MENTAL HEALTH SERVICES ACT
ALAMEDA COUNTY
FY 2023–2026

THREE YEAR PROGRAM & EXPENDITURE PLAN
(DRAFT)

MENTAL HEALTH SERVICES ACT (MHSA) DIVISION | ALAMEDA COUNTY BEHAVIORAL HEALTH CARE SERVICES DEPARTMENT
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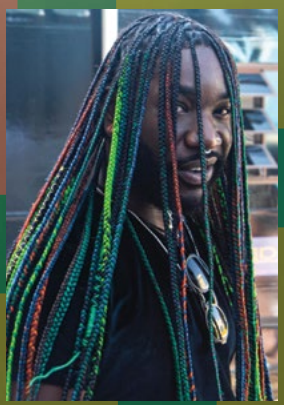
alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES



MENTAL HEALTH SERVICES ACT
FY23-26 THREE-YEAR PLAN
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Health Through Art

12th Call For Art winner: Haleigh Johnson · Teen, Alameda

Artist Statement: The reason I chose the message on the banner, "Choose Love," is because I wanted people to see a new perspective of those who are Islamic, one that shows them as people with feelings. Those who are Muslims are often wrongfully treated like torrists for the actions of ISIS and not their own, which is harmful to that person's mental health. Our mental health is easily affected by how we see the world and interact in others. In order for us to have a healthy mind, we need to treat those around us with love and respect and value them for their character.

alameda county behavioral health
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Karyn L. Tribble, PsyD, LCSW

MESSAGE FROM THE ACBH DIRECTOR

Welcome to Alameda County Behavioral Health Care Services (ACBH) Department's *New* MHSA Three-Year Program and Expenditure Plan!

This plan covers the Fiscal Years (FYs) 2023-2024 through 2025-2026.

As the Director of Alameda County's Behavioral Health Department, I personally invite you, one of our many valued stakeholders, to explore our new Three-Year Plan and provide public comment through our various forums. Our client experiences, data sources, and our own local community voices affirm that there is an ever-increasing need for mental health services and supports.

With the start of this new Three-Year Plan, we have had the opportunity to assess our progress to date as well as look toward our future. Following an extensive community input process and ongoing internal system reviews we look to address four strategic priorities over the next several years, these include:

- Infrastructure and Service Planning for Peer Support Specialist Certification (SB803) Behavioral Health Continuum Infrastructure Program (BHCIP) projects and Care Courts;
- Quality Improvement projects and New Programming (particularly for justice involved individuals and families);
- Workforce Engagement, and
- Health Equity.

Examples of our initial progress to address these four areas include: the MHSA 1X Capacity- Building public procurement process for our contracted providers; the approval of two (2) new Innovation projects for individuals who are justice involved and their families; implementation of our ACBH Forensic Plan; health equity work for our Asian American Pacific Islander (AAPI) community; new services and supports for the Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) community; and the continued advancement of the African American Wellness Hub. Details on these projects can be found in the Changes/Updates section.

As we continue to live through unprecedented times, ACBH is here to support our clients and family members while holding the spirit and core values of MHSA: *Community Collaboration, Cultural Responsiveness, Consumer and Family Driven, Wellness Recovery and Resiliency*, and *Integrated services*. We continue to invite your feedback and look forward to ongoing ways to promote partnership and community engagement. We are committed to continued and persistent improvement in our service delivery system and look forward to advancing these values, and the activities and programs listed in this Three-Year Plan. ***Together we can make a difference. Together we have hope!***

Sincerely,

Karyn L. Tribble, PsyD, LCSW, Director

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.

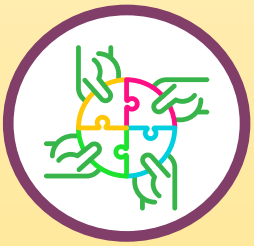
MHSA GUIDING PRINCIPLES

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) Three-Year Program and Expenditure Plan (Three-Year Plan) for fiscal years 2023-26. This Three-Year Plan begins July 1, 2023, and will be updated annually in fiscal years 2024-25 and 2025-26.

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

California's Mental Health Services Act

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

Mental Health Services Act Expenditures

The importance of MHSA support is well known to our department, as it's currently 26% of the overall ACBH budget. For State Fiscal Year (FY) 23/24, ACBH set aside up to $176.2 million in budget authority, which is just slightly higher than the previous fiscal year of 2022-23 at $173.5, but is 25% higher than the FY 21/22 budget. ACBH has been able to continue this positive budget trajectory 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 additional MHSA funding being released by the Department of Finance at the end of the previous fiscal year, i.e. no time to spend these funds in the current year the funds are released, workforce shortages and staff vacancies (at the county and CBO level), slow project start-up, and a slow ramp up of services and supports to pre-pandemic levels.

Within the past few years all counties in California have experienced increased MHSA allocations due to the success of the California economy. However, it should be noted that the MHSA funding stream is highly volatile with a two-year lag of final allocation amounts; so, while counties are currently receiving stable or increased allocations year over year it's important for ACBH to monitor the allocation estimates closely and adjust funding as needed so that as much funding as possible can be used in the communities of Alameda County.

At this time, The Department of Finance has estimated that the FY 23/24 MHSA county allocations will have a 1x increase or bump, followed by a lower allocation in FY 24/25. However, the allocation in FY 24/25 is still estimated to be higher than FY 22/23, so as mentioned above, as of now, MHSA revenue continues on an upward or fiscally positive trajectory.

These increases as well as any new information from the Governor's budget and/or California Legislature will be reviewed during next year's Community Program Planning Process and ACBH budget process. ACBH strives to balance community need in collaboration with fiscal responsibility so that there is not a fiscal

"cliff" where dramatic reductions will be needed and vice versa as much funding as prudently possible is allocated to mental health services within Alameda County. As an example of this accountability, ACBH has developed two budget workgroups (one for county staff and one for contracted provider/peers/family members). Within these workgroups MHSA spending strategies/guidelines are discussed and recommendations are made to ACBH Leadership. These processes take place in fall through early winter each year.

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 13-member MHSA Stakeholder Group (MHSA-SG), 21-member CPPP Planning Committee (CPPP-PC) and other representatives to participate in the development of our Plans (see MHSA CPP Annual Report).

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

Despite health factors precluding our department from convening large in-person forums due to COVID-19, ACBH has been committed to identifying creative ways in which to engage the community and various stakeholders over the course of our planning efforts. The CPPP for the Three-Year Plan is informed by activities conducted during the CPPP for previous Annual Plan Update cycles. The Three-Year Plan CPPP consisted of more than 100,000 community input invitations via a social justice public relations firm, social media, e-mail requests, and a community input webpage which amassed 16,457 pageviews. A community input survey was translated into 3 threshold languages with 581 unduplicated completions.

MHSA launched CPPP activities between October 28, 2022- January 31, 2023, facilitating 13 listening sessions with 145 total participants for inappropriately served groups, promoting a "How to Read the MHSA Plan" webinar and podcast series. Each listening session represented an important cross section of Alameda County populations in accordance with data from the Alameda County Profile. Some reoccurring themes from the listening sessions include the following:

- Address basic needs such as insecure housing
- Expand family reunification services and treatment courts

- Increase early intervention screenings and assessments
- Address the response time in systems such as ACCESS
- Isolation and lack of community
- Support the reentry community with diversion services
- Expand mobile crisis teams
- Address mental health workforce needs
- using non-traditional pathways
- More services for the African American community across the lifespan
- Supports and activities for the LGBTQ community, particularly the transgender community of color and sex workers
- Need for increased language capacity

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 50.4% of the county population, and is home to the 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 2022-23 Annual Plan Update are in response to the CPPP and operationalized through a three-pronged departmental lens: that of Alignment, Communication, and Organizational Structure. Specifically, we have determined it to be critical for the success of our MHSA strategies and programs to both be reflective of our community needs and supported through departmentwide organizational improvement strategies. Our CPPP and implementation of this Plan Update 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 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:

- MHSA Community Investment Opportunities for services, trainings, direct client, treatment, and COVID-19 accommodations
- Transform community-based Service Team and Case Management programs to Full-Service Partnership (FSP) model
- TAY Forensic Focused Full-Service Partnerships
- Early Childhood mental health expansion projects
- Washington Hospital partnership pilot project to address emergency department challenges
- Funding to plan and implemented multiple forensic programs
- New PEI/CSS blended programs for the LGBTQIA+ youth populations
- Psychiatry residency and training program in partnership with Sandford University

General System Improvement Efforts

Performance indicators for MHSA, including the FSP Programs and Prevention and Early Intervention component have been updated for FY23/24, and include performance measurements and outcomes. The MHSA plan and plan element evaluation reports are included in Appendices C-1 and D-5. In addition, the Performance Management section contains a summary of quality assurance and improvement strategies.

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

Closing

In summary, ACBH has aggressively approached its CPPP process in a manner designed to eliminate as many barriers as possible to promote inclusive outreach and engagement. This Three-Year Plan 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 (FY22/23)

Alameda County Behavioral Health Care Services (ACBH) began implementation of its MHSA Plan upon 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 Innovation (INN), which account for the full MHSA funding received by Alameda County[1]. The below programs are planned for implementation over the next several fiscal years.

I. MHSA COMMUNITY INVESTMENT OPPORTUNITY

a. One-Time Enhancement Fund Opportunity

II. COMMUNITY SERVICES AND SUPPORTS (CSS)

a. Continued analysis and transition of Service Team Case Management Model to Full Service Partnership Model
b. Transition Age Youth (TAY) Forensic Focused Full-Service Partnership
c. Program Closures of School-based Behavioral Health SBBH programs in OESD 34
d. Early Childhood Mental Health Services and Consultation program
e. Washington Hospital; Full Implementation of Pilot FY 23/24-FY 24/25
f. Peer/Family Member Stipend Policy Update
g. Funding for ACBH Forensic Plan
h. Asian American & Pacific Islander Older Adult pilot with City of Fremont

III. PREVENTION AND EARLY INTERVENTION (PEI)

a. New PEI/CSS blended program for LGBTQI youth/TAY
b. New PEI/WET blended program for the African American community

IV. INNOVATIONS (INN)

a. Approval of two Forensic Focused INN programs
b. New INN Programs under development

V. WORKFORCE, EDUCATION AND TRAINING (WET)

a. Increased Funding in WET Action 2: Training and Technical Assistance for the Implementation of MHSA required Capacity Assessment
b. WET Action 3: Mental Health Career Pathways, Closure of the Early Childhood Certification Program at Cal State East Bay
c. New Program in WET Action 4: Residency/Internship ACBH-Stanford Public Psychiatry Training Partnership

VI. CAPITAL FACILITIES AND TECHNOLOGICAL NEEDS (CFTN)

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

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

I. MHSA COMMUNITY INVESTMENT OPPORTUNITY

Alameda County Behavioral Health (ACBH) developed a new, one-time opportunity for the intention to invest a total of $10,000,000 of unexpended MHSA and 2011 Realignment funds, into our community-based organization (CBO) contracted provider community for FY 23/24, July 1, 2023-June 30, 2024. Each contracted provider was eligible to apply for up to $80,000 per entity through an official procurement request process called a Request for Pre-Qualification (RFPQ). The eligible areas of funding include:

1. Initiatives to support the launch and sustainability of CalAIM.
2. Staffing capacity investments.
3. COVID-19 accommodations.
4. Renovations/repairs or facility improvements.
5. Vehicles for program services.

The One-Time Enhancement Funds may not be used for the following categories: 1. Services, trainings or other items already enshrined in current contracts; 2. Direct client treatment or other services covered by Medi-Cal or any other federal or state funds; 3. Staff licensing; or 4. Ongoing costs.
The MHSA funding used for this opportunity will be a combination of CSS, WET and CFTN funding.

II. COMMUNITY SERVICES AND SUPPORTS (CSS)

Continued analysis and transition of Service Team Case Management Model to Full Service Partnership Model

In FY 23/24 ACBH will continue its fiscal and program analysis as part of the ongoing change process to transform the community-based Service Teams and Case Management programs into the Full-Service Partnership (FSP) model in order to increase system capacity and team centered quality of care for our clients who have a severe and persistent mental illness (SPMI). It is the goal to have a concrete plan of action for this transition by the end of FY 23/24.

As part of this transition, in FY 23/24 the Service Teams will be allocated flex funds to be utilized to assist clients in a similar manner to FSP clients. These funds can be used in a variety of ways including emergency housing costs, transportation, clothing, food, etc.

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

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

Transition Age Youth (TAY) Forensic Focused Full Service Partnership

In FY 23/24 ACBH will implement a new Transition Age Youth (TAY) Forensic, Diversion and Re-Entry Full Service Partnership (FSP) program that will focus on TAY that are justice involved including individuals who are in custody, on probation or in diversion programs. The FSP program will follow the Assertive

Community Treatment (ACT) model which is an Evidenced Based Practice for the mental health teams. The concepts of the ACT model include team-based approach, low client to staff ratios (1:10) assertive engagement, peer and clinical support, person centered, and strength-based services within the community.

Clients must be approved by ACBH Acute Crisis Care and Evaluation for Systemwide Services (ACCESS) for services. The ACCESS line can be reached by dialing: 1-800-491- 9099.

Voluntary Surrender of funds within the School-based Behavioral Health (SBBH) workplan OESD 34

MHSA funds were originally used to braid funding for expansion of School-Based Behavioral Health in multiple school districts. MHSA funding was 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) in order to assist these children and their families in becoming successful in school and at home.

By the end of FY 22/23 ACBH will have closed its school site contracts where ERMHS funds were braided with MHSA. These voluntary contract closures are a result of previous legislation that directed ERMHS funding to be managed by school districts.

OESD 34 will remain a workplan for other school-based behavioral health outreach programs and school-based programs braided with MHSA and EPSDT funding. The funding from the programs that were closed will remain for the ACBH Children's and Young Adult System of Care (CYASOC) to utilize in new or different mental health programming such as the new early childhood consultation program and a new LGBTQI youth/TAY program.

Early Childhood Mental Health Service and Consultation Program

The CYASOC will be seeking to identify a new early childhood (birth to 8) mental health provider through an official procurement process in the winter of 2023 for a program start date of July 1, 2023. As part of this procurement process the CYASOC will utilize MHSA funds to support the work of Mental Health Consultation through the work of peers, family partners, or other paraprofessional or adjunct staff.

