ethnic Services

Pool of Consumer Champions

Public Health Department, Community, Assessment, Planning, and Evaluation (CAPE)

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, 2021 rv4

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

DATE	TIME	LOCATION	MEETING THEMES
January 22, 2021 (Friday)	2:00-4:00pm	Go To Meeting	• MHSA Goal Setting/Finding A Common Link • Annual Plan Update • MHSA Community Planning Meetings (CPM) Outreach & Focus Group
February 26, 2021 (Friday)	2:00-4:00pm	Go To Meeting	• Program Spotlight: WET • INN recommendations • Focus Group recruitment • Review Operating Guidelines
March 26, 2021 (Friday)	2:00-4:00pm	GoToMeeting	• Program Spotlight: IHOT Evaluation
April 23, 2021 (Friday)	2:00-4:00pm	GoToMeeting	• Program Spotlight: UELP Evaluation • MHSA Plan Public Comment/Public Hearing
May 28, 2021 (Friday)	2:00-4:00pm	GoToMeeting	• Presentation: AB2022
June 25, 2021 (Friday)	2:00-4:00pm	Go To Meeting	• Quarterly Program Data Review • Government Funding
July 23, 2021 (Friday)	2:00-4:00pm	Go To Meeting	• Procurement Overview
August 27, 2021 (Friday)	2:00-4:00pm	Go To Meeting	• MHSA Policy & Legislation Review
September 24, 2021 (Friday)	2:00-4:00pm	Go To Meeting	• Program Spotlight:
October 22, 2021 (Friday)	2:00-4:00pm	Go To Meeting	• Program Spotlight/Presentation:
November 19, 2021 (Friday)**	2:00-4:00pm	Go To Meeting	• Program Spotlight/Presentation:
December 17, 2021 (Friday) **	2:00-4:00pm	Go To Meeting	• End of Year Celebration/Retreat • Interview Qs

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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

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*

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MENTAL HEALTH & SUBSTANCE USE SERVICES

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**

		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					

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MENTAL HEALTH & SUBSTANCE USE SERVICES

MHSA CPPP, 2020
Outreach & Marketing Plan
(Updated: July 23, 2020)

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*

					○ *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)**		

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MENTAL HEALTH & SUBSTANCE USE SERVICES

MHSA CPPP, 2020
Outreach & Marketing Plan
(Updated: July 23, 2020)

		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**		

		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 FY21/22

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 4/15/21 – 5/19/21
- **Share** information about the Mental Health Services Act.

Thu April 8	**Podcast***	COVID-19 Vaccine: Impact on African American's mental health
Thu April 22	**Podcast***	How to effectively navigate Telehealth online platforms
Mon April 26 2-3:30pm	**Webinar**	**"How to Read the MHSA Plan"** Please join the webinar from your computer, tablet, or smart device: https://global.gotomeeting.com/join/412991397 You can also dial in using your phone: United States (Toll Free): 1 (877) 309-2073 Access Code: 412991397#
Thu May 13	**Podcast***	MHSA Plan & Community Input for the upcoming May 17th Public Hearing
Mon May 17 5pm	**Public Hearing**	Mental Health Advisory Board - Public Hearing
Thu May 27	**Podcast***	The Telehealth new "normal" and how it Impacts our youth

*View this podcast at: acmhsa.org

RSVPS encouraged, but not required.
Learn more about MHSA podcasts and events, read the MHSA plans, and provide public comment at http://acmhsa.org

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HHREC HEALTH & HUMAN RESOURCE EDUCATION CENTER

Appendix B-3 MHSA Focus Group Question & Answer Sheet

ALAMEDA COUNTY BEHAVIORAL HEALTH
Mental Health Services Act (MHSA) 3-Year Program and Expenditure Plan

Community Program Planning Process, Focus Group Q&A

Focus Group: ACBH Senior Executive Team & Finance |Date: February 10, 2021| Attendee #: 8

Innovations Brainstorm

INN IDEAS	Population	Problem Trying to Solve	Strategies	Other
TAY Strategies for justice involved TAY	System involved TAY	high percent of TAY receiving MH services in most restrictive settings (JJC/Santa Rita), majority of which represent African American males and youth of color who primarily receive BH treatment within a detention setting.	TAY peer training coupled w/ intensive MH services; TAY developed outreach, engagement, & care coordination strategies	phones pre-programmed with MH supports for TAY leaving Santa Rita/JJC
Housing Supports/Advocacy	ACBH clients	Many ACBH clients are placed in housing, but end up failing due to lack of supports. How do we keep our clients housed, supported and educated about their housing rights so that they can move from healing/stabilizing to thriving?	Housing Ombudsman team, which includes peers	peer training on how to be a good housing advocate
Peer Respite for Justice Involved Individuals	ACBH clients being discharged from Santa Rita Jail who need respite and connection to services.	Many of our ACBH clients are discharged from Santa Rita with few resources and supports, leading to potentially high recidivism rates.	Peer Respite for Justice Involved Individuals	

ALAMEDA COUNTY BEHAVIORAL HEALTH
Mental Health Services Act (MHSA) 3-Year Program and Expenditure Plan
Community Program Planning Process, Focus Group Q&A

Ethnic and Cultural Communities, in particular the African American Community and the Transgender Community TO: Community Wholistic Response Team	Ethnically Diverse Communities, particularly for the African American & LatinX Communities	Team (interagency & Community based) response to support non-crisis but urgent community needs, social supports, and urgent community treatment, and referral (Short Term & Linkage); disaster response capability, including non-traditional responders, faith-based organization partner supports, and community organizations.	Holistic Approach (including partnerships with BH organizations, social service/other teams, advocacy groups, interfaith organizations, short term housing partners, etc.)	services for communities of color and those with limited resources, access to care, etc.
Peer-Based Strategies, Consumer Empowerment	Peers/Consumers	How to engage more of our ACBH clients in using DBT therapeutic supports. Also, how to engage more consumers in leading trainings and developing more peer support skills such as being able to lead an online evidenced based skill and strategies (CBT, DBT etc.) skills class. Looking at ways to reduce psychiatric hospitalizations.	Web-based skills modules/trainings developed for peer supporters who can then facilitate online and in person skills practice groups	

ALAMEDA COUNTY BEHAVIORAL HEALTH

Mental Health Services Act (MHSA) 3-Year Program and Expenditure Plan

Community Program Planning Process, Focus Group Q&A

New/Innovative Service Team Model	SMI in South & East County	How to better engage and treat SMI clients who qualify for ACBH services through a revamping of the service team model.	Build in natural linkages with an integrated primary care HUB; Build in community-based coordination; & Pilot a revamp of the Service Team Model.	Also, could be a model for warm hand off/drop off from crisis stabilization/crisis teams and CATT

ALAMEDA COUNTY BEHAVIORAL HEALTH

Mental Health Services Act (MHSA) Annual Update, FY 21/22

Community Program Planning Process (CPPP)

FOCUS GROUP - INPUT QUESTIONS & ANSWERS

Focus Group: MHSA Stakeholders |Date: February 26, 2021| Attendee #: 11

1. **identify 2-3 focus group populations based on data from the Three-Year Plan CPPPP highlights:**
   - African American
   - Black TAY male
   - African American veteran/homeless
   - Law Enforcement, for example: CIT-trained city police (MET Team in Fremont), Sheriff, Federal/local Probation; Judicial Courts (Public Defender, District Attorney)
   - Spanish-speaking population
   - Immigrant/refugee population
   - TAY Consumers
   - Non-TAY consumers to address stigma
   - Families/loved ones with SMI

2. **Please Identify Podcast Interview Topics for the MHSA Community Program Planning Process (CPPP)?**
   - How to read the plan
   - Black mental health
   - COVID-19 on community mental health
   - The Rise of Telehealth & Dr. Tribble's broadcasts- What does this mean and what is the impact on youth?

3. **How you feel about a *Community Holistic Response Team?***

   a) **What do holistic services look like?**
   - There are multiple uses of the word that should be clarified (1- medical model, 2-psychological, 3-non-traditional/organic approaches, addresses spirituality). It should emphasize the body and physical health. Psychological definition should address values, cultural upbringings, emotions
   - Certain definitions may turn some off/opposite of neutrality
   - Not a familiar word used in TAY population, consider using the word "comprehensive"
   - Treating whole body (spirit, mind, mental, physical), non-traditional medicine

   b) **What would be the ingredients/components we should consider when creating a holistic response team?**
   - Diverse providers
   - Collaboration (multidisciplinary field)
   - Diverse disciplines/traditions (spiritual) may address different ethnicities, collaborate and share information
   - Collaborative, field of strength, lived experience
   - Coordination between VA & healthcare system to help those who fall between the cracks based on eligibility
   - Emphasize role of family members

ALAMEDA COUNTY BEHAVIORAL HEALTH

Mental Health Services Act (MHSA) 3-Year Program and Expenditure Plan

Community Program Planning Process, Focus Group Q&A

Focus Group: PEER- Wellness Recovery Action Plan (WRAP®) | Date: April 24, 2020| Attendee #: 9

(Note: This focus group was conducted in Spanish. English translation is noted in red font)

1. **¿Qué preocupaciones relacionadas con los niños/jóvenes/jóvenes en edad de transición son las más importantes para usted y sus familiares?**
   - Coordinando servicios/citas con un psicólogo tarden mucho (tarde mucho tiempo entre citas).
     Coordinating services/appointments with a psychologist takes a long time (it takes a long time between appointments).
   - Los distritos no están poniendo atención a las necesidades de niños con problemas y con problemas de bullying al dentro de las esquelas.
     Districts are not paying attention to the needs of troubled children with bullying problems inside the schools.

2. **¿Qué preocupaciones relacionadas con los adultos/adultos mayores son las más importantes para usted y sus familiares?**
   - Cuando le dan cita a una persona, la gente de la oficina no habla español (y necesitamos gente que habla español)
     When they give an appointment to a person, the people in the office do not speak Spanish (and we need people who speak Spanish)
   - Los psicólogos que dan el servicio son muy jóvenes y no tienen la experiencia entender los problemas de sus pacientes en este estado de vida. Dan ejercicios o actividades y le mandan a casa hacer; las pacientes regresan a sus casas con algo que no les sirven.
     The psychologists who provide the service are very young and do not have the experience to understand the problems of their patients in this state of life. They give exercises or activities and send home to do; patients return home with something that doesn't work for them.
   - Tengo experiencia en este departamento y quiero decir que en Hayward ni en Alameda, no hay interpretación de servicios en las oficinas. Entonces hay frustración de los pacientes con el problema de no poder comunicar bien. Siente que hay discriminación
     I have experience in this department and want to say that in Hayward or Alameda, there is no interpretation of services in the offices. Then there is frustration of patients with the problem of not being able to communicate well. Feel there is discrimination.
   - Los niños de familias hispanas que crecen aquí también no saben hablar español, como que tengan vergüenza hablar el español. Este es una tarea importante de los abuelos y padres ensenar español con ellos. En efecto (el sistema) está perdiendo el lenguaje y la habilidad comunicar con las generaciones mayores que no hablan inglés. Este amplifica el problema de no tener gente en las oficinas a interpretar cuando hay una necesidad.
     Children from Hispanic families who grow up here also do not know how to speak Spanish, as they are ashamed to speak Spanish. This is an important task for grandparents and parents to teach Spanish with them. Indeed (the system) is losing language and ability to communicate

with older generations who do not speak English. This amplifies the problem of not having people in the offices to interpret when there is a need.

- Si no fuera por los mayores que saben unas palabras en inglés y entienden más o menos, no puedan entender los doctores.
  If it wasn't for the elders who know a few words in English and understand more or less, the doctors can't understand.

- En los hospitales, si una persona tiene un apellido en español, asumen que hablen español, y manden un doctor con un apellido español también, pero no sabe nada de hablar en español. Puede ser filipino. Básicamente, no asume que una persona habla español basada en el origen de su apellido.
  In hospitals, if a person has a surname in Spanish, they assume that they speak Spanish, and send a doctor with a Spanish surname as well, but he knows nothing about speaking Spanish. He could be Filipino. Basically, he does not assume that a person speaks Spanish based on the origin of his surname.

- Adultos Mayores tienen problemas o dificultades en aprender o usar la computadora. Necesiten ayuda con computación. Los mayores están sintiendo atrasada.
  Older adults have problems or difficulties in learning or using the computer. They need help with computing. The elders are feeling behind.

- He tenido muy malos experiencias (en el sistema): Tengo una hija con una diagnosis de bipolar psicótico. Ella es de mayor edad. Había un episodio violento con un primo. Después de ver 4 o 5 trabajadores sociales, no resolvió su situación. Siempre está cambiando los requisitos o hay cosas políticas. Dicen que hay protecciones por esta gente, y después de un ano (el caso cumplió en Oct 2020), no ha recibido una respuesta de su caso. Prometieron hacer muchas cosas, pero no ha visto ningunas resultas; ni una visita de un trabajador social. Hay mucha publicidad sobre protecciones por gente de “tercer edad”, pero en la práctica no ha tenido ningún beneficio. En general, después de tanto tiempo con el sistema y durante COVID19, se desmoraliza porque no ha visto ni recibido NADA beneficio; y mire muchas advertencias por beneficios; pero en su experiencia no ha mirado ni recibido nada.
  I have had very bad experiences (in the system): I have a daughter with a diagnosis of psychotic bipolar. She's older. There was a violent episode with a cousin. After seeing 4 or 5 social workers, he did not resolve his situation. It's always changing the requirements or there are political things. They say there are protections for these people, and after a year (the case concluded in Oct 2020), they have not received a response from their case. They promised to do many things, but they have seen no results; nor a visit from a social worker. There's a lot of publicity about protections for "third-aged" people, but in practice it hasn't had any benefit. In general, after so long with the system and during COVID19, it is demoralized because it has not seen or received ANYTHING benefit; and look at many benefit warnings; but in his experience he has not looked at or received anything.

- Al respeto a los servicios de traducción, los Estados Unidos no está viviendo su realidad con el tipo de comunicación que necesitan servir su población hispana; y población hispana es grande en este país.
  In compliance with translation services, the United States is not living its reality with the kind of communication it needs to serve its Hispanic population; and Hispanic population is large in this country.
- La habilidad por gente indocumentado a tener servicios psiciatras o conductivos es muy limitado; también por gente en Medi-Cal/Medicaid no pueden pagar por más. Personas necesitan más tiempo en terapia. Hay limitaciones en cuantas sesiones de terapia que pueda recibir y después, no más. Necesita más para se recupere.
  The ability of undocumented people to have psychiatric or behavioral services is very limited; also for people on Medi-Cal/Medicaid can't pay for more. People need more time in therapy. There are limitations on how many therapy sessions you may receive and then no more. A person needs more to recover.

3. ¿Cree que hay poblaciones o grupos de personas a los que el sistema de salud conductual del condado de Alameda no está atendiendo de manera adecuada?

- No personalmente, pero ha escuchado de latinos que no tiene seguranza o que tiene MediCal que toma mucho tiempo encontrar una cita, y muchas veces el proveedor se cancela (parece que no hay oportunidad igual al acceso de servicios). Se hacen largas sus citas y tienen que ir a la emergencia a recibir servicios.
  Not personally, but you have heard from Latinos that you do not have safeness or that you have MediCal that takes a long time to find an appointment, and many times the provider is canceled (it seems that there is no equal opportunity to access services). They make their appointments long and have to go to the emergency to get services.
- También problemas con huelgas en los hospitales. Las especialistas no pueden atender sus pacientes.
  Also problems with strikes in hospitals. Specialists can't care for their patients.
- No he tenido experiencias sobre este, pero he escuchado que otras personas, sí.
  I haven't had any experiences about this, but I've heard that other people, yes.
- Se desmoraliza uno cuando no puedan tener acceso a servicios de salud por parte del condado y andan buscando servicios.
  ]One is demoralized when they are unable to access health services by the county and are looking for services.

4. ¿Cuáles son los obstáculos que hacen que a las personas con problemas de salud mental y sus familiares les resulte más difícil acceder a los servicios de salud mental?

- Falta de información, stigma miedo a lo que la familia, comunidad, mejor educación para los familiares, o el mismo individuo, Falta de apoyo.
  lack of information, stigma fear of what family, community. Better education for family members, or the same individual, Lack of Support.
- Primero: dificultad de idioma. No hay suficientes interpretes.
  First: language difficulty. There aren't enough interpreters.

- También, unos interpretes dicen unas cosas que no son, o no dicen todo. Cambian o añaden información que no dicen el proveedor. Este es problema especialmente con ancianos.
  Also, some interpreters say some things that are not, or don't say everything. Change or add information that the provider doesn't say. This is especially a problem with the elderly.
- Algunas personas de tercera edad tienen problemas en comunicación; especialmente con mayores que han perdido parte de su oído (hearing). Se complica más la comunicación.
  Some third-aged people have communication problems; especially with older people who have lost part of their ear (hearing). Communication is more complicated.
- a no tener el contacto directo con doctores es un problema.
  not having direct contact with doctors is a problem.
- La soledad por ancianos. Sentimos muy sola. (En la experiencia de la mujer hablando), durante COVID, no ha salido en 8 meses. Un día salió de su casa y fue sorprendida ver el color de su casa…indico que su memoria faltaba. Como un anciano, si por ejemplo está caminando sola y no pueda reconocer su casa, la soledad y la falta de no poder comunicarse se pone en una situación difícil.
  Loneliness for the elderly. We're very lonely. (In the experience of the woman speaking), during COVID, she has not left in 8 months. One day she left her house and was surprised to see the color of her house... indicated that her memory was missing. As a senior, if, for example, you are walking alone and cannot recognize your home, being alone (i.e not having someone with you when going out) and lack of not being able to communicate puts you in a difficult situation.
- La realidad de ancianos en este pais es no ver y contar sus experiencias…que la sociedad piensa nada mas que “ya esta vieja; ya se va a morir”.
  The reality of elders in this country is not to see and tell their experiences... that society thinks nothing but "He's old; he's going to die."
- Falta mucha información sobre cambios en la vida; en particular la menopausia. Necesita información y educación por la familia entender los cambios hormonales, y no pensar que se vuelve loca por los cambios. Necesitan entender que está pasando por la persona. Ayuda no es solamente por el individuo, pero por toda la familia entender y tener paciencia con su miembro de la familia.
  A lot of information about life changes is missing; menopause in particular (menopause was the example the woman speaking gave, based don her experience). Information and education for the family is needed so they understand hormonal changes, and not think a woman is going crazy because of the changes. They need to understand what is happening for the person. Help is not only for the individual, but for the whole family so they understand and have patience with their family member.
- Otra área que necesita entendimiento es gente con demencia. Gente están olvidando de las cosas. No cuesta nada dar 2 o 3 minutos de su día. Está bien escuchar la persona al otro lado de la vocena. Aunque todos no son psicólogos/terapistas, ayuda mucho cuando uno puede escuchar y mostrar entendimiento de otra persona. Al ser escuchado ayuda mucho.
  Another area that needs understanding is people with dementia. People are forgetting things. It doesn't cost anything to give 2 or 3 minutes of your day (indicating a quick check in with the person who is forgetting). It's okay to listen to the person on the other side of the speaker (i.e

phone). Although everyone is not psychologists/therapists, it helps a lot when one can hear and show understanding of others. Just being helps a lot (for the person struggling).

- Por el pandémico de Covid, todos somos en el mismo barco; la experiencia del enerramiento y no tener contacto con nadie. Espera que uno se entiende.
  By the pandemic of Covid, we are all in the same boat; the experience of seeing and having no contact with anyone. One expects you to understand eachother.
- Para la salud mental, tener una línea contactar alguien a varias horas.
  For mental health, have a line contact someone within several hours.

5 ¿Qué servicios o programas han sido eficaces para abordar nuestras preocupaciones de salud mental locales?

- Hay preocupación sobre la segunda parte de la inyección de covid; por la mal reacción o síntomas que son típicos. Quiere que hay un grupo a quien llame a los ancianos a chequear en ellos por unos días después por su bienestar, a ver que estén bien. Y un grupo en general con quien gente mayor puede hacer chequeos.
  There is concern about the second part of the covid injection; because of the bad reaction or symptoms that are typical. He wants a group to call the elders to check on them for a few days later for their well-being, to see that they're okay. And a group in general with whom older people can do checkups.
- Una mujer recordó que había un grupo con tópicos de aprender por "La Familia" en Hayward. El grupo duró 8 semanas y cubrió varios tópicos en cómo ayudar personas con problemas mentales. Fue un curso por miembros de la familia. Le encontró muy interesante. Le gustaría repetir este curso. Había estudiantes de Berkeley que corrió el clase. La única cosa que no gustaba fue que no había el "follow up" a continuar un tipo de Learning grupo a mantener contacto. Aunque este parte no pasó, en general quiere un curso así otra vez.
  One woman remembered that there was a group with learning topics by the organization "La Familia" in Hayward. The group lasted 8 weeks and covered various topics in how to help people with mental health problems. It was a course by family members. She found it very interesting. She'd like to repeat this course. There were Berkeley students who ran the class. The only thing she didn't like was that there was no "follow up" to continue of a type of Learning group to keep in touch. Although this part didn't happen, she wants a course like this again.
- El grupo de POCC de los Elders; se junten dos veces al mes. Es muy bien juntar y tener la comunicación pos los elders. Por Covid, está suspendido, pero quiere que regresa pronto porque fue una gran ayuda a recibir información y manténganse en contacto con otros.
  The POCC Elders Group; it meets twice a month. It's great to get together and have communication for the elders. Because of Covid it is suspended, but he wants it to return soon because it was a great help to receive information and stay in touch with others.
- Un grupo de "Barak" cada viernes. Es un grupo de soporte por la salud mental que ha ayudado bastante.
  A "Barak" group every Friday. It's a mental health support group that has helped a lot.
- Best Now Peer Support grupo es muy bien.
  Best Now Peer Support group is great.
- En general, juntas de grupos ayudan.

In general, group meetings help.

- Como facilitador, puede usar más entrenamientos sobre varios aspectos de salud mental para expandir su conocimiento, y soportar grupos más.
  As a facilitator, you can use more workshops on various aspects of mental health to expand your knowledge, and support more groups.

6 **Proponga ideas innovadoras que ayudarían a mejorar los servicios de salud mental en este condado. Pregunte específicamente al grupo cómo se sienten acerca de un EQUIPO DE RESPUESTA HOLÍSTICA COMUNITARIA que se dirige a poblaciones étnicamente diversas ¿Cómo son los servicios de salud holísticos?" (holística definición: terapias mas naturales y todos los aspectos de la vida de una persona que pueda impactarle.") *¿Que funciona por la cultura latina? Y, ¿que sea practical por ellos y sus comunidades?***
Clarification by Mariana Real (MHSA Division): En particular, que pueda ayudar en la comunidad latina; sea creativa. In particular, that it can help in the Latino community; be creative. What works for Latin culture? What makes it practical for them and their communities?

a. **¿Cuáles serían los ingredientes/componentes que debemos considerar al crear un equipo de respuesta integral de la comunidad?**

- seminarios en Spanish para tener acceso a la sección 8 o aplicaciones de viviendas.
  Seminars in Spanish to access section 8 or housing applications.
- Un programa de distribución de comida directo a la casa. Especialmente por ancianos o los que no puedan salir sus casas ahora. Idea por el condado regalar verduras a un supermercado y coordinan una distribución.
  A food distribution program directly to the house. Especially for old people or those who can't leave their homes now. Idea for the county to give vegetables to a supermarket and coordinate a distribution.
- Necesita Servicios de Navegación de servicios ayudar coordinar y saber como combinar todos los pedazos del cuido que su niña necesita. No tienen social workers ayudar. Necesita navegadores ayudarle mover adelante, coordinar servicios, y sea un guion. Crea que su niña también tiene un problema con salud mental, pero necesita una evaluación y no sabe donde recibirlo.
  Family members managing MediCal for their kids: One lady has both Alliance and MediCal because mediCal doesn't cover everything and she needs coverage for various things. (the lady really didn't ask a question, but was posing this as a problem she's facing) Throughout the course of the conversation, it came out that she needs navigation and coordination services to learn and make sense, and ensure that she gets all the services needed from the various programs.
- Tener una oficina que pueda recibir información en general por el público. Una oficina que pueda llamar y hablar con una personal real, también en español a recibir información sobre asuntos corrientes que está pasando y recursos.
  Have an office that can receive information in general by the public. An office that can call and talk to a real staff, also in Spanish to receive information about current issues that are going on and resources.

- Quiere más gente LATINO que sabe la cultura y pueda entender el sentimiento de las gente latina. No solamente gente que habla español pero que no entienden la cultura. Hay una diferencia.
  He wants more LATINO people who know the culture and can understand the feeling of Latino people. Not just people who speak Spanish but don't understand the culture. There's a difference. (The context this person was bringing out was that people who translate or navigate services for the Latino community don't always have insight about the culture they're speaking to. They were getting at language and cultural appropriateness. It's not just about translating words: as an example, The speaker particularly mentioned philipinos who have spanish last names and may speak spanish. This doesn't mean they understand Latinos; even Mexican Americans; many who are born here lose the language and culutre of their origins. Remember that just because someone has a Spanish name or looks hispanic doesn't mean they can relate to the culture).

b. **¿Con cuál de los grupos de las partes interesadas se siente más identificado?**

- Paciente, y una persona que colecta y distribuye información para la comunidad
  Patient, and a person who collects and distributes information to the community
- Promovedora de la clínica y un soporte su comunidad
  Promoting the clinic and supporting your community
- Primero un bis-abuelo
  First a great-grandfather
- Un anciano y representante por la edad en que está
  A senior citizen and representative for his age group.
- Gente que pueda ayudar la próxima generación
  People who can help the next generation
- El pilar de la familia; el cerebro; la cabeza que está soportando y ayudando a todos
  The pillar of the family; the brain; the head that is supporting and helping everyone
- Participante, paciente, y ayudante de la comunidad. Quiere seguir preparándose para ayudar a otros.
  Participant, patient, and community assistant. She wants to keep preparing to help others.

Preguntas/Questions:

1. Necesita Servicios de Navegación de servicios ayudar coordinar y saber cómo combinar todos los pedazos del cuido que su niña necesita. No tienen social workers ayudar. Necesita navegadores ayudarle mover adelante, coordinar servicios, y sea un guion. Crea que su niña también tiene un problema con salud mental, pero necesita una evaluación y no sabe dónde recibirlo.

ALAMEDA COUNTY BEHAVIORAL HEALTH

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A focus group participant referenced questions related to problems she's currently experiencing with coordinating care (and knowing which resources are available to her). She also requested resources for her adopted daughter who was in the first grade (behavioral Health assessment and glasses), and referenced grief from a recent loss of her mother. MHSA addressed these issues by forwarding resources (including the ACCESS phone line and PEI-UELP program information) to the PEERS WRAP ® Program Manager on 2/23/21).

ALAMEDA COUNTY BEHAVIORAL HEALTH
Mental Health Services Act (MHSA) 3-Year Program and Expenditure Plan
Community Program Planning Process, Focus Group Q&A

Focus Group: Law Enforcement MH Crisis Teams (CATT/MET/CIT)| Date: March 10, 2021| Attendee #: 9

1. **What concerns related to Children/Youth/Transitional Age Youth (TAY) are most important to you, your colleagues, and your family member(s)?**
   - Education around mental health issues for cultural/ethnic communities for example the Asian population which comprises half of the City of Fremont. We have "pressure cooker" high schools focused on academics, and many [youth] suffer from anxiety/depression because of the competitive nature of schools. Many of times parents dont understand expectations placed on children. We need more education and in different languages.
   - I'm concerned around substance abuse and emerging mental health issues. They're 18 years old and we can't do anything when they age out of services. We refer folks to the hospital and the cycle repeats itself when they get out. The number one complaint from family is why they're keeping them and why aren't they getting help. All we can say is how the law is written. Our county is facing, and it would be beneficial to have a large county like Alameda County join in with other counties (such as Los Angeles and San Francisco) who are pressuring California to reform existing laws.
   - Growing pressure to remove law enforcement from local schools. Concerned around how this will impact their response time.
   - Spent 3 years as a Student Resource Officer (SRO). In the 3 years, I might have arrested a handful of TAY for serious crimes. Most of the time I had to send someone suicidal or depressed to Willow Rock-or maybe they didn't meet criteria so I bridged the gap with parents who maybe didn't understand the severity. The SROs got taken out of the schools this year. The calls for service time will be stacked as opposed to when they used to call my cell phone and I can show up in minutes.
   - Services like Amber House, do not have available resources for children. Even trainings for mobile crisis technicians are not "kid-expert". There isn't any kid system of care experts (except for TAY). Access to services is limited beyond sending them to willow rock or Children's Hospital. There aren't many resources to give to parents unless they have a case manager. With kids it's usually funneled through many systems like schools or primary care physicians. It's difficult to navigate the children's system of care
   - My concern of taking SROs out of schools: if there is a call to patrol they will lack a relationship with the kids and schools. SROs build strong relationships with the community.
   - Lack of service providers who know how to deal with children
   - Not enough providers for the amount of kids needing services.
   - Concerned with kids returning to school after COVID-19. We'll hear a lot about the issues with transitioning back to school and lack of resources to appropriately service them. We may have more law enforcement involvement that could have been prevented with more services.

ALAMEDA COUNTY BEHAVIORAL HEALTH

Mental Health Services Act (MHSA) 3-Year Program and Expenditure Plan

Community Participation and Feedback Survey

FOCUS GROUP - INPUT QUESTIONS & ANSWERS

2. **What concerns related to Adults/Older Adults are most important to you and your family member(s)?**
   - We have 2-week residential crisis programs such as Amber House, Woodrow, Jay Mahler, and the good is we get them in but what happens after the 2 weeks? More often we do a lot of follow-up care and sometimes they disengage. Why only 2 weeks? Gap in services for those who require long-term help.
   - We need more crisis programs to divert them from the hospital. We need 5 more in Oakland alone.
   - All the resources are in the northern part of the county and zero in south county or east county. We need more and more geographically dispersed.
   - Amber house has few barriers compared to others and has lower criteria. It's low barrier entry.
   - Allow adults to stay longer and achieve actual stabilization (not just the idea of it). Someone can be stable for 3 hours but that doesn't fix anything. The cycle is perpetuated. Folks don't want law enforcement responding to calls but unless the cycle is stopped in treatment than there will be a continuous need for crisis services. We'd have less crises if the treatment in CRT/residential programs were extensive, longer-term.
   - There needs to be a warm-handoff to some type of case management or program to follow up and check on them, ensure they take their medications.
   - We need a John George Psychiatric (JGP) type of facility in South County too
   - CRTs need full staffing throughout the week
   - You have clients who have mental health issues at a regional center, but dispatch is getting calls, and the clients are not doing anything we can arrest them for unless it's criminal activity. There's little we can do when their day treatment programs are closed during COVID-19 to keep them involved in activities where they're not walking around in communities. It's difficult. We have one client who is in and out of John George 8 times a day when he needs residential placement.

3. **Are there populations or groups of people whom you believe are not being adequately served by the behavioral system of Alameda County**?
   - High utilizers of the system. Those in and out of John George. There's never really a process at court to get conservatorship yet our law enforcement partners deal with them frequently. Our county needs to better serve high utilizers. It goes back to treatment and what's actually happening in treatment and those stabilized then getting connected to services the truth is some clients need conservatorship until they're stable, yet we don't go that route in this county.
   - I would like to ask that the number of consumers be compared to the number / capacity of services. I feel the number of "beds" significantly underserves the number of folks who could benefit from services. I have a guy who goes on medical transport multiple times a day and has 290 service calls to his house this year. These high utilizers are trained to only use

crisis services and should be trained to use conservatorship programs until we change behavior. There may be 700 people in the county who are high utilizers.

- Better / more effective use of conservatorship!!
- The SMI homeless population
- High utilizers, etc. are draining. We can provide data for you.
- Surprised we haven't talked about conservatorship.
- It's not just conservatorship, it's getting people admitted. In 2019-2020 (county data) we had 13,011 psychiatric holds and 352 admissions (2.7%). This is really flabbergasting. Our folks aren't even getting into inpatient to get 14-day holds much less conservatorship. At what point will we let these people really heal?
- Our mayor asked the questions because the state has a pilot program to address folks who have been on hold 8 times in a 12-month period. There is a pilot conservatorship program. Not sure the county participates, I feel like conservatorship is a bad word and is explained away and it should be an option. Not sure if there's a lack of funding or staff.
- We have more beds in our jail for the severe mentally ill than in the community. I worked in a previous county before returning to the bay and I was shocked we had more beds in the jail for SMI than in the community.
- I worked in Santa Rita as well and its disappointing to hear there's not more drive for inpatient psychiatric facilities.
- If they are unhoused it is nearly impossible to gain conservatorship
- It's sad many people receive better services in jail.

4. **What barriers make it more challenging for individuals and family member(s) with mental health challenges to access mental health services?**
   - Lack of substance use treatment
   - Medi-Cal Eligibility
   - Lack of Insight into illness
   - Alameda County contracts out over 80% of mental health services and finding the appropriate service provider for the client is confusing and frustrating.
   - Lack advertisement for services
   - Medical necessity-not qualifying for admittance to JGP
   - Multiple family members who are affected and unwilling to connect to services
   - Lack of inpatient resources as we only have JGP or Villa Fairmount.
   - The need for conservatorship that is not given to most unhoused folks
   - Lack of time given to folks in CRT programs that need much longer to fully stabilize.
   - Fragmented / Closed system... limited ways to get connected.
   - Lack of coordination of care
   - A lot of turnaround in community based organizations and lack of follow up for clients that need visits at least 3x a week.
   - Not enough services for the need
   - Lack of communication between mental health programs- The disappointing reality is that

some of these helpful programs have only been up and running for a little over a year... CSU's have been advocated for at least 10 years... it took 9 years + to get the first one. It's successful, how much longer until we can support expansion in other parts of the county and in the hardest hit communities? These programs will also reduce the number of crises in the field because folks or families can just walk in and leave.

5. **Which services or programs have been effective in addressing our local mental health concerns?**
   - Amber House
   - Full servie staff at CRT
   - Suzanne Shenfil
   - Amber House
   - CATT
   - CRT programs like Jay Mahler and O
   - CATT & ACSO' Behavior Health Unit
   - Mobile Evaluation Teams (Cop with Clinician) First responder model
   - BACS Woodroe house
   - Safer ground hotel program for homeless has helped stabilize many homeless persons and have put many in touch with mental health services
   - Safer ground is great because its low barrier with less paperwork to house people (largely SMI)

6. **Please brainstorm any innovative ideas which would help improve mental health services in this County. Specifically - how do you feel about a COMMUNITY HOLISTIC RESPONSE TEAM that targets ethnically diverse populations**

   a. **What do holistic health services look like?**
      - No responses

   b. **What would be the ingredients/components we should consider when creating a community holistic response team?**
      - Effective and address specific symptoms to stabilize them. Priority is enhancing available treatment to get them functioning at their best selves without repeatedly going ot John George or jail.
      - The bottom line for many people is getting people into a stable housing situation. Homelessness promotes trauma and exacerbates mental illness.
      - Recognize we have a plethora of response times and it's complicated when we add many peop0le. Let's bring people together to avoid fragmentation into one single agency/program
      - We have 17 law enforcement agencies in alameda county and we are young in and these officers are trying to learn their jobs and learn how to navigate the system. Many smaller agencies don't have the resources to attend meetings (e.g. Livermore) and there should be 1 email address/contact person that a cop can turn to. There

needs to be 1 portal and to make sure the information they provided is being acted on.