During MHSA Community Input processes there have been requests for additional early childhood programming as well as consultation services. This new funding opportunity is a result of these community voices.

Washington Hospital: Full Implementation of Pilot FY 23/24-FY 24/25

ACBH is partnering with Washington Hospital, located in Fremont, to address the emergency department's challenges with frequent visits for patients ages 18 and above, living in the Southern Region of Alameda County with behavioral health needs through increased service options and enhanced care coordination/linkage.

The goals of the program are to: provide immediate disposition resource for Emergency Department

(ED) patients with behavioral health needs, track high ED utilizers in the community with overarching goal to reduce utilization of ED, and provide care coordination & linkage to Alameda County (or other appropriate county/community services).

This program will be a two-year pilot funded by MHSA for $1,000,000. A procurement is planned for the spring of FY 22/23 for a start date of 7/1/23. The pilot will run for FY 23/24 and 24/25. Before the 2-year pilot ends, the program will be analyzed and reviewed to determine program sustainability.

Peer and Family Member Stipend Policy Update

ACBH has reviewed its current stipend policy and determined that this needed to be updated based on new and/or increased job roles as well as inflation. The policy update will include new roles and responsibilities as well as an increase in the hourly base stipend from $20/hr to $35/hr. Stipends provide a resource to our valuable Peer and Family Member community for multiple types of activities. The knowledge that Peers, Family Members and Cultural Brokers have brought to ACBH has been instrumental in the ongoing effort to transform our system to become more inclusive, culturally responsive and wellness and recovery focused.

Funding to Plan and Implement Multiple ACBH Forensic Plan Programs

The Forensic System redesign plan (aka Forensic Plan) is intended to reduce the number of incarcerated individuals with behavioral health conditions within Santa Rita Jail. The plan outlines investments in services to be provided at 'Intercepts to address behavioral health conditions, prevent incarceration and facilitate successful re-entry while reducing recidivism.

ACBH will use MHSA funds to plan and implement multiple projects that have been documented in the ACBH Forensic Plan, including the expansion of a satellite urgent care clinic with expanded hours, overnight mobile crisis services, overnight crisis support services, and additional outpatient mental health services for individuals released from jail.

Services for the forensic community have been a priority area that community stakeholders have identified during various community input meetings in the past several Community Program Planning Processes (CPPP). More information on these programs and their implementation will be included in the MHSA FY 24/25 Plan Update.

Asian American & Pacific Islander Older Adult pilot with City of Fremont

ACBH is committed to serving those with serious mental illness with appropriate, accessible and culturally affirming mental health services. ACBH recognizes the importance of flexibility and innovation, especially when deciding how best to engage those identified as underserved populations, two of which are the Asian American and Pacific Islander (AAPI) and older adult populations. According to 2020 Census, 64% of the population of the Alameda County City of Fremont identifies as members of the AAPI population. Furthermore, 43% of the older adult Medi-Cal beneficiaries in South Alameda County (Fremont, Newark, Union City) identify as AAPI. Finally, increasing language capacity and the older adult population have been priority areas identified in multiple CPPP processes.
To implement this pilot ACBH will work with our existing partners in the City of Fremont. They will hire two (2) additional bilingual full-time clinicians to provide Specialty Mental Health Services to the older adult AAPI community. This culturally specific program expansion will allow the City of Fremont to establish a presence in the two (2) Age Well Centers and in the three (3) Senior Housing Complexes

whose residents are primarily Chinese. The clinicians will provide 20 hours per week of direct group facilitation, with the remainder of their scheduled work hours dedicated to providing additional direct billable specialty mental health services. The clinicians will maintain an average caseload size of 35.

Pilot Goals and Objectives:

- Increase specialty mental health services to older adult AAPI clients by providing services in community settings.
- Strengthen relationships with AAPI older adults who receive specialty mental health services.
- Improve penetration rates within Alameda County for individuals in the older adult AAPI communities, with a focus on those residing in South Alameda County (Fremont, Newark, Union City); with a goal of future expansion.

More information on this pilot will be included in the MHSA FY24/25 Plan Update under OESD 4a.

III. PREVENTION AND EARLY INTERVENTION

New PEI/CSS blended program for
Lesbian, Gay, Bi-sexual, Transgender, Questioning, Intersex (LGBTQI) youth/TAY

ACBH will be developing a public procurement request for a new LGBTQI youth and young adult outreach, education and therapeutic services program. This process will be led by the ACBH Children and Young Adult System of Care (CYASOC) and will blend both CSS and PEI funding for a wholistic set of services. The CYASOC hopes to run a procurement process for this program in May 2023 for program start sometime in the 2023-2024 fiscal year.

Services and Supports for the LGBTQI community has been a significant priority that has been raised for several years during the MHSA Community Input process. ACBH is excited to have available funding to begin providing a comprehensive set of services for LGBTQI youth and young adults in the near future.

The PEI portion of this program will be listed under the PEI 22 workplan and the OESD 39 workplan in upcoming years.

New PEI/WET blended program for the African American community

ACBH will begin partnering with the City of Oakland's Oakland Frontline Healers (OFH) program to provide culturally congruent mental health services to the African American community.

MHSA funding will be blended to: 1) support the training of peers, called Credible Messengers, who will provide training and support to individuals in need without barriers, and 2) offer preventative services and supports such as outreach, restorative drumming circles, workshops and community events. In future Plans, information on this program will be listed under the following workplans: WET Action 2: Training and Technical Assistance and PEI 20: Culturally Responsive PEI programs for the African American Community.

IV. INNOVATION (INN)

Approval of two Forensic Focused INN Programs

In January 2023, ACBH received approval from the Mental Health Services Oversight and Accountability Commission (MHSOAC) for two new forensic focused 5-year pilot programs. Brief descriptions are listed below. Please see the INN section for additional details. For full program proposals please see the Appendix of the FY 22/23 MHSA Plan Update. More information on program implementation will be available in the FY 24/25 MHSA Plan Update and/or on https://ACMHSA.org

INN 7: Forensic Alternatives: Clinical Focus

This project is a collection of three co-located services that are intended to prevent incarceration and divert individuals from the criminal justice system into the mental health services. The services include:

- Forensic Crisis Residential Treatment (CRT);
- Arrest Diversion/Triage Center, and
- Reducing Probation/Parole Violations (RP/PV) project.

INN 8: Forensic Alternatives: Peer Focus

The Peer Led Continuum of Forensic Mental Health Services is a collection of four (4) projects, of which three are peer led and one is family focused. The project specifically seeks to support mental health consumers who are justice involved by helping them transition back into the community following an arrest or incarceration, identify and address the issues that led up to their arrest and/or incarceration, and connect with mental health and other services to support them in their recovery and reentry journey. The services include:

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

New INN Programs under Development

Consumer Empowerment Using CT-R (Recovery-Oriented Cognitive Therapy) Summary

ACBH is revising an INN project that was posted in the MHSA Plan Update FY 22/23 to introduce an innovative way to improve mental health through online/virtual peer to peer training.

The original project intended to employ Dialectical Behavior Therapy (DBT) as the training approach; however, in the spring and summer of 2022, it was decided to change the treatment approach that would be taught online from DBT to Recovery-Oriented Cognitive Therapy (CT-R). The change was brought forth because CT-R allows clients to find their own path through life's challenges while in recovery. Peers have an intimate understanding to these challenges and are well-suited to learn CT-R skills.

The CT-R project will develop an online Recovery-Oriented Cognitive Therapy (CT-R) Peer to Peer training program to train peers with the skills of CT-R. This program is to provide new skills as peers enhance their job readiness skills and increase their skills as peers when practicing within peer to peer groups. ACBH wishes to provide a learning environment that is removed from restrictive time and space. An online training program is able to provide an avenue that is self-paced, recovery-oriented, and builds mastery of the CT-R skill sets.

More information can be found in the INN section.

V. WORKFORCE, EDUCATION AND TRAINING (WET)

Increased funding in WET Action 2:
Training and Technical Assistance for the Implementation of MHSA required Capacity Assessment

The ACBH WET unit will conduct a workforce needs assessment survey in FY 23/24 to inform any program implementation changes during FY 23-24 and beyond.
Per the California Code of Regulations, each county shall conduct the Workforce Needs Assessment at least once every five years. The assessment covers the education and training needs of its Public Mental Health System workforce and identifies and evaluates current workforce needs. Specific requirements can be found here.

The previous assessment was conducted in 2020, which was coordinated by the Greater Bay Area (GBA) Regional Workforce Education and Training group. Information from this assessment can be found in the MHSA Plan Update FY 21/22.

Closure of the Early Childhood Certification Program at Cal State East Bay (CSUEB), WET Action 3:
Mental Health Career Pathways

ACBH has enjoyed partnering with CSUEB for the successful implementation of the pilot program to develop and implement an early childhood certification program. As the pilot ends in FY 22/23, CSUEB will now be able to utilize the developed early childhood curriculum and integrate it into ongoing psychology/social work courses so that CSUEB can continue to increase the number of qualified practitioners that can meet the culturally diverse, early childhood mental health needs of young children and their families in Alameda County.
WET Action 3 will still be an ongoing workplan as there are other mental health career pathway projects in this workplan.

New program in WET Action 4: Residency/Internships
ACBH-Stanford Public Psychiatry Training Partnership

ACBH seeks to improve access to high quality care mental health services and address the behavioral needs of our many diverse populations. Improving the pipeline of a diverse psychiatry workforce by growing our partnerships with psychiatry residency and fellowship training programs aligns with this mission as we seek to attract talented providers into our organization.
In collaboration with Stanford University's Department of Psychiatry Community/Public training track, we are proposing providing direct training and clinical supervision at a county-run site for one resident and child psychiatry fellow annually.
By exposing psychiatry trainees to our clinical settings, we hope to recruit talented providers from diverse backgrounds, increasing their presence in our workforce to meet the growing needs of our beneficiaries. Each rotating trainee would assess and treat ACBH clients longitudinally under the direct supervision of a licensed psychiatrist. In addition to direct clinical care, these trainees would also receive education about the many recovery-oriented services we provide in the county and have the opportunity to learn about the larger systems of care that inform their clinical work.

VI. CAPITAL FACILITIES AND TECHNOLOGICAL NEEDS (CFTN)

African American Wellness Hub Update

ACBH, in partnership with the Alameda County General Services Agency (GSA) department, continues to work on the development of the African American Wellness Hub Complex (HUB). This partnership continues by exploring and examining the inventory of County owned facilities for the HUB and other potential suitable sites.

In addition to the ongoing exploration of space and facilities, ACBH has created a video to chronicle the years long effort to build a wellness center that focuses on the mental and behavioral health needs of the African American community. A video link will added here and on our MHSA website once the video has been released in late April.

In preparation for the Wellness Hub, the Office of Health Equity will conduct multiple listening sessions in spring to better understand what types of services the community would like to see in the Hub once it's ready for operations. Results from these listening sessions will be available later in the calendar year of 2023.

Medical Respite Expansion Projects (CF2)

ACBH in collaboration with the Office of Homeless Care and Coordination, a division within the county's parent agency Health Care Services Agency, continue to develop new medical respite opportunities. The remaining funds within this workplan's original three-million-dollar allocation will be directed towards the Alameda Point Collaborative Project (workplan #CF4) and a new project called the St. Regis. The St. Regis is a building that was purchased by a local non-profit where ACBH hopes to develop multiple residential mental health services including medical respite. More information on the project can be viewed in the CFTN section of this Plan.

MHSA Technology Project (TN1)

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

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

Streamline and the integrated SmartCare Platform will incorporate all of the functionality necessary to ensure staff and contracted providers work together within and across organizational boundaries. This platform will help to advance the effective delivery of behavioral health care for our clients and the communities we serve. SmartCare will also provide our system with options to resolve system challenges and facilitate enhanced flexibility for data sharing. SmartCare is scheduled to go live on 07/01/2023.

Procurement process for new Behavioral Health Management Information System (EHR) (non-billing portion): ACBH is set to begin planning the procurement process for the additional clinical components of an EHR system in the fall of 2023. More information on this process will be shared in the FY 24/25 MHSA Plan Update.

MHSA Funding Summary Fiscal Narrative

	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 2023/24 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	81,408,092	6,076,425	17,636,755	467,576	3,974,610	
2. Estimated New FY2023/24 Funding	104,189,530	26,047,382	6,854,574			
3. Transfer in FY2023/24[a/]	(15,500,000)			7,500,000	8,000,000	
4. Access Local Prudent Reserve in FY2023/24						0
5. Estimated Available Funding for FY2023/24	170,097,622	32,123,807	24,491,330	7,967,576	11,974,610	
B. Estimated FY2023/24 MHSA Expenditures	129,106,341	22,126,051	7,490,120	7,950,528	9,599,481	
C. Estimated FY2024/25 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	40,991,281	9,997,756	17,001,209	17,048	2,375,129	
2. Estimated New FY2024/25 Funding	98,176,963	24,544,241	6,459,011			
3. Transfer in FY2024/25[a/]	(8,500,000)			4,500,000	4,000,000	
4. Access Local Prudent Reserve in FY2024/25						0
5. Estimated Available Funding for FY2024/25	130,668,244	34,541,997	23,460,220	4,517,048	6,375,129	
D. Estimated FY2024/25 Expenditures	101,826,430	22,126,051	5,618,701	4,295,858	5,324,527	
E. Estimated FY2025/26 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	28,841,814	12,415,946	17,841,519	221,189	1,050,601	
2. Estimated New FY2025/26 Funding	98,176,963	24,544,241	6,459,011			
3. Transfer in FY2025/26[a/]	(8,500,000)			4,500,000	4,000,000	
4. Access Local Prudent Reserve in FY2025/26						0
5. Estimated Available Funding for FY2025/26	118,518,777	36,960,187	24,300,530	4,721,189	5,050,601	
F. Estimated FY2025/26 Expenditures	98,694,630	24,242,551	6,976,846	4,295,858	4,724,527	
G. Estimated FY2025/26 Unspent Fund Balance	19,824,148	12,717,636	17,323,683	425,331	326,074	

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2023	14,593,038
2. Contributions to the Local Prudent Reserve in FY 2023/24	0
3. Distributions from the Local Prudent Reserve in FY 2023/24	0
4. Estimated Local Prudent Reserve Balance on June 30, 2024	14,593,038
5. Contributions to the Local Prudent Reserve in FY 2024/25	0
6. Distributions from the Local Prudent Reserve in FY 2024/25	0
7. Estimated Local Prudent Reserve Balance on June 30, 2025	14,593,038
8. Contributions to the Local Prudent Reserve in FY 2025/26	0
9. Distributions from the Local Prudent Reserve in FY 2025/26	0
10. Estimated Local Prudent Reserve Balance on June 30, 2026	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.

For Fiscal Year (FY) 23/24, the following items are important to note regarding the MHSA Budget:

- ACBH set aside up to $176.2 million in budget authority (sum of line B), which is similar or flat compared to FY 22/23 where ACBH had an MHSA budget of $173.5. Although these two fiscal year budgets are similar, ACBH continues on a upward fiscal trajectory, e.g. the FY 23/24 budget is 25% higher than the FY 21/22 budget.
    - This budget increase includes:
        - MHSA 1x Capacity Building grants for ACBH contracted providers,
        - Continuation of the Service Teams to FSP transformation,

  - New Full Service Partnership for Young Adults with a forensic focus,
  - New Services and Supports program for the LGBTQI community,
  - Expansion of an Asian American and Pacific Islander Older Adult program in south county,
  - New Innovation (INN) projects (2) as mentioned below,
  - Continuation of the Supportive Housing Community Land Trust INN project,
  - New partnerships with local hospitals and universities,
  - New funding for an African American Services and Supports project: Havens for Black Healing (HBH) Project,
  - Ongoing investment for a new Electronic Health Record System, and
  - COLA to MHSA funded programs.

- The carryover listed for the INN component will be attached to two new INN projects:
  - 1-Clinical Forensic Continuum ($13M over 5 years), and
  - 2-Peer/Family focused Forensic Continuum ($8M over 5 years).

  These projects were approved in early 2023 and will not be available for other projects. You can read about these more under the INN section.

- The Department of Finance has estimated that the FY 23/24 MHSA county allocations will have a 1x increase or bump, followed by a lower allocation in FY 24/25. However, the allocation in FY 24/25 is still estimated to be higher than FY 22/23, so as mentioned above, as of now, MHSA revenue continues on an upward or fiscally positive trajectory.

- It's also significant to mention that finalized MHSA allocations have a 2-year lag time where revenue expectations can change. Moreover, external events such as the global COVID-19 pandemic, the war in Ukraine, supply chain issues, the current precariousness in the stock market and possible new bills/laws all have possible effects on MHSA revenue, which can make the fund volatile, causing future planning to be somewhat lengthy and complex.

- As a final note even though ACBH, like all counties, is working from fiscal estimates of MHSA revenue that are not always clear or completely certain, the department has taken a stance to push its budget significantly higher than its allocation estimates in order to put as many resources, services and supports out in the communities of Alameda County. Through this next Three-Year Plan ACBH will continue this focus of providing as many resources as possible while also monitoring State information to ensure fiscal stability.

MHSA Funding Summaries

FY 2023-24 Through FY 2025-26 Three-Year Mental Health Services Act Expenditure Plan
Funding Summary

County: Alameda Date: 3/15/23

	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 2023/24 Funding						
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FY 2023-24 Through FY 2025-26 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: Alameda Date: 3/15/23

		Fiscal Year 2023/24					
		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	STAY	721,429	518,058	203,371			
FSP 4	Greater Hope	4,829,962	3,537,947	1,292,015			
FSP 10	Housing Services	20,849,120	19,923,665	342,439			583,016
FSP 11	Community Conservatorship	743,442	743,442	-			
FSP 12	Assisted Outpatient Treatment	805,396	805,396	-			
FSP 13	CHANGES	2,405,841	1,486,831	919,010			
FSP 14	STRIDES - Adult FSP	610,472	439,967	170,505			
FSP 16	Connections FSP	805,086	597,696	207,390			
FSP 17	East Bay Wrap 8-18	3,344,938	2,483,282	861,656			
FSP 18	Homeless Engagement	1,082,143	762,262	319,881			
FSP 19	No. Co. Senior Homeless	10,745,759	7,977,651	2,768,108			
FSP 20	Lasting Independence Forensic Team	721,429	534,723	186,706			
FSP 21	Prevention, Advocacy, Innovation, Growt	360,712	248,134	112,578			
FSP 22	Justice and Mental Health Recovery	9,813,912	6,923,220	2,767,243			123,449
FSP 23	Service Teams	11,772,973	6,861,346	4,911,627			
FSP 24	TAY Forensic FSP	1,626,674	1,626,674	-			
Non-FSP Programs							
OESD 4a	Mobile Integrated Assess Team for Senio	1,173,998	630,202	543,796			
OESD 5a	Crisis Response Program	9,581,680	7,791,113	1,419,611			370,956
OESD 7	MH Court Specialist Program	613,254	409,032	153,075			51,148
OESD 8	Juvenile Justice Trans. of Guidance Clinic	171,378	101,319	49,665			20,394
OESD 9	Multisystemic Therapy	1,035,030	1,035,030	-			
OESD 11	Crisis Stablization Services	13,686,037	10,545,923	3,140,114			
OESD 14	Staffing to Asian Population	1,916,777	1,768,538	148,239			
OESD 15	Staffing to Latino Population	975,499	975,499	-			
OESD 17	Residential treatment for Co-Occurring D	1,257,235	1,257,235	-			
OESD 18	Wellness Center	8,823,496	7,567,522	1,136,358			119,616
OESD 19	Medication Support Services	4,284,297	2,896,409	871,767			516,121
OESD 20	Individual Placement Services	6,478,786	4,252,686	1,723,363			502,737
OESD 23	Crisis Residential Svc	1,905,499	1,481,186	410,277			14,036
OESD 24	Schreiber Center	394,957	233,498	114,458			47,000
OESD 25	BH-Primary Care Integration Project	12,349,942	8,541,297	2,338,887			1,469,758
OESD 26A	Culturally Responsive Treatment progran	381,647	381,647	-			
OESD 26B	African American Reentry MH	425,940	402,811	23,129			
OESD 27	In-Home Outreach Team	3,283,871	2,195,960	1,087,911			
OESD 28	SAGE Case & Care Management	2,569,040	2,435,258	133,782			
OESD 30	Peer Respite	1,204,953	899,979	304,974			
OESD 31	1st Onset	1,476,815	819,350	624,481			32,983
OESD 32	Suicide Prevention Crisis Line	675,165	611,040	64,125			
OESD 33	Deaf Community Counseling Services	328,153	301,482	26,671			
OESD 34	School-Based Behavioral Health	327,600	327,600	-			
OESD 35	Outreach & Consultation	2,302,316	2,234,632	54,840			12,844
OESD 36	Presumptive Transfer Project	762,973	762,973	-			
OESD 37	Re-entry Treatment Teams	2,503,179	1,508,202	974,380			20,597
OESD 38	SSI Advocacy & Support Services	1,903,809	808,361	108,940			986,509
OESD 39	Intensive Care Coordinaion Servcies	400,000	400,000	-			
OESD 40	Capacity Building Funds	542,346	542,346	-			
CSS Administration		16,223,823	11,469,532	3,362,108			1,392,184
CSS MHSA Housing Program Assigned Funds		48,383	48,383	-			
Total CSS Program Estimated Expenditures		171,247,167	131,106,341	33,877,478	-	-	6,263,349
FSP Programs as Percent of Total		54.3%	119,636,809				

FY 2023-24 Through FY 2025-26 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: Alameda Date: 3/15/23

		Fiscal Year 2024/25					
		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
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FSP 10	Housing Services	15,517,503	14,592,048	342,439			583,016
FSP 11	Community Conservatorship	743,442	743,442	-			
FSP 12	Assisted Outpatient Treatment	805,396	805,396	-			
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FSP 14	STRIDES - Adult FSP	610,472	439,967	170,505			
FSP 16	Connections FSP	805,086	597,696	207,390			
FSP 17	East Bay Wrap 8-18	2,344,938	1,740,882	604,056			
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FSP 19	No. Co. Senior Homeless	5,745,759	4,265,651	1,480,108			
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FSP 21	Prevention, Advocacy, Innovation, Growt	360,712	248,134	112,578			
FSP 22	Justice and Mental Health Recovery	5,813,912	4,073,620	1,616,843			123,449
FSP 23	Service Teams	11,772,973	6,861,346	4,911,627			
FSP 24	TAY Forensic FSP	1,626,674	1,626,674	-			
Non-FSP Programs							
OESD 4a	Mobile Integrated Assess Team for Senio	1,173,998	630,202	543,796			
OESD 5a	Crisis Response Program	8,326,309	6,574,338	1,405,015			346,956
OESD 7	MH Court Specialist Program	613,254	409,032	153,075			51,148
OESD 8	Juvenile Justice Trans. of Guidance Clinic	171,378	101,319	49,665			20,394
OESD 9	Multisystemic Therapy	1,035,030	1,035,030	-			
OESD 11	Crisis Stablization Services	9,686,037	7,200,523	2,485,514			
OESD 14	Staffing to Asian Population	1,916,777	1,768,538	148,239			
OESD 15	Staffing to Latino Population	975,499	975,499	-			
OESD 17	Residential treatment for Co-Occurring D	1,257,235	1,257,235	-			
OESD 18	Wellness Center	8,823,496	7,567,522	1,136,358			119,616
OESD 19	Medication Support Services	4,284,297	2,896,409	871,767			516,121
OESD 20	Individual Placement Services	4,978,786	3,365,886	1,288,663			324,237
OESD 23	Crisis Residential Svc	1,905,499	1,481,186	410,277			14,036
OESD 24	Schreiber Center	394,957	233,498	114,458			47,000
OESD 25	BH-Primary Care Integration Project	8,248,479	5,963,861	944,392			1,340,226
OESD 26A-B	Culturally Responsive Treatment progran	807,587	784,458	23,129			
OESD 27	In-Home Outreach Team	3,283,871	2,195,960	1,087,911			
OESD 28	SAGE Case & Care Management	1,569,040	1,498,958	70,082			
OESD 30	Peer Respite	1,204,953	899,979	304,974			
OESD 31	1st Onset	1,476,815	819,350	624,481			32,983
OESD 32	Suicide Prevention Crisis Line	675,165	611,040	64,125			
OESD 33	Deaf Community Counseling Services	328,153	301,482	26,671			
OESD 34	School-Based Behavioral Health	327,600	327,600	-			
OESD 35	Outreach & Consultation	2,302,316	2,234,632	54,840			12,844
OESD 36	Presumptive Transfer Project	762,973	762,973	-			
OESD 37	Re-entry Treatment Teams	2,503,179	1,508,202	974,380			20,597
OESD 38	SSI Advocacy & Support Services	1,903,809	808,361	108,940			986,509
OESD 39	Intensive Care Coordinaion Servcies	400,000	400,000	-			
OESD 40	Capacity Building Funds	542,346	542,346	-			
CSS Administration		10,223,823	7,301,332	2,066,708			855,784
CSS MHSA Housing Program Assigned Funds		-					
Total CSS Program Estimated Expenditures		136,010,333	103,826,430	26,788,987	-	-	5,394,917
FSP Programs as Percent of Total		51.9%					

FY 2023-24 Through FY 2025-26 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: Alameda Date: 3/15/23

		Fiscal Year 2025/26					
		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	STAY	721,429	518,058	203,371			
FSP 4	Greater Hope	2,829,962	2,072,947	757,015			
FSP 10	Housing Services	14,517,503	13,592,048	342,439			583,016
FSP 11	Community Conservatorship	743,442	743,442	-			
FSP 12	Assisted Outpatient Treatment	805,396	805,396	-			
FSP 13	CHANGES	2,405,841	1,486,831	919,010			
FSP 14	STRIDES - Adult FSP	610,472	439,967	170,505			
FSP 16	Connections FSP	805,086	597,696	207,390			
FSP 17	East Bay Wrap 8-18	2,344,938	1,740,882	604,056			
FSP 18	Homeless Engagement	1,082,143	762,262	319,881			
FSP 19	No. Co. Senior Homeless	4,745,759	3,523,251	1,222,508			
FSP 20	Lasting Independence Forensic Team	721,429	534,723	186,706			
FSP 21	Prevention, Advocacy, Innovation, Growt	360,712	248,134	112,578			
FSP 22	Justice and Mental Health Recovery	5,813,912	4,073,620	1,616,843			123,449
FSP 23	Service Teams	11,772,973	6,861,346	4,911,627			
FSP 24	TAY Forensic FSP	1,626,674	1,626,674	-			
Non-FSP Programs							
OESD 4a	Mobile Integrated Assess Team for Senio	1,173,998	630,202	543,796			
OESD 5a	Crisis Response Program	8,326,309	6,574,338	1,405,015			346,956
OESD 7	MH Court Specialist Program	613,254	409,032	153,075			51,148
OESD 8	Juvenile Justice Trans. of Guidance Clinic	171,378	101,319	49,665			20,394
OESD 9	Multisystemic Therapy	1,035,030	1,035,030	-			
OESD 11	Crisis Stablization Services	9,686,037	7,200,523	2,485,514			
OESD 14	Staffing to Asian Population	1,916,777	1,768,538	148,239			
OESD 15	Staffing to Latino Population	975,499	975,499	-			
OESD 17	Residential treatment for Co-Occurring D	1,257,235	1,257,235	-			
OESD 18	Wellness Center	8,823,496	7,567,522	1,136,358			119,616
OESD 19	Medication Support Services	4,284,297	2,896,409	871,767			516,121
OESD 20	Individual Placement Services	4,978,786	3,365,886	1,288,663			324,237
OESD 23	Crisis Residential Svc	1,905,499	1,481,186	410,277			14,036
OESD 24	Schreiber Center	394,957	233,498	114,458			47,000
OESD 25	BH-Primary Care Integration Project	8,248,479	5,963,861	944,392			1,340,226
OESD 26A-B	programs for the African American	807,587	784,458	23,129			
OESD 27	In-Home Outreach Team	3,283,871	2,195,960	1,087,911			
OESD 28	SAGE Case & Care Management	1,569,040	1,498,958	70,082			
OESD 30	Peer Respite	1,204,953	899,979	304,974			
OESD 31	1st Onset	1,476,815	819,350	624,481			32,983
OESD 32	Suicide Prevention Crisis Line	675,165	611,040	64,125			
OESD 33	Deaf Community Counseling Services	328,153	301,482	26,671			
OESD 34	School-Based Behavioral Health	327,600	327,600	-			
OESD 35	Outreach & Consultation	2,302,316	2,234,632	54,840			12,844
OESD 36	Presumptive Transfer Project	762,973	762,973	-			
OESD 37	Re-entry Treatment Teams	2,503,179	1,508,202	974,380			20,597
OESD 38	SSI Advocacy & Support Services	1,903,809	808,361	108,940			986,509
OESD 39	Intensive Care Coordinaion Servcies	400,000	400,000	-			
OESD 40	Capacity Building Funds	542,346	542,346	-			
CSS Administration		8,223,823	5,911,932	1,634,908			676,984
CSS MHSA Housing Program Assigned Funds		-					
Total CSS Program Estimated Expenditures		132,010,333	100,694,630	26,099,587	-	-	5,216,117
FSP Programs as Percent of Total		51.5%					