- A law enforcement (LE) only, 24 hour a day 7 day a week access line with live people is essential. The access line has to be able to provide meaningful guidance and information in real time
- The 24/7 "LE hotline" is important because nothing is available... even some of the great programs, except Amber house, aren't available to the cop working at 3am on Saturday morning.

c. How would you develop a new service team model? How would you better engage and treat SMI clients who qualify for ACBH services through a revamping of the service team model in South & East County? What could be a model for warm hand off/drop off from crisis stabilization/crisis teams and CATT

- No responses

7. Which stakeholder group do you primarily identify with?

- Parent and Law Enforcement, both my daughters suffer from depression and anxiety.
- Law Enforcement/ SWAT TL/ Mother worked for Cal School for The Blind for 30 plus years /Sgt. CPU- Community Policing Unit
- I am a MSW and serve constituents all ages through life course, emphasis on most vulnerable populations, elderly, disabled and homeless.
- Law enforcement

8. Any other comments you'd like to share?

- No responses

ALAMEDA COUNTY BEHAVIORAL HEALTH

Mental Health Services Act (MHSA) 3-Year Program and Expenditure Plan

Community Participation and Feedback Survey

FOCUS GROUP - INPUT QUESTIONS & ANSWERS

Focus Group: African American Veterans | Date: March 10, 2021| Attendee #: 5

This event was cancelled due to low attendee turnout. Focus groups must have (at minimum 6 participants). The 5 attendees were sent the focus group questions and encouraged to submit their responses in case they were not able to attend the rescheduled event.

ALAMEDA COUNTY BEHAVIORAL HEALTH

Mental Health Services Act (MHSA) 3-Year Program and Expenditure Plan

Community Participation and Feedback Survey

FOCUS GROUP - INPUT QUESTIONS & ANSWERS

Focus Group: Ohlone College Transitional Aged Youth | Date: March 16, 2021| Attendee #: 8

1. **What concerns related to Children/Youth/Transitional Age youth (TAY) are most important to you and your family member(s)?**
   - Foster Youth – PTSD, anxiety, ACEs
   - Teaching children/youth about mental health young since a lot of people do not realize their issues. PTSD and other concerns from childhood days can impact individuals.
   - Teaching people to reach out to services. Beyond being aware of services, actually reaching out to those services is important.
   - In work with children with autism, not every parent considers behavior and mental health issues as serious. Many parents do not seem to care. It is crucial for parents to be aware of these services and to teach their children that it is ok to seek help. Parents need to know about services and that some of the services are even free.
   - A lot of children/teen seem to be afraid that their parents will be told of their issues. So, they are afraid of seeking help. They are afraid of their issues becoming too "big" by involving too many people.
   - Some TAY do not even realize that their mental health symptoms should lead them to seek profesional help.
   - A lot of students do not know the symptoms of mental health issues. So, they do not seek help since they do not realize that they need help.

2. **What concerns related to Adults/Older Adults are most important to you and your family member(s)?**
   - Money is always the biggest concern especially for those without insurance. (e.g. paying $135 for weekly sessions)
   - Culture can be a concern. A part of the Chinese culture is seeing mental health as taboo and not something to be discussed or dealt with. Mental health awareness is most important.
   - Working for Loss Prevention, PTSD is a major concern. People can threaten you with knives and guns and so there is difficulty sleeping.
   - For immigrants/refugees/ESL learners, mental health is even a larger problem since many of them had to leave their countries under adverse circumstances. Continually, they may not know how to seek help due to the language behavior.

3. **Are there populations or groups of people whom you believe are not being adequately served by the behavioral system of Alameda County**?
   - For queer people of color, having LGBTQ+ friendly therapists is helpful.
   - For rape survivors, there do not seem to be many services and resources for people with similar backgrounds. Going to the police, therapist, etc. does not often cover all the necessary topics. Even with calling in RAINN foundation, there was a 30-minute wait time just to talk with someone. A lot of people who go through similar experiences do not often talk about it since it is difficult to discuss.

- Even some therapists do not often provide helpful and comforting services.
- The system of working with rape survivors often seems followed. Having more counsellors specialized with rape cases would be very helpful. Even with the required reporting of the therapists, there may be more ways to help without immediately reporting.

4. **What barriers make it more challenging for individuals and family member(s) with mental health challenges to access mental health services?**
   - There is not a lot of education about what to do when experiencing a health crisis. Although there are "health" clases in high school, there is only teaching with mental health that talks more about pschology and illnesses rather than how to reach out and receive help for ourselves and others around us.
   - Pricing
   - The difference between a psychologist, therapist, and psychiatrist is not well-known. The way that diagnoses work is also not known.
   - There is a fear with getting involved with law enforcement. Talking about more "extreme" issues with therapists comes with a fear of being reported.
   - Clarity about when therapists and other providers will report.
   - Therapists and providers often do not receive true answers from consumers due to consumers fearing being reported and adverse impacts of that.
   - Lack of outreach. Better outreach especially by MHSA funds would be helpful
   - Individuals unaware of services
   - More PEI especially in schools would be helpful
   - Schools having links to services on their website would be helpful
   - At Ohlone, the mental health services offer random therapists if not specified. The names of therapists were also not listed on the website so students do not know who they can choose. Multiple therapists are sometimes even given to the same student.

   <u>Challenges for Family Members</u>
   - There is no teaching on how to best reach out for help for those around us.

5. **Which services or programs have been effective in addressing our local mental health concerns?**
   - Boldly Me → a non-profit organization for prevention and early intervention. Address local mental health concerns well especially for high schools. They address self-love, self-esteem, helping peers, etc. PEI programs are really helpful in schools. Some programs are funded by MHSA.
   - Mental health services at Ohlone College, Cal State Long Beach CAPS, Bay Area Community Health
   - Cal State Long Beach did well with outreach. Links would be put up on an online platform that remained on the top of student dashboards. They also sent out social media posts on

every channel about the services offered. Clubs also promote mental health services. The therapist there was very direct in problem-solving (only 6 sessions per student).

- Ohlone mental health services were really useful especially since they provided free sessions without insurance. Some programs are funded by MHSA WET funding

6. **Please brainstorm any innovative ideas which would help improve mental health services in this County. Specifically ask the group how they feel about a *COMMUNITY HOLISTIC RESPONSE TEAM* that targets ethnically diverse populations**
    a) **What do holistic health services look like?" (addressing the whole of a person)**
        - Maybe including art services?

    b) **What would be the ingredients/components we should consider when creating a community holistic response team?**
        - Having a centralized website/page that is easy to maneuver would be very helpful. This prevents individuals from getting overwhelmed/confused. A clear website with everything present and a guide to use the website.
        - Including a "how to navigate" tutorial/instructions

    c) **How would you develop a new service team model? How would you better engage and treat SMI clients who qualify for ACBH services through a revamping of the service team model in South & East County?**
        - No responses

    d) **What could be a model for warm hand off/drop off from crisis stabilization/crisis teams and CATT (e.g. a hand off from 9-1-1 [law enforcement] to care from therapists, licensed individuals)**
        - Anxiety would be a major concern in a situation involving law enforcement so having a point person that can be present long-term in the individual's life would be helpful and comforting. Having meetups with this point person along with reassurance from this point person with information on what to expect would be especially helpful.
        - A national effort for a new number (9-8-8) instead of 9-1-1 - NAMI
        - Having one non-judgemental person (reiterated) to be with you and be clear about what is going to happen is important.

7. **Which stakeholder group do you primarily identify with?**
    - A caring community member who has dealt with past issues who wants to help others
    - A navigator/liaison
    - Someone interested in a career in Psychology (Psychology major in college) → Future applied-psychology professional

ALAMEDA COUNTY BEHAVIORAL HEALTH

Mental Health Services Act (MHSA) 3-Year Program and Expenditure Plan

Community Participation and Feedback Survey

FOCUS GROUP - INPUT QUESTIONS & ANSWERS

- Queer, person of color, feminist (and feminist studies major), rape survivor, artist, past student ambassador/advocate
- Promoter of NAMI programs, caregiver, someone with a mental illness
- Future law enforcement professional, Criminal Justice Major, Future grad school counselling psychology, graduate intern at Ohlone Student Health Center

ALAMEDA COUNTY BEHAVIORAL HEALTH

Mental Health Services Act (MHSA) 3-Year Program and Expenditure Plan

Community Participation and Feedback Survey

FOCUS GROUP - INPUT QUESTIONS & ANSWERS

Focus Group: Veterans - BIPOC | Date: May 2021| Attendee #: TBD

Planning for this sixth focus group is in progress and anticipated to occur in May 2021. An updated MHSA Focus Group Questionnaire will be included in the appendices section of the FINAL MHSA Annual Plan for fiscal year 2021-22.

Mental Health Services Act Three-Year Plan FY 2020-2023

Community Program Planning Process Summary

Alameda County Three-Year Planning Process

MHSA 3YR CPPP	2018-2020	2020-2023
Outreach Timeline	September-October 2017	April-May 2020
Outreach Summary	1,000+	14,069+
Survey Responses	550	627
Focus Groups	18 *138 participants*	12 *198 participants*
Public Comments	10	227

CPPP SURVEY DEMOGRAPHICS: LANGUAGE AND FIRST TIME PARTICIPANT INFORMATION

Table 1. Number of Survey Respondents by Survey Language (n=627)

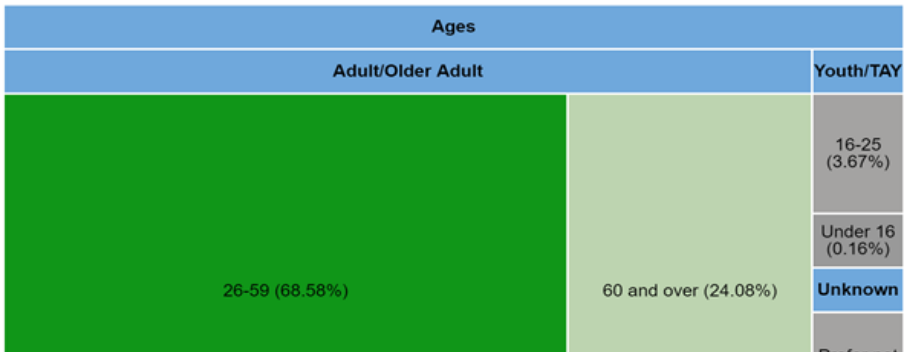
Survey Languages	Number of Responses
1. English	587
2. Chinese	31
3. Spanish	9
4. Farsi	0
5. Korean	0
6. Tagalog	0
7. Vietnamese	0
Total	**627**

Table 2. First Time Participating in MHSA Community Program Planning Process (n=627)

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

CPPP SURVEY DEMOGRAPHICS: AGE GROUPS

Figure 1. Participant's Age Groups (n=627)



CPPP SURVEY DEMOGRAPHICS: RACE AND ETHNICITY

Figure 2. Participant's Ethnicity (n=553)

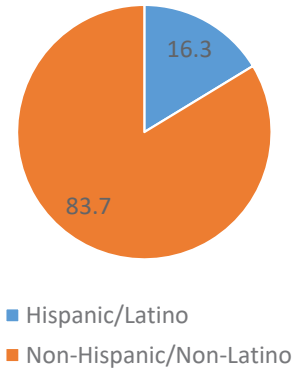
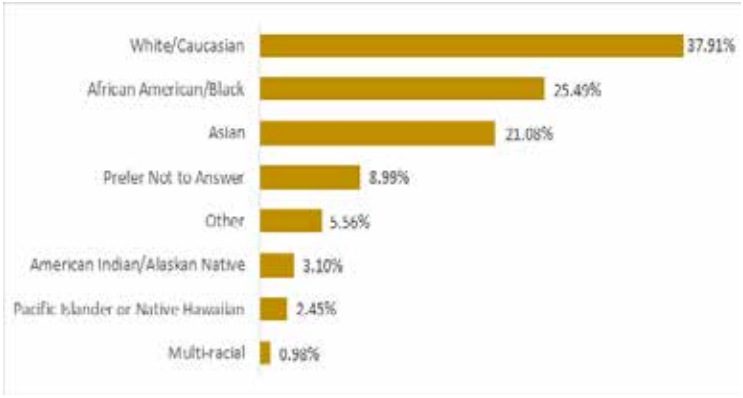


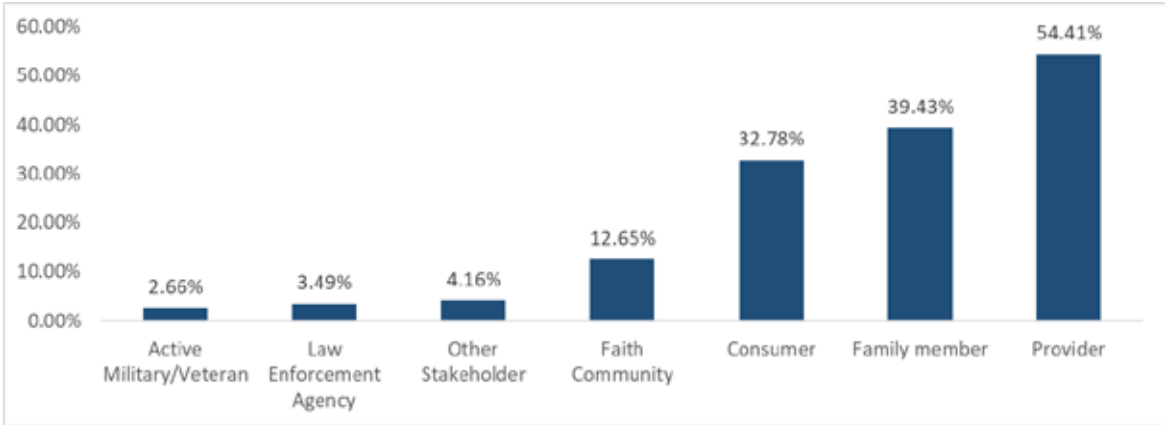
Figure 3. Participant's Race (n=612)



*Participant's allowed to choose more than one category so percent total is more than 100%.

CPPP SURVEY DEMOGRAPHICS: STAKEHOLDERS

Figure 4. Participant's Stakeholder Group (n=601)



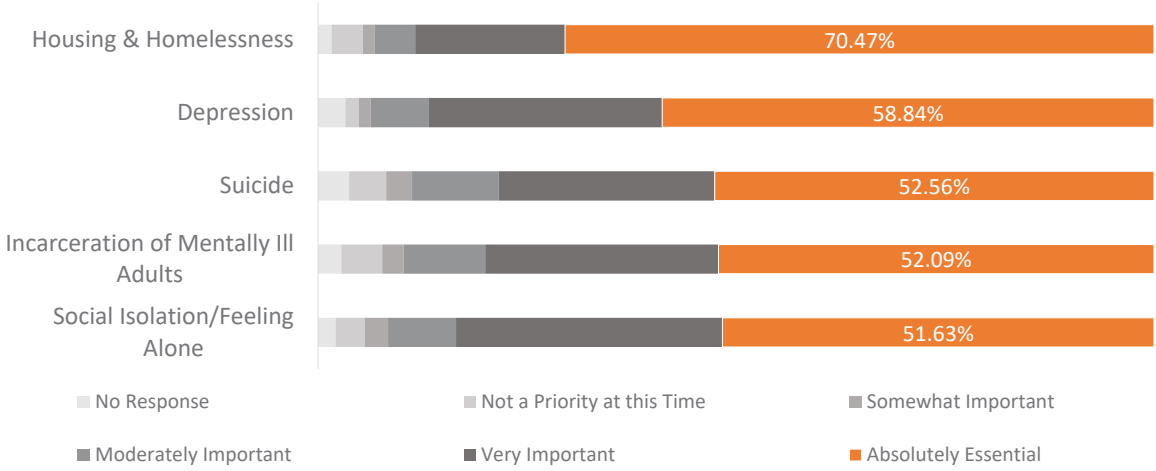
*Participant's allowed to choose more than one category so percent total is more than 100%.

Top Five Priority Mental Health Needs

Figure 5. Top Five Priority Mental Health Needs for Children, Youth and TAY (N=627)

CPPP Survey Highlights: Adults & Older Adults
Top Five Priority Mental Health Needs

Figure 6. Top Five Priority Mental Health Needs for Adults and Older Adults (N=430)



NOT ADEQUATELY SERVED BY SYSTEM

Figure 7. Populations or Groups not Adequately Served by System (n=591)

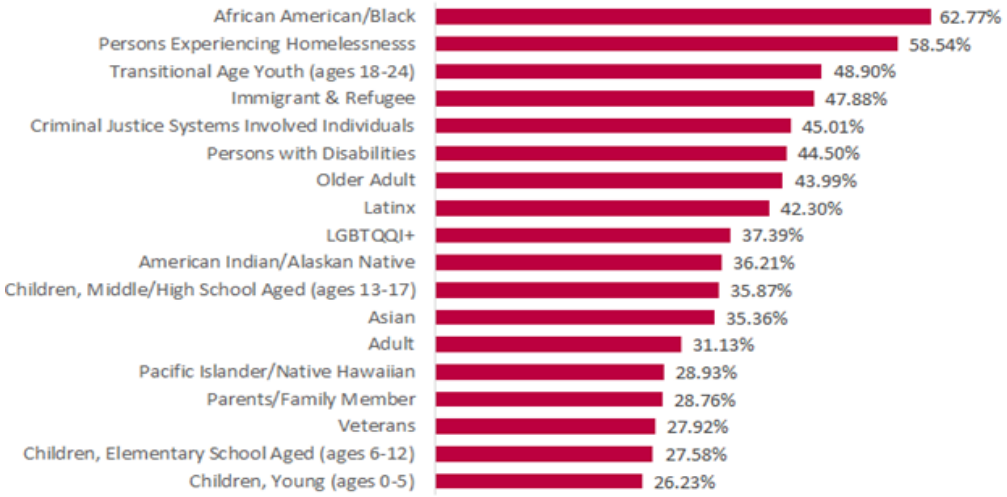
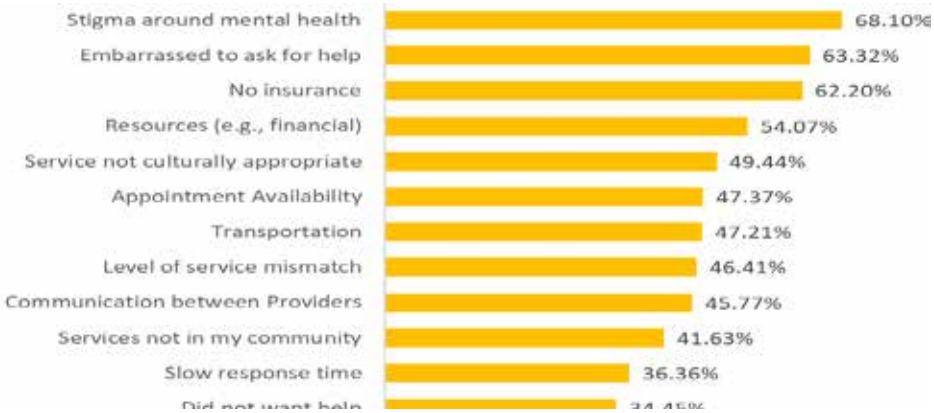


Figure 8. Barriers to Accessing Mental Health Services (n= 627)



CPPP SURVEY HIGHLIGHTS: INNOVATION (INN) IDEAS

- Community and Home-base Services
- Services for Transition Age Youth (TAY)
- Outreach/Education for Stigma Reduction
- Housing Supports
- School-based Services
- Increasing Culturally Responsive Services
- Care Coordination/Provider Communication
- Telehealth – individual and group
- Creativity and recreation-based therapies
- Increasing peers in the workforce
- Supporting Families

PUBLIC COMMENT HIGHLIGHTS:

- Prop 47/ Mental Health Treatment Teams
- Collaborative Courts-(Mental Health Services)
- African Immigrants/African American Innovation Grants
- PEI UELP 5: Outreach, Education & Consultation-Latinx Community
- Zero Out Incarceration of Mentally Ill
- Increase Oversight & Accountability of Contractors

MHSA FY 20/21 Plan Changes

- Planning and allocation of funds to develop an African American focused Wellness Hub.
- New Full Service Partnership (FSP) Outcome and Impact metrics dashboard.
- COVID-19 outreach materials disseminated for multiple cultural and ethnic communities disproportionally effected by the pandemic.
- PEI services are now being provided to the Middle Eastern community through the underserved ethnic and linguistic program (UELP) model.

Alameda County's Unserved/ Underserved Ethnic Language Population

Prevention and Preventive Counseling Community Survey and Focus Group Results
Fiscal Year 19/20

February 2021
Alameda County Behavioral Health | Prevention & Early Intervention, MHSA Division

Acknowledgements

This report was produced in coordination and partnership with Alameda County Behavioral Health and the Unserved/Underserved Ethnic Language Population (UELP) programs.

- Afghan Coalition
- Asian Health Services
- Bay Are Community Health (formerly known as TriCity Health Center)
- Center for Empowering Immigrants and Refugees
- Diversity in Health Training Institute
- Filipino Advocates for Justice
- International Rescue Committee
- Korean Community Center of the East Bay
- La Clínica de La Raza
- Native American Health Center
- Partnerships for Trauma Recovery
- Portia Bell Hume Center
- Richmond Area Multi-Service, Inc.

Authors

Carly Rachocki, MPH
Management Analyst
Alameda County Behavioral Health

Kelly Robinson, MPA
Prevention and Early Intervention Coordinator
Alameda County Behavioral Health

Cheryl Narvaez, LCSW, MPA
Program Specialist, Prevention and Early Intervention -Mental Health Service Act Division
Alameda County Behavioral Health

Tracy Hazelton, MPH
Division Director, Mental Health Services Act
Alameda County Behavioral Health

This work would not have been possible without the previous work of the previous evaluator, Lauren Pettis, MSW.

Table of Contents

Executive Summary

History

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 2019/2020 administration.

Evaluation Methods

The health assessment and satisfaction survey were disseminated to the UELP community in 23 different languages including English, Spanish, Vietnamese, Chinese, Dari, Hindi, Khmer, Nepali, Korean, Thai, and Burmese and covered the following outcomes:

- Forming and strengthening identity;
- Changing knowledge and perception of mental health;
- Building community and wellness;
- Connecting individual and family with their culture;
- Improving access to services and resources;
- Transforming mental health services; and
- Increasing workforce and leadership development.

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 under the following outcomes. Detailed information about each of these critical findings can be found in the chapters that appear later in this report.

During Fiscal Year 2019-2020, a total of 386 respondents from 12 of the 13 UELP programs completed the survey.

Forming and Strengthening Identity

Participants are more **empowered** and confident in themselves. Eighty-nine percent of *Prevention* and seventy-nine percent of *PC* respondents reported feeling better about themselves. While participating in their programs, they developed the strength, motivation, and courage to address their challenges.

Changing Individual Knowledge and Perception of Mental Health Services

Providers are working towards changing the perception and narrative around mental health. Ninety-four percent of *Prevention* respondents and ninety-one percent of *PC* respondents reported having a stronger belief that most people with mental health experiences can grow, change, and recover. Having these discussions more frequently and openly works towards normalizing mental health and reducing the ***stigma*** associated with it.

Building Community and Its Wellness

UELP providers are working towards a healthier community for their clients. Respondents reported ***establishing relationships*** because of their participation in services. UELP programs provide an instant community for clients and reduce the risk of social isolation. Ninety-three percent of *Prevention* respondents and eighty-three percent of *PC* respondents reported that they have people with whom they can do enjoyable things.

Connecting Individual and Family with Their Culture

UELP programs provide clients with opportunities to connect with their culture. Focus group/interview respondents reported that they had increased respondents from participants spoke about ***feeling comfortable*** at the UELP programs and that "they want to be there." Eighty-six percent of *Prevention* respondents and sixty-nine percent of *PC* respondents reported feeling more connected to their culture and community.

Improving Access to Services and Resources

UELP programs strive to improve access to services and resources for their client populations. Respondents reported several examples in which their program has connected them to ***resources*** such as employment, housing, and financial services. Eighty-eight percent of *Prevention* respondents and seventy-eight percent of *PC* respondents reported becoming more effective in getting the resources that they or their family need.

Transforming Mental Health Services

UELP programs are transforming the way mental health services are delivered in Alameda County. One example is by providing ***linguistic and cultural competency***. Ninety-eight percent of *Prevention* respondents and 91% of *PC* respondents said that staff were sensitive to their cultural backgrounds. They also reported strong ***relationships with service providers*** and often referred to staff as family. Ninety-three percent of *Prevention* respondents and 97% of *PC* respondents reported that program staff treated them with dignity and respect. UELP programs also provide a welcoming and ***safe space*** for their clients. This is reflected in the high percentage of *Prevention* (95%) and *PC* (96%) respondents agreeing that they would recommend this program to a friend or family member.

Transforming Alameda County Systems: Mental Health, Criminal Justice, School, Healthcare, Social Welfare, and Housing

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 (57%) of *PC* respondents reported fewer crises, this is reflected in the focus groups saying that they might not "be here today" without the UELP Program.

Remaining Challenges

Focus group respondents suggested that participation might be more exciting and long-term if the there was a ***project*** to work on. They want to grow a healthier community and a long-term project could help both attract new participants and encourage long-term participation in the program. When asked what they would like to see more of both client satisfaction survey and focus group respondents mentioned that they wanted ***financial and housing resources***. Housing continues to be an issue for UELP program participants and Alameda County residents.

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 a program evaluator to better capture the results of PEI programs and the longer-term impact on clients.

Program Overview

Alameda County currently provides mental health *Prevention* and *Preventive Counseling (PC)* services to underserved and unserved populations through funding from the Mental Health Services Act (MHSA), also known as Proposition 63. Prop 63 was passed by California voters in November 2004 to develop and expand community-based mental health programs based on principles of wellness and cultural competence. Prevention and Early Intervention (PEI) services are viewed as a critical strategy to:

- "Prevent mental illness from becoming severe and disabling"
- Create "access and linkage to mental health treatment"
- Promote strategies that are "non-stigmatizing and non-discriminatory," and
- Improve "timely access for underserved populations"

Alameda County is an incredibly diverse population of over 1.6 million people. To address its diversity, Alameda County Behavioral Health (ACBH) has contracted thirteen programs to provide culturally responsive Mental Health PEI services to state-identified underserved populations, which include the communities of Afghan/South Asian, African, Asian/Pacific Islander (API), Native American, and Latinos. These thirteen programs are called the Underserved Ethnic and Language Population (UELP) programs. The providers of these programs and their *priority populations* include:

- Afghan Coalition – *Afghan*
- Asian Health Services – *Asian (East)*
- Bay Are Community Health (formerly known as TriCity Health Center) – *Asian (East)*
- Center for Empowering Immigrants and Refugees – *Southeast Asian*
- Diversity in Health Training Institute – *Middle Eastern and Arabic*
- Filipino Advocates for Justice – *Filipino*
- International Rescue Committee - *Afghan*
- Korean Community Center of the East Bay – *Asian (East)*
- La Clínica de La Raza
- Native American Health Center – *Native American*
- Partnerships for Trauma Recovery – *African*
- Portia Bell Hume Center – *South Asian*
- Richmond Area Multi-Service, Inc. – *Native Hawaiians and Pacific Islander*

Each UELP program is built on a framework of three core strategies: 1) Outreach & Engagement, 2) Mental Health Consultation, and 3) Early Intervention (also known as preventive counseling) services. These strategies are implemented through a variety of services, including one-on-one outreach; 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 counseling sessions for individuals and families who are experiencing early signs and symptoms of a mental health concern.

In FY 19/20, the data shows that these UELP providers in total produced:

- 7,472 *Prevention* events, which is a 5% decrease from last year;
- 46,538 people were served at these *Prevention* events (duplicated count); and
- 1,092 unique clients were served through *PC* services, which is a 22% increase in the number of clients served in FY 18/19.

Evaluation Methods

Data Collection Tools

To better understand the impact of these services on clients, ACBH, in partnership with the seven UELP programs, collaboratively designed a survey tool in 2014 to assess both client satisfaction and outcomes. In 2016, the survey was revised and separated into two different tools (health assessment and satisfaction survey) to better assess the impact and success of these programs. The new tools were translated into English, Spanish, Vietnamese, Chinese, Dari, Hindi, Khmer, Nepali, Korean, Thai, and Burmese and then implemented in 2017. Since then, the tools have been translated into a total of 23 different languages to reflect the expansion of providers and address the expanding diversity of cultures of UELP program participants.

In FY 19/20, both 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;
- Changing knowledge and perception of mental health;
- Building community and wellness;
- Connecting individual and family with their culture;
- Improving access to services and resources;
- Transforming mental health services; and
- Increasing workforce and leadership development.

The surveys have moved the evaluation from just measuring the "short-term" outcomes to measuring some "intermediate" outcomes as well (See Logic Model, Appendix 5). The UELP evaluation uses a mixed design. A mixed-method approach collecting both quantitative and qualitative data offers multiple benefits, including 1) opportunities to triangulate between different data types; 2) a fuller understanding of outcomes; 3) capacity to overcome weaknesses of individual methods.

Community Health Assessment

The health assessment is a data collection tool that is only completed by new *PC* clients due to the higher intensity of services they receive. *PC* clients were given the pre-assessment during intake and the post-assessment during discharge or after they received at least six months of service. A short-term panel survey was conducted at two points in time (pre/post), using the same sample of respondents (n=116) to measure change over time for their level of crisis, health status, and level of activity. It is important to note that during the data collection process, only 116 health assessments were matched and qualified for panel analysis (comparing pre and post-test results).

The remaining health assessment data included unmatched pre- (n=62) and post-assessments (n=37) and were evaluated using cohort analysis (See Appendix 1). Cohort analysis allows the evaluation to compare the metrics for a group over time rather than the individual. By analyzing these patterns across time, the UELP system can identify the needs of those specific cohorts as well as tailor its services to better meet those needs.

Community Wellness Client Satisfaction Survey

Clients receiving *PC* or *Prevention* services completed the client satisfaction survey at one point in time during November 1, 2019 to January 31, 2020. Each client must have participated in a minimum of four sessions to be eligible for the survey. A total of 386 respondents from 12 of the 13 UELP programs completed the client satisfaction survey. Respondents were asked 16 questions with statements about the benefits of service (e.g., community connection and empowerment) that they could attribute specifically to their participation in one of the UELP programs. They were also asked six questions about the program specifically (staff, hours, location, etc.). Demographic data (age, city of residence, gender, and race/ethnicity) and open-ended questions were also asked. Responses to these survey questions were analyzed separately for *Prevention* and *PC* services to assess any differences between the two types of services. It is also important to note that 37 respondents (less than 10% of the respondents) did not specify the type of services they receive. The denominator is slightly lower for the survey responses that we analyze separately (*Prevention*, n=257 and *PC*, n=101).

The results below were based on a five-point Likert scale, ranging from strongly-disagree to strongly-agree. The data were reviewed for errors, duplicates, and omissions. The analysis involved case-wise deletion, meaning that any data coded as missing or non-applicable was not included in the individual analysis, which resulted in different denominator sizes. To address potential literacy issues, the surveys were translated into the clients' native language, and the scale also included a "thumbs up" or "thumbs down" graphic to match the scale's text. For the open-ended questions, UELP program staff is asked to translate any non-English responses to English prior to submitting the surveys to ACBH.

Focus Groups

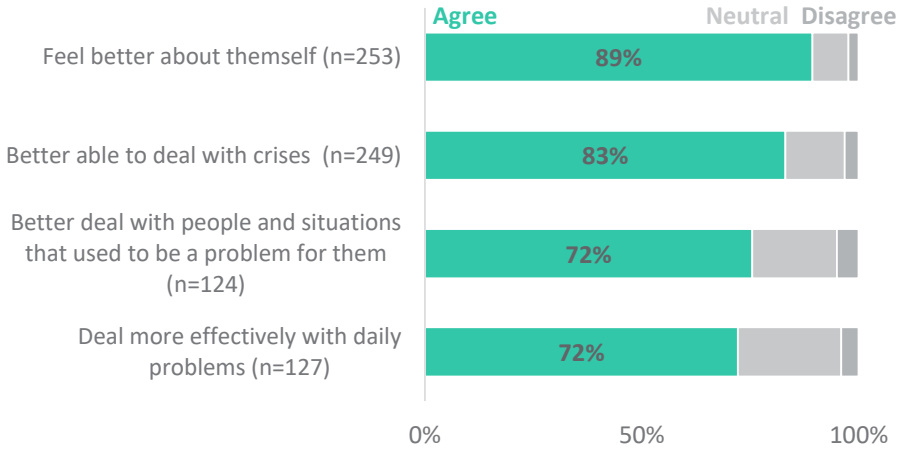
In addition to the survey tools described above, four focus groups were conducted to get a deeper look into the client perspective as well as a better understanding of service provision, the benefits of that service, and program recommendations. The focus groups were conducted during October 2020 due to a delay caused by COVID-19.

In the past, providers were selected for focus groups and ACBH staff conducted the focus group at the program's facility. Due to the impacts of COVID-19 and the transition to online platforms for UELP programs to provide their services ACBH staff chose four groups that had low or no participation in previous focus groups. These groups were Pacific Islanders, Men, Afghans, and Transitional Age Youth (18-25) from eight of the 13 programs. Each group contained a combination of participants receiving *Prevention* and *PC* services. The focus groups were conducted using GoToMeeting or Zoom. They were facilitated by the ACBH Program Specialist of the UELP Programs and the Management Analyst of the MHSA Division. They were transcribed and analyzed using Taguette, a free and open source qualitative research tool. In 2020, a total of 18 clients participated in the focus groups. See Appendix 3 for the focus group guide.

Forming and Strengthening Identity

After participating in these services, UELP participants were better equipped to handle problematic situations and crises. The following data shows that UELP participants have strengthened their identity and improved their self-efficacy. This suggests that the support and tools clients have received in their programs have given them the strength and empowerment needed to deal with crises more effectively. This is consistent with data reported in the open-ended responses and in the focus groups.

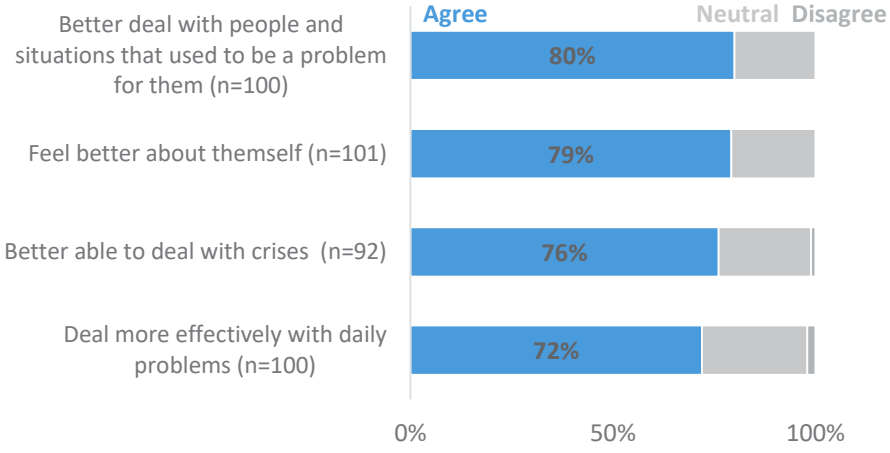
Figure 1. Prevention Services Enhances Self-Efficacy



Eight-nine percent of survey respondents receiving *Prevention* services reported that they feel better about themselves. Eighty-three percent of survey respondents receiving *Prevention* services reported that they are better able to deal with crises

See Figure 1.

Figure 2. Preventive Counseling Enhances Self-Efficacy



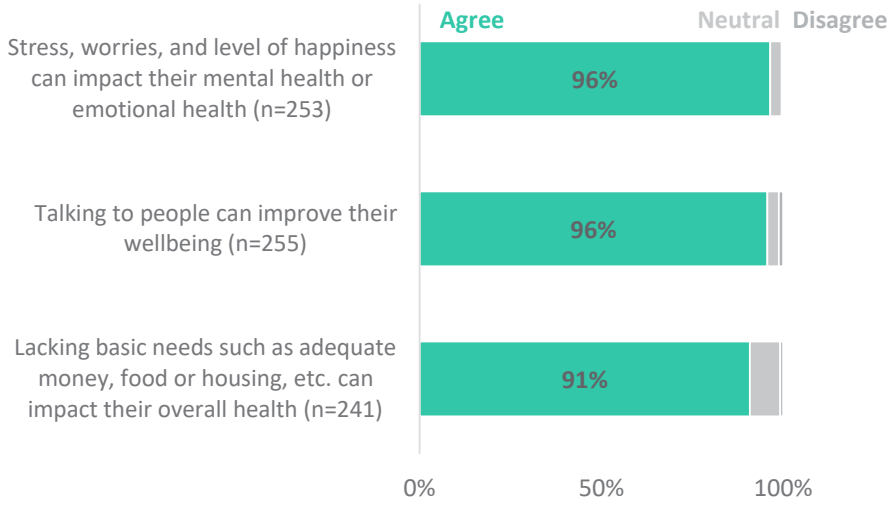
PC clients have also gained the skills necessary to better handle different types of challenges, ranging from everyday problems to extreme crises. Eighty percent of *PC* clients reported that they are better able to deal with people and situations that used to be a problem. Seventy-nine percent of *PC* clients reported feeling better about themselves. These all decreased compared to last year's *PC* respondents.

See Figure 2.

Changing Individual Knowledge and Perception of Mental Health Services

UELP programs are meant to raise awareness and understanding of mental health services and, in turn, decrease internalized stigma. This data shows that respondents have a firm understanding of how different types of moods can impact their mental, emotional, and overall health. The data also show a shift in the perception of mental health in both *Prevention* and *PC* services, further suggesting a reduction in internalized stigma.

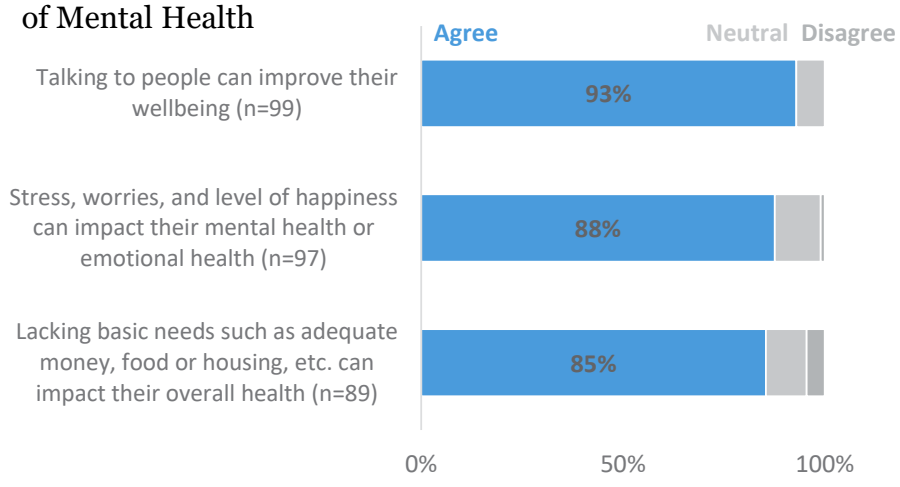
Figure 3. Prevention Services Improve Understanding of Mental Health



Ninety-six percent of respondents receiving *Prevention* services reported a better understanding that stress, worries, and level of happiness can impact their mental or emotional health and talking to people can improve their wellbeing. Ninety-one percent of respondents reported having a beer understanding that lacking basic needs can impact their overall health. All of these are increased over last year's *Prevention* respondents.

See Figure 3.

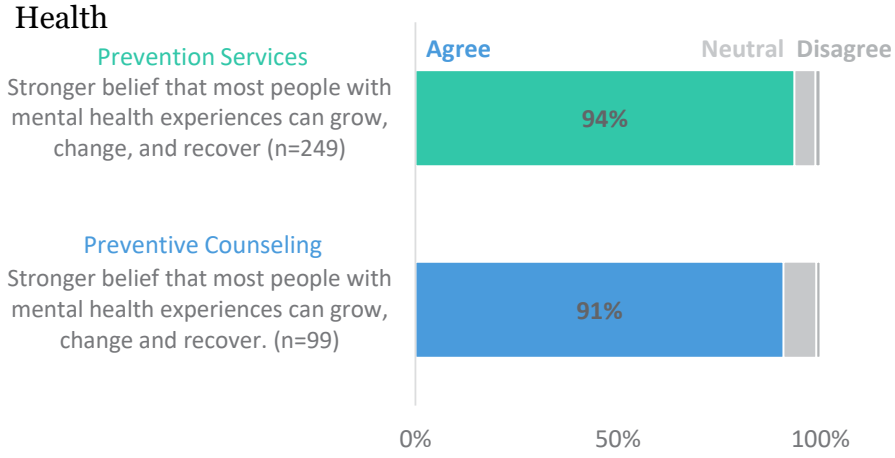
Figure 4. Preventive Counseling Improve Understanding of Mental Health



Of the respondents receiving *PC* services, 93% better understand that talking to be can improve their wellbeing. 88% agree that stress, worries, and level of happiness can impact their mental or emotional health. 85% agree that lacking basic needs can impact overall health. Compared to last year's *PC* respondents this is a decrease in agreement on all statements.

See Figure 4.

Figure 5. Services Develop Positive Perception of Mental Health



Both *Prevention* (94%) and *PC* (91%) have improved their perception of people with mental health experiences believing that they can grow change and recover. This an increase compared to last year's *Prevention* respondents, eighty-eight percent agreed with this question. The agreement among *PC* respondents stayed the same.

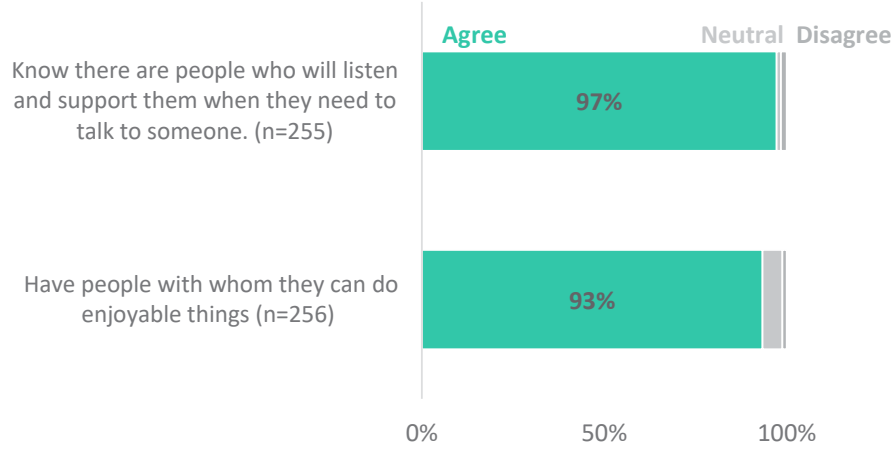
See Figure 5.

Building Community and its Wellness

UELP providers continue to create opportunities for clients to build new friendships and support systems within their programs. The data shows that clients have established relationships with people in their community and have people they can rely on for support. This suggests a reduction of stigma in the community around having and talking about mental health challenges.

These findings corroborate both focus group/interview and survey data collected over the last four years, showing that a compelling reason clients enjoy participating in their UELP program is that it keeps them from being isolated. It allows them to see and make friends and come to a safe place where they can speak to people whom they trust. Social isolation can worsen the symptoms of mental illness or contribute to developing a severe mental health disorder.

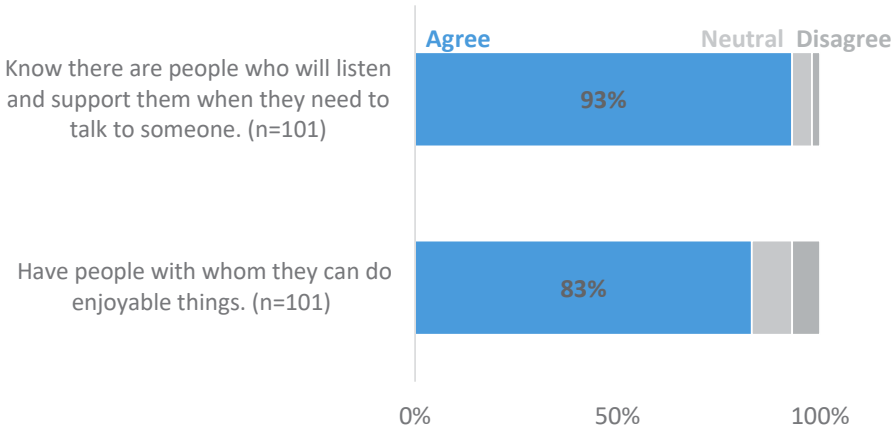
Figure 6. Prevention Services Improves Understanding of Mental Health



Of the respondents that receive *Prevention* services, 97% have people who will listen and support them when they need to talk. 93% have people with whom they can do enjoyable things. Compared to last year more respondents agree with these statements.

See Figure 6.

Figure 7. Preventive Counseling Improves Understanding of Mental Health



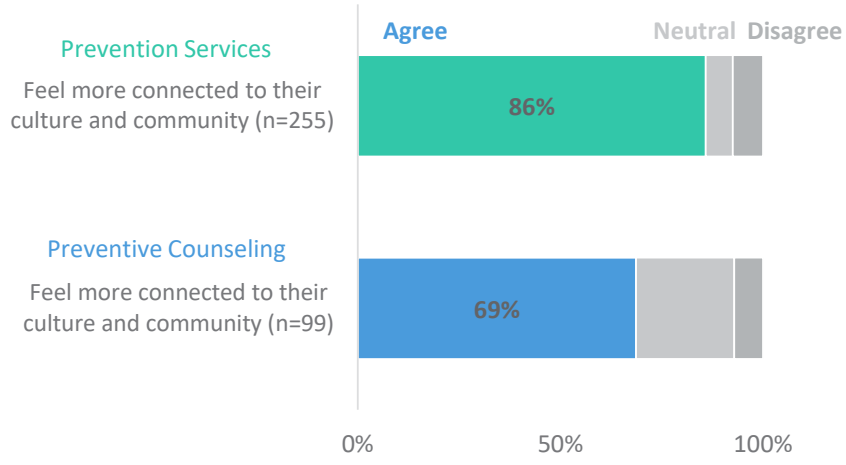
Respondents who participate in *PC* services reported receiving emotional benefits as well. 93% have people who will listen and support them when they need to talk. 83% have people with whom they can do enjoyable things, while this is still a large proportion of respondents that agree it is a decrease when compared to last year's respondents (90%).

See Figure 7.

Connecting Individual and Family with Their Culture

UELP services aim to bolster the connection clients have with their culture by utilizing their cultural norms as a bridge to provide services, which can be achieved in many ways. Some examples include using cultural practices, celebrations, and validations in program activities. The data shown below demonstrates that UELP services are facilitating a connection between clients, their culture, and communities. This is consistent with data found in the open-ended responses as well as the focus groups.

Figure 8. Services Strengthened Connection to Culture



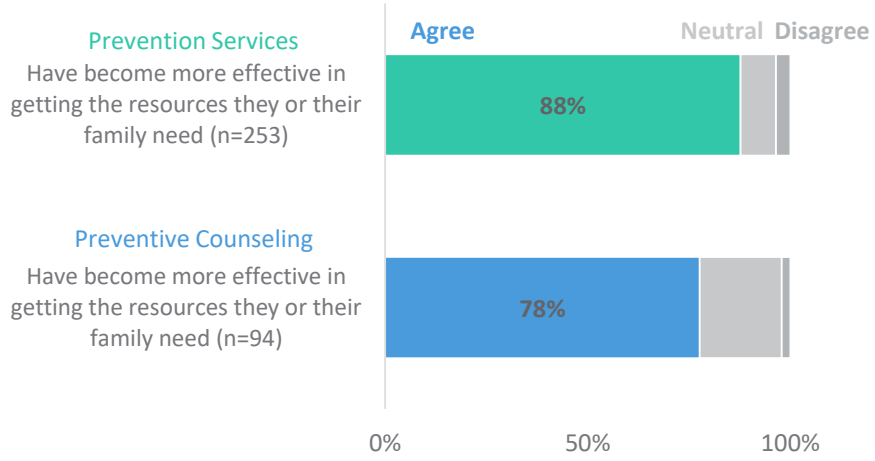
86% of *Prevention* respondents reported that they felt more connected to their culture and community. Fewer *PC* clients (69%) agree that they felt more connected to their culture and community. While more *Prevention* respondents agree with the statement this year compares to last year (86% vs 83%), fewer *PC* respondents agree with this statement (69% vs 90%).

See Figure 8.

Improving Access to Services and Resources

Monolingual or LEP (Limited English Proficiency) populations may experience challenges navigating the behavioral health care system and accessing services or resources, particularly when they are in need or in crisis. This is extremely important because barriers to access can lead to increased stress, anxiety, isolation, depression, and other mental health concerns. With the assistance of UELP services, the majority of participants are more successful at navigating the system in order to obtain the services and resources they need.

Figure 9. Services Increased Ability in Getting Resources



Eighty-eight of *Prevention* and seventy-eight percent of *PC* respondents feel that they have become more effective in getting resources they or their family needs. Similarly, to other statements, this is an increase among *Prevention* respondents when compared to last year (80%) and a decrease in percent that agree among *PC* respondents (81%).

See Figure 9.

Transforming Mental Health Services

UELP service agencies are determined to provide transformative mental health services. The idea is to move away from the "one size fits all" approach to mental health, emphasizing the use of culturally congruent mental health methods with marginalized populations. The data below shows that respondents are satisfied with the services they receive in UELP. Participants continue to report that they are treated well and would recommend these services to friends or family members.

Figure 10. Prevention Services Clients were Satisfied with Services

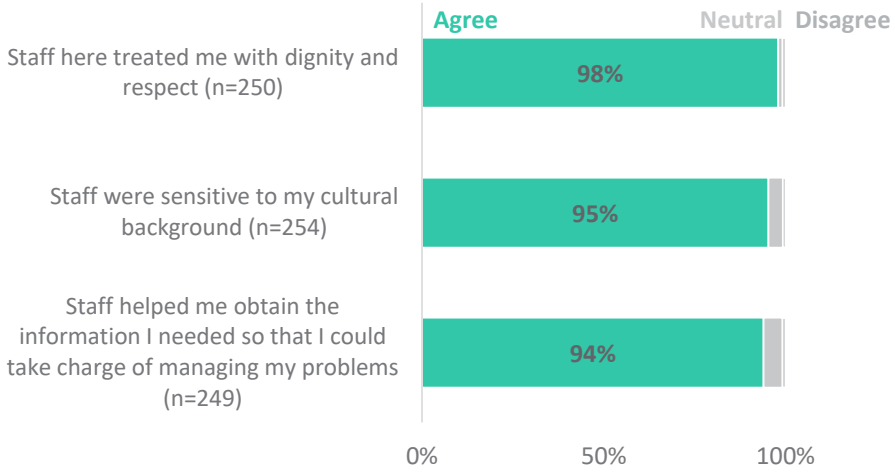
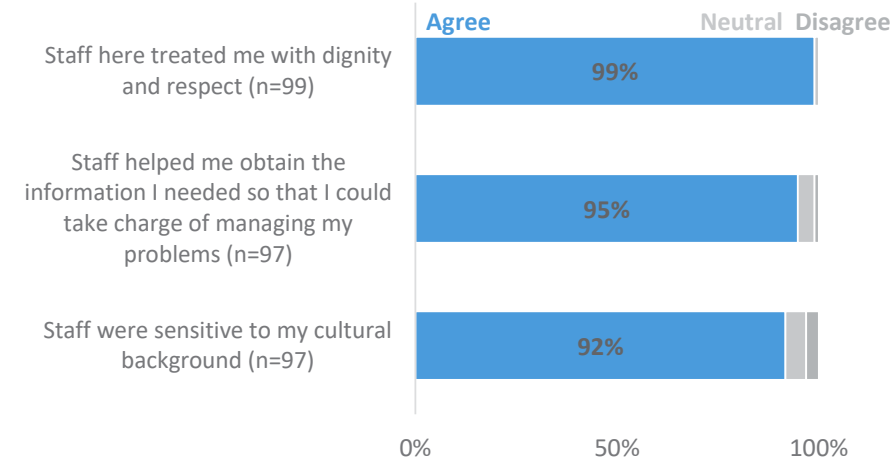


Figure 11. Preventive Counseling Clients were Satisfied with Services



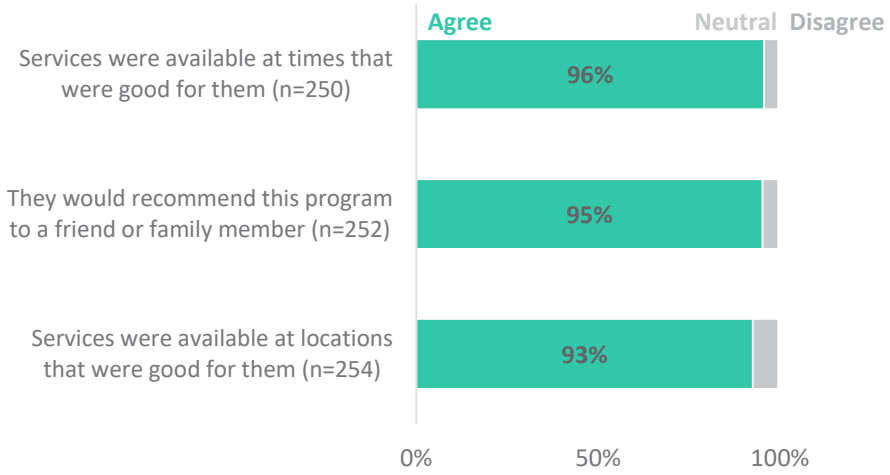
Ninety-eight percent of respondents reported that program staff treated them with dignity and respect. It seems that *Prevention* services were beneficial and useful because the majority 95% of respondents also said that staff were sensitive to their cultural background. 94% of respondents said that staff provided them with the information needed to help manage their problems.

See Figure 10.

The data shown here conveys that staff members were an integral part of improving survey respondents' quality of life. Almost all (99%) survey respondents said that staff treated them with dignity and respect. Ninety-five percent of *PC* survey respondents reported that the support they received from staff helped them obtain the information they needed to manage their problems. 92% felt that staff were sensitive to their cultural background.

See Figure 11.

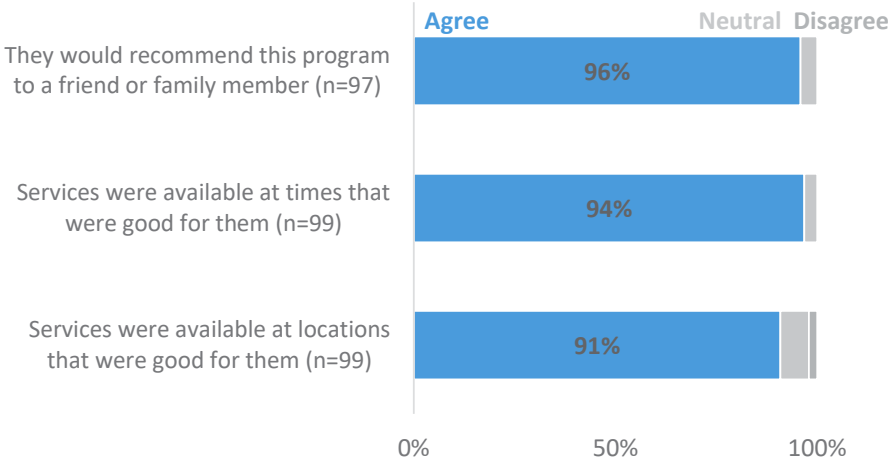
Figure 12. Prevention Services were Convenient and Highly Satisfactory



The majority (96%) of *Prevention* respondents thought that the services were available at good times, 95% of these respondents also said they would recommend these services to a friend or family member, and 93% thought the locations were good. This data suggests that *Prevention* clients think that these services are convenient, helpful, and that others can benefit from them. All of these are a higher percentage that agree than the Prevention respondents from last year.

See Figure 12.

Figure 13. Preventive Counseling Services were Convenient and Highly Satisfactory



About the same number of respondents receiving *PC* services reported that the services they receive are convenient and satisfactory. The majority (96%) of respondents said they would recommend their program to friends or family. Ninety-four percent of respondents reported that services were offered at convenient times and 91% of these clients reported that services were offered at convenient locations. Agreement with service times and locations being good for respondents increased for *PC* respondents compared to last year's respondents.

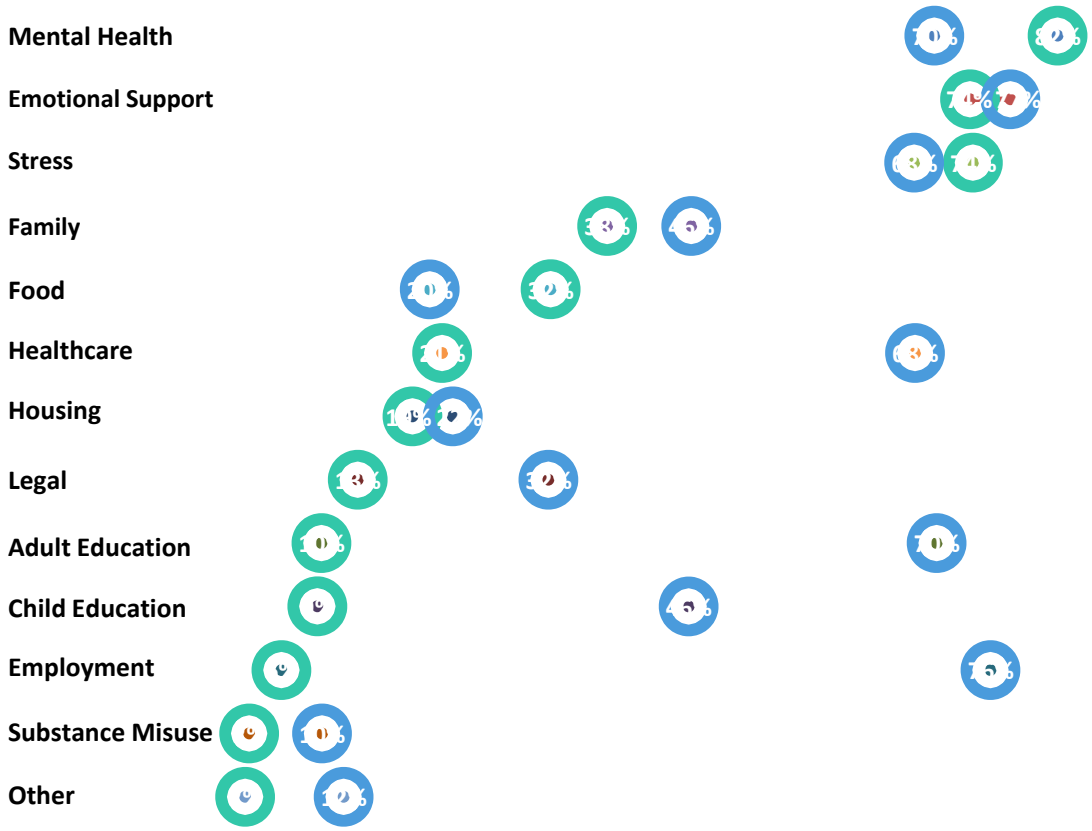
See Figure 13.

Areas of Improvements

Survey respondents were asked to specify which areas of their lives have improved as a direct result of their participation in UELP services. They were given a choice of 13 different categories from which to choose, including an "other" choice, and were asked to check all that apply.

As a direct result of their participation in UELP services respondents were asked to provide areas of improvement. Mental health was the largest area of improvement for *Prevention* survey respondents. This is consistent with the responses to the open-ended questions. Emotional support was the largest area of improvement for *PC* respondents, which is also reflected in the open-ended questions. Emotional support, mental health, and stress were high ranking areas of improvement for both *PC* and *Prevention*. Employment (76%) was also highly ranked as an area of improvement for *PC* respondents.

Figure 14. Prevention Services and Preventive Counseling Respondent's Areas of Improvement



Open-Ended Responses

Four open-ended questions were asked in the survey to understand better: 1) if and how respondents felt services were beneficial to them; 2) what kind of needs they currently have; 3) if and how their lives would be different if they were *not* receiving *Prevention* or *PC* services; and 4) anything else they thought would be helpful for service providers to know.

During the analysis, answers to each question were grouped into themes and categorized under headings to help assess which topics were most important to respondents. There are a few themes in each question that did not fit under any category and were reported as “Other.” The following tables list each theme by the number of respondents who reported it. Responses from participants in *Prevention* and *PC* programs were combined. To further illustrate the frequency of certain themes, a "word cloud" of the most common words is included in every section. The larger the word in the graphic, the more frequently it appeared in the answers given for each question. Each word cloud was generated using a website called WordClouds.com.

Note: Only themes with five or greater responses were included in the tables and word clouds below to showcase the ones that came up most frequently by respondents.

Most Beneficial Services and Supports

334 survey participants responded to this question

Categories: Services	# of responses
Support Groups	36
Therapy	25
Help with Paperwork	16
Translation	5
Education	7
Total:	**89**

Support Groups received the most responses in the Services category, followed by therapy (individual or group sessions). Several participants reported how much they enjoyed coming to their sessions. Other services mentioned were help with translation, adult and childhood education, and help filling out paperwork.

"The understanding that some people always here to help get through tough situation has been the most beneficial to me."

Categories: Social	# of responses
Friends	10
Communication	8
Community	8
Total:	**26**

Social category refers to respondents' statements about and being able to meet and spend time with new friends, which was the largest theme in this category.

"I find more friend that I can share my problem with them."

Categories: Emotional Wellness	# of responses
Mental Health	43
Talking to Someone	38
Stress	33
Emotional Support	16
Happiness	12
Self-Confidence	11
Self-care	6
Fell Better	5
Total:	**164**

Emotional Wellness is the largest category in this section, just as it has been in previous reporting years. Respondents expressed that the program was beneficial for supporting their mental and emotional wellness they also spoke about feeling supported, having someone to talk to/share with, and dealing with stress.

"My mental health has improved and I feel like I have an emotional support."

"To speak with someone who understands me and analyze and solve my mental stress."

Categories: Referrals to Resources	# of responses
Healthcare	26
Housing	9
Immigration	5
Total:	**40**

Referrals to Resources is another important category with recurring themes. Healthcare was a large theme this year. This referred mostly to helping with either insurance or doctor's appointments. Respondents also reported that they have benefited from services because of information sharing by the providers.

"Calling my doctor has been the most beneficial, GA, SSI paperwork, etc."

Categories: Other	# of responses
All	31
Family	9
Safe Place	8
Total:	**48**

Other category includes statements that do not fit into the other categories. It includes positive statements about how the program is helpful or agreement with the question, without identifying specifically how the program is beneficial. Additionally, how the services helped their family and how the program created a safe place.

"All. Help was greatly appreciated."

Categories: Activities	# of responses
Physical Activities	8
Classes/Workshops	19
Total:	**27**

The **Activities** category refers to respondents' statements about physical and classes/workshops organized and implemented by the programs.

"The workshops and activities we have done have been most helpful."

"Outing time in the field."

Additional Client Needs

307 survey participants responded to this question

Categories: Activities	# of responses
Soccer Training	5
Total:	**5**

Soccer was a theme that was provided by participants of a youth-focused program.

"More professional training on soccer."

Categories: Emotional Wellness	# of responses
Therapy	69
Relationships	18
Total:	**87**

Emotional Wellness is a large category that includes participant's saying that they need therapy and help with their relationships.

"The family. How to strengthen family relationships, emotional ties."

"Hope to increase visit time and frequency to understand deeply with my mental distress and pain."

Categories: Referrals to Resources	# of responses
Housing	31
Health	22
Language	18
Basic Needs	11
Employment	11
Transportation	10
Child Education	10
Immigration	7
Adult Education	5
Total:	**125**

Referrals to Resources is another important category with recurring themes. Housing is the most common theme in this category and continues to be a tremendous need for UELP program participants and affordable options are extremely limited in Alameda County. Healthcare was a large theme this year. This referred mostly to helping with insurance, doctor's appointments, and health problems. Language refers to learning English and translation.

"I need more support to find housing."

"More knowledge about health"

"Learn more of English and grammar."

Categories: Services	# of responses
Repeat Current Program	34
Support Group	12
Paperwork	7
Total:	**53**

Repeating the current program that the participants are currently in received the most responses in the Services category, followed by support groups, and help filling out paperwork.

"I think if we have that kind of service every six month. It would be really helpful."

Categories: Other	# of responses
None	36
Nothing Specific	19
Total:	**55**

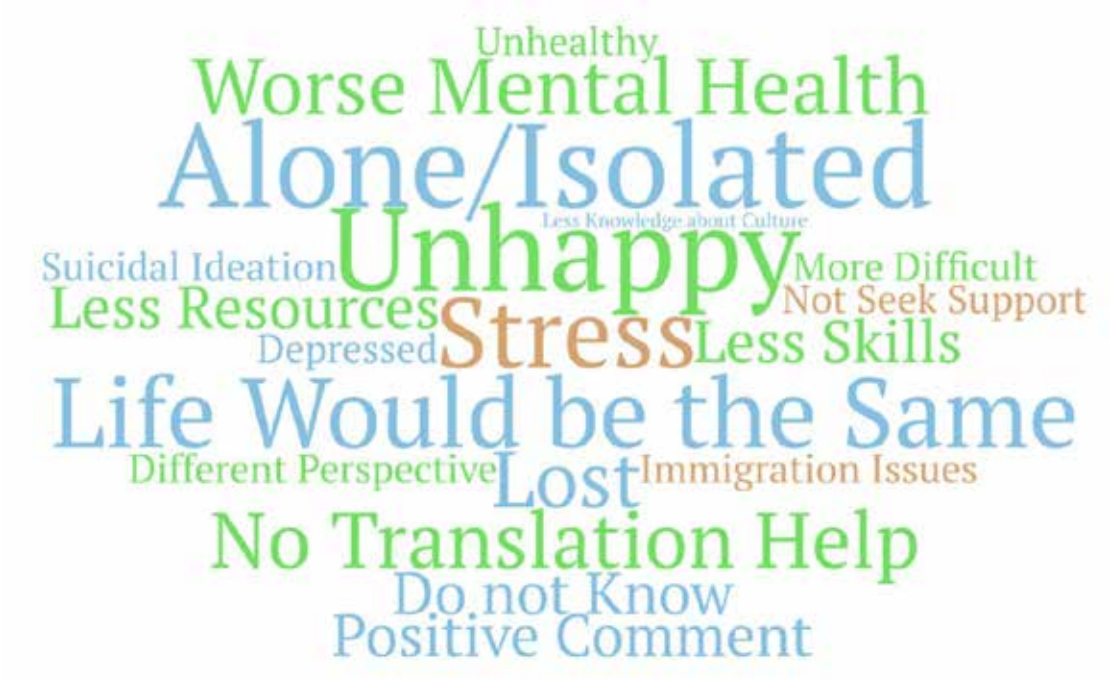
Participants replied that they had **no needs** or **did not specify a need**.

"None, thankfully."

"Nothing specific for now."

What Would Have Been Different Without These Services?

298 survey participants responded to this question



Category: Decreased Access to Resources or Develop Skills	# of responses
No Translation Help	16
Less Skills	12
Less Resources	12
Unhealthy	10
Not Seek Support	9
Immigration Issues	7
Total:	**66**

Decreased Access to Resources or Develop Skills is a recurring theme in the open-ended survey responses. Survey respondents repeatedly expressed that without these programs and services, they would not have information and resources, especially when completing application forms or documentation.

"Difficulty communication due to language issues."

"How to cope with stress. How to save money."

Categories: Emotional Wellness	# of responses
Unhappy	67
Alone/Isolated	40
Stress	38
Lost	17
Worse Mental Health	17
Depressed	11
Suicidal Ideation	6
Total:	196

Categories: Other	# of responses
Life Would be the Same	21
Do not Know	16
Positive Comment	12
Different Perspective	9
More Difficult	6
Less Knowledge about Culture	5
Total:	69

Emotional Wellness category refers to respondents' mental and emotional health needs. Respondents reported that without their participation in these programs, they would be unhappy, alone/isolated, more stressed, lost, worse mental health, depressed, and would have suicidal ideation. The data clearly shows that respondents would have been mentally and emotionally worse off without UELP services. This is consistent with data reported in previous years.

"I will be miserable without the program."

"I think I would be more isolated, less connected and lack the tools to be mentally well."

"I don't know if I'm still alive. This program gives me hope of living a full life."

Life would be same, not knowing, and general positive comments and appreciation were the top three themes under the "Other" category.

"My life would have gone on without changes, and I'd need to figure things out myself."

"All concerns which I had are now getting solved."

"I don't know if I'm still alive. This program gives me hope of living a full life."