FY 2023-24 Through FY 2025-26 Three-Year Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: Alameda Date: 3/15/23

		Fiscal Year 2023/24					
		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	1,020,103	879,984	99,331			40,788
PEI 1B	School-Based MH Access & Linkage in Elementary, Midd	1,095,155	1,095,155	-			
PEI 1C	Early Childhood Mental Health Outreach & Consultation	435,319	395,000	25,236			15,083
PEI 1D	Unaccompanied Immigrant Youth Outreach	826,466	658,611	167,855			
PEI 4	Stigma & Discrimination Reduction Campaign	1,855,800	1,837,605	11,610			6,585
PEI 5	Outreach, Education & Consultation for Latino Commun	1,556,931	953,309	603,622			
PEI 6	Outreach, Education & Consultation for Asian Pacific Isla	3,130,088	2,516,464	535,484			78,140
PEI 7	Outreach, Education & Consultation for South Asian/Afg	1,447,480	1,342,985	104,495			
PEI 8	Outreach, Education & Consultation for Native American	353,500	223,942	96,152			33,406
PEI 9	Outreach, Education & Consultation for Middle Eastern (	750,444	376,648	373,796			
PEI 10	Outreach, Education & Consultation for African Commur	353,381	288,536	64,845			
PEI 12	Suicide Prevention/Crisis Text Line	2,134,994	1,982,775	152,219			
PEI 19	Older Adult Peer Support	340,974	339,119	-			1,855
PEI 20A-G	Culturally Responsive PEI programs for the African Amer	2,395,603	2,249,064	140,543			5,996
PEI 22	LGBT Support Services	499,352	499,352	-			
PEI 24	Sobrante Park Comm Proj	350,000	350,000	-			
PEI 25	Trauma Informed Services	179,192	163,619	9,937			5,636
PEI 26	MH Applications	121,499	121,499	-			
PEI 27	Hearing Voices Groups	24,500	24,500	-			
PEI 28	PEI Admin	972,893	972,893	-			
PEI Programs - Early Intervention							
PEI 3	Mental Health for Older Adults, Geriatric Assessment & I	1,019,914	631,939	272,011			115,964
PEI 17A-B	TAY Resource Center	983,176	983,176	-			
PEI Administration		1,664,144	1,239,876	297,636			126,632
PEI Assigned Funds		0					
Total PEI Program Estimated Expenditures		23,510,908	20,126,051	2,954,773	-	-	430,085

FY 2023-24 Through FY 2025-26 Three-Year Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: Alameda Date: 3/15/23

		Fiscal Year 2024/25					
		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	1,020,103	879,984	99,331			40,788
PEI 1B	School-Based MH Access & Linkage in Elementary, Midd	1,095,155	1,095,155	-			-
PEI 1C	Early Childhood Mental Health Outreach & Consultation	435,319	395,000	25,236			15,083
PEI 1D	Unaccompanied Immigrant Youth Outreach	826,466	658,611	167,855			-
PEI 4	Stigma & Discrimination Reduction Campaign	1,855,800	1,837,605	11,610			6,585
PEI 5	Outreach, Education & Consultation for Latino Commun	1,556,931	953,309	603,622			-
PEI 6	Outreach, Education & Consultation for Asian Pacific Isla	3,130,088	2,516,464	535,484			78,140
PEI 7	Outreach, Education & Consultation for South Asian/Afg	1,447,480	1,342,985	104,495			-
PEI 8	Outreach, Education & Consultation for Native American	353,500	223,942	96,152			33,406
PEI 9	Outreach, Education & Consultation for Middle Eastern (	750,444	376,648	373,796			-
PEI 10	Outreach, Education & Consultation for African Commur	353,381	288,536	64,845			
PEI 12	Suicide Prevention/Crisis Text Line	2,134,994	1,982,775	152,219			
PEI 19	Older Adult Peer Support	340,974	339,119	-			1,855
PEI 20A-G	Culturally Responsive PEI programs for the African Amer	2,395,603	2,249,064	140,543			5,996
PEI 22	LGBT Support Services	499,352	499,352	-			-
PEI 24	Sobrante Park Comm Proj	350,000	350,000	-			-
PEI 25	Trauma Informed Services	179,192	163,619	9,937			5,636
PEI 26	MH Applications	121,499	121,499	-			-
PEI 27	Hearing Voices Groups	24,500	24,500	-			
PEI 28	PEI Admin	972,893	972,893	-			-
PEI Programs - Early Intervention							
PEI 3	Mental Health for Older Adults, Geriatric Assessment &	1,019,914	631,939	272,011			115,964
PEI 17A	TAY Resource Center	983,176	983,176	-			
PEI Administration		1,664,144	1,239,876	297,636			126,632
PEI Assigned Funds		-					
Total PEI Program Estimated Expenditures		23,510,908	20,126,051	2,954,773	-	-	430,085

FY 2023-24 Through FY 2025-26 Three-Year Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: Alameda Date: 3/15/23

		Fiscal Year 2025/26					
		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	1,020,103	879,984	99,331			40,788
PEI 1B	School-Based MH Access & Linkage in Elementary, Midd	1,095,155	1,095,155	-			
PEI 1C	Early Childhood Mental Health Outreach & Consultation	435,319	395,000	25,236			15,083
PEI 1D	Unaccompanied Immigrant Youth Outreach	826,466	658,611	167,855			
PEI 4	Stigma & Discrimination Reduction Campaign	1,855,800	1,837,605	11,610			6,585
PEI 5	Outreach, Education & Consultation for Latino Commun	1,556,931	953,309	603,622			
PEI 6	Outreach, Education & Consultation for Asian Pacific Isla	3,130,088	2,516,464	535,484			78,140
PEI 7	Outreach, Education & Consultation for South Asian/Afg	1,447,480	1,342,985	104,495			
PEI 8	Outreach, Education & Consultation for Native American	353,500	223,942	96,152			33,406
PEI 9	Outreach, Education & Consultation for Middle Eastern (	750,444	376,648	373,796			
PEI 10	Outreach, Education & Consultation for African Commur	353,381	288,536	64,845			
PEI 12	Suicide Prevention/Crisis Text Line	2,134,994	1,982,775	152,219			
PEI 19	Older Adult Peer Support	340,974	339,119	-			1,855
PEI 20A-G	Culturally Responsive PEI programs for the African Amer	2,395,603	2,249,064	140,543			5,996
PEI 22	LGBT Support Services	499,352	499,352	-			-
PEI 24	Sobrante Park Comm Proj	350,000	350,000	-			-
PEI 25	Trauma Informed Services	179,192	163,619	9,937			5,636
PEI 26	MH Applications	121,499	121,499	-			-
PEI 27	Hearing Voices Groups	24,500	24,500	-			
PEI 28	PEI Admin	972,893	972,893	-			-
PEI Programs - Early Intervention							
PEI 3	Mental Health for Older Adults, Geriatric Assessment & I	1,019,914	631,939	272,011			115,964
PEI 17A-B	TAY Resource Center	983,176	983,176	-			
PEI Administration		4,664,144	3,356,376	917,436			390,332
PEI Assigned Funds		-					
Total PEI Program Estimated Expenditures		26,510,908	22,242,551	3,574,573	-	-	693,785

FY 2023-24 Through FY 2025-26 Three-Year Mental Health Services Act Expenditure Plan
Innovations (INN) Component Worksheet

County: Alameda Date: 3/15/23

	Fiscal Year 2023/24					
	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	2,744,629	2,381,525	284,204			78,900
INN 4 Land Trust	2,549,821	2,549,821	-			
INN 7 Forensic Alternatives: Clinical Focused	1,466,081	1,466,081	-			
INN 8 Forensic Alternatives: Peer Focused	738,793	738,793	-			
INN 9 Online Peer Training Project	100,000	100,000	-			
INN Administration	335,226	253,900	51,893			29,433
Total INN Program Estimated Expenditures	7,934,550	7,490,120	336,097	-	-	108,333

	Fiscal Year 2024/25					
	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 4 Land Trust	1,363,782	1,363,782	-			
INN 7 Forensic Alternatives: Clinical Focused	2,337,831	2,337,831	-			
INN 8 Forensic Alternatives: Peer Focused	1,444,188	1,444,188	-			
INN 9 Online Peer Training Project	219,000	219,000	-			
INN Administration	335,226	253,900	51,893			29,433
Total INN Program Estimated Expenditures	5,700,027	5,618,701	51,893	-	-	29,433

	Fiscal Year 2025/26					
	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 4 Land Trust	1,363,782	1,363,782	-			
INN 7 Forensic Alternatives: Clinical Focused	3,209,580	3,209,580	-			
INN 8 Forensic Alternatives: Peer Focused	2,149,584	2,149,584	-			
INN Administration	335,226	253,900	51,893			29,433
Total INN Program Estimated Expenditures	7,058,172	6,976,846	51,893	-	-	29,433

FY 2023-24 Through FY 2025-26 Three-Year Mental Health Services Act Expenditure Plan
Workforce, Education and Training (WET) Component Worksheet

County: Alameda Date: 3/15/23

	Fiscal Year 2023/24					
	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	746,689	565,542	115,588			65,559
Action 2 Training/Technical Assistance	3,278,442	3,278,442	-			
Action 3 Mental Health Career Pathways	1,061,155	1,061,155	-			
Action 4 Residency/Internship	400,000	351,480	30,960			17,560
Action 5 Financial Incentive	2,745,009	2,693,909	36,225			14,875
WET Administration	-					
Total WET Program Estimated Expenditures	8,231,295	7,950,528	182,773	-	-	97,994

	Fiscal Year 2024/25					
	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	746,689	565,542	115,588			65,559
Action 2 Training/Technical Assistance	2,243,781	2,243,781	-			
Action 3 Mental Health Career Pathways	1,061,155	1,061,155	-			
Action 4 Residency/Internship	400,000	351,480	30,960			17,560
Action 5 Financial Incentive	125,000	73,900	36,225			14,875
WET Administration	-					
Total WET Program Estimated Expenditures	4,576,625	4,295,858	182,773	-	-	97,994

	Fiscal Year 2025/26					
	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	746,689	565,542	115,588			65,559
Action 2 Training/Technical Assistance	2,243,781	2,243,781	-			
Action 3 Mental Health Career Pathways	1,061,155	1,061,155	-			
Action 4 Residency/Internship	400,000	351,480	30,960			17,560
Action 5 Financial Incentive	125,000	73,900	36,225			14,875
WET Administration	-					
Total WET Program Estimated Expenditures	4,576,625	4,295,858	182,773	-	-	97,994

FY 2023-24 Through FY 2025-26 Three-Year Mental Health Services Act Expenditure Plan
Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: Alameda Date: 3/15/23

		Fiscal Year 2023/24					
		A	B	C	D	E	F
		Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects							
CF2	Respite Bed Expansion	2,200,000	2,200,000	-			
CF4	APC Medical Respite Project	1,500,000	1,500,000	-			
CF5	AA Wellness Hub	1,500,000	1,500,000	-			
CF6	A Street Shelter Project	800,000	800,000	-			
CFTN Programs - Technological Needs Projects							
TN1	Behavioral Health Management System	524,226	524,226	-			
TN4	Consulting Services	848,966	848,966	-			
TN5	Capacity Building Funds	1,082,228	1,082,228	-			
CFTN Administration		1,510,511	1,144,061	233,827			132,623
Total CFTN Program Estimated Expenditures		9,965,931	9,599,481	233,827	-	-	132,623

		Fiscal Year 2024/25					
		A	B	C	D	E	F
		Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects							
CF2	Respite Bed Expansion	1,000,000	1,000,000	-			
CF5	AA Wellness Hub	1,000,000	1,000,000	-			
CF6	A Street Shelter Project	800,000	800,000	-			
CFTN Programs - Technological Needs Projects							
TN1	Behavioral Health Management System	531,500	531,500	-			
TN4	Consulting Services	848,966	848,966	-			
CFTN Administration		1,510,511	1,144,061	233,827			132,623
Total CFTN Program Estimated Expenditures		5,690,977	5,324,527	233,827	-	-	132,623

		Fiscal Year 2025/26					
		A	B	C	D	E	F
		Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects							
CF2	Respite Bed Expansion	800,000	800,000	-			
CF5	AA Wellness Hub	800,000	800,000	-			
CF6	A Street Shelter Project	600,000	600,000	-			
CFTN Programs - Technological Needs Projects							
TN1	Behavioral Health Management System	531,500	531,500	-			
TN4	Consulting Services	848,966	848,966	-			
CFTN Administration		1,510,511	1,144,061	233,827			132,623
Total CFTN Program Estimated Expenditures		5,090,977	4,724,527	233,827	-	-	132,623

Alameda County Profile

Demographics

Alameda County is the twenty-first most populous county nationally, seventh most populous county in California, with the City of Dublin being one of the 15 fastest growing cities in the United States. Compared to neighboring Bay Area counties, Alameda, experienced the highest estimated numeric increase in population from 2017 to 2019 with over 4,500 people and the third highest percent of foreign-born residents (32.9%). Since the 2010 Census, the population has increased 11%, the highest of any Bay Area County (**Table 1**).