Anything Else to Share

223 survey participants responded to this question

Categories: Other	# of responses
No	57
Thank you/Grateful	32
General Positive	36
Total:	**125**

Other refers to participants not having anything else to add, thanking the program, and general positive comments.

"This program is a very helpful for all refugee/immigrant. Thank you for all your support."

"Thanks for this program/organization. I met people who would always be there for me and have taught me everything."

Categories: Services	# of responses
Continued this Program	45
Different Service Suggestions	15
More Funding	10
Culturally and Linguistically Specific Programming	9
Therapy	6
Longer Time	5
Total:	**90**

Services is a theme that includes participants asking for continued support, different service suggestions, and more funding. This is a theme that further expresses the respondents' need for services to continue.

"I wish these kinds of program to continue."

"Outing, field trip, camping, and keep [UELP program] open."

Categories: Referrals to Resources	# of responses
Housing	8
Total:	8

Housing continues to be a need for UELP program participants.

"Help with cheaper housing."

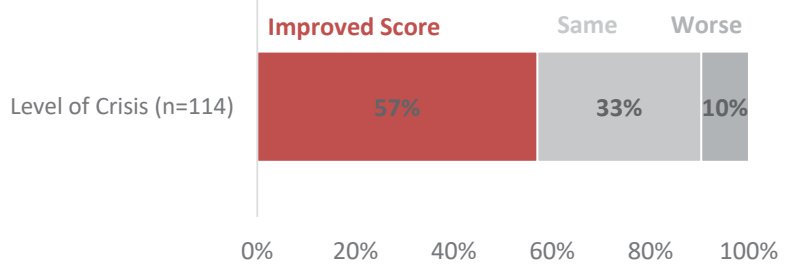
Community Health Assessment Results (Panel Data Analysis)

A short-term panel survey was conducted at two points in time (pre/post), using the same sample of *PC* clients to measure change over time. The following data summarizes change over time for 116 participants, a more than threefold increase over last year. The assessment asks clients to self-rate their level of crisis on a scale from one to ten, giving the examples of feelings/behaviors associated with a crisis (e.g., cannot focus, frustrated, feeling isolated, angry, lost, constant crying, feeling paralyzed, and urge to use drugs/alcohol), health status, and level of activity.

Most participants reported improved or the same scores from the pre- to post-assessment, and very few reported a worse score. This is similar to last year's data. Overall the data demonstrates that services are helping to address crises and challenges that clients may be experiencing. It is important to note that most respondents reported the same scores for physical, mental, and overall health. Compared to the pre-assessment, poor mental health reported in the post-assessment could have contributed to respondents reporting higher same/worse scores for the number of days their physical or mental health disrupted their usual activities.

Health Surveillance

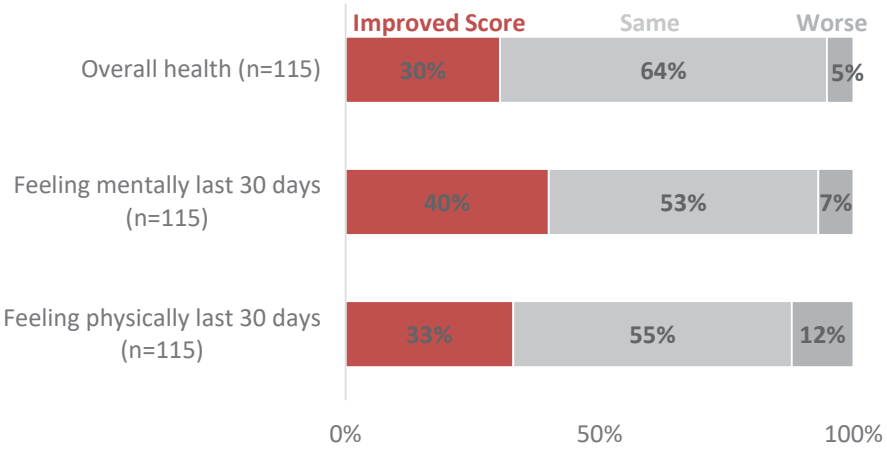
Figure 14. Level of Crisis Decreased among Preventive Counseling Respondents



The majority (57%) of respondents decreased their perceived level of crisis between their pre-and post-assessments. Thirty-three percent maintained the same level of perceived crisis, and only 10% reported a worse score.

See Figure 14.

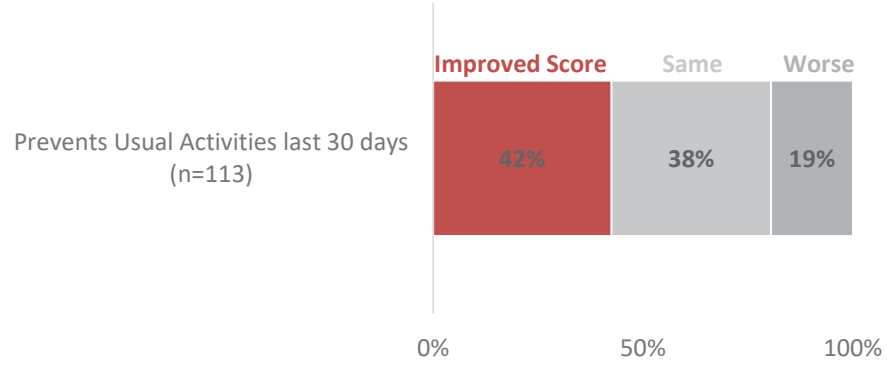
Figure 15. Respondents' Physical, Mental, and Overall Health Either Improved or Stayed the Same



More than half of clients reported the same level of overall health (64%), mental health (53%), and physical health (55%) between the pre- and post-assessments. However, more clients reported an improved score in each of these groups than a worse score over time.

See Figure 15.

Figure 16. Respondents' Number of Days Unable to Perform Usual Activities Decreased



Compared to last year more respondents' this year reported a decrease in the number of days that they were unable to perform their usual activities due to physical and/or mental health problems (36% vs 42%). Thirty-eight percent of respondents reported the same level of activity from pre- to post-assessment and 19% reported their usual activities were disrupted for more days, which is the same as last year.

See Figure 16.

Focus Group Responses

ACBH conducted four focus groups with UELP program participants. In addition to the survey tools described above, four focus groups were conducted to get a deeper look into the client perspective as well as a better understanding of service provision, the benefits of that service, and program recommendations.

In the past providers were selected for focus groups and ACBH staff conducted the focus group at the program's facility. Due to the impacts of COVID-19 and the transition to online platforms for UELP programs to provide their services ACBH staff chose four groups that had low or no participation in previous focus groups. These groups were Pacific Islanders, Men, Afghans, and Transitional Age Youth (18-25) from eight of the 13 programs. Each group contained a combination of

participants receiving *Prevention* and *PC* services. The focus groups were conducted using GoToMeeting or Zoom. Participants were asked questions about:

- How they found out about the services/program;
- How they dealt with stress and what kind of service they were connected to prior to the program;
- What made participation in the program easy and hard;
- What it is like to receive services from someone of the same cultural background and that speaks the same language;
- What their life be like without the program; and
- What they would like to see more of.

See Appendix 3 for a listing of all focus group questions.

Focus Groups

Each of the focus groups were conducted in October 2020. The focus groups had participants from both *PC* and *Prevention* services.

- **Afghani Group**
  - Two females and two males attended
    - All over 18
  - A Dari interpreter was used during the session

- **Transition Age Youth (TAY)**
  - Two males, two females, and one non-binary person attended all over 18 attended
  - A Farsi interpreter was used during the session

- **Pacific Islander/Richmond Area Multi-Service, Inc. (RAMS)**
  - Three males and two females all over 18 attended the session.

- **Men's Group**
  - All four men were over 18

The interpreters present for two of the focus groups used consecutive interpretation.[1] Consecutive interpretation is when the interpreter pauses at the end of each thought and delivers what was said. Each of the focus groups were recorded using the video conference platforms ensure a record of exact (translated into English) quotes. Transcriptions were created from the English translations on the recordings. Content analysis was used to analyze the data and group them into themes.

Some of the themes in this section contain direct *Quotes* from focus group/interview participants themselves, indirect quotes translated by the interpreters labeled as *Example*, paraphrasing what one or multiple participants said.

[1] *Definition of Translation Services http://www.languagescientific.com/6-major-types-of-interpreting/*

Focus Group Findings

The following section highlights the themes resulting from the focus groups. Each of the themes are organized under the UELP outcomes and the remaining challenges listed at the end of the section. An explanation is under the main outcome with sub-outcomes in bold and bulleted with a quote to follow.

Note: The following summary is written in third person pronouns to further protect clients' anonymity.

Forming and Strengthening Identity

Many participants reported feeling empowered and an increased sense of well-being since receiving services. Respondents reported that because of their and their children's participation in programs, they are happier and feel better about their life. Other respondents reported that the services they have received in their respective programs had given them the strength, motivation, and courage to address their challenges. Respondents from all focus groups reported that they would have less ability to deal with people and situations that used to be a problem for them. The respondents reported using skills that they learned in their programs. One respondent mentioned that they really appreciated the tools because they can use those techniques when away from the program. This is consistent with data reported in the client satisfaction surveys, where respondents reported feeling better about themselves.

- **Increase sense of well-being (empowered, hopeful, feeling heard/validated).**

  Example: Indeed, I came to the conclusion that this is an important step, we cannot hide it and keep it to ourselves. It is better to share with others and specifically with professional people like the psychologist at Afghan Coalition, who was a great help not only for myself but also for my [children]. They received the services and they feel like they are much better.

  Quote: "I had just recently moved and I also started a new job like post college. So, a lot of the times I felt like quitting or just didn't feel good enough. I think that the services, not just the one-on ones, but also the group settings were really helpful because I started to realize that it is kind of like growing pains...I feel like I'm more comfortable and I have a lot more capacity to handle it. I don't know what I would have done."

- **Empowered and building/strengthening and self-esteem.**

  Quote: "Because of the program I can be social, I can go out, I can talk to people, and I can be myself."

  Quote: "I feel like if I have never participated in the program I would be in an even worse spot before I started participating on it. The program really taught me how to react to stress, how to life balance so many hours of my life, how to have confidence and self-love. I feel like without all of those things I wouldn't really be here today."

Changing Individual Knowledge and Perception of Mental Health Services

During each of the sessions, participants were asked how they would describe the services they received to a friend. The majority of them reported that they were very comfortable sharing their experiences with others, especially with the hope that it may help the person with whom they are sharing. They explained that other people are also in need of these types of services, and it becomes important to share with them just how their life can benefit from participating. Having these discussions more frequently and openly is working towards normalizing mental health and reducing the stigma associated with it. Additionally, the other services that the UELP programs provide helps attract those that might have stigma associated with mental health services and provides a way to make a recommendation to the program. This is

consistent with the survey responses that they understand how stress, worries, and level of happiness can impact their mental health or emotional health and that talking to people can improve their wellbeing.

- **Raising awareness and understanding of mental health services.**
  Quote: "We always discuss the kind of benefits for anxiety, stress, and depression, with our friends and neighbor. We share the information with them because it is a good benefit to help the community."

  Quote: "When I was opening up to her it was something new. She helped me. When my other friends from my country they don't understand that they can do the same. I recommend the program to them."

- **Reduce personal stigma of mental health and its services.**
  Quote: "Sometimes if you don't know anything, you think you know everything. I used to think that I could handle everything on my own but I can't."

  Quote: "There is also a housing crisis in Oakland and the services are in Oakland and a lot of my friends were going through that as well. Knowing that FAJ didn't just offer a youth services they offered other things that helped for like immigrant parents and workers. I feel like FAJ is really multi-faceted. There is like other things besides our youth program that they could look into. I remember even at the beginning of the pandemic they had a fund that they were giving out to people. I really talked to a lot of my friends who were able to get passed the Google form. There's like a lot of services being offered."

Building Community and Its Wellness

Reduce individual, family, and community isolation is the largest themes to come out of the focus groups. The majority of respondents referred to their specific UELP program as a family. Arriving in the United States and not having any family or system of support in the area, clients risk becoming isolated. Research has shown that social isolation can worsen the symptoms of mental health and may lead to severe mental health disorders. UELP programs provide an instant community for clients, especially for ones that do not have family or a support system here in America. Through their UELP program participation, they have built friendships and a community, which in turn can be used to combat isolation. Participants from CERI and RAMS spoke about how they had made lifelong friends by coming to the program. Their new awareness has also strengthened and improved interactions with their family. However, an outcome not mentioned by the participants was the building of cross community relationships, which increases the sense of safety.

- **Reduce individual, family, and community isolation.**
  Example: "Before [they were] with services with Afghan Coalition [they had] a lot of problem in [their] family…[They] tried to keep [themselves] busy with work and all the time focusing on work even when [they were] at home [they were] working from [their] computer."

  Quote: "What I would do was I would isolate myself, too from other people. I wouldn't tell anyone. It would just be me trying to solve my own problems without trying to look for help. That was not a good thing. I know that know that back then I should have talked to more people than just keeping stuff to myself because that didn't help me at all."

- **Reduce community stigma of mental health and its services.**
  Quote: "But then I told them that they were really understanding and that there was really a sense of community. You didn't feel like you were out of place if you felt some type of way. You didn't feel alone going through your issues or problems. I think the biggest piece that I always used to use was like community, because Pacific Islanders grew up in community-based and surrounded by a lot of people and big families."

Quote: "Number one is food, but I tell my friends and family that this is important because there are things that you didn't know about it out there in the community that you learn from the classes and workshops. Many resources that I wasn't aware of. So, I knew it from the workshop. It's very important. It's just like bring you closer to other people in your community or in your area."

Connecting Individual and Family with their Culture

UELP programs provide clients with opportunities to connect with their culture. One way is by sharing information about cultural activities happening in the community and implementing their own activities. When participants were asked what makes it easy for them to participate in the programs, respondents from participants spoke about feeling comfortable at the UELP programs and that "they want to be there." Beyond connecting with culture, the programs also work towards improving intergenerational interactions and communication and reducing acculturative stressors. A few respondents spoke about having their children participate in these programs and how helpful they are.

- Supporting and strengthening individual connection to culture.

  Quote: "I'll go. For me what made it easier was the person who I was talking to, with the one-on-ones, he understood me and he really tried his hardest to help me. That's one thing that I really appreciated about him"

  Quote: "I just have this relationship with having a similar demographic background and culture that made it easier to share my struggles and talking about things that I was dealing with."

- Improves intergenerational interactions and communication (one-to-one, family relationships).

  Quote: "I have Tongan kids. You know long story short it didn't work out between me and their Mom and they were kind of missing that part of their culture, right? Because I'm Samoan and they're Tongan and so when we went…it provided something for them that I can't. I know everything about my culture, but there is a difference and I can't provide that for them. So, when we went there and they got a chance to interact with other Tongan people and they were not judging them about not knowing about the culture and like that. That was huge for me. I've always been around the Tongan and Samoan community but that's different than trying to teach your kids about the culture and then put it in the concept of mental health is even more difficult. So, I mean when we went to the focus group for Micronesians and it was hosted by the Samoan and Tongan community it was just huge for me. I was just sold. 'We're home, this is family.' Like everybody said it always means something different when the people look like you and they understand what you're going through because we're all the same people. It's very different than just going in and doing breathing exercises with someone that doesn't look like you. That's just huge for me."

- Reduction of acculturative stressors (access to cultural practices, celebrations, traditions; cultural validation).

  Quote: "If I'm in a room with Non-Pacific Islander, Non-Samoan, Non-Tongan and somebody comes in and sits down and says 'Man, I'm just so stressed. I had three funerals in the last month.' Like that means something different for a Polynesian. The whole stress, there is always the spiritual piece to that and the emotional loss, but knowing what that Tongan person that just said that. You know what they've gone through. You know wow that is a ton, the loss of three people that you love, but it's all the work and all the stuff that goes into that process. You're able to relate to everybody there."

Quote: "Like moving to a new country so you don't know anything. So, the rules, the culture so it is very hard for everyone not only Afghan people. It's very good at the beginning that the IRC helps and through them people are able to find the Afghan Coalition and any other organizations. So, life will get easier."

Improving Access to Services and Resources

As mentioned in the quote above, it can be quite challenging moving to the United States from a different country and trying to gain access to much-needed services or resources, which is tied for the second largest theme. Each UELP program provides assistance for their clients to gain access to an array of different resources and services they need (e.g., legal, political/voting elections, housing, and employment). Respondents from CERI, PTR, Afghan Coalition, DHTI, and IRC reported that whenever they need help with translations to fill out paperwork or navigating to services they come to their program for help. These responses are consistent with the data found in the open-ended responses to the client satisfaction survey.

Quote: "If there was no organization like Afghan Coalition it would be more difficult for the people to go to find out how to get benefits through the county and other organizations. Maybe it would take months and months to find out how to apply and where they should go because everybody here is busy and nobody has time to go through or show you. The organization is big help and hand for a community that people can take advantage of. They can go to Afghan Coalition to ask questions or get information from them. It's a big help."

Quote: "If I didn't know this program my life would be more harder. There is nobody working in my household so through this program we received some benefits."

Transforming Mental Health Services

Transforming Mental Health services is the richest outcome from the focus groups, it includes using culturally mental health methods, increasing the practice of transformative healing, providing multiple access points, and offering services in a convenient and comfortable setting. Use of culturally congruent mental health methods is tied for the second largest theme to come out of the focus groups. Every respondent spoke well about the staff from whom they are receiving services. Respondents reported strong relationships with staff and knowing that at any time they are in need, there is someone available for them to speak to whom they trust. Staff are not just service providers; they are often regarded as family. When participants were asked what makes it easier for them to participate in their program, the first thing nearly everyone mentioned was the staff and the environment that they created. Many respondents felt that this was the first time with therapists that they did not have to explain their culture and that they felt understood, not just because they spoke the same language but that was also important. Limited English proficiency (LEP) can often be a barrier for people when trying to gain access to the services they need. There is a sense of comfort and ease experienced by program participants, knowing that they can communicate some of their most vulnerable feelings with someone who "gets it." They do not have to "over-explain" about what it is like where they come from or why they behave a certain way culturally since the staff already know. Another sentiment echoed across all the focus groups/interview is that it is a relief to have staff that speak their language, especially when explaining problems. Sometimes using an interpreter is a challenge because some words or concepts do not translate to English. Sometimes interpreters cannot express the person's feelings accurately. Some things that are difficult to describe in English are much easier to express in their home language.

- **Use of culturally congruent mental health methods (movement away from one size fit all).**
  Quote: "You feel like finally somebody can understand you. When I first came here I had the language barrier, even know if I'm trying to open up my heart to everyone in my mother language, or my first language, it is more easy even though I have been here for a long time…She spoke French and she was in

Cameroon, and she already know about everything back home and my case. It was just easy. It's hard to find someone you can relate to and gets you, you know…We want to have a conversation with someone and they treat us normal and not look at us with pity and stuff like that. It was just very helpful."

Quote: "I agree with them because it just kind of feels like "oh finally, someone who speaks the same language as me." Because my first language is Spanish and I use that language for conversations...We came from a very similar background because they immigrated here from like an older age. So, we kind of went through like the same exact things…We really bonded and he could really understand me and what I was going through because he went through very similar things."

Example: Similar factors with the Afghan Coalition [they] feel more comfortable expressing in [their] own native language. Also, since they know the sensitivity of cultures and people's language barriers [they] feel more comfortable going to Afghan Coalition. Not only do [they] feel comfortable, more importantly, when [their] spouse who doesn't speak English had to go to Afghan Coalition [they] feel more comfortable going there."

- Increase practice of transformative healing.

  Quote: "For me it is the feeling like you belong over there and you feel like you are just like a family. Everyone is like open-up and easy to share. I have feelings like, "it's just my family" and we're going through the same thing and we're on the same level."

UELP agencies provide a welcoming and inviting atmosphere that is safe for clients. This is consistent feedback from respondents over the last few reporting years. Clients are comfortable and willing to share their thoughts and experiences within their UELP programs because it is a safe space, a large theme under this outcome. Trust has been established between clients and their providers.

- Services offered in convenient and comfortable setting.

  Quote: "But even going to one session with my friend who was really going through some issues regarding her family life and like her self-esteem. When we went to an appointment together with one of the clinicians it really helped. She really got to cry it out and talk about at least where she could say what was on her mind without being judged by her family or friends. I thought it was really impactful that there was this type of space where we were allowed to do that."

  Quote: "Providing a space that was safe and brave for folks to either come in and decompress or talk about something that was heavy on their heart."

The fact that clients continue to participate in services and trust their providers enough to refer other family, friends, and community members is another indication of the safe and welcoming culture created by the program. When asked about how they learned about the services respondents spoke mostly about learning about it through community-based organizations and school, but in total there were seven different points of access mentioned. Respondent spoke about how they found out about services from friends and family members and that they are comfortable speaking to friends, family, and community members about services they refer friends and family to the UELP programs when they need someone to talk to. They explain to the person that the staff will help and reassure them that they do not need to be afraid, and they do not need to keep how they are feeling inside.

- Provide multiple access points.

  Quote: "I actually got turned on to Cafe Wellness by another community program, Journey to Empowerment in Daly City by Asian American Recovery Services."

Example: Those services at the beginning [they] found out through the school. The school directed [them] to this organization and then [they were] connected to IRC and received services."

Transforming Alameda County Systems: Mental Health, Criminal Justice, School, Healthcare, Social Welfare, and Housing

Under this long-term outcome includes that services increase quality of life. Respondents reported improved quality of life since participating in their programs. Many respondents spoke about having less resources than they had prior to joining the program. Some respondents indicated that even though they may have struggled with something in the past, but that the program saved their life. This is consistent with the survey responses that respondents agree that they can better deal with a crisis and that multiple areas of their life have improved.

- **Quality of Life**

  Quote: "For me, I think if I did not with CERI I don't know what's going on. I don't know what's going on. Maybe I could kill myself."

  Quote: "I feel like without all of those things I wouldn't really be here today."

  Example: I want to share my own personal experience with you, I came to this country 4 years ago. However, I was acquainted with this organization a year ago. I wish I knew 4 years ago because my problems would be resolved today. When I came here we didn't have friends and we didn't know anybody and we didn't have connections with organizations. I was asking from other Afghans and after making friends in this community and a lot of people in the US are really busy and cannot help other people because of their busy schedule and can't take time off to take me to governmental organizations. Since I have been connected to Afghan Coalition I have received a lot of help and am very happy.

Remaining Challenges

Many respondents suggested that participation might be more exciting and long-term if the there was a project to work on. They want to grow a healthier community and a long-term project could help both attract new participants and keep excitement up to keep coming to the program.

- **Project**

  Quote: "It would motivate me more if there was something more project based. I don't know if there is projects like a zine and then everyone contributed to that I think that would make more inclined and "I feel really excited about it.""

  Quote: "Maybe more like community projects would be cool. I know FAJ in the Union City section they have a community garden, but I don't know how active it is. But it would be cool to have one in the Oakland section or another community project similar to that."

Similar to open-ended responses on the client satisfaction surveys the focus groups mentioned that they also wanted financial and housing resources when asked what they would like to see more of. Housing continues to be an issue for UELP program participants.

- Resources

  Quote: "If there is any resources for financial help and assistance. Right now the main problem I have is financial resources and no other problem."

  Quote: "I would like a program that would be easy to get and apply for housing, Section 8. These programs will help lots of people that are facing lots or problems because the rent is very high. During this pandemic most of the people have lost their jobs and nowadays unemployment is also less. It's very good to make it more available for people. The process for example is very hard to get the application it should be more available."

Discussion

Consistent with the last five reporting years, findings from both the survey and the focus groups suggest that both *Prevention* and *PC* clients are benefitting from the ethnic-specific and culturally sensitive mental health services provided through UELP. Focus group findings corroborated survey findings regarding program benefits and client needs/challenges. When asked open-ended questions about the benefits of UELP programming, respondents reported themes that align with the outcomes assessed through the survey.

The survey and focus groups found that UELP clients benefitted in the UELP target outcomes as follows:

Forming and Strengthening Identity

Participants are more **empowered** and confident in themselves. Eighty-nine percent of *Prevention* and seventy-nine percent of *PC* respondents reported feeling better about themselves. While participating in their programs, they developed the strength, motivation, and courage to address their challenges.

Changing Individual Knowledge and Perception of Mental Health Services

Addressing ***stigma*** and changing the perception of and narrative around mental health can be a very challenging task. UELP service providers try to accomplish this by providing education in hopes of reducing the misconceptions associated with mental health. Ninety-four percent of *Prevention* respondents and ninety-one percent of *PC* respondents reported having a stronger belief that most people with mental health experiences can grow, change, and recover. Each reporting year, more clients are reporting becoming comfortable sharing their experiences with people outside of their programs., especially with the hope that it may help that person with whom they are sharing. They explained that instead of keeping it a secret, it was important to share their experiences with others so they too could benefit from the services. Having these discussions more frequently and openly is working 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. Many client participants have come to the United States without any family or support and run the risk of social isolation. Research has shown that social isolation can worsen the symptoms of mental health challenges or illness and often lead to severe mental health disorders. UELP programs provide an instant community for clients. ***Establishing relationships*** is one of the most prominent themes to come out of the focus groups/interview. Ninety-three percent of *Prevention* respondents and eighty-three percent of *PC* respondents reported that they have people with whom they can do enjoyable things.

Connecting Individual and Family with Their Culture

UELP programs provide clients with opportunities to connect with their culture. Focus group/interview respondents reported that they had increased respondents from participants spoke about ***feeling comfortable*** at the UELP programs and that "they want to be there." Eighty-six percent of *Prevention* respondents and sixty-nine percent of *PC* respondents reported feeling more connected to their culture and community.

Improving Access to Services and Resources

An important component of UELP programming is connecting clients to services and resources. It can be quite difficult gaining access to services for persons new to the United States or having Limited English proficiency (LEP). Respondents reported several examples in which their program has connected them to ***resources*** such as employment, housing, and financial services. Eighty-eight percent of *Prevention* respondents and seventy-eight 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. Limited English proficiency (LEP) can be a significant barrier for people trying to access services. UELP services are offered to clients in their own language and by people who understand their cultural background. UELP programs demonstrating ***linguistic and culturally competency*** provide relief and comfort for clients, especially when explaining problems. Interpreters are useful, but sometimes they do not accurately express what the client is trying to convey. Services are offered to program participants in the language that they speak and by people who understand their cultural background. Ninety-eight percent of *Prevention* respondents and ninety-nine percent of *PC* respondents also said that staff were sensitive to their cultural backgrounds.

When respondents were asked what makes it easier for them to participate in their program, the first thing nearly everyone mentioned was the staff. Respondents reported strong ***relationships with service providers*** and often referred to staff as family. Ninety-three percent of *Prevention* respondents and ninety-seven percent of *PC* respondents reported that program staff treated them with dignity and respect.

Consistent feedback over the last five years of reporting is that UELP programs provide a welcoming and ***safe space*** for their clients. Trust was built between the providers and clients, which in turn leads to them being comfortable talking about the program and the services they receive. This is reflected in the high percentage of *Prevention* (95%) and *PC* (96%) respondents agreeing that they would recommend this program to a friend or family member.

Transforming Alameda County Systems: Mental Health, Criminal Justice, School, Healthcare, Social Welfare, and Housing

Fiscal year 19/20 data demonstrates that UELP clients are benefiting from their services. Overall, respondents reported improved ***quality of life*** because of their participation in their programs but still reported a need for continued support. *PC* respondents are also benefitting from more intensive services from their UELP providers. More than half (57%) of *PC* respondents reported fewer crises, this is reflected in the focus groups saying that they might not "be here today" without the UELP Program. Very few respondents reported worse scores on the overall health measure (5%).

Remaining Challenges

Focus group respondents suggested that participation might be more exciting and long-term if the there was a ***project*** to work on. They want to grow a healthier community and a long-term project could help both attract new participants and keep excitement up to keep coming to the program.

Similar to open-ended responses on the client satisfaction surveys the focus groups mentioned that they also wanted ***financial and housing resources*** when asked what they would like to see more of. Housing continues to be an issue for UELP program participants. Alameda County is still in a housing crisis. Housing access and affordability continue to be a large barrier for UELP program participants.

Additional Findings

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

After assessing all the data for fiscal year 19/20, it is evident that UELP clients are benefiting from program services. Respondents reported improved quality of life because of their programs. The data has shown improvements in the areas of mental health, emotional health, stress, and for *PC* respondents employment; although respondents still report a need for continued support.

This is the third year that evaluation has assessed *PC* respondents over time using panel analysis. *PC* clients are a subset of participants that are at higher risk and already showing signs of having a mental illness. The data demonstrates that *PC* respondents are benefitting from more intensive services from their UELP providers. The majority of respondents (57%) decreased their level of crisis from the pre- to post-assessment period. Forty percent *PC* respondents reported that their mental health improved over time as well. Very few respondents reported a worse score. Data from the cohort analysis (Appendix 1) shows that clients are still reporting higher numbers of crises and poor health. This is a consistent with what was reported last fiscal year. More research is still required to properly address these challenges.

Methodological Limitations

Although this round of data shows many positive results, it is important to note the following limitations of surveys and focus group:

1. Since the number of respondents (n=386) is just a small sample of the total number of clients that are served by the UELP programs, it may not be representative of the entire population served. The small sample size limits our ability to determine whether differences between different ethnic or language groups are statistically significant.

2. More UELP providers submitted client satisfaction surveys (n=12) and matched health status assessments (n=10) compared to last year. However, the range of client satisfaction surveys collected is 5 to 100 and for the matched health assessments it is 2 to 30, which limits our ability to see differences between programs. Therefore, the data in this report may not accurately reflect all the UELP programs.

3. Considering the community-based survey was conducted at just one point in time, the data only represents a snapshot of clients during the time they took the survey, which limits our ability to assess whether the UELP *Prevention* and *PC* services led to any long-term change in each of the outcome areas of connection, identity, knowledge, community, access, and transformation. The lack of a comparison group makes it difficult to distinguish the effects of the program from other factors in clients' lives. There is no clear baseline or likely trajectory for clients against which we could measure whether clients are doing better than what would be expected if they were not receiving program services. This fiscal year, the evaluation team will explore potential populations and data sources for developing a comparison group.

4. Clients were asked if they achieved the items on the survey because of the services and supports they have received in their UELP programs. It is possible that other factors outside of the UELP programming could have contributed to the positive results discussed in the report. A true experimental research-design would need to be completed to determine if the UELP programming is the direct cause of the results.

5. There were a lot of similar or repeat answers in the open-ended section of the client satisfaction survey tool. This might suggest that some respondents completed their surveys in a group setting and may have shared answers. It is possible that some of the answers to the open-ended questions reflected someone else's ideas and not the respondents'. Additionally, it may not be clear to the respondents that this evaluation does not affect funding.

6. The funder (ACBH) facilitated the focus groups, it is possible that the participant's feelings or opinions about the funder could have influenced how they answered the focus group questions.

7. The data from the community health survey and assessment tool is based on client self-report, and the survey participants reported many positive results. It is important to consider the possibility that survey participants modified their responses to appear more positive because they knew their answers were being evaluated.[2] This could happen for several reasons, including wanting to please the program, fear of the program going away, feeling embarrassed about negative responses, and/or wanting to save face, etc.

8. Lastly, the qualitative data from the focus group and open-ended survey responses are subject to interpretation by the evaluators. Additionally, the participants may hold views that are different from those who did not attend the focus group or fill out the surveys.

Next Steps

For future survey rounds, ACBH will continue working with an evaluator to strengthen its evaluation to better capture any changes and the long-term impacts of these PEI programs. In addition, a short term UELP Work Group made up providers and ACBH staff was established in June 2020 to review existing evaluation tools and make recommendations on how to make the process more culturally and linguistically relevant and staff/respondent-friendly.

- The next round of focus groups or key informant interviews will include different groups that have not had a chance to participate. UELP provider staff will participate in another focus group.
- More research is needed to know what success looks like for these programs. Appropriate targets are needed, such as national standards, to compare this data against to help measure program effectiveness.
- ACBH will continue training for UELP providers and their staff to make sure that the Community Health Assessment (pre/post) form is completed and collected correctly.
- The evaluation is moving towards developing a more age-appropriate survey, targeted specifically for youth ages 5 to 14.
- The Work Group has already updated the logic model and will continue to update the client satisfaction survey, health assessment, and focus group questions.
- The updated client satisfaction survey and health assessments will be translated by the UELP providers as part of a pilot translation project.

[2] *See definition for Hawthorne Effect* http://methods.sagepub.com/book/key-concepts-in-social-research/n22.xml

Appendix 1: Community Health Assessment Results (Cohort Analysis)

- N=62 participants completed only the Pre-Health Status Assessment
    - Like last year the top three highest needs that brought clients in for services were mental health, stress, and emotional support.
    - The majority (92%) of respondents reported that they were experiencing a crisis at the time of the assessment, which is less than last year. Only 21 respondents explained the reason for a crisis and of those insomnia was the top reason.
    - Nineteen percent of respondents were not doing well physically and 27% respondents were not doing well mentally in the past 30 days from when they took the assessment.
    - Overall health was rated "not good" by 17% of respondents.
    - Health problems disrupted a little less than half (47%) of clients from participating in their usual activities for multiple days (three to six or more days).

- N=37 participants completed the Post-Health Status Assessment
    - The majority (92%) of respondents reported that they were experiencing a crisis at the time of the assessment. Physical symptoms seemed to be one of the top reasons for those reported crises.
    - Sixteen percent of respondents were not doing well physically or mentally in the past 30 days from when they took the assessment. This is a slight improvement compared to the pre-assessment.
    - Overall health was rated "good" or excellent by 32% of respondents.
    - Less clients in the post-assessment (36%) had a health problem disrupting their days as did in the pre-assessment (47%). In the post-assessment, their usual activities were disrupted for fewer days (zero to two days).

These questions have been adopted from the Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance Survey (BRFSS).[3] The data shows a slight decline in positive metrics from the pre- to post-assessment as compared to last year's report. However, when combining the data from the satisfaction form with this health status assessment, it is consistent with the data collected over the past four years. Clients are improving and getting better. Although there is an improvement from the pre to the post health assessment, a large number of survey respondents are still reporting poor health. More data needs to be collected in this area.