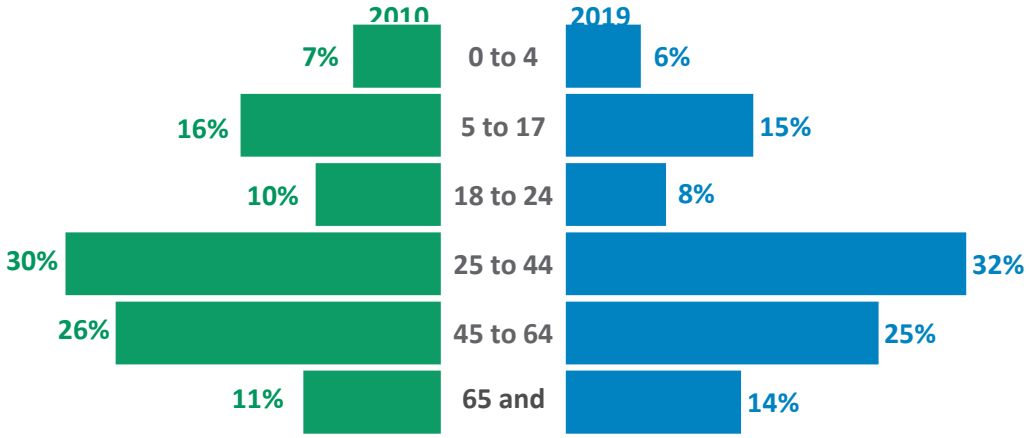
Table 1: Alameda and Select Bay Ares Counties Population Characteristics

Description	Alameda	Contra Costa	Marin	San Francisco	Santa Clara
Census, April 1, 2020	1,682,353	1,165,927	262,321	873,965	1,936,259
Census, April 1, 2010	1,510,271	1,049,025	252,409	805,235	1,781,642
Estimates, July 1, 2019, (V2019)	1,671,329	1,153,526	258,826	881,549	1,927,852
Estimates, July 1, 2021, (V2021)	1,682,353	1,165,927	262,321	873,965	1,936,259
Change April 1, 2010 (estimates base) to July 1, 2019, (V2019)	11%	10%	3%	10%	8%
Total change estimates, July 1, 2017 to July 1, 2019	4,573	3,007	-836	853	-4,485
Foreign-born residents, percent 2017-2021	32.9%	25%	18.5%	34.1%	39.9%

Source: 2020 Census Quickfacts and Annual Estimates of the Resident Population for Counties in California: April 1, 2010 to July 1, 2021 (CO-EST2021-POP-06), U.S. Census Bureau, Population Division, Release Date: 3/2022, Retrieved: 1/9/2023

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 50.4% of the county population and is home to 46,965 Veterans (2017-2021), which is the highest number among Bay Area Counties with Marin having the least.

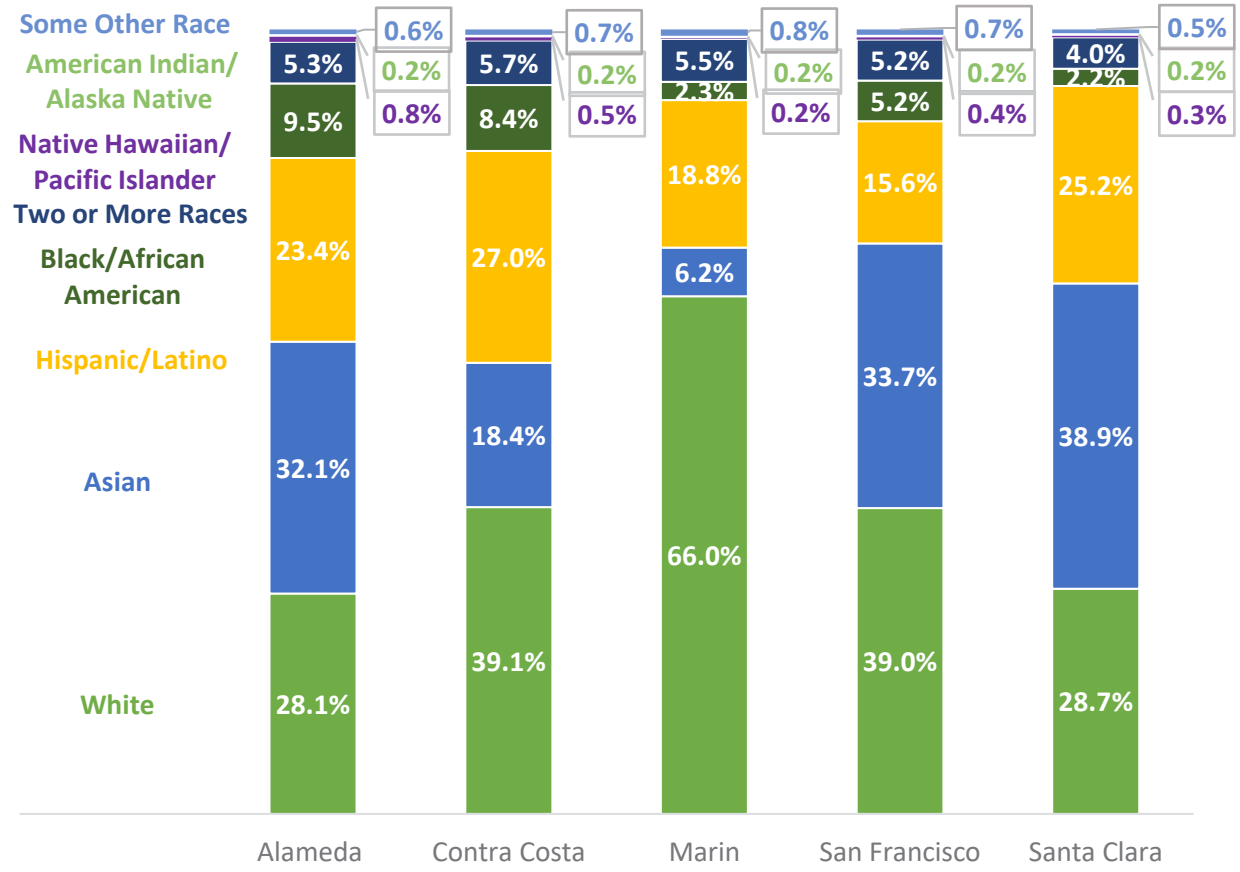
Figure 1: Alameda County Age Group as a Percentage of Total Population, 2010 v. 2019



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

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

Figure 2: Bay Area Counties Percent Race and Ethnicity 2020



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

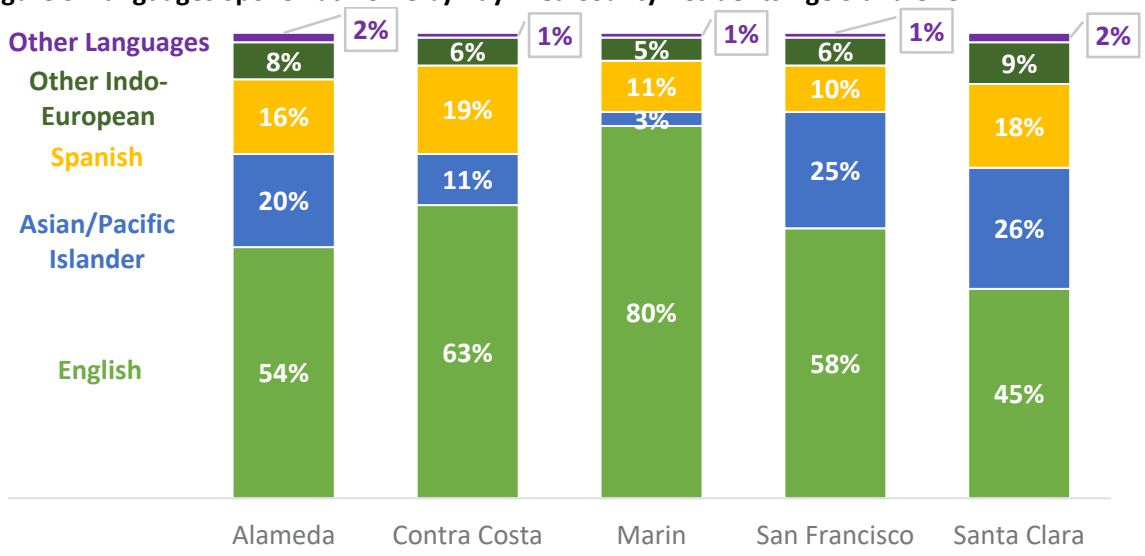
At home, Alameda County residents speak a variety of languages. Among the neighboring Bay Area Counties, Alameda has the second highest percent of residents who speak non-English languages at home. While over half of residents speak English at home (54.3%), 20.0% of residents speak Asian/Pacific Island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

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

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

Threshold languages are defined as those where at least 3,000 residents or 5% of the Medi-Cal beneficiary population, whichever is lower, identify that language as their primary one. Farsi is no longer a threshold language, but Alameda County is committed to providing materials in this language because of how close it is to becoming a threshold language. Mental health providers must comply with cultural competence and linguistic requirements set out by the state for these languages, including oral interpreter services and general program literature used to assist beneficiaries.

Figure 3: Languages Spoken at Home by Bay Area County Residents Age 5 and Over



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

Burden of Poverty

Alameda County Behavioral Health Care Services (ACBH) clients face a variety of challenges around income, housing, and food security. Compared to other Bay Area counties Alameda County residents have the lowest median household and per capita income (**Table 2**). While the median rent is the lowest among the Bay Area Counties, Alameda County has the higher rental rate compared to Contra Costa, Marin, and Santa Clara counties, meaning a higher percentage of residents do not own a home. Additionally, 48.5% of renters spend 30% or more of their income on their rent, indicating financial burden imposed by these rent payments. Alameda County also has the second highest percent of people in poverty for all ages; it is the third highest of the 5 Bay Area counties for people under 18 years old living in poverty. The Supplemental Nutrition Assistance Program (SNAP) is a federal program for low-income individuals that provides help with purchasing food and beverages. Alameda County is tied with San Francisco with respect to the percent of households that receive SNAP.

Table 2: Poverty Indicators for Bay Area Counties

Indicator	Alameda	Contra Costa	Marin	San Francisco	Santa Clara
Median household income±, 2017-2021	**$ 112,017**	$ 110,455	$ 131,008	$ 126,187	$ 140,258
Per capita income, past 12 months±, 2017-2021	**$ 53,815**	$ 53,656	$ 78,995	$ 77,267	$ 65,052
Median gross rent, 2017-2021	**$ 2,043**	$ 2,061	$ 2,307	$ 2,130	$ 2,530
Rental Occupied, 2017-2021	**46.1%**	33.0%	36.2%	61.8%	43.9%
Households whose rent is 30% or more of their income	**48.5%**	53.6%	51.6%	37.0%	45.0%
Poverty percent, all ages	**8.9%**	8.2%	6.9%	10.3%	6.7%
Poverty percent, under 18	**9.40%**	10.20%	7.40%	10.10%	6.60%
Households with SNAP/Food stamps, percent	**6.90%**	6.80%	3.60%	6.90%	4.40%

±In 2021 inflation-adjusted dollars; Source: US Census Bureau, American Community Survey, "Selected Social Characteristics in the United States," "Selected Economic Characteristics," and "Selected Housing Characteristics," 2017-2021 American Community Survey 5-Year Estimates (ACSDP5Y2021) Data Profiles, accessed March 08, 2023, https://data.census.gov/table?y=2021&d=ACS%205-Year%20Estimates%20Data%20Profiles&tid=ACSDP5Y2021.DP02&g=0500000US06001

Every two years, the Alameda County Continuum of Care (ACCC), conducts comprehensive counts of the homeless population in Alameda County to measure the prevalence of homelessness as part of the required Point-in-Time Count. Due to the COVID-19 Pandemic the 2021 count was postponed and was conducted in 2022. This most recent count recorded 9,746 people experiencing homelessness, which is a 21% increase from the last count in 2019. Seventy-three percent (7,134) were unsheltered, meaning they lived in tents, parks, vehicles, vacant buildings, underpasses, and so forth. The other 27% were sheltered, indicating that they were inhabiting a county shelter during the count. 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):

49%
Rent Assistance

26%
Benefits/ Income

37%
Employment Assistance

27%
Mental Health Services

Survey respondents reported the following health conditions:

42%
Post-traumatic Stress Disorder

14%
Traumatic Brain Injury

49%
Psychiatric/Emotional Conditions

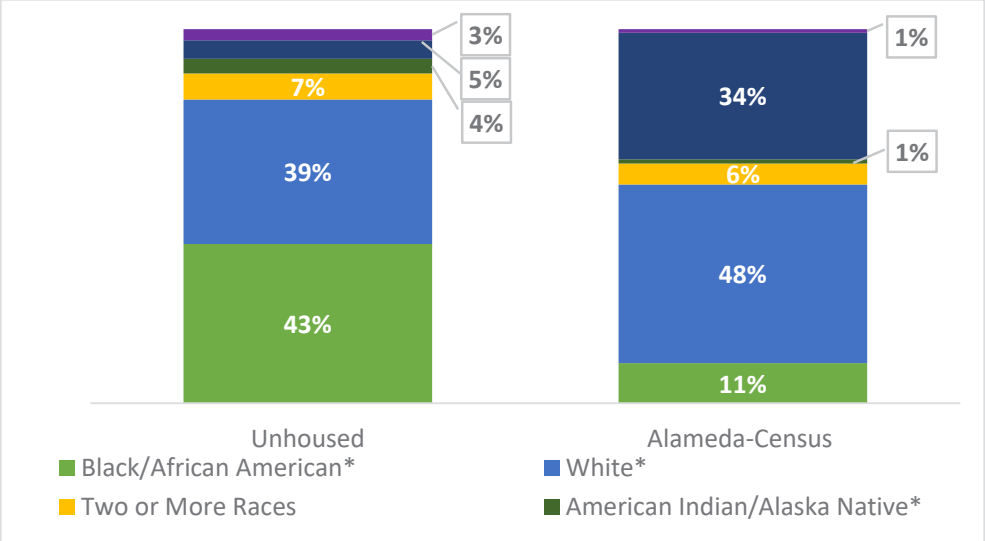
30%
Alcohol/Drug Counseling

Only three percent of respondents were not interested in independent, affordable rental housing, or housing with supportive services. The lack of affordable housing has impacted Alameda County residents, the workforce, and consumers and family members in MHSA programs. During the MHSA Community Program Planning Process, the top concern that survey respondents named for all age groups was housing and homelessness and persons experiencing homelessness were one of top three groups that respondents felt were not adequately served by the ACBH system[1].