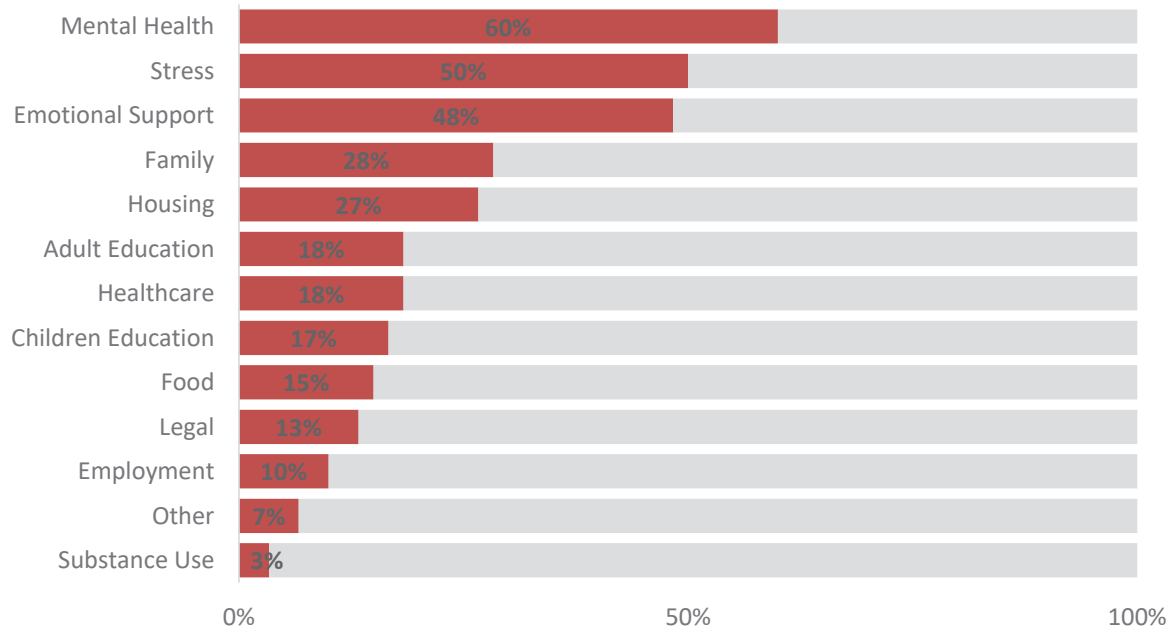
[3] *More information on these questions, please go to http://www.cdc.gov/nccdphp/brfss/.*

Pre-Assessment Results (n=62)

Agencies with Unmatched Pre-Assessments

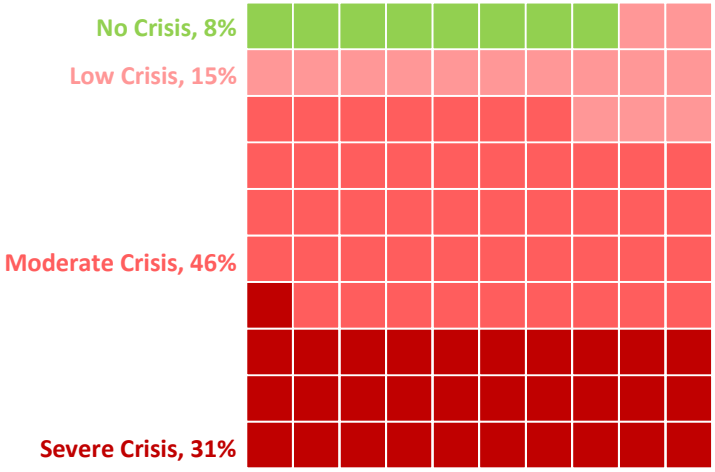
Agency	Percent
La Clínica de La Raza/La Familia	35%
Asian Health Services	23%
International Rescue Committee	19%
Afghan Coalition	15%
Partnership for Trauma Recovery	5%
Center for Refugees and Immigrants	3%

Needs for Respondents with Unmatched Pre-Assessments (n=60)



Number of Clients Experiencing a Crisis

Most Clients were Experiencing a Crisis (n=59)



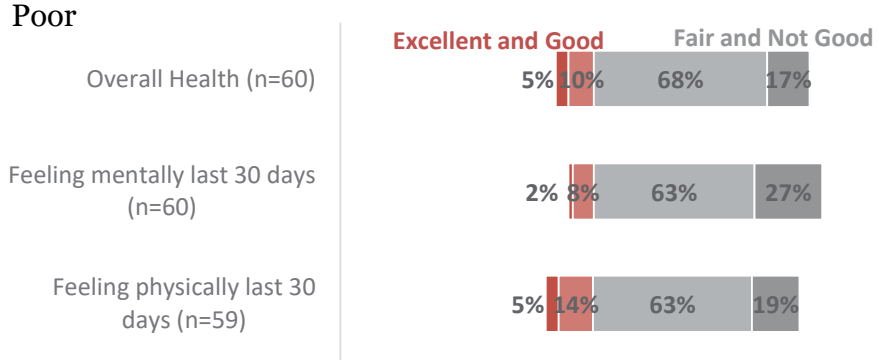
Top Reasons for the Crisis (n=21)

- Insomnia 24%
- Anxiety 14%
- Resentment/Anger 14%
    - Example: Much pain, resentment, hate and sometimes I don't want to exist anymore.
- Issues with Children 14%
    - Example: I'm in despair because my son ignores us.

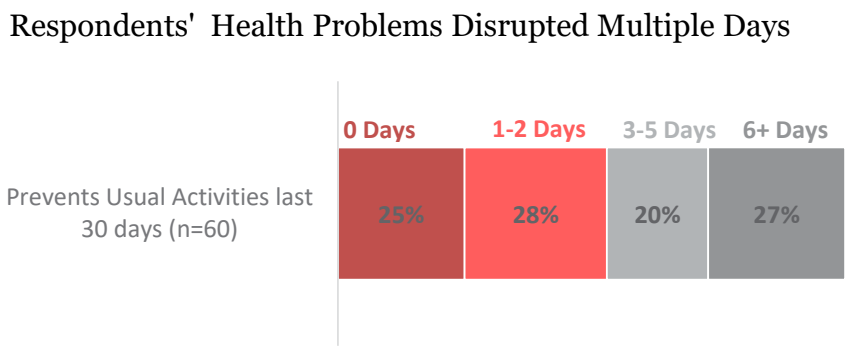
Health Surveillance

The following questions asked respondents, *how are you feeling today, in the past 30 days and overall?* The responses were offered on a four-point scale ranging from poor to excellent.

Respondents' Physical, Mental, and Overall Health was Poor



The following set of questions asked respondents, *how many days during the past 30 days has your health been poor and how many days did your health keep you from doing your usual activities such as self-care, work, or recreation?* The responses offered ranged from six or more days to zero days.



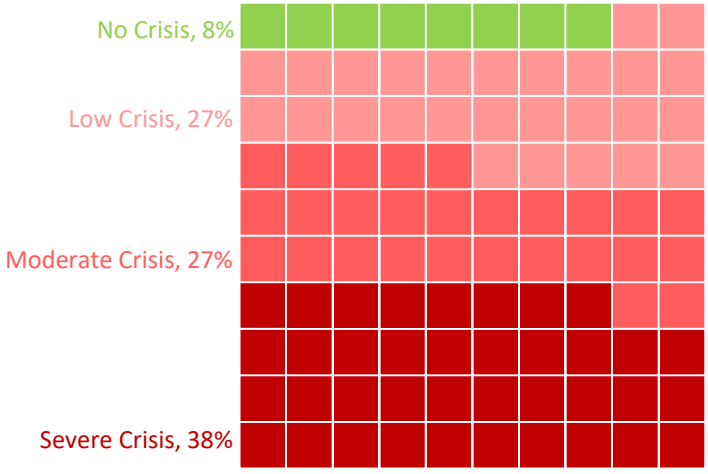
Post-Assessment Results (n= 37)

Agencies with Unmatched Post Assessments

Agency	Percent
Afghan Coalition	46%
International Rescue Committee	32%
La Clínica de La Raza/La Familia	14%
Center for Refugees and Immigrants	5%
Korean Community Center for the East Bay	3%

Number of Clients Experiencing a Crisis

Most Clients were Experiencing a Crisis (n=37)



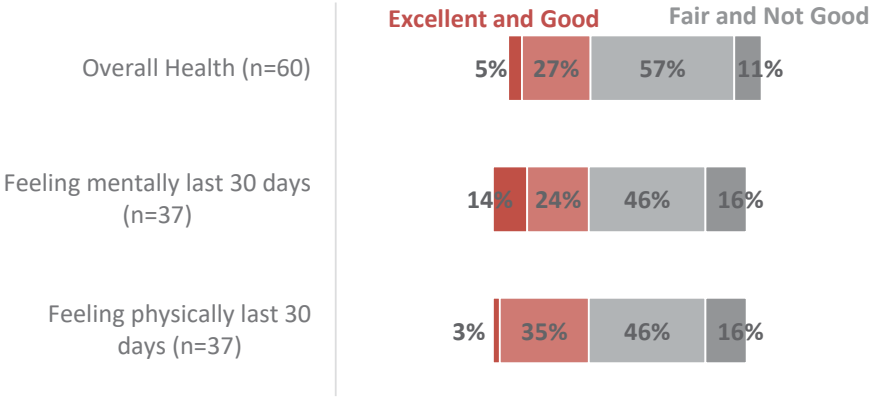
Top Reasons for the Crisis (n=26)

- General Positive Comments 15%
    - Example: Since I have been seeing and talking with Dr. Masoud I am feeling excellent. Your program was very effective in my life. I changed.
- Physical Health 15%
    - Example: Pain on hands, feet. Pain on lower back. Had only two panic attacks in Afghanistan.

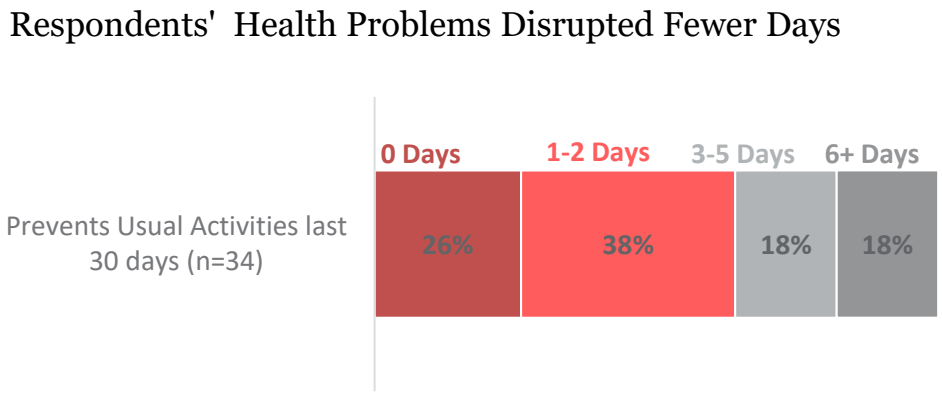
Health Surveillance

The following questions asked respondents, *how are you feeling today, in the past 30 days and overall?* The responses were submitted on a four-point scale ranging from poor to excellent.

Respondents' Physical, Mental, and Overall Health was Poor



The following set of questions asked respondents, *how many days during the past 30 days has your health been poor and how many days did your health keep you from doing your usual activities such as self-care, work or recreation?* The responses submitted ranged from six or more days to zero days.



Appendix 2. Description of Survey Respondents

Note: This section only includes the number and percent of clients that took the client satisfaction survey.

Table 1.

Agency	Number (n=386)	Percent
Center for Refugees and Immigrants	100	26%
Portia Bell Hume Center	82	21%
Bay Area Community Health	43	11%
International Rescue Committee	41	11%
La Clínica de La Raza/La Familia	24	6%
Afghan Coalition	22	6%
Filipino Advocates for Justice	22	6%
Korean Community Center for the East Bay	21	5%
Partnership for Trauma Recovery	12	3%
Diversity in Health Training Institute	9	2%
Native American Health Center	5	1%
Richmond Area Multi-service	5	1%

Twelve out of the thirteen UELP providers were represented in the client satisfaction surveys. Center for Refugees and Immigrants (26%) and Portia Bell Hume Center (21%) sent in the highest percentage of surveys completed.

See Table 1.

Table 2.

Types of Service	Number (n=358)	Percent
Prevention	257	72%
Preventive Counseling	101	28%

The majority (72%) of survey respondents receive *Prevention* services. More than a quarter (28%) of respondents receive *PC* services, which are higher intensity than *Prevention* services. The 37 clients with no service checked are excluded.

See Table 2.

Table 3.

Length of Service	Number (n=331)	Percent
0-3 months	126	38%
4-6 months	76	23%
7-11 months	38	11%
1-3 years	51	15%
4-6 years	10	3%
7-14 years	22	7%
15+ years	8	2%

Thirty-eight percent of the survey respondents have been receiving services for up to three months. Half of the respondents reported receiving services anywhere from four months to three years.

See Table 3.

Demographics

Table 4.

Gender	Number (n=357)	Percent
Female	249	70%
Male	101	28%
Genderfluid, Non-binary, Queer, and Transgender	7	2%

Almost three-quarters (70%) of survey respondents were Female. This is consistent with the data from the last four reporting years. Twenty-eight percent (n=101) of respondents were male. Multiple respondents identified as genderfluid, non-binary, queer, and transgender (2%). This is the first time reporting another gender.

See Table 4.

Table 5.

Age	Number (n=345)	Percent
8-15	33	10%
16-25	65	19%
26-59	144	42%
60-91	103	30%

Forty-two percent of respondents were 26-59 years old. Nineteen percent of respondents were transition-age youth (TAY), 16-25 years old. Thirty percent of respondents were older adults, over 60 years old, and 10% percent of respondents were children aged 8-15 years old.

See Table 5.

Table 6.

City of Residence	Number (n=237)	Percent
Oakland	150	42%
Fremont	67	19%
Newark	26	7%
Other/Out of County	19	5%
Union City	17	5%
Alameda	16	5%
San Lorenzo	14	4%
Hayward	12	3%
San Leandro	12	3%
Dublin	11	3%
Berkeley	4	1%
Albany	2	1%
Pleasanton	2	1%
Emeryville	1	<0%

Most of the survey respondents (42%) reported living in Oakland. This is consistent with previous years. The next highest city of residence is Fremont, sixty-seven (19%) reported living there. The respondents that reported living out of the county (5%) were mostly from Contra Costa County (Richmond, Pittsburg, El Cerrito, and Concord), followed by two people from out of state.

See Table 6.

Table 7.

Race/Ethnicity	Number (n=237)	Percent
Cambodian	95	26%
Chinese	44	12%
Afghan	40	11%
Filipino	25	7%
Asian	24	7%
Bhutanese	24	7%
Hispanic/Latino	21	6%
Indian	11	3%
Nepalese	11	3%
African	7	2%
Persian	7	2%
Arabi	6	2%
Multi-Racial	6	2%
Korean	5	1%
White	5	1%
Punjabi	4	1%
Tigrinya	4	1%
Middle Eastern	3	1%
Pakistan	3	1%
Eritrean	2	1%
Ethiopian	2	1%
Native American	2	1%
Taiwanese	2	1%
Tongan	2	1%
Vietnamese	2	1%
Black	1	0%
Salvadorian	1	0%
Samoan	1	0%

A quarter of the respondents were Cambodian, followed by Chinese (12%) and Afghan (11%).

See Table 7.

Appendix 3. Focus Group Questions

Opening Questions

1. How did you find out about the services here?

Issues and connections prior to the program

2. Prior to the program, when feeling stressed or going through life changes what did you do?
3. What kind of services were you connected to before the program? How was that experience? *(Prompt: any challenges or barriers)*

Participation

4. What makes it easier for you to participate in the program? *(Prompt: things like location, transportation, hours, friends with other participants in the program)*
5. What makes it harder?
6. If you were to describe the services you receive here to a friend, what would you say?

Benefits of the program

7. Tell me what it is like to receive services from someone that understands your cultural background?
8. What would have been different if you hadn't found this program or these services?

Like to see/recommendations

9. What resources would you like to see more of?

Appendix 4. Survey Tools

UELP Community Health Status Assessment **PRE**

Date: Month ☐☐ Day ☐☐ Year ☐☐☐☐

Agency/Program: _____

1. Which of the following needs brought you in for services? (Check all that apply)

- ☐ Housing
- ☐ Healthcare
- ☐ Employment
- ☐ Food
- ☐ Family
- ☐ Substance Abuse
- ☐ Adult Education (formal education)
- ☐ Children's Education
- ☐ Mental Health
- ☐ Emotional Support
- ☐ Legal (includes: victims of crime, domestic violence evaluation, probation)
- ☐ Stress
- ☐ Other:_____

2. Are you currently experiencing a crisis? (Example feelings/behaviors associated with a crisis: can't focus, frustrated, feeling isolated, angry, lost, constant crying, feeling paralyzed, urge to use drugs/alcohol etc.)

Please circle the number the best reflects your current situation.

0 1 2 3 4 5 6 7 8 9 10

No Crisis Moderate Crisis Severe Crisis

If yes, please explain:

3. How have you been feeling *physically* in the **past 30 days**?

O Excellent O Very Good O Fair O Not Good

4. How have you been feeling *mentally* in the **past 30 days**?

O Excellent O Very Good O Fair O Not Good

5. How would you rate your **overall health**?

O Excellent O Very Good O Fair O Not Good

6. During the **past 30 days**, for about how many days did physical or mental health problems keep you from doing your **usual activities**, such as self-care, work, or recreation?

☐ 0 ☐ 1-2 ☐ 3-5 ☐ 6+

******For Staff Use ******

Client Name or ID: _____ Staff Name or ID: _____

UELP Community Health Status Assessment POST

Agency/Program: _____ **Date:** Month ☐☐ Day ☐☐ Year ☐☐☐☐

1. Are you currently experiencing a crisis? (Example feelings/behaviors associated with a crisis: can't focus, frustrated, feeling isolated, angry, lost, constant crying, feeling paralyzed, urge to use drugs/alcohol etc.)

Please circle the number the best reflects your current situation.

0 1 2 3 4 5 6 7 8 9 10

No Crisis Moderate Crisis Severe Crisis

If yes, please explain:

2. How have you been feeling *physically* in the **past 30 days**?

O Excellent O Very Good O Fair O Not Good

3. How have you been feeling *mentally* in the **past 30 days**?

O Excellent O Very Good O Fair O Not Good

4. How would you rate your **overall health**?

O Excellent O Very Good O Fair O Not Good

5. During the **past 30 days**, for about how many days did physical or mental health problems keep you from doing your **usual activities**, such as self-care, work, or recreation?

☐ 0 ☐ 1-2 ☐ 3-5 ☐ 6+

********For Staff Use ********

Client Name or ID: _____ Staff Name or ID: _____

Alameda County Prevention and Early Intervention Community

Agency/Program:_____ **Date:** Month ☐☐ Day ☐☐ Year ☐☐☐☐

Please check which service the participant is receiving: Prevention Service ☐ Preventative Counseling Service ☐

How long (in months) has participant received services? _____

Please help us improve our services and activities by telling us how you feel about the following statements. Read each statement carefully and then check the box that best represents how you feel about the statement. Mark only one response per question.

Client Satisfaction

AS A RESULT OF THE SERVICES AND SUPPORTS I'VE RECEIVED IN THIS PROGRAM…	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	N/A
1. I know there are people who will listen and support me when I need to talk to someone	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	NA ☐
2. I feel more connected to my culture and community	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	NA ☐
3. I have people with whom I can do enjoyable things	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	NA ☐
4. I feel better about myself	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	NA ☐
5. I can better deal with people and situations that used to be a problem for me	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	NA ☐
6. I have become more effective in getting the resources I or my family need	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	NA ☐
7. I deal more effectively with daily problems	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	NA ☐
8. When I have a crisis, I am better able to deal with it	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	NA ☐
9. I better understand that lacking basic needs such as adequate money, food or housing, etc. can impact my overall health	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	NA ☐
10. I better understand that stress, worries, and level of happiness can impact my mental health or emotional health	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	NA ☐
11. I have a stronger belief that most people with mental health experiences can grow, change and recover	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	NA ☐
12. I better understand that talking to people can improve my wellbeing.	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	NA ☐

Please turn over to answer a few more questions

13. Which of the following areas of your life have improved as a direct result of your participation in these services? (Check all that apply)

- ☐ Housing
- ☐ Healthcare
- ☐ Employment
- ☐ Food
- ☐ Family
- ☐ Substance Abuse
- ☐ Other:_____
- ☐ Adult Education (formal education)
- ☐ Children's Education
- ☐ Mental Health
- ☐ Emotional Support
- ☐ Legal (includes: victims of crime, domestic violence evaluation, probation)
- ☐ Stress

HOW MUCH DO YOU AGREE WITH THE FOLLOWING STATEMENTS ABOUT YOUR PROGRAM?	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	N/A
1. Services were available at times that were good for me	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	NA ☐
2. Services were available at locations that were good for me	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	NA ☐
3. Staff were sensitive to my cultural background (race, religion, language, etc.)	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	NA ☐
4. Staff here treated me with dignity and respect	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	NA ☐
5. Staff helped me obtain the information I needed so that I could take charge of managing my problems	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	NA ☐
6. I would recommend this program to a friend or family member	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	NA ☐

*******Final Thoughts*******

******Staff please complete the below section with clients in English******

Client Info:

RACE/ETHNICITY: _____ AGE: _____

GENDER: _____ CITY WHERE YOU LIVE: _____

1) In thinking about the services and supports you received through this program what has been most beneficial or helpful to you?

_____

2) What needs do you still have that you would like or need help with?

_____

3) What would have been different if you hadn't found this program or these services?

_____

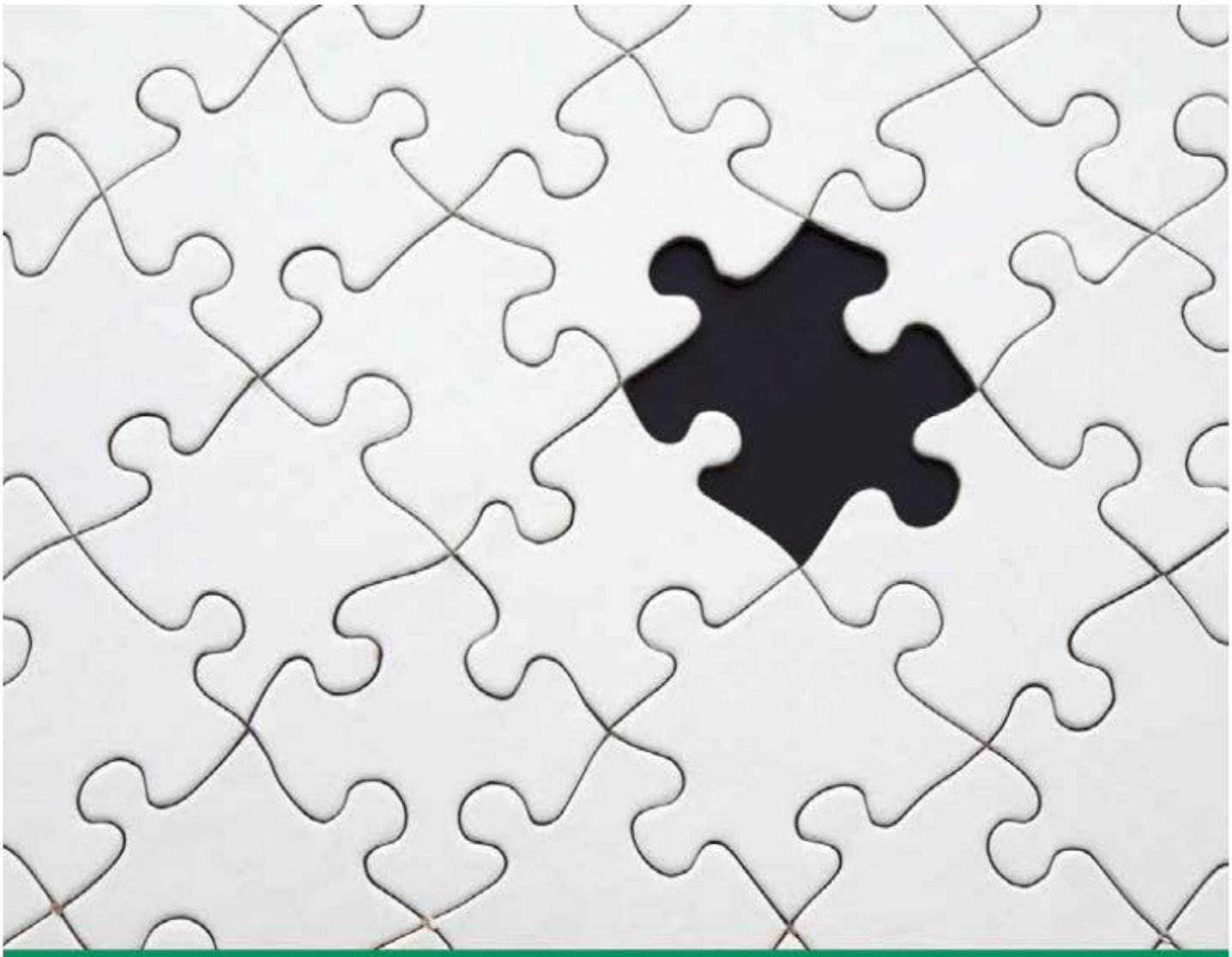
4) Is there anything else you'd like to tell us about?

_____

Thank you for taking the time to answer these questions.

Appendix 5. Logic Model

Outcomes		
Short Term →	**Intermediate Term** →	**Long Term**
1. Connecting individual and family with their culture. • Supporting and strengthening individual connection to culture. • Improves intergenerational interactions and communication (one-to-one, family relationships). • Reduction of acculturative stressors (access to cultural practices, celebrations, traditions; cultural validation).	**1. Transforming mental health services.** • Use of culturally congruent mental health methods (movement away from one size fit all). • Services offered in convenient and comfortable setting. • Provide multiple access points. • Increase practice of transformative healing.	**1. Moving toward personal well-being and community wellness among served and unserved communities in Alameda County.**
2. Forming and strengthening identity. • Increase sense of well-being (empowered, hopeful, feeling heard/validated). • Empowered and building/strengthening and self-esteem.	**2. Increase workforce and leadership development.**	**2. Transforming Alameda County Systems: mental health, criminal justice, school, healthcare, social welfare, housing.** • Services increase quality of life. • Services inclusive to everyone.
3. Changing individual knowledge and perception of mental health services. • Raising awareness and understanding of mental health services. • Reduce personal stigma of mental health and its services.	**3. Assisting communities to build capacity by supporting current and emerging leaders.**	**3. Increasing mental health workforce diversity with people who possess language capacity and cultural understanding of the underserved and unserved communities.**
4. Building community and its wellness • Reduce individual, family, and community isolation. • Reduce community stigma of mental health and its services. • Cross community relationship building. Increasing sense of safety.	**4. Systems changes** • Building capacity • Increasing CBPR support	**4. Reduce cultural stigma surrounding mental health issues.**
5. Improving access of services and resources.		



Alameda County Behavioral Health's In-Home Outreach Teams Program Evaluation

Fiscal Year 18/19

alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

Alameda County Behavioral Health | Mental Health Services Act Division | December 2019

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Authors from Alameda County Behavioral Health include:

Carly Rachocki, MPH
Management Analyst
Mental Health Services Act Division

Michael Castilla, MPA
Senior Program Specialist
ACT, AOT/IHOT/CC
Adult and Older Adult Systems of Care

Daniel Ku, LMFT
AOT Investigator
Assisted Outpatient Treatment (AOT) and In-Home Outreach Teams (IHOT)

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Assistant Director Adult/Older Adult System of Care

Tracy Hazelton, MPH
Division Director Mental Health Services Act

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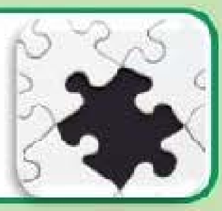
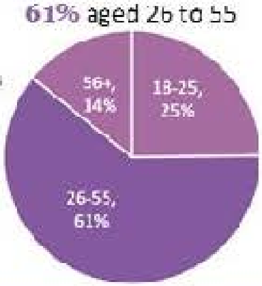
Evaluation Summary Fiscal Year 18/19
December 2020



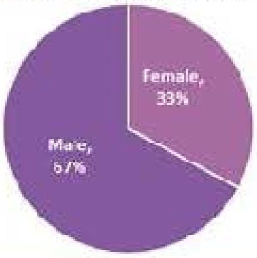
How Much Did We Do?

The IHOTs served **395 duplicate partners** during the fiscal year. When comparing the race/ethnicity of IHOT partners to ACBH Outpatient Beneficiaries the IHOTs served a higher percentage of **Asians**, **Hispanics/Latinos**, and **Whites**.

61% aged 26 to 55



67% identified as Male

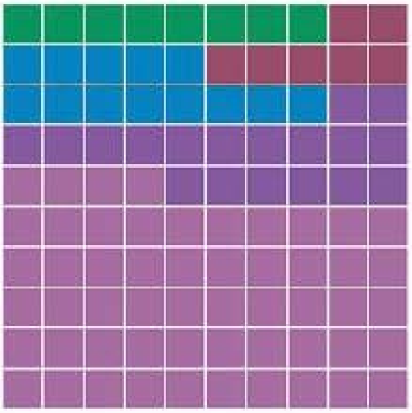


91% spoke English

How Well Did We Do It?

There were **384 partners discharged** during the fiscal year, the chart to the right shows the discharge outcomes of 169 partners (44%). The other 56% of discharged partners had unclear outcomes and have been excluded from the chart to the right.

62% of IHOT partners were successfully engaged

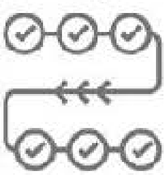


The main goal of the IHOTs is to connect clients to mental health services, either a new one or re-connect with a previous provider, and community-based services. Successful engagement means that partners trust and have a rapport with the IHOT. Through 13 one-on-one interviews with family members and current or former partners revealed how IHOTs built trust and rapport with partners.

How IHOTs Build Trust with Partner

Listening to the partner

Navigating a complex system to connect partners to wanted/needed services



Being persistent and consistent

How IHOTs Build Rapport with Partner

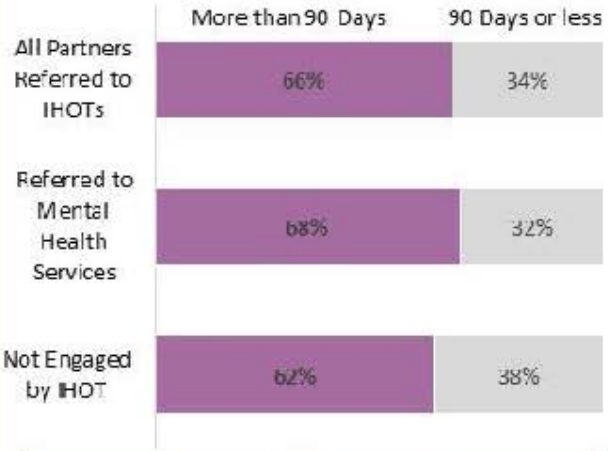
Facilitating goal setting

Becoming like family or a support system

Demonstrating care for the partner

How Well Did We Do It?

Of the 169 partners that have clear discharge outcomes, **more than half were open for longer than 90 days**. There is not a significant difference between the length of time partners are open and whether they are subsequently referred to mental health services.



Areas of Concern

Partners and family members spoke about how the IHOT, mental health, and community-based services could be improved. The areas of concern the interviewees spoke about that can harm the relationship with the IHOT and decrease the perceived quality of the services received are:

1. Time it takes to link to services
2. Not enough time each week with the client
3. Staff turnover throughout the ACBH system

Is Anyone Better off?

The connection to community-based services, mental health services, and the IHOT improved the partners' and family members' lives in the following ways:

Being more recovery oriented

"I'm not there, but I can see myself getting healthy. I can see myself passing a college class. I can see myself getting back to work before the end of the year." – Partner

Asking for help

"One thing that changed was that [the partner] was at least willing to talk about getting help. The IHOT was at least talking about getting psychiatry so then [the partner] was agreeing to it. So at least that opened the door for us to get [the partner] to it." – Family Member

Accomplishing goals

"I enrolled in classes in Merritt College." – Partner

Improving hygiene

"I think that was first and foremost, [the partner] started taking care of [their] health better, taking more showers, getting [themselves] cleaned up." – Family Member

Life saving

"They saved our life. They saved [my child's] life, they saved my life." – Family Member

"I truly believe that the IHOT team saved my [child's] life." Family Member

Recommendations for Program Improvements during FY 20-21

1. Continue to improve data entry quality, collaborate to build a data dashboard, and explore the logic model outcomes for appropriateness with the IHOT teams.
2. Expand the language diversity of IHOT partners using a brochure created for the IHOTs.
3. Increase the amount they connect with families, including having a conversation to set expectations about what the IHOT will reasonably accomplish. The brochure could facilitate the expectation setting conversation.
4. ACBH Program Specialists will work with IHOT and ACCESS to figure out a workflow to best link partners to the level of care that the partners need.

MENTAL HEALTH SERVICES ACT · PROPOSITION 63 · CALIFORNIA

WELLNESS · RECOVERY · RESILIENCE

The full report is available at www.acmhsa.org.

Introduction

Program Background

Alameda County Behavioral Health's (ACBH) In-Home Outreach Teams (IHOTs) provide outreach to adults and transition age youth (TAY) over 18 that are living with the most serious mental health diagnoses and who struggle to engage with services. These individuals can have a cycle of repetitive psychiatric crises, resulting in hospitalizations, incarcerations, and homelessness. ACBH launched their IHOT programs in July 2016 based on a model implemented in San Diego that showed a reduced use of psychiatric emergency services and a demonstrated increased use of ongoing outpatient mental health treatment among individuals who engage in IHOT services, as compared to before engagement[1]. The goal of the Alameda County's IHOTs is to engage referred individuals and link them to community-based and mental health services.

The IHOTs are funded by the Mental Health Services Act (MHSA), which 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.

Evaluation Rationale

ACBH's IHOTs were last evaluated at the end of their first year of program implementation. In September 2019, the MHSA Division hired a Management Analyst to perform program evaluations of their funded services. The aim of this FY 18/19 evaluation was to:

1. Create a logic model for the IHOT programs through engagement with stakeholders and establish program outcome measures (See Appendix A).
2. Utilize the logic model and the Results Based Accountability (RBA) framework to gather available data and measure the outcomes created for the programs.
3. Conduct and analyze interviews to deepen the understanding of the family and client experience and to use this understanding to create a product for outreach.

The RBA framework uses a simple iterative process to help organizations assess current performance, identify strategies to improve, and facilitate rapid implementation of action plans. It uses the following questions as their framework:

1. How much did we do?
2. How well did we do it?
3. Is anyone better off?

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 the department and/or contracted services.

Stakeholder Identification and Engagement

The primary intended users of this evaluation include the ACBH Program Specialists that manage the IHOTs, the Assistant Director of Adult/Older Adult System of Care, the MHSA Division Director, and the IHOT programs. This evaluation will be used to inform ongoing program development and improvement

[1] Source: https://www.sandiegocounty.gov/content/dam/sdc/hhsa/programs/bhs/TRL/2014-15%20Updates/Section%206%20Docs/Innovation%20Evaluation%20Report%20rev5.11.16.pdf Retrieved: 10/16/2020

and reporting to funders at Alameda County and the State of California. Below are the evaluation components and the stakeholder groups that were engaged (**Table 1**).