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

Races, American Indian or Alaska Native, Native Hawaiian or other Pacific Islander (**Figure 4**),

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



*Includes persons reporting only one race

Source 1: US Census Bureau, QuickFacts, Population Estimates, July 1, 2022 (V2022), accessed March 08, 2023, https://www.census.gov/quickfacts/fact/table/alamedacountycalifornia/PST045222

Source 2: Applied Survey Research, Alameda County 2022 Homeless Count and Survey Comprehensive Report (2022), accessed March 08, 2023, https://homelessness.acgov.org/homelessness-assets/docs/reports/2022-Alameda-County-PIT-Report_9.22.22-FINAL-3.pdf

Physical Health

Alameda County has the second lowest life expectancy, at 82.8 years compared to the neighboring counties. Alameda and San Francisco Counties have much higher rates of violent crime than the other neighboring counties. Alameda County has the lowest percent of those without health insurance under the age of 65 (5.0%). However, rates are similar across all neighboring Bay Area Counties. The percent of those under 65 that are disabled, defined as limited or restricted to fully participate in activities at school, home, work, or in their community, is 4.7% in Alameda County (**Table 3**).

Indicator	Alameda	Contra Costa	Marin	San Francisco	Santa Clara
Life expectancy, years	**82.8**	82.2	85.2	83.7	84.7
Violent crime rate (per 100,00 people)	**629**	336	178	760	264
Persons without health insurance, under age 65 years	**5.0%**	4.9%	4.2%	5.4%	4.9%
With a disability, under age 65 years, 2014-2018	**4.7%**	5.7%	5.1%	7.5%	5.7%

Source 1: University of Wisconsin Population Health Institute, County Health Rankings & Roadmaps (2023), accessed March 09, 2023, https://www.countyhealthrankings.org/explore-health-rankings/california/alameda?year=2022

Source 2: US Census Bureau, QuickFacts, Population Estimates, July 1, 2022 (V2022), accessed March 08, 2023, https://www.census.gov/quickfacts/fact/table/alamedacountycalifornia/PST045222

	Drug Overdose	Suicide

County	Deaths	Deaths per 100,000	Deaths	Deaths per 100,000[1]
Alameda	761	15	767	9
Contra Costa	560	16	587	10
Marin	130	17	212	14
San Francisco	1186	45	459	9
Santa Clara	693	12	790	8
Healthy People 2030 Objective[1]	-	20.7	-	12.8

Source 1: University of Wisconsin Population Health Institute, County Health Rankings & Roadmaps (2023), accessed March 09, 2023, https://www.countyhealthrankings.org/explore-health-rankings/california/alameda?year=2022

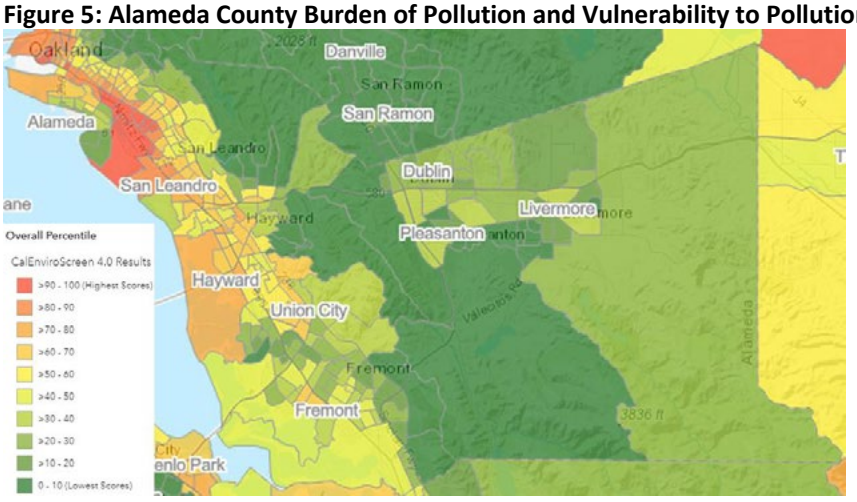
Source 2: US Department of Health and Human Services, Office of Disease Prevention and Health Promotion, Healthy People 2030 (2023) , accessed March 09, 2023, https://health.gov/healthypeople/objectives-and-data/browse-objectives/drug-and-alcohol-use/reduce-drug-overdose-deaths-su-03

In contrast to life expectancy, Alameda County has the second lowest age-adjusted[2] death rates due to drugs (12 per 100,000), which is lower than the Healthy People 2030 goal. However, the age-adjusted suicide rate is 9.0 per 100,000, which is lower than Health People 2030 goal, but higher than neighboring Santa Clara County (**Table 4**).

Environmental Health

California's Office of Environmental Health Hazard Assessment has created the CalEnviroScreen 3.0 model[3] to assess pollution burden and population characteristics that increase vulnerability to pollution among census tracts throughout the state. The pollution burden is measured through the averages of environmental exposures and effects. Population Characteristics are measured through the average of sensitive populations and socioeconomic factors components. The total score is calculated by combing the pollution burden and population characteristics. Below is a map of the 2021 CalEnviroScreen results for Alameda County (**Figure 5**). Briefly, the areas with lower burden and vulnerability to pollution are green and the neighborhoods with the highest are red. Areas of Oakland, San Leandro, and Hayward have the highest burden of pollution and vulnerability to pollution.

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



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

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

Mental Health

The California Health Interview Survey (CHIS) is conducted continuously through internet and telephone surveys to give a detailed picture of health and the healthcare needs of Californians, this includes a set of questions about mental health. Of the Bay Area Counties, San Francisco (15%) has the highest percentage of their population that reported to have "likely had psychological distress during the last year" and the rest have 12% (**Table 5**). Alameda County has the third highest percentage of moderate or severe "social life impairment" during the past year (18%), and "ever seriously thought about committing suicide" (11%) compared to other Bay Area counties. Additionally, 22% of Alameda County respondents, the second highest among Bay Area Counties, reported that they "needed help for emotional/mental health problems or use of alcohol/drugs." Of those Alameda County respondents, 71% of them reported receiving treatment, which is the lowest percent. The ratio of mental health providers to residents is 150:1 in Alameda County, which makes it in the middle among neighboring counties.

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

Indicator	Alameda	Contra Costa	Marin	San Francisco	Santa Clara
Likely has had serious psychological distress in the past year	**12%**	12%	12%	15%	12%
Moderate or severe social life impairment in the past year	**18%**	15%	15%	24%	20%
Ever thought about committing suicide	**11%**	12%	11%	15%	13%
Needed help for emotional/mental health problems or use of alcohol/drugs	**22%**	20%	19%	30%	21%
Of those that needed help, received treatment for mental/emotional and/or alcohol/drug issues	**71%**	75%	74%	83%	73%
Mental health providers	**150:1**	300:1	130:1	110:1	290:1

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

In Alameda County there are inequities in these same measures across racial and ethnic groups in the county (**Table 6**). Whites have highest rates of all the mental health indicators, except needing help for emotional or mental health or alcohol or drugs. Those that are Two or More Races had a much higher percentage reporting that they "needed help for emotional/mental health or alcohol/drugs" (39%). Among those that needed help for emotional/mental health problems African Americans were the least likely to receive help (64%). These rates do not reflect the role that stigma might play in survey participant's responses that may result in underreporting among certain racial and ethnic groups.

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

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

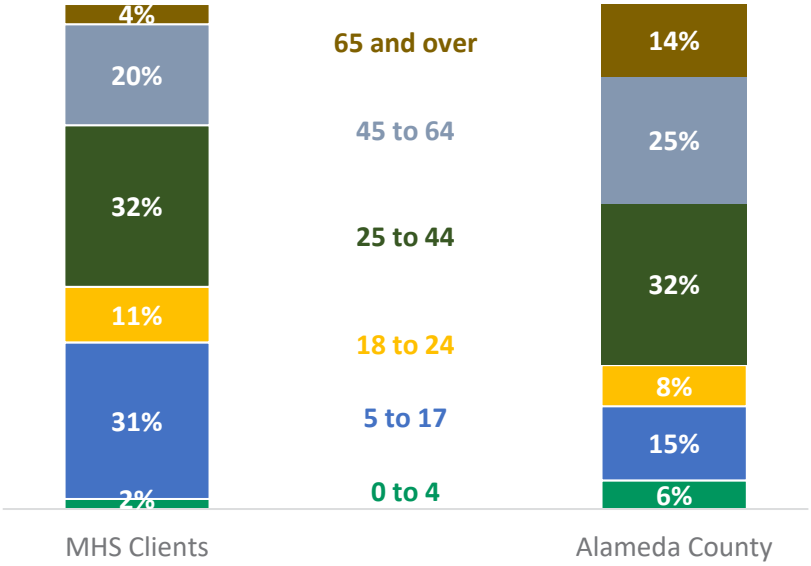
* = suppressed because statistically unstable; Note: American Indian or Alaska Native and Native Hawaiian or Pacific Islander suppressed due to statistically unstable or sample size.

Source: 2015, 2016, 2017, 2018, 2019, and 2020 California Health Interview Survey

Alameda County Behavioral Health Care Services Utilization

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

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



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

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

Table 7: Fiscal Year 20/21 Alameda County Mental Health Services Medi-Cal Penetration Rate by Race and Ethnicity

Race/Ethnic Group	Number of Recipients	Served with Medi-Cal	Penetration Rate	Served in Outpatient	Outpatient Penetration Rate	Served without Medi-Cal	Total Served
Asian or Pacific Islander	97,377	1,553	2%	1,425	1%	838	2,391
Alaska Native or American Indian	1,063	66	6%	58	5%	32	98
White	47,995	2,761	6%	2,336	5%	1,378	4,139
Black or African American	73,657	5,572	8%	4,541	6%	1,589	7,161
Other/Unknown	115,896	4,985	4%	4,105	3%	1,645	6,630
Hispanic or Latino	113,485	4,984	4%	4,548	4%	138	5,122

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

Total	**449,473**	**19,921**	-	**17,728**	-	**5,620**	**25,541**

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

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

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

COVID-19 in Alameda County

Alameda County's first confirmed case of COVID-19 was reported on February 28, 2020 and the Bay Area's first shelter in place order went into effect on March 17, 2020. As of January 25, 2022, Alameda County has the second highest number of cases of the Bay Area counties with 227,260 cases and 1,581 deaths. Alameda's case rate is 13,826 per 100,000, which is the third highest rate in the Bay Area, and the death rate is 96.2 per 100,000, which is the fourth highest (**Table 9**). These are all large increases compared to last year when this data was retrieved. Alameda County has fully-vaccinated 81% of their residents.

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

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

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

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

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

rates higher than the overall case and death rates are highlighted in red below. African American/Black, Hispanic/Latino, Pacific Islander, and Native American have case rates higher than the overall case rate of 9,568/100,000. The groups with the highest death rate were among those of Two or More Races, African American/Black, Hispanic/Latino, and Pacific Islander race/ethnicity. **Figure 7** is a map of the cases in Alameda County by zip code, where the darker the color the higher the case rate. This also reflects the disproportionate burden in Hispanic/Latino neighborhoods.

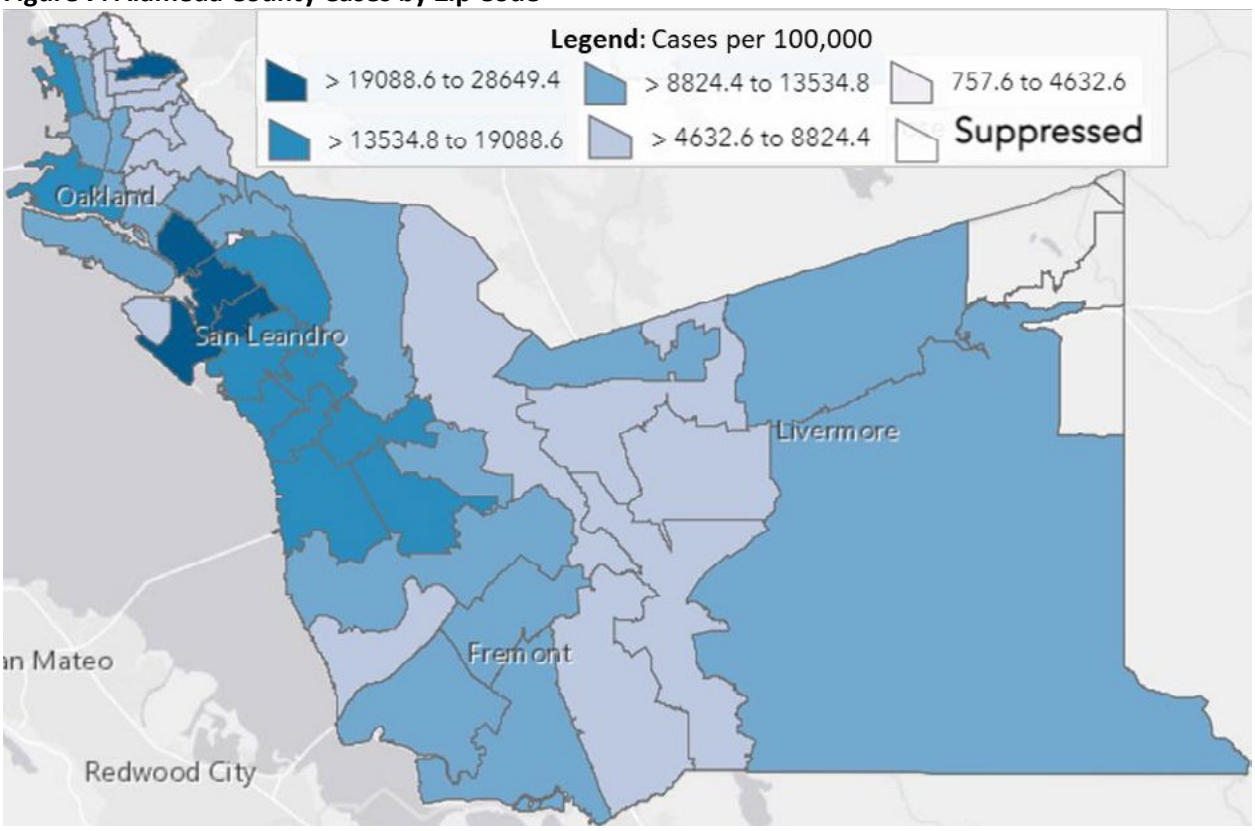
Table 10: Alameda County's COVID-19 Cases and Deaths Rates by Race/Ethnicity

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

*Suppressed on dashboard

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

Figure 7: Alameda County Cases by Zip Code



MHSA Community Program Planning Process (CPPP)

The California Welfare & Institutions Code (WIC) Sec 5848 and Sec 3300 require Counties conduct a Community Program Planning Process (CPPP) every three years as the basis for deeloping the Three-Year Program and Expenditure Plans (Three-Year Plan). The ACBH MHSA Division conducts additional CPPPs as the basis for gathering data each of the two annual update periods to the Three-Year Plan. Statutory requirements expect Counties to ensure the CPPP is adequately staffed, and that positions and/or units are designated to ensure stakeholders (people with a vested interest in mental health services) are trained and/or have the opportunity to particpate in the CPPP. Although local health jurisdictions are given relatively wide latitude on how to develop a local CPPP in line with the needs and culture of their communities, MHSA programs are required to demonstrate a partnership with local consitutents (voters) and stakeholders as it concerns mental health policy, program planning, implementation, monitoring, quality improvement, evaluation, and MHSA budget allocations.