Table 1. Evaluation Components and Stakeholder Group Engaged

Evaluation Component	Stakeholder Group
Logic Model	➢ ACBH Program Specialists that manage the IHOTs ➢ ACBH Assistant Director of Adult/Older Adult System of Care
Interview Guide	➢ ACBH Program Specialists that manage the IHOTs ➢ ACBH Assistant Director of Adult/Older Adult System of Care ➢ IHOT Providers
Interview Recruitment	➢ IHOT Providers ➢ ACBH Family Dialog Group*

*Family Dialog Group out of the Office of Family Empowerment is composed of family members of people who have received services in the ACBH system of care.

Program Description

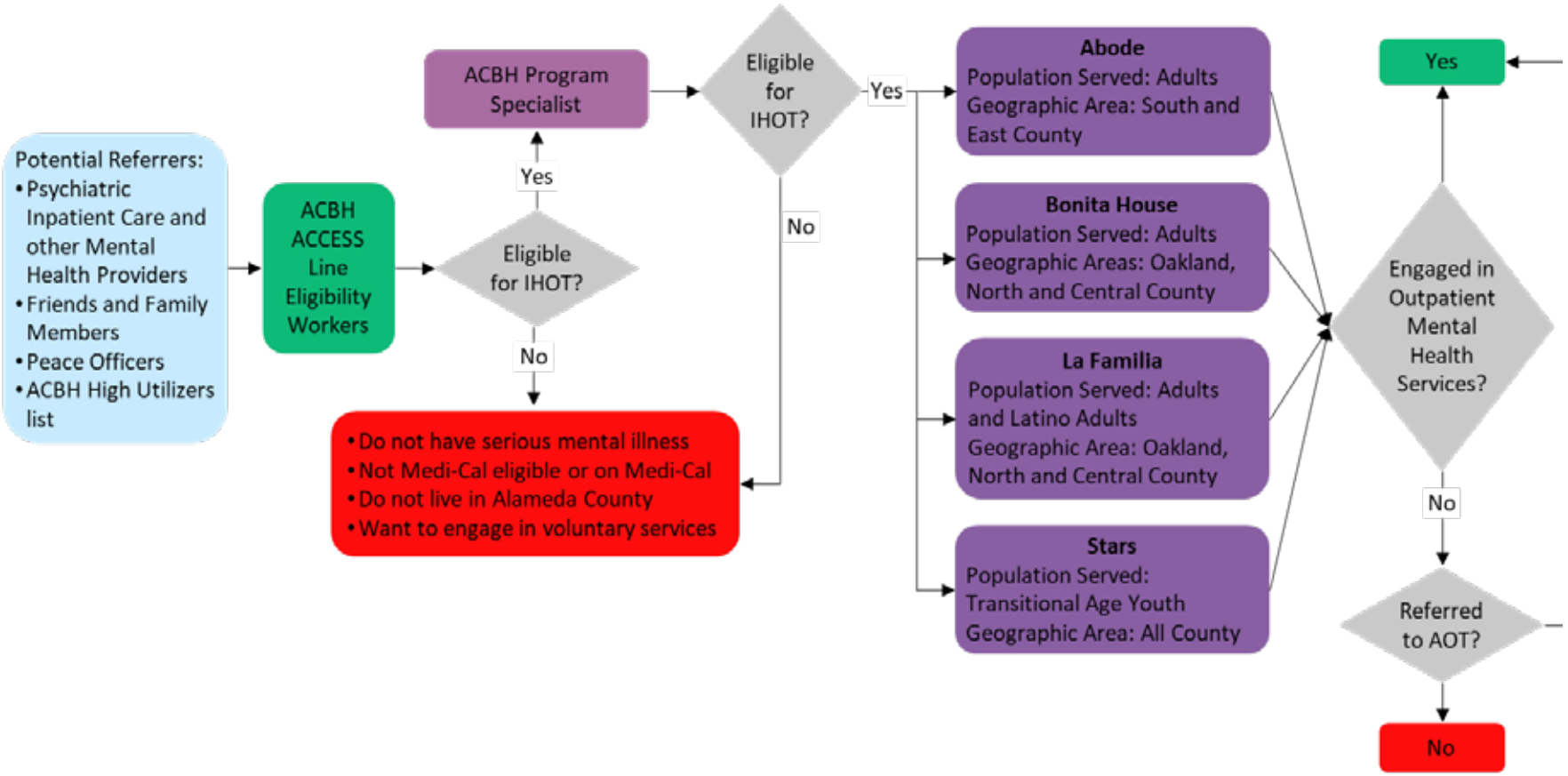
Referrals to ACBH's IHOT programs are through the ACCESS phone line, eligibility workers screen and evaluate those referred for medical necessity and then refer to appropriate providers in the ACBH system. Referrals can come from psychiatric inpatient care, friends, family members, peace officers, and the ACBH High Utilizers list. Initial eligibility is determined using the following criteria: those who are suspected to be living with a serious mental illness; have or are eligible for Medi-Cal; live in Alameda County (including those experiencing homelessness); and people that are reluctant to engage in outpatient mental health services. One of the ACBH Program Specialists that manage the IHOTs reviews the list and confirms eligibility, then distributes the potential partners to the appropriate IHOT or directly to Assisted Outpatient Treatment (AOT). AOT is different from IHOT in that it is a statute driven program (AB 1421), which uses the assertive community treatment (ACT) model and is connected to a court process that determines eligibility for the program and compels individuals to participate in services. Once referred to an IHOT, the team is responsible for using the referral information to try to contact and engage the partners. The referral flow is shown in **Figure 1**.

There are four community-based IHOT providers, each of which has a specific cultural and/or geographic focus, as shown in **Figure 1**. Each IHOT provider employs culturally relevant and age-specific mobile outreach strategies to build trust and rapport with referred individuals and their families, in order to connect them to voluntary specialty mental health services and community-based services. To be successful at employing these strategies, the IHOT maintains the following team:

1. Clinician
2. Peer Advocates (Two)
3. Clinical Lead
4. Family Advocate

If at any time during the IHOT outreach and engagement process individuals that are not engaging in voluntary services and appear to meet AOT eligibility criteria, they may be referred to AOT.

Figure 1. Referral Flow of IHOT Partners



Evaluation Methods

Design

The evaluation utilizes a mixed-methods approach of quantitative and qualitative data to assess program outcomes. These evaluation methods were chosen to best ascertain how referrals to community based and mental health services were distributed by IHOTs and used by partners and their family members. The quantitative components came from reports in the electronic health record (EHR) and the qualitative data came from interviews with former and current partners and family members. **Table 2** below describes the data elements and sources.

Table 2. Data Elements and Sources

Data Element	Data Source
How many people assessed for eligibility by IHOT Program Specialist	Clinician's Gateway
How many IHOT partners referred to AOT	Clinician's Gateway
Demographics of IHOT partners	Clinician's Gateway
First outreach attempt made within three business days of referral	Clinician's Gateway
Referred partners are found by IHOT (contact is made with partner)	Clinician's Gateway
At least 50% of partners are successfully linked to outpatient mental health services or rehabilitation and recovery services within the first 90-days of referral.	Clinician's Gateway
Referred partners' family members, friends, and others engaged to help find partner	Interviews with former and current partners and their families
Trust with partner established	Interviews with former and current partners and their families
Rapport with partner established	Interviews with former and current partners and their families
Partner linked to community-based services	Interviews with former and current partners and their families
Partner linked to mental health services	Clinician's Gateway Interviews with former and current partners and their families
Support groups provided to partner's family members	Interviews with family members
Overall length of services 90-days or less	Clinician's Gateway

Data Collection, Processing, and Analysis Procedures

Qualitative Data

A series of 13 one-on-one interviews with family members and current or former partners were conducted to gather data. Initially, the evaluation was going to include a focus group made up of the Family Dialog Group, but scheduling constraints and the Shelter-in-Place due to COVID-19 lead to shifting to one-on-one interviews. This type of interview allows for more in-depth information, unlike focus-groups, which have multiple people sharing information with a limited amount of time.

Additionally, there is minimal influence on responses, the interviewer is the only possible source of influence to the responses of the interviewee.

The interview guide used was fairly structured with possible probes. The areas covered in the interview guide included: outreach by IHOT, how trust and rapport is built with the partner, linkage to community-based and mental health services, and the quality of the services the partner was connected to. The guides ask slightly different questions depending on whether they were a family member or a client (see guides in Appendix B).

Interviewees were chosen by the IHOTs and most family members were participants of the Family Dialogue Group. However, if the management analyst had interactions with the family members of a partner being interviewed then she offered the opportunity to interview the family member. Incentives of $20 gift cards were used for the interviews. Potential participants were deemed eligible if they were at least 18 years of age and either had a family member that had previously or were currently receiving services from IHOT or a current or former IHOT partner.

The Management Analyst read the questions aloud and answers were recorded digitally. An evaluator-administered interview limits misunderstood questions, inappropriate, and incomplete responses. Demographic information of race/ethnicity, age, city of residence, gender identity, and whether they (if partner) or their family member were currently receiving mental health or substance misuse treatment services were also voluntarily collected (see survey Appendix C). Demographic data was not reported in this report due to the small numbers, but will be kept for reference for planning future interviews and focus groups.

There were a variety of ethical concerns going into this evaluation. First, was to make sure that the participants all had informed consent. An informed consent document was either given to each participant or read aloud prior to the start of the interview. They were all offered a copy to keep or mailed a copy if it was a phone interview. Another concern was that of risk assessment and more specifically psychological stress of the participants. During the interview, each potential participant was informed that the interview was completely confidential, voluntary, they could stop the interview at any given time, and they were also given information of who they could contact in case of any psychological stress.

The largest ethical issue with any interview is confidentiality, to protect this the names of the participants, their gender, and the name of the IHOT team that provided services are not reported. To ensure confidentiality, identifying information was changed when quoting interview participants including the gender of the partner. The data is stored on a password protected computer and the recordings were destroyed a week after the interview. The rest of the data (transcripts, coded transcripts, and field notes) will be maintained on the same pass-word protected computer for a year and then destroyed. These terms were agreed upon by all participants via the informed consent.

The Management Analyst transcribed all interviews and used qualitative coding software called Taguette to code the data. The management analyst reviewed all answers and categorized them into common response themes. Thematic analysis was chosen to analyze this data, it proved useful in finding the common experiences that the IHOT partners and their family members shared and allowed for the use of patterns to build themes in the analysis.

Quantitative Data
The quantitative data was entered into the EHR by the ACBH Program Specialists and members of the IHOTs. ACBH's information systems pulled two different reports from the EHR and provided them to the Management Analyst. They included the information listed in **Table 2** above. One report had the demographic information of the partners, referral information, and the opening and closing dates. The other, called the Referral Tracker, was used to keep track of all of the interactions they had with either the partners or their families.

The data were analyzed using Excel. Prior to analysis, the Management Analyst reviewed the data files for errors, duplicates, and omissions. The analysis involved case-wise deletion, meaning that any data coded as missing or non-applicable was not included in the individual analysis, which resulted in different sample sizes. Due to limitations set forth by the Health Insurance Portability and Accountability Act (HIPAA), groupings of less than 10 individuals are not explicitly reported or are combined with other groups to make them larger than 10.

Data Synthesis
The quantitative and qualitative data were synthesized to create the evaluation findings. Throughout the evaluation process, the Management Analyst collaborated with ACBH Program Specialists and the IHOT providers to vet analytic decisions and findings. This was done both formally through presentations and informally through conversations with ACBH Program Specialists and the IHOT providers. Findings from qualitative content analyses were integrated with the quantitative data throughout the report and both were used when creating recommendations. Discussion of results with IHOTs informed the explanation of the qualitative themes and the evaluation recommendations.

Limitations

As is the case with all real-world evaluations, there were important limitations to consider. Data for pre-enrollment time periods compared to post-enrollment time periods for partners in each program were currently unavailable. Additionally, there was high variability in the amount of data entered by IHOT providers into Clinician's Gateway; in many instances the location, number of interactions, and outcome of each encounter could not be determined. This may reflect that many IHOT partners are challenging to engage and providers may be struggling with how to meaningfully communicate the results of the encounter in the EHR.

Due to the sensitive nature of the services, interviews with participants and families aimed to maximize participation and build trust between the outside evaluator and interviewees. However, there are several compromises involved in the use of an evaluator-administered interview for sensitive topics, such as use of mental health services. Participants may be reluctant or unwilling to discuss sensitive questions with outside evaluators. Also, respondents' answers may be subject to social desirability biases, as respondents may wish to give the 'correct' response or hide/minimize certain behaviors. This may result in evaluation findings that do not truly reflect respondent behavior (for example, potential over-reporting of use of community-based services or under-reporting need for mental health services).

Another limitation of the interviews is that it relies on a convenience sample – that is, participants are selected based on being readily available to participate, and not by random chance. Accordingly, the responses of the partners and family members who agree to participate in the interviews may differ from those of users who refuse to participate and/or who were not asked to participate.

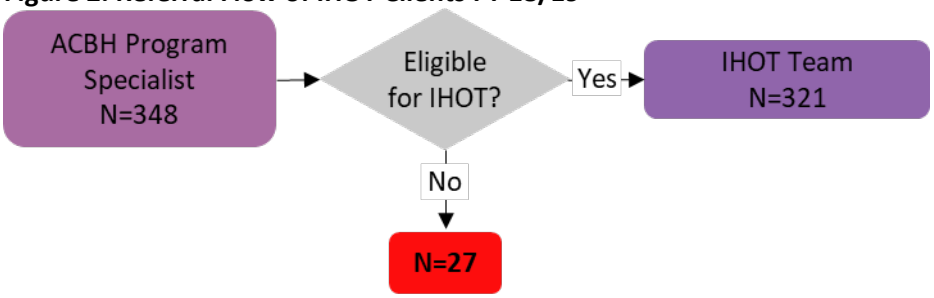
Finally, the sample itself is limiting, originally the goal was to find IHOT partners or family members of IHOT partners that are currently receiving or having received services in the last year from the time of the interview, because they would have better recall of their experiences. However, some of this sample of family members is made up of family members that have received services more than a year from the interview. This means that the data gathered might not be as detailed as it could have been due to the time that has passed. Also, the interviews were originally going to be in-person to facilitate trust and rapport building, but due to locations of partners and the COVID-19 Shelter-in-Place orders in California about half of the interviews were conducted over the phone.

Findings – How Much Did We Do?

Referral Flow of those Referred to IHOT

During FY 18/19, there were 745 cases open in the electronic health record, these include those referred from the ACBH ACCESS line to the Program Specialist, all partners that received services from IHOTs during that year, and contain duplicates. There were 395 duplicated partners that were served by IHOTs. All IHOTs served more than their contracted number of clients with the percent of open partners ranging from 20%-29%. There were 20 cases opened prior to FY 18/19. **Figure 2** below, describes the flow of episode referred during FY 18/19.

Figure 2. Referral Flow of IHOT Clients FY 18/19

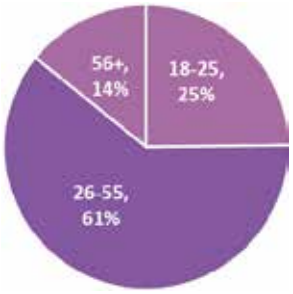


During the interviews, most of the family members stated that they were already connected to the ACBH system of care when they learned about the IHOTs and were referred by an ACBH contracted provider.

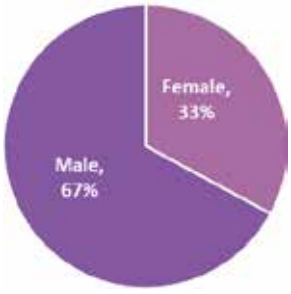
> "…I got a phone call one day and hearing about the services and they asked if I would be willing to and I said yes. I was trying to get all the help that I could get at that time for my [child]."
> –Family Member

Partner Demographics

61% were between the ages of 26 to 55.



67% identified as Male.



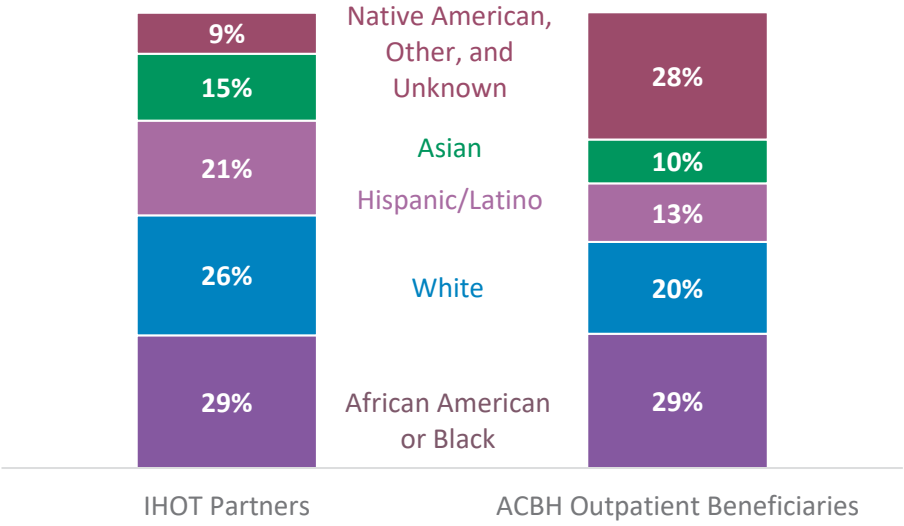
91% spoke English.

The demographics above are of the 395 duplicated partners open to the IHOTs during FY 18/19. Even though over 90% of partners spoke English, clients spoke a variety of languages. The next highest served language was Spanish at 4% and the rest served spoke Arabic, Cantonese, a Chinese Dialect, a Filipino Dialect, Korean, Mandarin, Other, Unknown/Not Reported, or Vietnamese.

When comparing the IHOT clients to the demographics of the ACBH outpatient population, which includes those that are not in crisis stabilization, subacute, hospital, jail or juvenile justice. Adults 26-55 are represented in the IHOT population at about the same percent as the outpatient populations (61% vs 60%). Whereas, TAY are overrepresented in the IHOT population (25% vs 18%) and Older Adults are underrepresented (14% vs 22%). Male identified IHOT partners are overrepresented (67% vs 47%). English speaking IHOT partners are overrepresented when compared to the outpatient population (91% vs 86%).

Figure 4. Race and Ethnicity of Engaged IHOT Partners

IHOTs served a higher percentage of **Asian**, **Hispanic/ Latino**, and **White** partners compared to ACBH Outpatient Beneficiaries.



While most clients spoke English the race and ethnicity of the clients was across many different groups. IHOTs served more Asian, Hispanic/Latino, and White partners than the ACBH outpatient providers.

In speaking with the IHOT teams, they had the following thoughts on the racial/ethnic differences between IHOTs and ACBH Outpatient Beneficiaries:

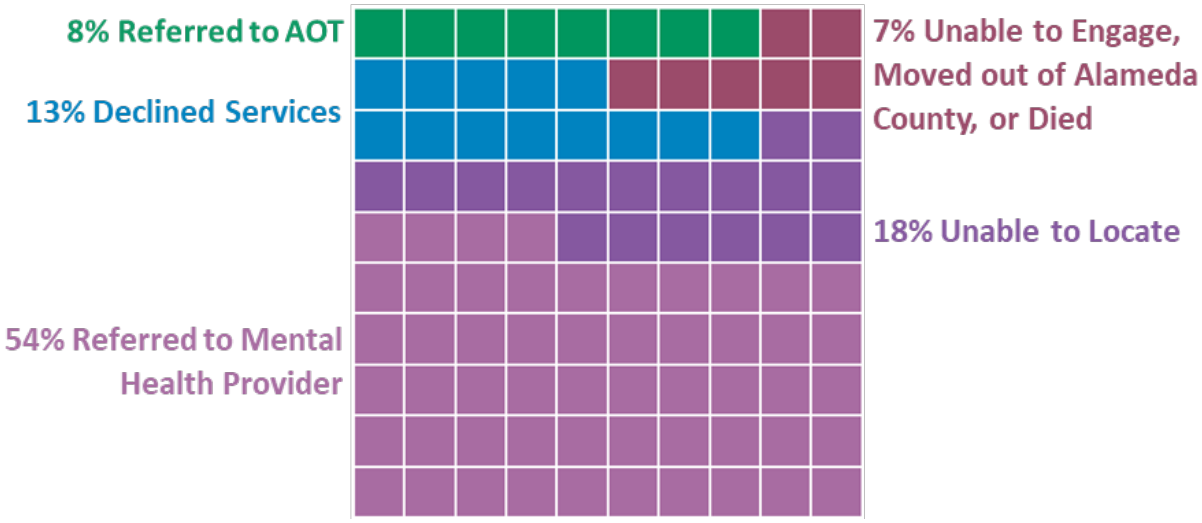
1. Men may be overrepresented because they are more likely to have the police called on them and have a more outwardly expressed symptoms, whereas women's symptoms may not be as obvious or threatening to the family. So, the women may have less interaction with this part of the ACBH system of care.
2. English-speaking patients already have more interaction with the system and have more non-family member referrals so the system already knows if they are reluctant to engage in treatment. Those that do not speak English as their first language or have limited English proficiency are often not engaged in the system and are referred by family members.
3. Asian patients were engaged by the IHOTs at a higher percentage because a provider that serves a lot of Asians has very few case managers that go out in the field and they use the IHOTs to get their partners reconnected to care.

Findings – How Well Did We Do It?

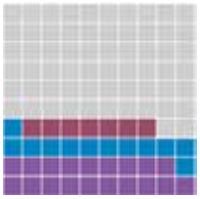
Partner Discharge Outcomes

The IHOTs are asked to try to connect with new clients within three business days. Of the 161 referrals made during the FY 18/19 that were tracked in the Referral Tracker database, 55% (n=88) were contacted within three days. The rest had first contact more than three days after the referral date. There were 384 partners discharged during the FY 18/19, 56% (n=215) of the discharge codes used were not clear so they have been excluded from the following results. Below are the discharge outcomes of the 169 partners that had clear discharge codes.

Figure 5. Referral Outcomes



Unsuccessful Engagement



According to the interviews, client's and family's first impressions varied by how involved they were with the referral and lead to varying levels of knowledge about the IHOT team trying to contact them. Those that were less involved did not always have a positive first impression and therefore could be harder to engage.

"…I didn't, like it was just an onslaught you know…I didn't know what he was talking about, where he was going, what he knew." – Partner not involved

"…they didn't know what they were doing." – Family member less involved

According to the conversations with IHOT teams, those less involved family members could be out of state and it is neighbors or mobile crisis that are engaging with and referring these clients.

Clients and families that were involved with their referral, generally had a positive first impression of the team.

"…that they were very friendly. [That] if they could help in any way they would." – Partner that advocated for themselves to receive services

"Well she was just a warm, caring person. It was nice to know that there were people fighting to get my [child] the help that [they] desperately needed. It was a relief knowing that I wasn't in the struggle by myself." – Family member more involved

However, depending on the severity of their mental illness family members might not be able to prepare the person referred for meeting the team.

> "Yeah, I was in not a good condition I was paranoid about their services at first but once I got working with [the IHOT] …I had a good experience with them." – Partner

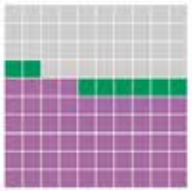
> "The other thing was [the partner] stopped [their] meds. So, [they were] severely depressed, [they] didn't move. That's why you couldn't engage [them]." – Family Member

Additionally, it might be hard to engage or even locate clients because families and potential clients did not have a network of people that could help connect the client to the services.

> "First, I heard it through my parents. They said that they were going to contact me and then I received a phone call or text message." – Partner

> "My [child] doesn't have any friends, [they are] still very, very sick… [They have] no friends, no brothers, no sisters so it was just me and the team." – Family Member

Successful Engagement



The main goal of the IHOTs is to connect clients to mental health services, either a new one or re-connect with a previous provider, and community-based services. While first impressions of the IHOT were not always positive, successful engagement with IHOTs means that partners trust and have a rapport with the IHOT. The tables below discuss what was revealed in the interviews about how the IHOTs built trust and rapport with partners.

How IHOTs Build Trust with Partner		
Listening to the partner		
"I'm hard to listen to sometimes and so with that in mind, actually, she did a very good job as far as active listening." – Partner		"She listened to me when I was talking about my parents…and kind of just listened to what I had to say and asked very intellectual, very helpful questions." – Partner
Navigating a complex system to connect partners to wanted/needed services		
"I like that she got involved… I think they were able to get to the higher people in [a Community-Based Organization] and stuff like that to get things done. Because I was having problems with [them]." – Partner		"And they help you get to the place you want to be. Like they've gotten me so much further in my housing then I would have done by myself…They pulled out resources that I didn't even know existed." – Partner
Being persistent and consistent		
"Trying to have conversations with [the partner] was very difficult in the beginning. [They] did not want to engage but [they] came around and it didn't take too long…But [the IHOT] kept showing up." – Family Member		"Having consistency in [the partner's] life that [they] knew that every Wednesday [they] would hear from [the IHOT] …the structure is important for people with mental health issues and that is what they provided for [the partner]." – Family Member

Listening icon created by Vectorstall, navigating icon created by IconPai, and persistent and consistent icon created by Becris. All icons downloaded from the Noun Project.

How IHOTs Build Rapport with Partner		
Facilitating goal setting		
"Just, you know, build me up with what I did, my work experience and what I could do or accomplish. And gave me some good advice." – Partner		"I think one of the goals was [they] really wanted to go back to work. Work was really, really important to [them] so [the IHOT] would set a goal [for the partner]." – Family Member
Becoming like family or a support system		
"I'm just glad we were just there to talk like family and [the] outreach team is wonderful." – Partner		"It was like going to lunch with your family…They would ask [the partner] questions without focusing so much on the mental health." – Family Member
Demonstrating caring for the partner		
"She's also asked me like what am I doing, how's it going what I'm doing, how my relationship with my parents is it fruitful." – Partner		"Everything that she does is with care." – Partner

Goal setting icon created by Adrien Coquet, family or support system icon created by Made x Made, and caring icon created by shanthagawri. All icons downloaded from the Noun Project.

Linking to Community-based Services

There was a combination of ways that the IHOT helped the partner find and connect to community-based services. The services ranged from housing to nutrition assistance to addiction remission services. If the client was willing and able they would connect themselves to community-based services. However, the IHOT was there to advocate for them when needed.

> "She helped me get around and she worked on making sure I wasn't going to be on the streets… They were able to get me into a hotel for like a month or something. She fought for that." – Partner

> "It's mainly, she'll give me information about a facility and then I'll call them and set up an appointment." – Partner

While IHOTs cannot refer to mental health services, they can help the client call the ACCESS line to get referred to outpatient mental health services. They would also advocate on the partner's behalf, regardless of whether they were previously or newly connected to mental health services.

> "No, [the partner] wasn't on medication and the [IHOT]…put the fire up under [Mental Health Provider] but I wasn't actually getting stuff that I know that I could get…I would say that they were very much instrumental in getting [Mental Health Provider] to kind of get on the ball." – Family Member

> "So, I know they did speak to the doctor there in the hospital to let them know, "Hey this is what's going on with this young man," and that helped get him a lengthier stay and help, too." – Family Member

Persuasion to Engage in Mental Health Services

Building trust and rapport with partners is important to empowering them to agree to be connected to mental health services. Partners and their family members spoke about why the partner decided to engage in mental health services.

Partners often reported that they knew they needed mental health services, which is how they were persuaded to connect to these services.

> "Yes, so I needed to, I knew I couldn't go forever without the meds. Even though I'm pretty good at it, it's better to get the meds...When I found out that there were psych appointments I said good I'll take one."

However, family members felt that the IHOT teams were instrumental to enabling the partner to want to connect with mental health services.

> "I think that once [they partner] had [an] interaction with this person it started to make [them] think [they] wanted to get better. [They] definitely began to consider recovering because [the partner] was interacting with somebody else besides just us… [the IHOT] definitely got [them] opened up to mental health recovery."

> "I think by the time [the IHOT] left [the partner] was aware that [they] needed more than the IHOT was created to provide. [They were] aware that [they] needed more."

After discussing with the IHOTs, they reported that they are successful at connecting people to mental health services because of their experience decreasing barriers to care. However, IHOTs often felt like they could not advocate enough to help partners get hospitalized, especially for hard to reach patients. Family members also mentioned the importance of hospitalization. Partners spoke about being hospitalized, but did not comment on their feelings about it.

IHOTs felt that families might decrease their success connecting partners to mental health services because they might be create barriers to successful engagement and take it out on the IHOT staff when the partner does not get dramatically better. An effective solution found by an IHOT was asking family members, "what are you expecting the IHOT to do?" and then telling the family what is reasonable to expect. Also, speaking with families about the longevity of mental illness and that the partner will be living with it for the rest of their life. Another area that could be clarified for families and others that refer partners is that IHOT is "outreach only" and do not respond to crises. As such, IHOTs are encouraged to discuss resources with families upfront to deal with crisis, such as calling Alameda County's Mobile Crisis Unit.[2]

Family Supports

Not only are the IHOTs expected to provide services to their clients, but they are expected to also provide support groups to the family members as well. Family members reported varying levels of support and referrals to groups from the IHOT teams.

> "Yes. And they have contacts for me also to get into groups…They're going to come here to meet with me."

[2] Currently, all Crisis Services 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. More information can be found in the MHSA Plan # OESD 5 at https://acmhsa.org/wp-content/uploads/2019/12/19-20-MHSA-Plan-Update2.pdf

> "No, once the first interview was over we pretty much didn't have any family support…they didn't send us information about family support groups or anything. It was very weird."

> "They would say, 'If you need help you can go to this and this and that.' I would say that I'm a trained [mental health] facilitator and this had nothing to do with IHOT…and it is hard there is not a support group for facilitators."

IHOT teams reported that the amount of support varied depending on whether the family wanted it and the severity of the partner's illness. Additionally, they felt that there are not a lot of resources in the county for families. Families might not know how they are influencing the partner's ability to get services and do not necessarily want anything to do with referring them to mental health services. Some IHOT team members felt that the family and the partners both need to heal and work intensely to assist the families.

Time Open by IHOTs

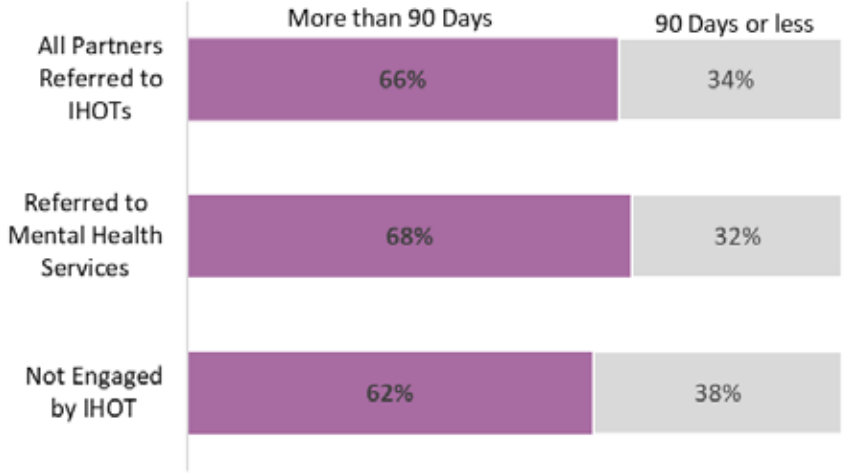
The IHOTs are expected to follow-up with the partner once the client has begun to participate in outpatient mental health services for up to 90 days or three months. Additionally, the length of stay shall not be extended beyond six months or 180 days without approval and those that the IHOTs are unable to locate for 90 days despite their attempts to contact those referred or if the referred consistently declines treatment despite their attempts to engage the client. Clients and family members varied in remembering a conversation about how long they were expected to be worked with. However, they did explain the purpose of their work.

> "She didn't say, 'I am going to be working with you for this long' but yes, she explained what they do and how they can help." – Partner

> "IHOT made it very clear to me that this was their work, this is what we do, we want to make certain that [the partner] is stable and we won't leave until [they are] stable. I don't remember them saying 'We are only going to be here for two months, if [they are] not stable at two months we're gone.' I don't remember that." – Family Member

Of the 169 partners that had a known discharge outcome, more than half were open for longer than 90 days. There is not a significant difference between the length of time partners are open and whether they are subsequently referred to mental health services (**Figure 6**). Among the 106 partners referred to mental health services or AOT, 67% were open for less than six months. However, this does not reflect how long partners were opened once they were engaged in services.

Figure 6. More IHOT Partners were Open for 90 Days



The IHOT teams feel that the 90-day time limit is too restrictive because they are a hard to engage population and, as previously mentioned, the time it takes to connect partners to services. Engaging IHOT referrals versus getting them ready to get them to treatment can take longer. Additionally, trying to connect the partner to mental health services does not always succeed. There are partners that may agree to treatment versus those that sign a treatment plan.

Areas of Concern

Partners and family members spoke about how the IHOT, mental health, and community-based services could be improved. What can harm the relationship with the IHOT and decrease the perceived quality of the services received are: the time it takes to link to services, not enough time spent each week with the partner, and staff turnover throughout the system.

Time it takes to link to services was mentioned as a frustration to getting services, not just services the IHOT was trying to connect the partners to, but also the subsequent services.

> "But then there's been inconsistencies with how that is handled in a timely fashion." – Family Member

> "We kept wondering when [the partner] was going to get a psychiatrist. The [IHOT] would sort of pass along and talk briefly about the possibility of seeing a psychiatrist and [the partner] got on board." – Family Member

> "But see the only thing that was maybe a problem is just the sheer amount of time it was taking to do these things." – Partner

> "And, um, they ended up supposedly this was supposed to help with finding SLEs [sober living environments] and all this stuff…with the rehab…I didn't find out till like a week or two at the end but there was no help at the rehab and I couldn't get help anywhere on any type of housing or anything." – Partner

After discussing these findings with the IHOTs they said that this was also their biggest concern. They mentioned that the speed with which referrals are completed and "at the mercy of whoever is over the program." When referrals do not go through, then the partners can fall through cracks. The other concern the IHOTs mentioned was that the partners might not meet county criteria for services because the system is built to "fail-up" to higher levels of care. Oftentimes, because these individuals have been reluctant to engage in services then they do not have enough interaction with the ACBH system to justify a higher-level of care. They are also frustrated with a lack of services for co-occurring disorders.

Partners and family members also felt like that they did not get enough time. They wanted more time and more frequent contact with the IHOT team. However, partners can be rereferred to IHOT if needed.

> "But as far as there's really nothing other than it needs to be more. But not uniformly, more because of the fact that the service is actually really helpful and they need more people. So that they're not as bogged down." – Partner

> "Once a week was nowhere near enough to keep anything going at all. If [the partner] had had more meetings a week [they] might have pulled [themselves] out. But if [they] only had to pull it together for an hour a week, [they were] unconscious the rest of the week so there was no progress." – Family Member

The 161 referrals that were in the Referral Tracker had 3,615 contacts with the IHOTs, which averages to 22 contacts per referral, a mean of 16, a min of one contact, and a max of 103. Because the amount of

contact varied this probably influences how many services they were connected to or if they were successfully engaged. This does not measure the length of time or quality of each contact. This may also be why clients decline services or do not engage. However, increasing the number of contacts per week might create outsized expectations for the care they will get with other providers. Additionally, some of the partners might need a higher level of care that they might not have access to when being discharged from IHOT.

This area of concern is also positive because partners and families want more time. After speaking with the IHOTs, they spoke about how there was a lot of intention to connect with the person because of the 90-day limit (explored above). The IHOTs want to give their partners a lot of care during the time they have, because the partners are often in crisis and there is a need to create relationships quickly.

Most clients only had one or two IHOT team members that they worked with consistently. However, staff turnover was often the reason for working with multiple people and it would take time for the partners and the team to create a relationship with a new IHOT member and with others within the ACBH system of care.

> "I think part of it has been there was turnover in staff a lot. That instability for [them] was not great. There was not much communication with me at all." – Family Member

> "We know for sure it was staff turnover they had told [the partner] that. The first person shared with [the partner] that she was leaving and even shared some of her reasons why she was leaving and then had one session where she brought the new person in to introduce [the partner] to the new person…Anyway, like I said it was pretty clear that team was struggling right then." – Family Member

The frustration with staff turnover carried through to the services that they were referred to.

> "To start therapy and two months later they're gone. And they've only had maybe three sessions an intro…but not enough." – Family Member

The staff turnover for the IHOTs has decreased after FY 18/19. The IHOTs agreed that a warm hand-off is important among transitioning team members and they would like this also for when the IHOTs refer to another agency. They felt that the transition between IHOTs and other agencies could be better if the teams reached out to debrief and work collaboratively to engage with partners.

Findings – Is Anyone Better Off?

The connection to community-based services, mental health services, and the IHOT improved the partners' and family members' lives. Once connected to services the changes in partner's lives included being more recovery oriented, asking for help, accomplishing goals, improving their hygiene, and having their life saved by the IHOT.

Partners and family members spoke about how the services made the partner more recovery oriented. For mental health services they reported the following:

> "I got some stuff off my chest. I learned about myself speaking about things." – Partner

> "[The partner] had you know someone else to talk to in the whole scheme of things and someone else to go over things with, which is what [they] need." – Family Member

> "Because I wasn't there for it but I saw an upswing in [the partner's] behavior. A lot more happiness and a lot more abilities to do things." – Family Member

Being connected to community-based services also helped them become recovery-oriented:

> "I'm not there, but I can see myself getting healthy. I can see myself passing a college class. I can see myself getting back to work before the end of the year." – Partner

> "They kept me off the streets I mean they helped a lot. They helped me not get stuff taken or stolen when I wasn't around and let me have a secure place where I could leave my stuff and go out. It made me feel secure." – Partner

Specifically, family members spoke about the partner being willing to ask for help with their mental health.

> "One thing that changed was that [the partner] was at least willing to talk about getting help. It actually opened [them] up to being willing to get help. The IHOT was at least talking about getting psychiatry so then [the partner] was agreeing to it. So at least that opened the door for us to get [the partner] to it." – Family Member

The partners' time with IHOT also helped them accomplish goals, which is important for self-determination.

> "I enrolled in classes in Merritt College." – Partner

> "It's more easygoing, I mean I quit drinking altogether and I haven't relapsed or anything. I'm feeling better now that I don't get too depressed and so but I'm taking medication." – Partner

Even small, but important, changes to the partners' daily routines were commented on by family members, such as increase in hygiene.

> "I think that was first and foremost, [the partner] started taking care of [their] health better, taking more showers, getting [themselves] cleaned up." – Family Member

> "It was interesting, once [the partner] started taking [their] meds all of the other stuff like combing [their] hair and taking a bath, all of those things came naturally to [them]." – Family Member

Many family members spoke about how the IHOT ultimately saved both their life and the partner's life.

> "They saved our life. They saved [my child's] life, they saved my life." – Family Member

> "I truly believe that the IHOT team saved my [child's] life." – Family Member

When speaking with the IHOT teams they said that feedback like this is what keeps them going. Hearing the appreciation for their work.

Summary and Recommendations

Summary

This evaluation was undertaken to create a logic model, measure outcomes created for programs, and deepen the understanding of the family and client experience. The goal is to use this understanding to create a product for outreach. IHOTs served a racial and ethnically diverse population of mostly men, adults, and English speakers. Discharge data from the IHOTs was not complete, with over half (56%) of the discharged partners were missing a clear discharge code. Of those that did have a clear discharge code 62% were referred to mental health services or to AOT. In order to successfully link partners to services, IHOTs need to build trust and rapport with the partners in a variety of ways, including being persistent and consistent with outreach and becoming a support system for the partner. Families conveyed that they wanted support and referrals to services, but varied in whether they received that support. From the interviews the respondents were concerned about the time it takes for things to get moving, the limited amount of time with the IHOTs, and staff turnover throughout the system. Partners were better off because they were working towards recovery, asking for mental health help, accomplishing goals, increasing hygiene, and that the IHOT was life-saving for the partners and the family.

Recommendations

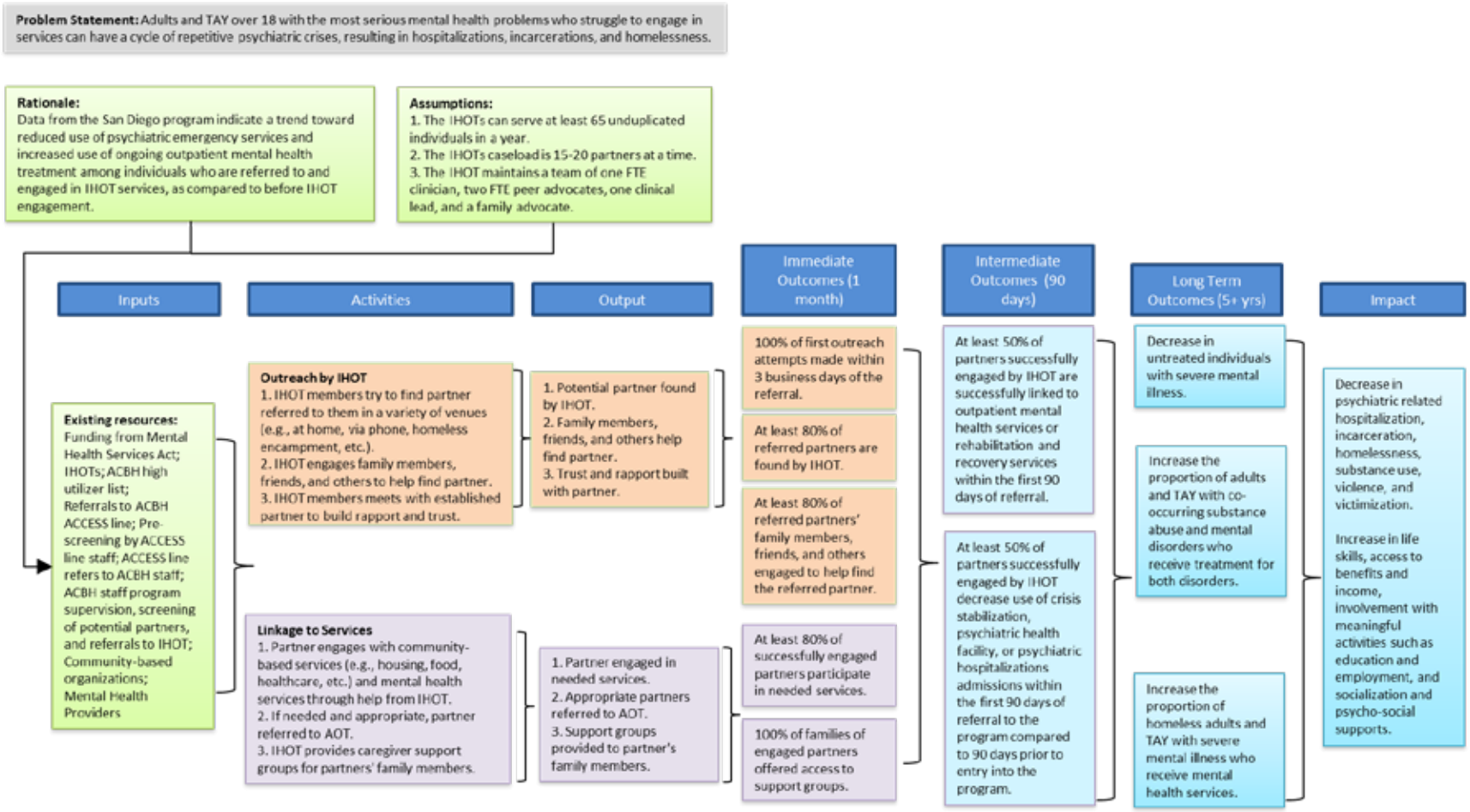
Considering these findings, this evaluation has demonstrated the IHOTs value to the Alameda County Behavioral Health system of care. The IHOT's current services appear to be accomplishing the goal of connecting those with serious mental illness to community-based and mental health services. These findings suggest that the services are both needed and valued by the partners and their family members. To continue to provide and improve upon the services, the following recommendations are made for the IHOTs and the ACBH Program Specialists:

1. Improve data quality:
    a. The Program Specialist provides guidance to the IHOTs to improve destination codes in Clinician's Gateway – this is already in progress.
    b. ACBH's Program Specialists, Management Analyst, Information Systems, and the IHOTs collaborate to build a dashboard to review data during the FY 20-21 fiscal year. At minimum, the dashboard will include incarceration, hospitalization, and psychiatric emergency use data for pre- and post-enrollment time periods and IHOT discharge destinations.
    c. Explore the logic model outcomes for appropriateness with the IHOT teams, particularly the 90-day time limit during FY 20-21.
2. Increase IHOT Partners' language diversity and set expectations for family members using a brochure created for the programs (Appendix D). The brochure will be used for the following:
    a. Outreach to diverse communities. The Program Specialist has already scheduled a meeting with providers that focus on underserved ethnic and language communities in March 2021.
    b. Use when meeting clients/families for the first time, which could include mailing them to families after referral.

3. IHOTs increase the amount they connect with families, including having a conversation to set expectations about what the IHOT will reasonably accomplish. The brochure could facilitate the expectation setting conversation. This is because of family member's desire for support and the IHOT's recognition that families influence the recovery of the partner.
    a. During FY 20-21, the ACBH Program Specialists will set aside at least one IHOT Collaborative meeting to discuss working with family members and develop a workplan for increasing engagement. This may include reminding the referrals sources that IHOT is "outreach only" and that they do not respond to crises. IHOTs will be encouraged to discuss resources with families upfront to deal with crisis, like calling Alameda County's Mobile Crisis Unit.
4. ACBH Program Specialists will work with IHOT and ACCESS to figure out a workflow to best link partners to the level of care that the partners need. Since IHOT and the interviewees expressed concern over the difficulty it can be to connect partners to Mental Health Services.

Appendix A

Logic Model Alameda County Behavioral Health's (ACBH) In-Home Outreach Teams (IHOT)



Appendix B

Individual Interview Guide – In Home Outreach Teams FY 18/19 Evaluation

Introduction

Thank you for agreeing to be interviewed. My name is Carly Rachocki, I am a Management Analyst for Alameda County Behavioral Health and I work on evaluating programs. Today we are going to spend the next hour talking about the In-Home Outreach Teams or IHOT. The purpose of this discussion is to help ACBH understand the quality of the services we are providing.

The consent form needs to be signed before we begin. Please take time to read it over, but the main points are that this interview is voluntary, you do not have to answer any questions that you do not want to, and you can stop participating at any time. We will be reporting the results of the interviews to a variety of different groups but will not be using any names when reporting so your answers will remain confidential. Do you have any questions?

Great. Please complete the consent form and return them to me.

I am going to start recording now.

Outreach by IHOT

1. IHOTs (Agency Name or Team Member they are familiar with) provide outreach and engagement to people with the intention of connecting them to mental health care and community supports. When and how did you first hear that the IHOT was trying to contact you?
    a. What was your first impression upon meeting them?
2. What other experiences do you have working with the IHOT (**probe:** did they spend time talking to you/your other family members about mental health symptoms; explain the purpose of their work and the length of time they were expected to work with you)?

Linkage to Services

3. Describe the ways that the IHOT tried to build trust with you (**probe:** were they empathetic; used active listening; communicate; recognized you as an individual; or met you where you were at)?
    a. Which of those worked at building trust? Why?
    b. Which of those did not work at building trust? Why?
4. Describe the ways that IHOT tried to build rapport or a relationship with you (**probe:** did you work with the same person over and over or were there multiple people; holding silence when productive; using laughter; or setting attainable goals)?
    a. Which of those worked at building rapport? Why?
    b. Which of those did not work at building rapport? Why?
    c. Follow-up if they speak about the same person working with them or multiple people: How did that go?

5. What community-based services did the IHOT connect you with (**probe:** health insurance; housing; food; jobs; social security; substance use; disability services; general assistance)?
    a. How did these services help?
    b. In what ways could these services have been better?
    c. How did the IHOT assist you to connect with these services (**probe:** educating you about services available; providing you with the application; helping you to fill out the application; helping you get to appointments)?
6. What mental health services did the IHOT connect you with?
    a. How did these services help?
    b. In what ways could these services have been better?
    c. How did the IHOT assist you to connect with these services?
    d. What persuaded you to connect with mental health services?
7. After engagement with IHOT how did your life change?
8. Is there anything else about the IHOT or your experience receiving services that you want to add?

Closing

Thank you for your time. Please fill out this questionnaire to tell me a little bit about yourself. Do you want a copy of the consent form?

Focus Group Guide – In Home Outreach Teams FY 18/19 Evaluation

Introduction

Thank you for coming. My name is Carly Rachocki, I am a Management Analyst for Alameda County Behavioral Health and I work on evaluating programs. Today we are going to spend the next 45 minutes talking about the In-Home Outreach Teams or IHOT. The purpose of this discussion is to help ACBH understand the quality of the services we are providing.

I am passing out a consent form that needs to be signed if you agree to participate. Please take time to read it over, but the main points are that this focus group is voluntary, you do not have to answer any questions that you do not want to, and you can stop participating at any time. We will be reporting the results of this focus group to a variety of different groups but will not be using any names when reporting so your answers will remain confidential. Do you have any questions?

Great. Please complete the consent form and return them to me.

In order to help me facilitate, can you go around an introduce yourselves? Thank you.

I am going to start recording now.

Introduction questions

9. IHOTs (Agency Name or Team Member they are familiar with) provide outreach and engagement to people with the intention of connecting them to mental health care and community supports. They receive referrals from a variety of places, including family members. How did you hear about IHOT and the services they provide?

Outreach by IHOT

1. What was your experience working with the IHOT to connect your family member?
    a. What was your first impression upon meeting them?
    b. Tell me about other people that they engaged to help connect your family member? What was their role in helping find them?
2. What other experiences did you have working with the IHOT (**probe:** did they spend time talking to you/your other family members about mental health symptoms; explain the purpose of their work and the length of time they were expected to work with you)?

Linkage to Services

3. Describe the ways that the IHOT tried to build trust with your family member (**probe:** were they empathetic, used active listening, communicate, recognize the individual).
    a. Which of those worked at building trust? Why?
    b. Which of those did not work at building trust? Why?
4. Describe the ways that the IHOT tried to build rapport or a relationship with your family member (**probe:** did they work with the same person over and over or were there multiple people; holding silence when productive; using laughter; or setting attainable goals)?
    a. Which of those worked at building rapport? Why?
    b. Which of those did not work at building rapport? Why?

   c. Follow-up if they speak about the same person working with them or multiple people: How did that go?
5. What community-based services did the IHOT connect your family member with (**probe:** health insurance; housing; food; jobs; social security; substance use; disability services; general assistance)?
   a. How did these services help?
   b. In what ways could these services have been better?
   c. How did the IHOT assist your family member to connect with these services (**probe:** educating you about services available; providing you with the application; helping you to fill out the application; helping you get to appointments)?
6. What mental health services did the IHOT connect your family member with?
   a. How did these services help?
   b. In what ways could these services have been better?
   c. How did the IHOT assist your family member to connect with these services?
   d. What persuaded your family member to connect with mental health services?
7. After engagement with IHOT, how did you family member's life change?
8. Tell me about your experience learning about the support group provided by IHOT.
   a. If you chose to attend the support group, what was your experience with it?
   b. If you did not choose to attend it, tell me why you chose not to.
   c. Describe the other family supports that they referred you to.
      i. What was your experience with those supports?
9. Is there anything else about the IHOT or your experience receiving services that you want to add?

Closing

Thank you for your time. I am going to pass around a questionnaire to tell me a little bit about yourself and so that I know who is participating in the focus group. While you are filling that out is there anyone that wants a copy of their consent form?

Appendix C

Demographic Survey Individual Interviews

Please let us know a little bit about yourself by filling out this survey. *Your participation is voluntary and will not affect your ability to receive program services.* Alameda County Behavioral Health will use the results of this survey when reporting to stakeholders. Information shared with us will be anonymous because it will be combined with other surveys before sharing the results.

1. What is your race/ethnicity? _____

2. What is your age? _____

3. What is your gender identity?

☐ Male

☐ Female

☐ Female-to-Male (FTM)/Transgender Male/Trans Man

☐ Male-to-Female (MTF)/Transgender Female/Trans Woman

☐ Genderqueer, neither exclusively Male nor Female

☐ Additional Gender Category/ (or Other),

Please specify: _____

4. What city do you live in? _____

5. Are you currently receiving mental health services?

☐ Yes
☐ No

6. Are you currently receiving treatment for substance abuse?

☐ Yes
☐ No

Demographic Survey Focus Group

Please let us know a little bit about yourself by filling out this survey. *Your participation is voluntary and will not affect your ability to receive program services.* Alameda County Behavioral Health will use the results of this survey when reporting to stakeholders. Information shared with us will be anonymous because it will be combined with other surveys before sharing the results.

4. What is your race/ethnicity? _____

5. What is your age? _____

6. What is your current gender identity?
   - ☐ Male
   - ☐ Female
   - ☐ Female-to-Male (FTM)/Transgender Male/Trans Man
   - ☐ Male-to-Female (MTF)/Transgender Female/Trans Woman
   - ☐ Genderqueer, neither exclusively Male nor Female
   - ☐ Additional Gender Category/ (or Other),

     Please specify: _____

4. What city do you live in? _____

5. Did you have a family member that received IHOT services?
   - ☐ Yes
   - ☐ No

6. Is your family member currently receiving mental health services?
   - ☐ Yes
   - ☐ No

7. Is your family member currently receiving treatment for substance abuse?
   - ☐ Yes
   - ☐ No

Appendix D

"I truly believe that the IHOT team saved my [child's] life."
-Family Member

The organizations below provide IHOT services.

ABODE SERVICES
Because everyone should have a home.

Bonita House INC

LA FAMILIA

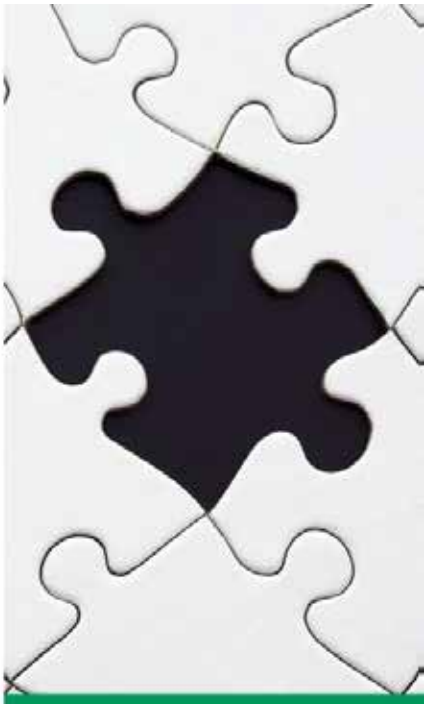
STARS Community Services
Respect · Compassion · Trust · Positivity · Inspire Wholeness ·

"I'm not there, but I can see myself getting healthy. I can see myself passing a college class. I can see myself getting back to work before the end of the year."
-Client

Funding for these programs provided by the Mental Health Services Act or Prop. 63. For more information visit Alameda County's MHSA Website at www.acmhsa.org. Please call the multilingual ACCESS hotline 24 hours a day/7 days a week at 1-800-491-9099 to refer someone for services.

MENTAL HEALTH SERVICES ACT · CALIFORNIA · 63
WELLNESS · RECOVERY · RESILIENCE

alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES



Alameda County Behavioral Health's In Home Outreach Teams

Linking People To Mental Health and Community-based Services

In Home Outreach Teams (IHOT) work with the most vulnerable Alameda County residents.

IHOTs outreach to adults and transition age youth (TAY) over 18 living with the most serious mental health diagnoses who struggle to engage in services. These individuals can have a cycle of repetitive psychiatric crises that result in hospitalizations, incarcerations, and homelessness. IHOTs **do not provide treatment** but they do work with individuals and their loved ones to help link these individuals to needed community-based and mental health services.

IHOTs work with participants and their families to:

- Explain what services are available in the community to fit their needs, including information about specialty mental health care.
- Teach skills in order to engage with services in the community and mental health.
- Work towards improving their mental health and quality of life.

"It was nice to know that there were people fighting to get my [child] the help that [they] desperately needed. It was a relief knowing that I wasn't in the struggle by myself."
-Family Member

Someone is eligible for IHOT Services if they:

- Are suspected of having a serious mental illness.
- Have Medi-Cal or are eligible for Medi-Cal.
- Live in Alameda County, including those experiencing homelessness.
- Reluctant to engage in outpatient mental health services.

Anyone can refer someone to IHOT.

- Clients do not have to refer themselves to IHOT services. Members of the community can refer to IHOT, including, but not limited to family, caretakers, law enforcement, and mental health providers.
- If you or someone you know would benefit from IHOT services **please call the multilingual ACCESS hotline 24 hours a day/7 days a week at 1-800-491-9099.**

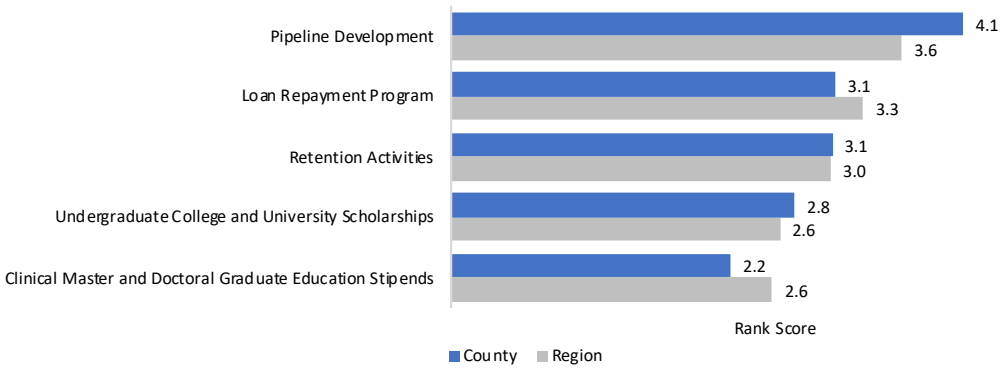
Behavioral Health Workforce Needs Assessment: Survey Results
Alameda County

SURVEY RESPONDENTS

County	N = 38	Region	N = 76

WORKFORCE STRATEGY PRIORITIES

Rank Score is calculated by each weighted rank assignment divided by the number of rankings.



STAFF RECRUITMENT

To what extent is your clinic or program able to recruit the staff necessary to meet the community's needs?*

	County	Region
To a great extent	31%	21%
Somewhat	61%	63%
Very little	8%	11%
Not at all	0%	4%

Which of the following language skills need to be recruited in order to have a behavioral health workforce that is reflective of the community being served? (Select all that apply)

	County	Region		County	Region
Arabic	46%	33%	Laotian	19%	15%
Armenian	19%	11%	Punjabi	16%	10%
Cambodian	30%	21%	Russian	11%	14%
Chinese	54%	49%	Spanish	89%	90%
Farsi	43%	30%	Tagalog	41%	43%
Hindi	24%	16%	Thai	16%	8%
Hmong	22%	11%	Vietnamese	49%	38%
Japanese	22%	14%	Other	19%	19%
Korean	38%	25%			

STAFF RETENTION AND CAREER ADVANCEMENT

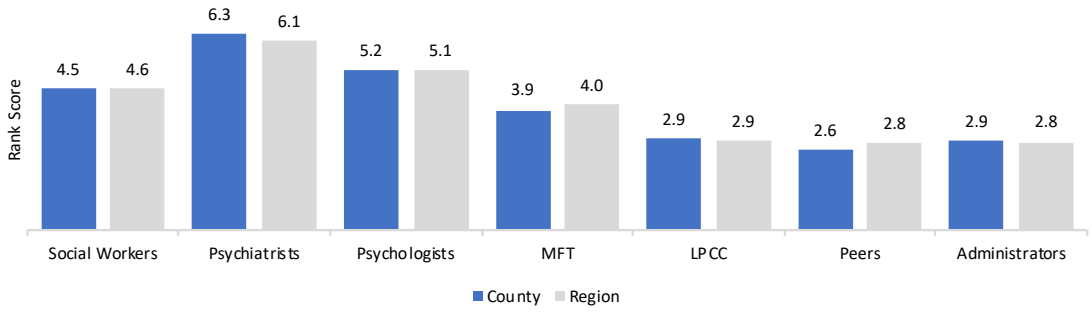
To what extent is your organization or program able to effectively retain staff?*

	County	Region
To a great extent	33%	24%
Somewhat	61%	66%
Very little	6%	8%
Not at all	0%	1%

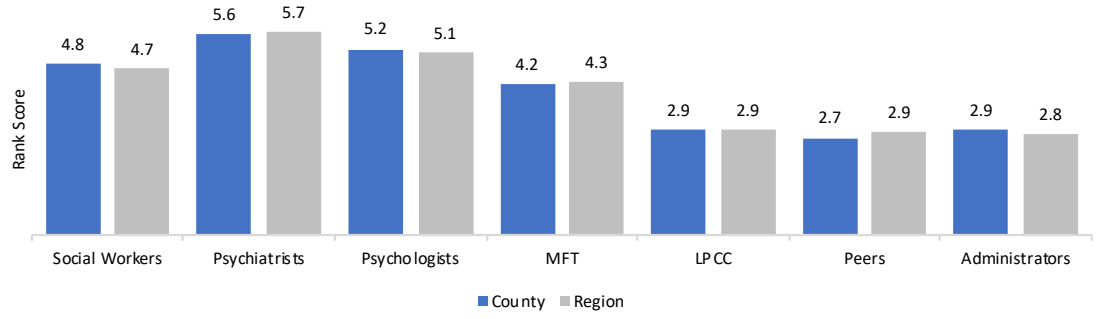
To what extent are individuals successfully supported to advance in their career in the behavioral health workforce?*

	County	Region
To a great extent	16%	15%
Somewhat	54%	51%
Very little	30%	28%
Not at all	0%	6%

Which are the most difficult professionals to recruit?



Which are the most difficult professionals to retain?



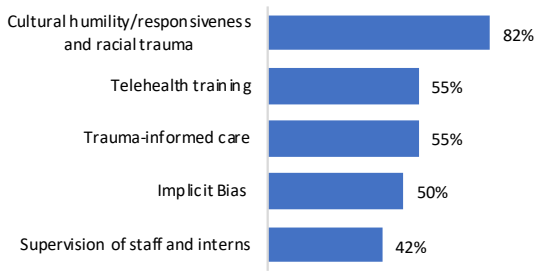
STAFF TRAINING

To what extent do staff in your clinic or program have the training necessary to meet the needs of the region's diverse population?*

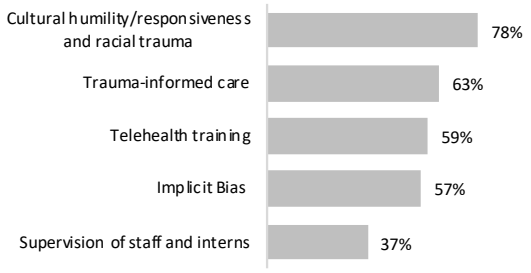
	County	Region
To a great extent	34%	36%
Somewhat	50%	48%
Very little	13%	15%
Not at all	3%	1%

What are the top training needs over the next 5-10 years?

County



Region



For which populations do behavioral health staff need more training, in order to effectively serve them?

	County	Region		County	Region
Racial/ethnic minorities	82%	87%	First episode psychosis	29%	21%
Religious minorities	53%	21%	Eating disorders	18%	13%
Refugees	58%	46%	Autism	26%	24%
Immigrants	63%	66%	OCD	5%	4%
Undocumented	61%	63%	Borderline Personality Disorder	18%	15%
LGBTQ	61%	62%	Criminal justice involved	74%	55%
Elders	37%	38%	Dual diagnosis	37%	37%
Indigenous	26%	28%	People with physical disabilities	29%	18%
Low-income	42%	40%	People with developmental disabilities	40%	30%
Homeless	61%	59%	Other	5%	5%
Substance use disorders	37%	38%			

SURVEY RESPONDENT DEMOGRAPHICS

Primary Job Setting

	County	Region		County	Region
State Government	0%	0%	Faith-based organizations	0%	0%
City Government	3%	11%	Training consortia	11%	7%
County Government	18%	28%	Non-profit organizations	24%	17%
K-12	3%	8%	Children network	5%	4%
Colleges/Universities	5%	7%	TAY network	3%	3%
Community Colleges	5%	4%	Aging network	0%	0%
CBO/Service Provider	21%	17%	Social service agencies	5%	8%
Foundation	0%	0%	Corporate/Private Business	0%	0%
Union	0%	0%	Workforce Investment Boards (WIBs)	3%	1%
Healthcare	18%	11%	Veteran Services	0%	0%
Public Health	5%	7%	Other	18%	0%

Primary Job Classification or Function

	County	Region		County	Region
Administrative	11%	11%	Community Program Planning and Coordination	5%	7%
Direct Service/Clinical	16%	11%	Clinical Supervisor/Unit Chief	8%	5%
Peer/Lived Experience	0%	5%	Administrative Supervisor	0%	7%
Educators/Teachers/Faculty	8%	7%	Manager/Senior-Level Administrator	21%	24%
Family Member Support Service Provider	0%	1%	Other	21%	15%
Field Placement/ Internship/Training Coordinator	11%	9%			

Source: Bay Area Behavioral Health Workforce Development Training and Support Needs Survey, fielded by RDA in July - August 2020, N=76.
*Totals calculated do not represent those who responded "Don't know / N/A".