The Alameda County MHSA CPPP builds upon data received during previous fiscal year input processes to ensure efforts target the underserved, unserved, underreported, and inadequately served populations. MHSA engages stakeholders in various outreach efforts, education forums, workgroups, and planning panels to ensure the plan is devleoped with the community In mind. Since 2007, over 2,731 Alameda County residents have contributed to the development of all five MHSA component plans through formalized stakeholder meetings, focus groups and planning councils.

For the Three-Year Plan (FY2023-26), the CPPP was conducted between October 28, 2022 through January 31, 2023. During this time outreach invitations were sent to more than 100,000 Stakeholders **(see** *Appendix B-1 CPPP Outreach Plan*)**.** The process was faciliated by multiple leadership groups representing the diversity of consumers, family members, and service providers. Stakeholder leads were provided training on core MHSA elements, policies & procedures, participant expectations, and listening session facilitation. MHSA provided technical assistance and stipends to participants with lived mental health.

<u>Community Program Planning Process Planning Committee</u>

The MHSA CPPP Planning Committee (MHSA CPPP-PC) is a short-term planning group consisting of 21 members which was re-established in September 12, 2022 to steer CPPP activities. In addition to the MHSA Stakeholder Group (MHSA-SG), the MHSA CPPP-PC was leveraged as an additional resource to assure continuity of services and adminsitrative transparency for all community outreach efforts, which include:

- Endorses CPPP outreach plan
- Participates in CPPP activities (such as listening sessions)
- Approves CPPP assessment instruments
- Liases with mental health affiliate groups to increase CPPP stakeholder engagmenet

The CPPP-PC participated in a total of 7 biweekly planning meetings.

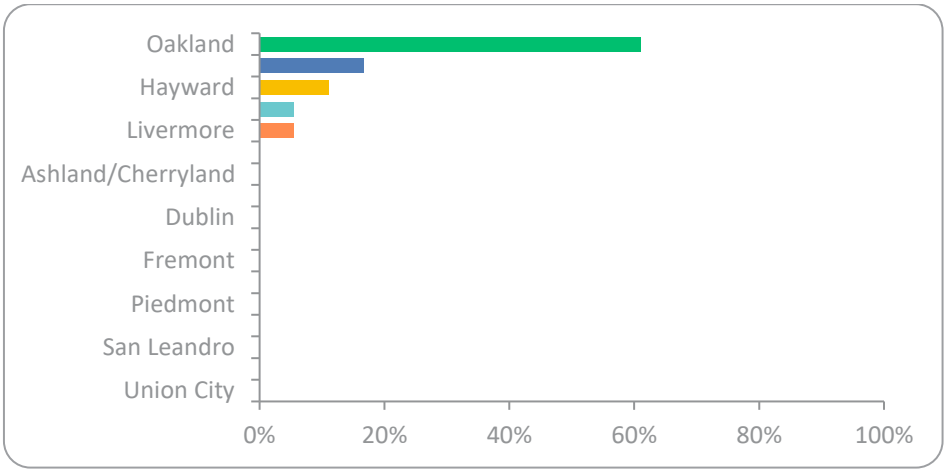
Table 1: MHSA Three-Year Plan CPPP Planning Committee Roster

Name/Title	Organization/Program Unit
Alexis Peciulis	**La Familia, Chief Clinical Officer**
Ana Rasquiza	**First 5 Alameda County**

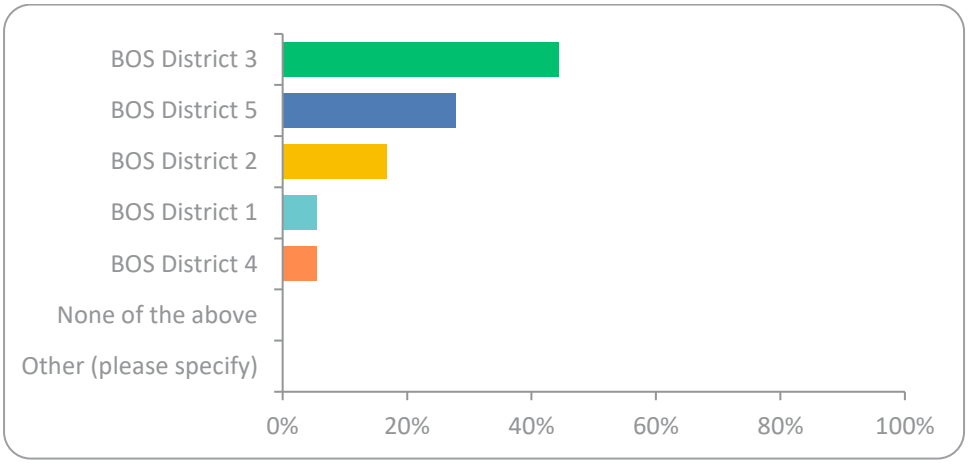
Bianca Anderson / Odessa Canton	**Mental Health Association of Alameda County (MHAAC), FERC Community Engagement Manager**
Brian Bloom	**ACBH Budget Stakeholder Advisory Committee Assistant Public Defender, Retired Alameda County Care First/Jail Last Task Force Mental Health Advisory Board (MHAB), Criminal Justice Committee Co-Chair**
Elizabeth Gama	**Alameda County Network of Mental Health Clients (BESTNOW!), Program Manager**
Danielle Guerry, LMFT	**Telecare Alameda Court Collaborative Program, Clinical Director**
Jasmin Koukhan, MSW	**Diversity in Health Training Institute**
Jennifer Vanaman	**Peers Engaging in Recovery Services (PEERS), Executive Director**
Jessica Lobedan	**City of Hayward Office of the City Manager, Management Analyst**
Karen Nemsick	**FUSE Corps Executive Fellow Supportive Housing Community Land Alliance, Former**
Larissa Estes White, Dr.P.H.	**ALL IN Alameda County, Director College for Behavioral Health Leadership**
Maileen Mamaradlo	**PEERS, Program coordinator II/API**
Mariana Real, MPH, MCHES	**Mental Health Service Act (MHSA) Division**
Mory Chhom, MPH	**Center for Empowering Refugees and Immigrants- East Bay (CERI), Program Director**
Narges Zohoury Dillon, LMFT	**Crisis Support Services of Alameda County, Executive Director**
Pauline Padrul	**Sutter Health / University of California-Berkeley**
Odessa Canton	**MHAAC Family Education Resource Center (FERC), Director**
Robert Williams	**Health & Human Resource Education Center (HHREC), MHSA Program Manager**
Suphaine Htaung	**Diversity in Health Training Institute, Executive Director**
Terry Land	**MHAB, Family Member**
Tracy Hazelton	**MHSA, Division Director**

Table 2: MHSA Three-Year Plan CPPP Planning Committee Demographics

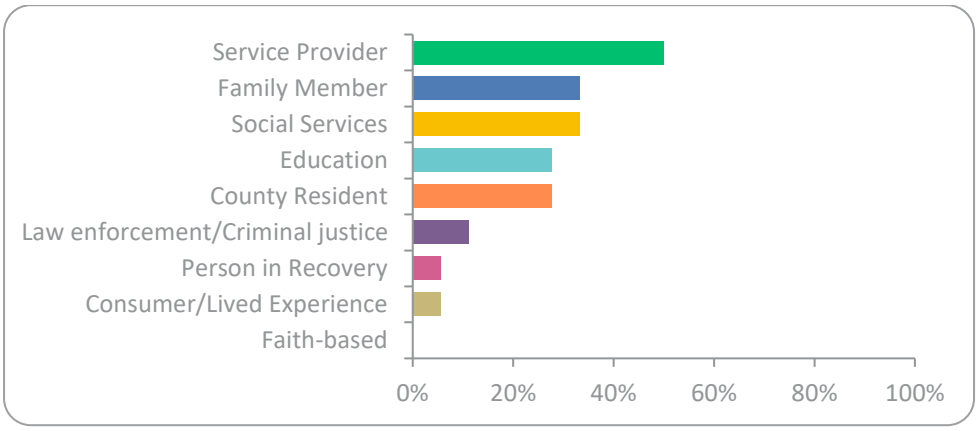
CPPP-PC City of Residence.



CPPP-PC BOS District.



CPPP-PC Stakeholder Affiliation.



MHSA Stakeholder Group

The MHSA 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 mental health peers with lived experience, 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 represent those impacted by mental health issues, 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*).

Membership selection is a multi-step process beginning with a Selection Panel consisting of three MHSA-SG members. The MHSA-SG reviews programmatic data, participated and coordinated CPPP listening sessions (formerly named focus groups), conducts virtual site visits, provids input on program implementation, and makes recommendations for quality improvement.

Table 3: MHSA-SG Demographics, FY22/23

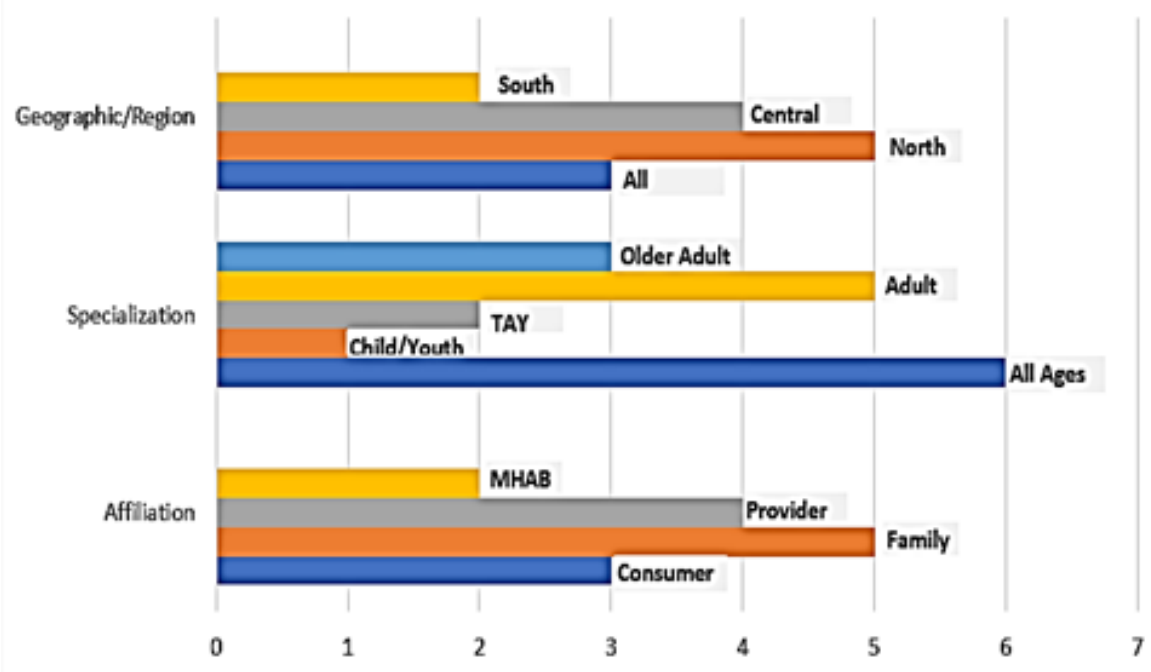


Table 4: Current MHSA Stakeholder Group Roster and Participating ACBH Leadership

Full Name	Seat/Role	Title/Affiliation
Annie Bailey	Provider	City of Fremont Youth & Family Services Division Administrator
Viveca Bradley	Peer with lived experience	Mental Health Advocate
Jeff Caiola	Peer with lived experience	Recovery Coach
Lisa Carlisle	ACBH – Agency Leadership	Children's System of Care Director
Aaron Chapman	ACBH – Agency Leadership	ACBH Medical Director
Margot Dashiell	Family Member	Alameda County Family Coalition, African American Family Support Group
Tracy Hazelton	ACBH - Agency Leadership	MHSA Division Director
Kate Jones	ACBH - Agency Leadership	Adult & Older Adult System of Care Director

L.D. Louis	MHAB	Vice-Chair, MHAB/ Assistant District Attorney
Karen Capece	ACBH - Agency Leadership	*Interim* Deputy Director/ Plan Administrator
Elaine Peng 彭一玲	Peer with lived experience/ Family Member	Mental Health Association for Chinese Communities (MHACC)
Katy Polony	Provider	Family Advocate, Abode Services
Mariana Real	ACBH- MHSA	MHSA Senior Planner
Liz Rebensdorf	Family Member	President, National Alliance on Mental Illness (NAMI)- East Bay
Carissa Samuels	Provider-TAY Student	UC Berkeley Student/ Former Ohlone College Mental Health Ambassador
Karyn Tribble	ACBH - Agency Leadership	Behavioral Health Director
James Wagner	ACBH- Agency Leadership	Deputy Behavioral Health Director
Mark Walker	Provider	Associate Director of East Bay Programs, Swords to Plowshares
Shawn Walker-Smith	Family Member	Business Owner

COVID-19 Impact on Planning Activities

The COVID-19 public health emergency remains 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-PC from FY2020-23 identified the following three key implementation challenges and solutions to combat barriers: **Administrative barriers, Resource Disparities**, and **Community Stressors.**

The MHSA CPPP-PC 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. The MHSA CPPP-PC adapted the MHSA public outreach campaign, re-launched a community input website resulting in 4,058 new users and 16,457 pageviews, coordinated outreach through social media platforms (e.g. Facebook, YouTube), 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 brainstorming webform, 2) remote listening sessions, and 3) an online community input survey embedded in electronic palm cards, e-flyers, and proctored by trained volunteers. In the midst of the ongoing COVID-19 epidemic, MHSA identified key successes related to planning activities, such as:

- **MHSA Staff Support**: The MHSA CPPP-PC highlighted the importance of the MHSA Sr. Planner/MHSA CPPP-PC 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-PC leveraged the expertise and knowledge of established and engaged MHSA-SG to coordinate planning and outreach strategies. Trained volunteers and partners exhibited ownership of MHSA planning activities, provided community canvassing, participated in planning committee meetings, listening sessions, and helped brand outreach activities.