FY 20-21 MHSA WET Plan_Addendum 2_Training Institute_2019-20 List of Trainings

ACBH Trainings: FY19-20 87 trainings; 2,126 ACBH and provider staff attended; 353 & 235 CEs

Date	Training Title	ACBH Sponsor/ Coordinator	Attendance	CEs	Location	Audience
7/10/2019	Dynamic Mindfulness- 1 day ONLY	Training Institute	23	0.0	San Leandro, 1000 SL Blvd, Creekside	ACBH & Providers
7/12/2019	Dynamic Mindfulness- 2 days (Full course for CEs, participants also attended day 1 on 7/10)	Training Institute	21	12.0	San Leandro, 1000 SL Blvd, Creekside	ACBH & Providers
7/24/2019	Tobacco Treatment Services within the Criminal Justice System	SUD	12	3.0	Dublin, Santa Rita	Santa Rita staff
7/29/2019	Youth MHFA (Lisa C.)	Training Institute	18	0.0	Oakland, 1900 Embarcadero, Brooklyn B	Faith-Based Community
7/30/2019	Youth MHFA (Lisa C.)	Training Institute	26	0.0	Oakland, 2000 Embarcadero, Gail Steele	Para-Prof at school sites
7/30/2019	QA: Clinical Documentation and Standards Training for SUD Providers	QA	20	5.0	Oakland, 2000 Embarcadero, Joaquin M	SUD Providers
8/7/2019	5150/5585 certification (for ACBH Adult Forensics Behavioral Health & Youth Guidance Clinic)	Crisis Division	38	6.5	Dublin, Santa Rita	Forensic Staff
8/15/2019	Trauma Informed Systems 101	Training Institute	27	3.0	Oakland, 1900 Embarcadero, Brooklyn B	ACBH & Providers
8/20/2019	The Stories We Tell at Work: Building Sustainability for Providers	Training Institute	12	3.0	San Leandro, 500 Davis St	ACBH & Providers
8/23/2019	Preventing Vicarious Trauma: A Grounding Experiential Workshop with Culture	Training Institute	13	0.0	Berkeley, A Better Way, 3200 Adeline Street	ACBH & Providers
9/6/2019	QA - Clinical Documentation Training for Clinician's Gateway-Electronic Health Record (EHR) Users	QA	16	5.0	Oakland, 2000 Embarcadero, Joaquin M	ACBH & Providers
9/11/2019	QA - Clinical Documentation Training for Fee-For-Service Providers	QA	11	5.0	Oakland, 2000 Embarcadero, Joaquin M	Fee-for-Service Providers

FY 20-21 MHSA WET Plan_Addendum 2_Training Institute_2019-20 List of Trainings

9/12/19 & 9/13/19	Conscious Nonviolent Parenting (2-day training)	Training Institute	25	13.0	San Leandro, 500 Davis St	ACBH & Providers
9/19/2019	Suicide Assessment & Intervention (6-hour)	Training Institute	48	6.0	Oakland, 2000 Embarcadero, Gail Steele	Clinical staff
9/20/2019	The African American Community's View of Behavioral Health - How These Ideas Were Formed & What Can be Done to Decrease Stigma	Ethnic Services	61	5.5	Oakland, Executive Inn & Suites Hotel, Embarcadero	ACBH & Providers
9/24/2019	Adult MHFA	Training Institute	19	0.0	Fremont, Fremont Family Resource Ctr	ACBH & Providers
9/26/2019	Youth MHFA	Training Institute	19	0.0	Fremont, Fremont Family Resource Ctr	ACBH & Providers
10/2/2019	Trauma Informed Systems	Training Institute	16	3.0	San Leandro, 1100 S.L. Blvd, Creekside	ACBH & Providers
10/15/2019	Trauma Informed Systems	Training Institute	27	3.0	Fremont, Fremont Family Resource Ctr	ACBH & Providers
10/16/2019	QA -Clinical Quality Review Team (CQRT) Mental Health Training (no CEs) no sign in sheets on file since no CEs given by TI - ? Attendance #	QA		0.0	Oakland, 2000 Embarcadero, Joaquin M	ACBH & Providers
10/17/2019	Asset-based Approaches to Working with Latinx Communities: Creating Shared Language and Understanding on the Road to Racial & Social Equity	Ethnic Services	26	5.5	Oakland, 1900 Embarcadero, Brooklyn B	ACBH & Providers
10/25/2019	How to Heal Trauma with These 3 Steps	Ethnic Services	38	5.0	Oakland, Executive Inn & Suites Hotel, Embarcadero	ACBH & Providers
10/28/2019-10/30/2019	CA Assoc of Collaborative Courts Conference (10/28-10/30); CEs for RNs and Addiction Professionals only	SUD	21	9.0	Sacramento, Holiday Inn	Statewide SUD Providers
11/4/2019	Tobacco Brief Intervention	SUD	14	3.5	Oakland, 2000 Embarcadero, Gail Steele	SUD Providers
11/7/2019	5150/5585 certification (Only for Crisis, AFBH, CCM, & Guidance Clinic)	Crisis Division	23	6.5	San Leandro, Juvenile Justice Center	Crisis, AFBH, CCM, & GC

FY 20-21 MHSA WET Plan_Addendum 2_Training Institute_2019-20 List of Trainings

11/7/2019	Trauma Informed Systems	Training Institute	31	3.0	Dublin, Dublin Library	ACBH & Providers
11/13/2019	Disaster Behavioral Health training	Crisis Division	19	3.5	Oakland, 1900 Embarcadero, Brooklyn B	ACBH Clinical staff
11/13/2019	QA - Clinical Documentation Training for Fee-For-Service Providers	QA	8	5.0	Oakland, 2000 Embarcadero, Joaquin M	Fee-for-Service Providers
11/15/2019	Trauma Informed Systems	Training Institute	19	3.0	Hayward, EBAC	EBAC staff
11/20/2019	QA - Clinical Documentation Training for Clinician's Gateway-Electronic Health Record (EHR) Users	QA	19	5.0	Oakland, 2000 Embarcadero, Joaquin M	Clinical staff
11/22/2019	Understanding MH Through Indigenous Eyes	Ethnic Services	30	6.0	Oakland, 1900 Embarcadero, Brooklyn B	ACBH & Providers
12/4/2019	DSM-5 Diagnoses: History, Cultural Factors and Diagnoses	Training Institute	42	6.0	Oakland, 2000 Embarcadero, Gail Steele	Clinical staff
12/5/2019	Trauma Informed Systems	Training Institute	15	3.0	Oakland, Eastmont Town Center	ACBH & Providers
12/6/2019	Trauma Informed Systems (for PEI/UELP Providers)	Training Institute	27	3.0	Oakland, Gail Steele	PEI/UELP Providers
12/10/2019	Annual African American Conference-The Souls of Black Folks: Reclaiming Our Humanity from Racialized Trauma *(Total cumulative C.E.s = 4.5 for all sessions of day)*	Ethnic Services	162	4.5	Oakland, Hilton Airport	ACBH & Providers
12/11/2019	FALL 2019 Semester, Aug - Dec 2019 (7 session dates) CSU East Bay, Infant & Early Childhood Mental Health Post-Graduate Certificate Program (15 credits/semester; 60 total)	Training Institute	15	15.0	Online - Cal State East Bay, Clinical time at Children's Hospital Oakland	CSUEB Graduate Students
1/9/2020	Trauma Informed Systems	Training Institute	28	3.0	Oakland, 1900 Embarcadero, Brooklyn B	ACBH & Providers
1/15/2020	Trauma Informed Systems	Training Institute	20	3.0	Hayward, EBAC	EBAC staff
1/16/2020	Implementing Cultural Responsiveness Practices at the Individual & Organizational Levels	Ethnic Services	69	5.5	Oakland, 1900 Embarcadero, Brooklyn B	ACBH & Providers

FY 20-21 MHSA WET Plan_Addendum 2_Training Institute_2019-20 List of Trainings

1/22/2020	Preventing Vicarious Trauma	Training Institute	24	6.0	Dublin, Santa Rita	Santa Rita
1/28/2020	Adult MHFA	Training Institute	22	0.0	Oakland, 1900 Embarcadero, Brooklyn B	ACBH & Providers
1/30/2020	Youth MHFA	Training Institute	20	0.0	Oakland, 1900 Embarcadero, Brooklyn B	ACBH & Providers
2/3/2020	Preventing, De-Escalating, and Managing Aggressive Behavior in Behavioral Health Setting	Training Institute	37	5.5	San Leandro, 1000 SL Blvd, Creekside	ACBH & Providers
2/4/2020	Preventing, De-Escalating, and Managing Aggressive Behavior in Behavioral Health Setting	Training Institute	35	5.5	San Leandro, 1000 SL Blvd, Creekside	ACBH & Providers
2/6/2020	Trauma Informed Systems	Training Institute	16	3.0	Oakland, Seneca office, Chabot Rd	Seneca staff
2/11/2020	Brief Tobacco Cessation Interventions Training	SUD	13	3.5	Oakland, 2000 Embarcadero Gail Steele	SUD Providers
2/24/2020	Suicide Assessment & Intervention (6-hour)	Training Institute	52	6.0	San Leandro, Creekside - 1100 S.L. Blvd, Redwood	Clinical staff
2/26/2020	Eating Disorder or Disordered Eating	CYASOC	30	3.0	San Leandro, JJC Guidance Clinic	ACBH & Providers
2/28/2020	Black Mental Health Stigma: Tools & Strategies for Engaging Black Communities in Healing	Ethnic Services	66	5.5	Oakland, 2000 Embarcadero Gail Steele	ACBH & Providers
2/28/2020	The Journey Towards Cultural Competence in the Delivery of Behavioral Health Care Services: A Culturally Conscious Model of Care	Ethnic Services	40	6.0	Oakland, Executive Inn & Suites Hotel, Embarcadero	ACBH & Providers
2/28/2020	Caught in the Crossfire of Cultures, Part I: Refugees Struggle / Home Away From Home (working with the Afghan immigrant population in Alameda County)	Ethnic Services	8	4.0	Oakland, 1900 Embarcadero, Brooklyn B	Clinical staff
3/3/2020	Clinical Documentation for Mental Health Fee-for-Service Providers	QA	9	5.0	Oakland, 200 Embarcadero Joaquin Miller Rm	Fee-for-Service Providers
3/3/2020	Trauma Informed Systems	Training Institute	13	0.0	Oakland, Lincoln Children's Center	Lincoln staff

FY 20-21 MHSA WET Plan_Addendum 2_Training Institute_2019-20 List of Trainings

3/6/2020	Understanding Whiteness: Intent vs. Impact	Ethnic Services	40	0.0	Oakland, 2000 Embarcadero Gail Steele	ACBH & Providers
3/11/2020	Suicide Assessment and Intervention -Youth focused (3 CEs)	Training Institute	26	3.0	Fremont, Family Resource Center	Clinical staff
3/20/2020	Eight Stories Up and Thirteen Reasons: Choosing Hope Over Suicide	Ethnic Services	1	6.0	Online	ACBH & Providers
4/16/2020	Starting the Conversation: How to speak with families about the effects of trauma on childhood development and family systems (PROVIDED IN SPANISH)	Training Institute	44	0.0	Online	Spanish speaking clinicians
4/22/2020	Suicide Assessment & Intervention - Youth Focused (6 CEs); Part 1: 4/22, Part 2: 4/27 or 4/29	Training Institute	33		Online	Clinical staff
4/27/2020 & 4/29/2020	Suicide Assessment & Intervention - Youth Focused (6 CEs) Part 1: 4/22, Part 2: 4/27 or 4/29	Training Institute	31	6.0	Online	Clinical staff
5/1/2020	Trauma Informed Systems	Training Institute	40	0.0	Online	Eden Housing staff
5/13/2020	Suicide Assessment and Intervention Part 1 (6-hr for Santa Rita plus others); Part 2: 6/10/20	Training Institute	20	6.0	Online	Santa Rita staff
5/15/2020	Trauma Informed Systems (CEs not provided by TI -? Attendance#)	Training Institute		3.0	Online	West Coast Children's staff
5/18/2020	Serious Mental Illness (SMI) Primer (Community Assessment & Transport Team (CATT) Workshop Series 5/18-5/26)	Crisis Division	5	2.5	Online	Crisis-CATT
5/18/2020	Trauma Informed Care (CATT Workshop Series 5/18-5/26)	Crisis Division	5	2.0	Online	Crisis-CATT
5/19/2020	Psychiatric symptoms, Substance Use Disorders, Cognitive Symptoms and Spectrum (CATT Workshop Series 5/18-5/26)	Crisis Division	5	3.0	Online	Crisis-CATT
5/19/2020	Brief Assessment & Interventions for Mental Health and Substance Related Disorders -Part 1 (CATT Workshop Series 5/18-5/26)	Crisis Division	5	2.5	Online	Crisis-CATT

FY 20-21 MHSA WET Plan_Addendum 2_Training Institute_2019-20 List of Trainings

5/19/2020	Risk Assessment (CATT Workshop Series 5/18-5/26)	Crisis Division	5	2.0	Online	Crisis-CATT
5/19/2020	Mandatory Reporting Responsibilities (CATT Workshop Series 5/18-5/26)	Crisis Division	5	1.5	Online	Crisis-CATT
5/20/2020	Brief Assessment & Interventions for Mental Health and Substance Related Disorders -Part 2 (CATT Workshop Series 5/18-5/26)	Crisis Division	5	2.5	Online	Crisis-CATT
5/21/2020	AC Care Connect (CATT Workshop Series 5/18-5/26)	Crisis Division	5	2.0	Online	Crisis-CATT
5/21/2020	Understanding Nervous System Regulation and Culturally Sensitive Restorative Practices for Providers and Clients in Times of Crisis	Training Institute	29	4.0	Online	ACBH & Providers
5/22/2020	INVOLUNTARY PSYCHIATRIC HOLDS 5150/5585 TRAINING (CATT Workshop Series 5/18-5/26)	Crisis Division	5	6.5	Online	Crisis-CATT
5/22/2020	Child and Family Team (CFT) Facilitator Training	CYASOC	5	5.0	Online	ICC Coordinators
5/27/2020	Dialectical Behavioral Therapy (DBT)	Training Institute	19	0.0	Online	Clinical staff
5/29/2020	Mental Health Disparity Among Asian Americans	Ethnic Services	26	3.0	Online	ACBH & Providers
5/31/2020	CSU East Bay Infant & Early Childhood Mental Health Program (Spring Semester-Jan-May '20) 15 credits/semester (60 total CE credits) 6 Sessions	Training Institute	12	15	Online - Cal State East Bay, Clinical time at Children's Hospital Oakland	CSUEB Graduate Students
6/3/2020	Intimate Partner Violence: How to Recognize and Treat the Impact of Domestic Violence	Training Institute	27	5.0	Online	Clinical staff
6/9/2020	Suicide Assessment & Intervention (Adult & Youth, 6 CEs)-Part 1; Part 2 is on 6/11 or 6/16	Training Institute	38	6.0	Online	Clinical staff
6/10/2020	Suicide Assessment and Intervention Part 2 (6-hr for Santa Rita + others)-Rescheduled from 5/20/20; Part 1 on 5/13	Training Institute	17	6.0	Online	Santa Rita staff
6/11/2020	Suicide Assessment & Intervention (Adult & Youth, 6 CEs)-Part 2; Part 1 was on 6/9	Training Institute	25	6.0	Online	Clinical staff

6/16/2020	Suicide Assessment & Intervention (Adult & Youth, 6 CEs)- Part 2; Part 1: 6/9/20	Training Institute	13	6.0	Online	Clinical staff
6/18/2020	Race, Sexuality, Power, and Healing: Addressing Issues and Challenges of Marginalized Populations with a focus on LGBTQ people of color	Ethnic Services	47	3.0	Online	ACBH & Providers
6/18/2020	QA: CQRT for Mental Health 2020	QA	20	0.0	Online	ACBH & Providers
6/24/2020	Clinical Documentation for Fee-for-Service Providers	QA	20	6.0	Online	Fee-for-Service Providers
6/26/2020	Trauma and its Impact on Black Communities: Preparing Patients & Families for Mental Health Treatment	Ethnic Services	33	6.0	Online	ACBH & Providers
6/26/2020	Immigration Trauma: Special Focus on Professionals Working with Central American Clients	Training Institute	33	4.5	Online	ACBH & Providers
6/29/2020	Linguistically Responsive & Trauma Informed Care Principles and Interventions for Spanish Speaking Clients (*Presented in Spanish*)	Training Institute	19	4.5	Online	Spanish speaking clinicians
	TOTAL		**2126**	**353**		

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION[1]

County/City: ALAMEDA

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

Local Mental Health Director	County Auditor-Controller / City Financial Officer
Name: Karyn Tribble, ACBH Director	Name: Melissa Wilk
Telephone Number: (510) 567-8100	Telephone Number: (510) 272-6565
E-mail: Karyn.Tribble@acgov.org	E-mail: melissa.wilk@acgov.org
Local Mental Health Mailing Address: 2000 EMBARCADERO COVE, SUITE 400 OAKLAND, CA 94606	

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

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

KARYN TRIBBLE, ACBH DIRECTOR
Local Mental Health Director (PRINT)

Signature 4/2/2021
Date

I hereby certify that for the fiscal year ended June 30, 2020, the County/City has maintained an interest-bearing local Mental Health Services (MHS) Fund (WIC 5892(f)); and that the County's/City's financial statements are audited annually by an independent auditor and the most recent audit report is dated December 23, 2020 for the fiscal year ended June 30, 2020. I further certify that for the fiscal year ended June 30, 2020, the State MHSA distributions were recorded as revenues in the local MHS Fund; that County/City MHSA expenditures and transfers out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that the County/City has complied with WIC section 5891(a), in that local MHS funds may not be loaned to a county general fund or any other county fund.

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

MELISSA WILK, AUDITOR-CONTROLLER
County Auditor Controller / City Financial Officer (PRINT)

Signature 4/14/21
Date

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

ALAMEDA COUNTY
HEALTH CARE SERVICES
AGENCY
COLLEEN CHAWLA, Director

AGENDA _____ August 3, 2021

OFFICE OF THE AGENCY DIRECTOR
1000 San Leandro Blvd., Suite 300
San Leandro, CA 94577
TEL (510) 618-3452
FAX (510) 351-1367

July 13, 2021

The Honorable Board of Supervisors
Administration Building
1221 Oak Street
Oakland, CA 94612

SUBJECT: ADOPT THE FISCAL YEAR 2021-22 MENTAL HEALTH SERVICES ACT ANNUAL PLAN UPDATE FOR ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES

Dear Board Members:

RECOMMENDATION

Adopt the Mental Health Services Act Annual Plan Update for Fiscal Year 2021-22, which has been certified by the Alameda County Behavioral Health Care Services Director and the Auditor-Controller to meet specified requirements in accordance with Welfare & Institutions Code Section 5847.

DISCUSSION / SUMMARY

Alameda County Behavioral Health (ACBH) is requesting your Board to adopt the FY 2021-22 Mental Health Services Act (MHSA) Annual Plan Update (the Plan). Following your approval, ACBH will submit the Plan to the Mental Health Services Oversight & Accountability Commission (MHSOAC) within 30 days. The Plan must be certified by the ACBH Director or designee and the County Auditor-Controller to meet specified MHSA requirements in accordance with Welfare & Institutions Code Section 5847, attesting that ACBH has:

1. Complied with fiscal accountability requirements as directed by the State Department of Health Care Services (DHCS);

2. Ensured expenditures are consistent with the MHSA requirements; and

3. Prepared and circulated a draft plan for review and comment for at least 30 days to representatives of stakeholder interests or interested parties.

The Fiscal Year 2021-22 Plan meets those requirements and provides an overview of the various MHSA-funded programs being implemented in the County as well as a fiscal overview of MHSA funds the County has received.

Assembly Bill 1467, the Omnibus Health Trailer Bill for FY 2012-13, chaptered into law on June 27, 2012 requires each county mental health program to prepare and submit a Board-adopted three-year program and expenditure plan, and annual plan updates, to the MHSOAC.

On February 23, 2021, your Board approved Item No. 7, the adoption of the MHSA Three-Year Program and Expenditure Plan for Fiscal Years 2020-21 through 2022-23. The Three-Year Program and Expenditure Plan was submitted to MHSOAC on March 10, 2021, and ACBH is in the process of completing the next MHSA Three-Year Plan which will be presented to the Health Committee and your Board at a future date.

On April 15, 2021, ACBH posted the Fiscal Year 2021-22 Annual Plan Update, which is the second year of the Three-Year Plan on its website for a 30-day public comment period. The Mental Health Advisory Board hosted a public hearing on May 17, 2021, at which time ACBH addressed public questions and concerns. ACBH presented the Plan to the Alameda County Board of Supervisors Health Committee at its public meeting on June 14, 2021, and the Health Committee recommended the Plan go to the full Board for adoption.

The MHSA Plan continues with the implementation of over 107 ongoing and short-term programs and projects in treatment, prevention, workforce development, innovation and capital facilities/technology. The main changes from the previous years include:

I. COMMUNITY SERVICES AND SUPPORTS (CSS)

Outreach, Education and System Development (OESD) Programs

- New Mental Health Urgent Care pilot project for the East County/Tri Valley area
- New Pediatric Care Coordination Pilot through the Alameda Health Consortium
- Expansion of mental health supports in the Collaborative Courts
- Transformation of the Service Team Model
- Continued Development of two Re-entry Treatment Teams

II. PREVENTION AND EARLY INTERVENTION (PEI)

New Trauma Support Groups for youth in Albany Unified School District

III. INNOVATION (INN)

Augmentation to the Community Assessment & Treatment Team (CATT) INN budget

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

Although WET and CFTN completed their ten-year block grant period in Fiscal Year 2017-18, ACBH is committed to continue WET activities with the CSS funding. CFTN has available funding for Fiscal Years 2020-21 and 2021-22.

a) WET Program

- New African American Focused TAY Academic and Career Pathway Pilot Project
- New Asian Pacific Islander (API) Graduate Student Internship Program

b) CFTN Projects

- During Fiscal Year 2020-21, multiple CFTN projects will be completed and others will continue through Fiscal Year 2021-22. The main new project is the replacement of the ACBH billing system.

FINANCING

Appropriations outlined in the Plan Update are offset by MHSA revenue already included in the ACBH Fiscal Year 2021-22 MOE budget. There will be no increase in net County cost as a result of your approval.

VISION 2026

The Fiscal Year 2021-22 MHSA Plan Update meets the 10x goal pathway of **Healthcare for All** in support of our shared vision of a **Thriving and Resilient Population**.

Sincerely,

DocuSigned by:
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Colleen Chawla, Director
Health Care Services Agency

Attachment: Plan with Certification

CC/TH/bn

ALAMEDA COUNTY BOARD OF SUPERVISORS
MINUTE ORDER

The following action was taken by the Alameda County Board of Supervisors on 08/03/2021

Approved as Recommended ☑ **Other** ☐

Unanimous ☐ **Chan:** ☐ **Haubert:** ☐ **Miley:** ☐ **Valle:** ☒ **Carson:** ☐ - ☒ **4**
Vote Key: N=No; A=Abstain; X=Excused

Documents accompanying this matter:

Documents to be signed by Agency/Purchasing Agent:

File No. _____
Item No. 11

Copies sent to:

Brenda Ng, QIC 22702

Special Notes:

I certify that the foregoing is a correct copy of a Minute Order adopted by the Board of Supervisors, Alameda County, State of California.

ATTEST:
Clerk of the Board
Board of Supervisors

By: Cheryl Perkins
Deputy

APPENDIX F: MHSA PLAN UPDATE, FY 21-22
PUBLIC COMMENTS

Name or Contact	Comments:	Date Submitted
1. Nancy B Ranney *Crisis Support Services of Alameda County*	As the preference for texting grows, Alameda County would benefit from 24/7 text support. Current text services are limited to youth, and expanding the target population could also increase access to help in other groups. ACBH/MHSA Response: Thank you for your public comment. This suggestion will be forwarded to the Office of the Director and the Systems of Care.	5/12/2021
2. Kaylan LiCausi *Crisis Support Services of Alameda County*	At CSS, I see a great need for expanded hours for the Mobile Crisis Team and CATT teams, especially weekends and evenings, and more alternative options to police intervention in mental health crises. ACBH/MHSA Response: Thank you for your public comment. This suggestion will be forwarded to the Office of the Director and the Crisis Director. Additionally, there are future plans to expand the CATT project once the pilot phase is complete.	5/12/2021
3. Geri Thomas *Crisis Support Services of Alameda County*	As a volunteer with the CSS crisis line, I can fervently state that we need expanded hours for mobile crisis teams. The safety net for our community members has run thin and there are so few hours and circumstances that the mobile crisis units can support people. This issue is exacerbated by concerns and fears of callers and third-party bystanders that they do not want to call the police since they don't trust that they are trained well enough to handle mental health crises. The second service I would advocate for is more alternatives to police involvement in mental health crises. ACBH/MHSA Response: Thank you for your public comment. This suggestion will be forwarded to the Office of the Director and the Crisis Director.	5/12/2021
4. Dianne Lam *Families Advocating for the Seriously Mentally Ill (FASMI)*	First thing is to know what SMI is. Those people are supposed to get this funding. People with psychosis, delusions, hallucinations, you know, serious stuff that keeps them from having a life. This money should not go to any other programs, only to those who have SMI. They have so little as it is, lets offer them treatment. They need beds, treatment beds. Secure treatment beds offer SMI a chance to stabilize, a chance at a life away from the streets, jail and the morgue. Volunteer services do not work for those who just walk away from them, so that is a false treatment. Who would walk away?? Those with anosognosia, those who do not want to be locked up. These are the SMI that will be homeless, in jail or the morgue. I know, they have the right to that but as a mother, I'd like my child to have a chance away from that. ACBH/MHSA Response: Thank you for your public comment, it will be forwarded to the Office of the Director.	4/16/2021

	MHSA funding is required to be spent in the following percentages: 76% for Community Services and Supports, 19% Prevention and Early Intervention and 5% for Innovative projects. Also, per regulations, MHSA funds cannot be spent on services that clients do not voluntarily accept, i.e funds cannot be used in a jail setting nor a locked facility.	
5. Alice Feller *Oakland Community Support Center (OCSC)*	More than half of the people we serve at the Oakland Community Services Center (OCSC) suffer from schizophrenia, a major mental illness that affects one out of every hundred people world-wide. It strikes early in life, often in adolescence, and is disabling if not properly treated. As a psychiatrist providing medication management at OCSC, I see the tragic waste of so many lives because of inadequate treatment of this major mental illness. Studies show that Early Intervention in Psychosis, an intensive, coordinated treatment program designed by NIMH, can make the difference between a lifetime of disability and a full and meaningful life. The four elements of this program are: individual psychotherapy to help the young person adapt to the illness, family support and education, close work with the psychiatrist to find the right medication and then the lowest dose possible, and crucially, help to enable the young person to resume his or her place in school or at work. ACBH/MHSA Response: Thank you for your public comment. This suggestion will be forwarded to the Transition Age Youth (TAY) Division Director. This Division Director also oversees ACBH's early psychosis program run by the Felton Institute. More information on this program can be found at https://felton.org/social-services/early-psychosis-programs/	4/16/2021
6. Gavin O'Neil *Superior Court of California, County of Alameda*	Dear Alameda County Mental Health Advisory Board, I am respectfully requesting that you review this "Public Comment" on the Mental Health Services Act (MHSA) Three-Year Program and Expenditure Plan for FY 20/21 – 22/23," during the presentation and public hearing on Monday, May 17, 2021. I am asking that attention be brought to the Collaborative Courts and other specialty courts happening every day in the Superior Court of California, County of Alameda. The Court hosts many programs that are successfully addressing mental health issues in the justice system. Alameda County Behavioral Health (ACBH)/MHSA has already received supportive public input from the District Attorney, Public Defender, Chief Probation Officer, Director of the Department of Children and Family Services, and many other stakeholders at the complex intersection of justice and mental health. All parties spoke about the invaluable contribution made by the treatment courts.	5/14/2021

	I would like to personally thank Dr. Karyn Tribble and her staff at ACBH/MHSA for "hearing" the community during the previous Public Comment process in last year's plan. The MHSA has allocated crucial funding to support mental health services inside the court system. I believe the collaborative courts can respond by supporting ACBH's published goals for 2021-2022. My office coordinates eight collaborative courts serving about 200 participants on any given day. These are justice-involved people assessed at high risk to recidivate due to high need for mental health services. The majority of our participants (31%) are African American. The Court also hosts a Behavioral Health Court for the seriously mentally ill, and a number of specialty courts I will list at the bottom of this document. These court programs are in greater demand since the Department of Justice published its report on mental health services in Alameda County and our justice system. The collaborative courts divert people with mental health issues from custody and into community services. They provide constant mental health case management and judicial oversite to ensure participants are successful in the least restrictive environments possible. About 40% of our $2,710,582 annual budget is provided by unsustainable federal and state grants. These are local programs serving our county's most vulnerable (mostly homeless) people, and my goal is to sustain these services through local funding. The collaborative courts are behavioral health's change agents in the justice system. In my eight years leading this department I have witnessed many judges, prosecutors, probation officers and child welfare workers learn effective, trauma-informed practices of collaborative justice. The partnership between ACBH and the Superior Court goes back to 1990 when together we created the country's first treatment courts for people with co-occurring disorders. We have experienced great success at reunifying families in the dependency courts. Parents who lose custody of their children due to untreated mental health issues do not typically experience a successful resolution of their case in the courts. Our graduates are reunifying at close to 90%. These are some of the most vulnerable families in our county, and we are seeing very low recurrences of maltreatment as we track these families beyond case completion. Below are some promising mental health outcomes we are tracking. Our most current mental health data is showing impressive outcomes that support the goals of the MHSA plan: · About 80% of our court participants have received mental health services in Alameda County.	

	· Many treatment court clients have serious mental illness (SMI) and are linked to services that effectively keep them out of jail and psychiatric hospitalization. · About 40% have a history of psychiatric hospitalization in Alameda County, with an average stay of about 15 days. · About 85% of these participants were not re-hospitalized after entering a collaborative court. · About 70% received services from Adult Forensic Behavioral Health (AFBH) at the Santa Rita jail, with an average of 6 treatment episodes. · About 64% of these participants did not have AFBH contact after entering their court program. We have achieved these outcomes because: · The Treatment courts in Alameda County have a mental health team · These licensed clinicians screen and assess incoming court participants and provide clinical consultation to Judges · They provide crisis support and coordinate crisis response efforts · They ensure that all participants with mental health needs are linked to ongoing mental health services The court is fully funding a new Management Information System for the Collaborative Courts so we can better track and report the impact we are making with the justice-involved mental health population. We also contract with a Ph.D.-level independent evaluator to analyze data and assist with continuous quality improvement. Current Collaborative and Specialty Courts: Mental Health Pre-Charging Diversion Behavioral Health Court Veterans Court Military Diversion Court Reentry Court (2) Drug Court (2) Family Treatment Court (3) Mentor Diversion Court Early Intervention Court Misdemeanor diversion court Clean Slate (2) Homeless Court Prop 47 & 64 Resentencing Transitional Age Youth Program Ok Board Members! Thank you for your service and for taking the time to read this. I can't imagine the bandwidth you are covering at the moment, and I appreciate your time and attention. Keep fighting the good fight. Please feel free to call me and discuss this information.	

	ACBH/MHSA Response: Thank you for your public comment, ACBH appreciates the continued partnership with the Collaborative Courts.	
7. Paul McCormick *Fremont Police Department*	We would like to see more funding and resources to expanding Alameda County Mobile Crisis Teams (MCT). Currently there are only 2 teams to service the entire county. An increase in staffing and available hours would be helpful, not only for community members, but also for other governmental agencies who frequently deal with individuals with mental illness in the field (law enforcement, EMS, human services). Currently, there are no Crisis Stabilization Units (CSUs) for adults outside of Oakland, Amber House being the only one. Additionally, the 12-bed capacity of the CSU for all of Alameda County means availability is severely limited. This has a negative impact on individuals who are seeking assistance, but do not meet the criteria for an involuntary hold. One of the stated priorities of the Three-Year MHSA Plan is care coordination and community outreach. However, there were no services identified which supported a collaborative effort between law enforcement and ACBH. ACBH/MHSA Response: Thank you for your public comment. This suggestion will be forwarded to the Office of the Director and the Crisis Director. Additionally, through Innovation funding, ACBH hopes to develop new services in south and east county to support ACBH justice involved clients as well as their family members and caregivers. As this Plan is developed it will become available for input and public comment.	5/16/2021
8. Juilet Leftwich *Mental Health Advisory Board (MHSA)*	Thanks very much for your presentation at our MHAB meeting today. I didn't have a chance to put my comments in the chat, so I wanted to provide them in writing here. As alluded to at our meeting, I would like to see MHSA money used to: 1) expand the Safe Landing Project at Santa Rita Jail; and 2) support renovations of the former Glenn Dyer Jail with respect to those portions of the facility that will not be used for involuntary treatment (I believe the proposal we saw only dedicated one of seven floors to that purpose). These comments are provided in my individual capacity. Also, could you please let me know where in the MHSA governing statutes or regulations it states that funds may not be used for involuntary treatment? I haven't researched the issue, but am curious about that limitation, which is of concern to some of us. ACBH/MHSA Response: Thank you for your public comment. Below is information on the intention of MHSA and specific sections of the California Code of Regulations to give you more information regarding the prohibition of MHSA funds for locked/involuntary facilities/services.	5/17/2021

What MHSA Can Fund:

- MHSA funds services in which individuals voluntarily participate.
- Individuals who have been released from jail and/or probation facilities may receive MHSA-funded services in the community. *In fact, individuals released from these facilities are identified as part of the Full Service Partnership programs.*
- Individuals who are incarcerated in jail and/or probation facilities may receive MHSA funded services solely for the purpose of discharge planning and linkage to community based care.

What MHSA cannot Fund:

- With the exception of pre-release planning, MHSA funds cannot be used for care of persons who are in institutional (involuntary) settings such as prisons, jails, and inpatient units.
- MHSA funds cannot pay for law enforcement or court personnel-even when such personnel are involved in collaborative programs serving individuals with mental illness. *Example: MHSA funds a mental health provider that delivers services to individuals involved in a court diversion program. MHSA cannot fund the expenses of the court personnel.*

References in the Mental Health Services Act, January 2020 version:

- Section 7:5813.5(f) page 3: Funds shall not be used to pay for persons incarcerated in state prisons.

References in the Community Services and Supports (CSS) Plan Regulations:

California Code of Regulations: Section 3610 https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=I79922AD0D45311DEB97CF67CD0B99467&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)

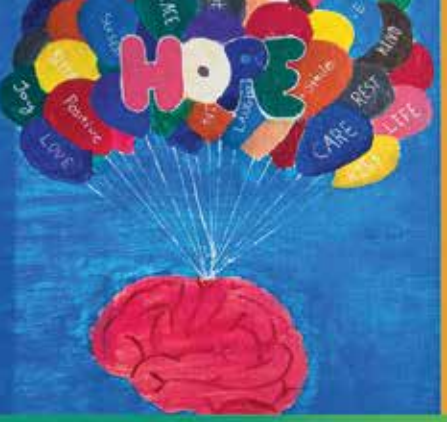
- When CSS programs/services include collaboration with the juvenile or criminal justice systems, any law enforcement function and/or any function that supports a law enforcement purpose shall not be funded.

- The County shall not provide MHSA funded services to individuals incarcerated in state/federal prisons.

- The County may use MHSA funds for programs/services provided in juvenile halls and/or county jails only for the purpose of facilitating discharge.

	California Code of Regulations: Section 3400 https://govt.westlaw.com/calregs/Document/I75B47B70D45311DEB97CF67CD0B99467?viewType=FullText&originationContext=documenttoc&transitionType=CategoryPageItem&contextData=(sc.Default) • Programs and or services provided with MHSA funds shall be designed for voluntary participation. No person shall be denied access based solely on his/her voluntary or involuntary legal status. (The intention of this section is to provide flexibility to allow individuals who've been conserved to still be able to participate voluntarily in MHSA funded programs. Or for MHSA programs to bill for the time it takes to provide the logistics and a warm hand off for an individual who's been placed on an involuntary hold to a psychiatric ER or psychiatric hospital.) • The county is not obligated to use MHSA funds to fund court mandates. California Code of Regulations: Section 3620 https://govt.westlaw.com/calregs/Document/I7A2458B0D45311DEB97CF67CD0B99467?viewType=FullText&originationContext=documenttoc&transitionType=CategoryPageItem&contextData=(sc.Default) • Notwithstanding Section 3400(b)(2), the County may pay for short-term acute inpatient treatment, for clients in Full Service Partnerships when the client is uninsured for this service or there are no other funds available for this purpose. ACBH considers "short term" to be 30 days or less. • Long term hospital and/or long-term institutional care cannot be paid for with MHSA funds.	
9. John Lindsay-Poland *Mental Health Advisory Board (MHSA)*	Has this been presented to MHAB or another public body earlier in the 30-day public comment period? It is not practical to expect anyone to comment in the last 40 minutes of the comment period. I imagine the document subject to comment is dense and lengthy, no? ACBH/MHSA Response: Thank you for your public comment. Information was published on April 15th on our www.ACMHSA.org and www.acbhcs.org as well as the HCSA newsletter. Additional distribution also occurred through various stakeholder groups. ACBH can always improve on its outreach to inform the Alameda County community regarding when the MHSA Plans are open for public comment. This process will be approved upon in coming years.	5/17/2021

10. Alison Monroe *Families Advocating for the Seriously Mentally Ill (FASMI)*	I would encourage people to comment on this document but I feel it is kind of a waste of their time...the MHSA stakeholder process tends to dilute concrete and urgent concerns with a mass of generalities from other stakeholders, and dilute it also by offering for comment masses of numbers and acronyms that are really just not accessible to most people even those with years of experience with the system. FSPs and other ACT programs are a good idea and save lives--including my family members'-- but I'd like to also save the people who can't stay in them. I would like to keep the people alive and well who have not made the decision that they want to be saved. If they need to be, they should be isolated from meth for example while we hope for them to form an intention to recover Here's a comment about MHSA--it was intended to serve the seriously mentally ill, and it was a mistake to interpret it to exclude involuntary treatment even when that is the least restrictive alternative that is appropriate. Inasmuch as MHSA money does not save the lives and health and potential of the most seriously mentally ill who do not try to save themselves--it fails. I wish it could start by saving the people at most risk. With no such constraint, it goes to those who can be reached with the resources we have. Which is something--but probably not what the millionaires voted for ACBH/MHSA Response: Thank you for your public comment. ACBH appreciates all public comments and encourages individuals, stakeholder groups and communities to comment and provide feedback to the department.	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TRUST
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EXERCISE
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COMMUNITY
BALANCE

For questions or additional information regarding this report, please contact the report developer:

Mariana D. Real, MPH, MCHES

MHSA Senior Planner/TIC Coordinator

MHSA@acgov.org