The revised strategy was coordinated in response to COVID-19 barriers and resulted in more than 100,000 Alameda County residents and employees receiving CPPP invitations. In addition, virtual listening session trainings were coordinated for ACBH and community members. (**See** *Appendix B-1 for MHSA CPPP Outreach Plan*)

Community Outreach & Engagement Summary

MHSA CPPP outreach activities launched October 28, 2022 and ended January 31, 2023 (**see** *Figure 1*). MHSA employed a variety of tactics to engage the public such as hosting community listening sessions, recording educational podcasts with community partners and mental health leaders, and coordinating 13 listening sessions with diverse stakeholders.

MHSA Community Podcasts & Forums for Young Men of Color:

MHSA and media partner Health Human Resource Education Center (HHREC) coordinated TAY health podcasts and forums, which focused on navigating stressful environments, and dealing with the ramifications of the pandemic's impact on TAY mental health. Each forum was facilitated virtually on Zoom and live recordings were publicly posted on YouTube. Subsequent forums focused on the COVID-19 pandemic and its impact on TAY mental health. The recorded events are publicly posted to the HHREC YouTube Page at https://www.youtube.com/channel/UCXL5FVNzGgHSI7YEy4Rc63g/videos

MHSA Podcast Series

MHSA and HHREC designed a series of mental health focused podcasts featuring interviews with local leaders in the field. The first podcast for the CPPP featured an interview from Dr. Karyn Tribble, ACBH Director which garnered over 48,000 views. New podcasts will be released Spring 2023 to highlight the 30-day public comment period. Thirty-seven MHSA podcasts are available on the HHREC YouTube Page at https://www.youtube.com/channel/UCXL5FVNzGgHSI7YEy4Rc63g/videos

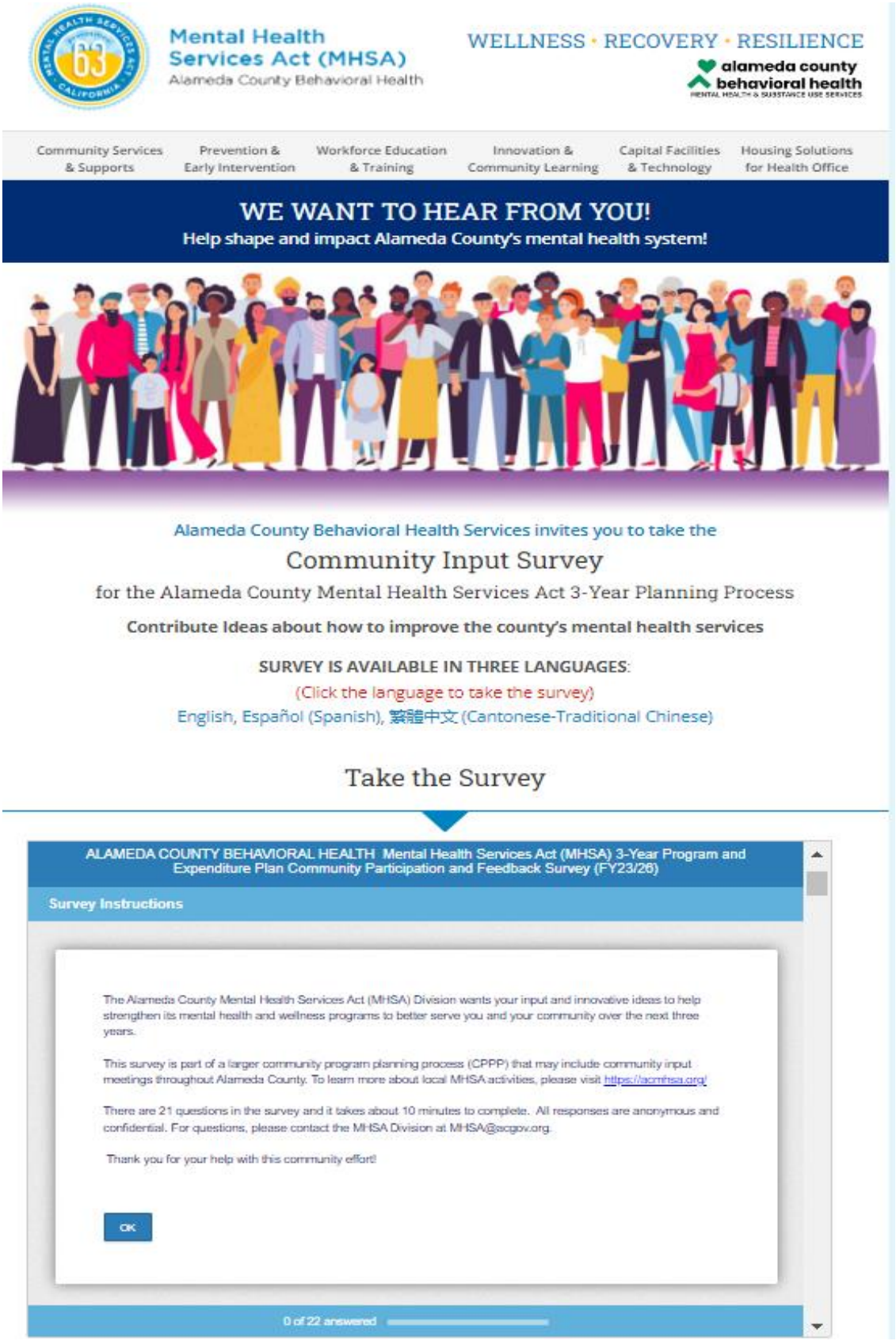
MHSA Innovation Brainstorm

The Innovative (INN) service category launched a webform to solicit feedback on three INN ideas suggested during the Annual Update process for FY22/23 (**see** *Appendix D-4)*. The proposed INN projects were:

- **Consumer Empowerment Using DBT (Dialectical Behavioral Therapy):** The DBT project will develop an online DBT Peer to Peer training program to train peers with the skills of DBT
- **Peer-Led Continuum of Forensic Services:** The project seeks to support mental health consumers who are justice involved transitioning back into the community.
- **Alternatives to Confinement Continuum of Forensic Services**: A collection of three (3) services that work together and are intended to prevent incarceration and divert individuals from criminal justice system into mental health services

Alameda County stakeholders were asked to prioritize their preference, identify outcomes, and target groups. The launch coincided with the MHSA CPPP and remains active throughout the year. One response was submitted on 12/29/22. Current INN projects can be viewed online at https://acmhsa.org/innovation-community-based-learning/.

Figure 1: MHSA Community Input Website (at https://acmhsa.org/community-input/ **):** CPPP & 30-Day Public Comment Outreach Period: October 28, 2022 – April 30, 2023



More Information on Listening Sessions and Podcast Dates to Come

Outreach & Media Toolkit

- MHSA Community Input Flyer
- MHSA Listening Session Schedule (2022)
- Share your Innovative Ideas HERE!
- Press Release
- Sample Public Service Announcements (PSAs)
- Sample Social Media Messages

MHSA Overview

- Want to know more about MHSA? Watch this video.
- MHSA 101 PowerPoint (PDF)
- MHSA 101: Fact Sheet (Spanish)
- Profile Sheet: MHSA Community Services & Supports
- Profile Sheet: MHSA Prevention & Early Intervention
- Profile Sheet: MHSA How Well Did We Do?
- Profile Sheet: MHSA Service Team Report (CSS)

MHSA Listening Session Workbook | (Spanish)
MHSA Listening Session Presentation
MHSA Listening Session Demographic Survey

Click below to preview the Community Participation & Feedback Surveys (PDF)
English, Español (Spanish), 繁體中文 (Cantonese-Traditional Chinese)

Watch MHSA 101 webinar: How to Read The MHSA Plan

FY 22/23 MHSA Annual Plan Update

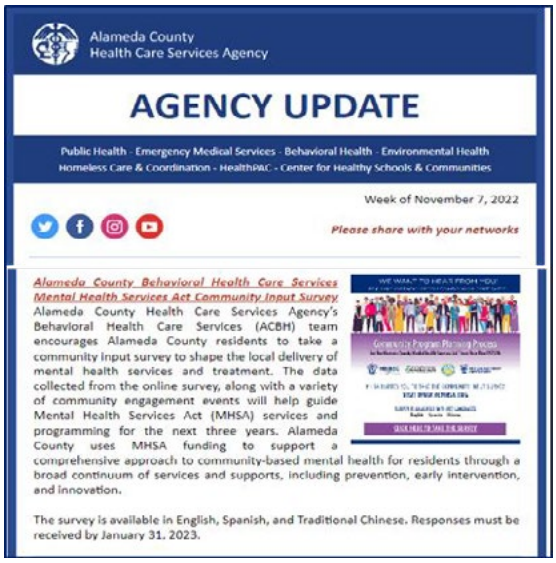
- Read the Plan
- Watch This Webinar (PowerPoint presentation)
- How to Read the MHSA Plan Infographic

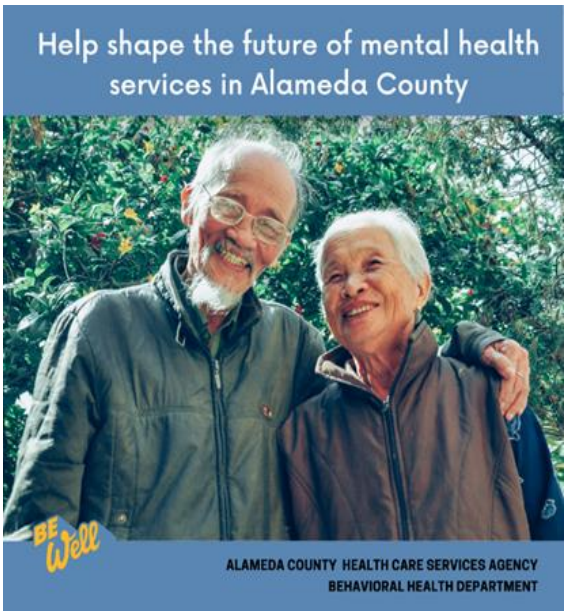
FY 22/23 MHSA Community Program Planning Process (CPPP) Annual Report

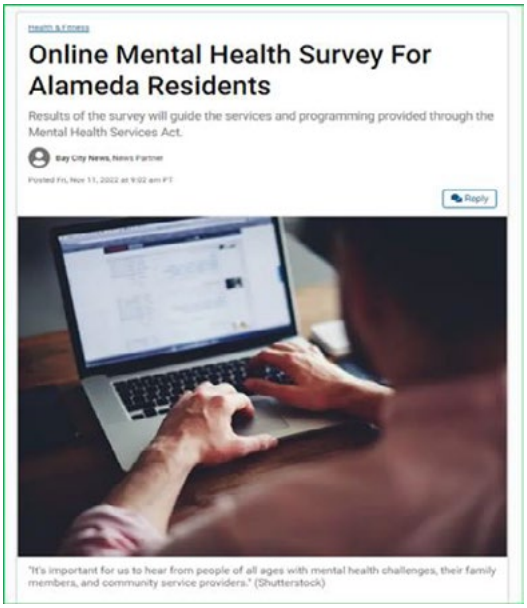
- Read Community Input report

Figure 2: MHSA Community CPPP E-Flyers/Palm Cards (see *Appendices B-2*)

Figure 3: Media Announcements (see *Appendices B-2*)







"How to Read the Plan" webinar

MHSA facilitated the MHSA 101 webinar: How to Read the MHSA Plan" on May 4, 2022. The overarching webinar aimed to broaden the public's ability to understand, synthesize, and apply information provided in MHSA Plans. The webinar was launched on Zoom and attended by 22 participants. The recorded event is available on the HHREC YouTube page and yielded 1.52K views. The webinar is publicly posted to the MHSA Community Input webpage at https://acmhsa.org/community-input/ and HHREC YouTube Page at https://www.youtube.com/channel/UCXL5FVNzGgHSI7YEy4Rc63g/videos

Community Input Meetings

Thirteen CPPP listening sessions were coordinated by ACBH and community-based organizations. Approximately 145 community stakeholders participated in the FY23/26 MHSA CPPP in which stakeholders provided input on mental health needs, prioritized underserved populations and recommended mental health services (**see** *Table 5*).

Image 1: MHSA & HHREC facilitating virtual CPPP Listening Session with TAY participants

MHSA developed a revised listening session toolkit consisting of MHSA 101 Fact Sheets, MHSA 101 webinar and infographic, and facilitator workbook (includes a standardized agenda, facilitator guide, and question & answer to record responses). The toolkit is publicly available on the new MHSA Community Input website at https://acmhsa.org/community-input/ ACBH staff and community volunteers participated in remote listening session trainings and facilitated 13 sessions.

During the listening sessions, the MHSA Senior Planner, MHSA Division Director and co-presenters facilitated a MHSA educational overview. Participants provided input on five questions to help identify mental health challenges, prioritize existing services, identify unserved/underserved populations, and recommend future innovative programs and services. Interpreter services were available upon request. The following questions were asked of participants:

- What are the top or most pressing mental health challenges right now in your community?
- Are there individuals, groups, and/or cultural communities who you believe are not being adequately served?
- What do you see as barriers and gaps for people to get mental health resources and appropriate/effective treatment needed for their recovery?
- Related to challenges identified in question 1, what are your ideas on how to address these challenges or others that you may see to better serve your community?
- What MHSA-funded services are you aware of, either as services you or someone you know has taken advantage of, or as services you would feel comfortable recommending to others?
- An Innovation project is proposing a title change to Consumer Empowerment Using Recovery Oriented Cognitive Therapy (CT-R). The framework of this peer training project will not change. What innovative ideas do you have to improve mental health services?
- Other comments/suggestions you'd like to share?

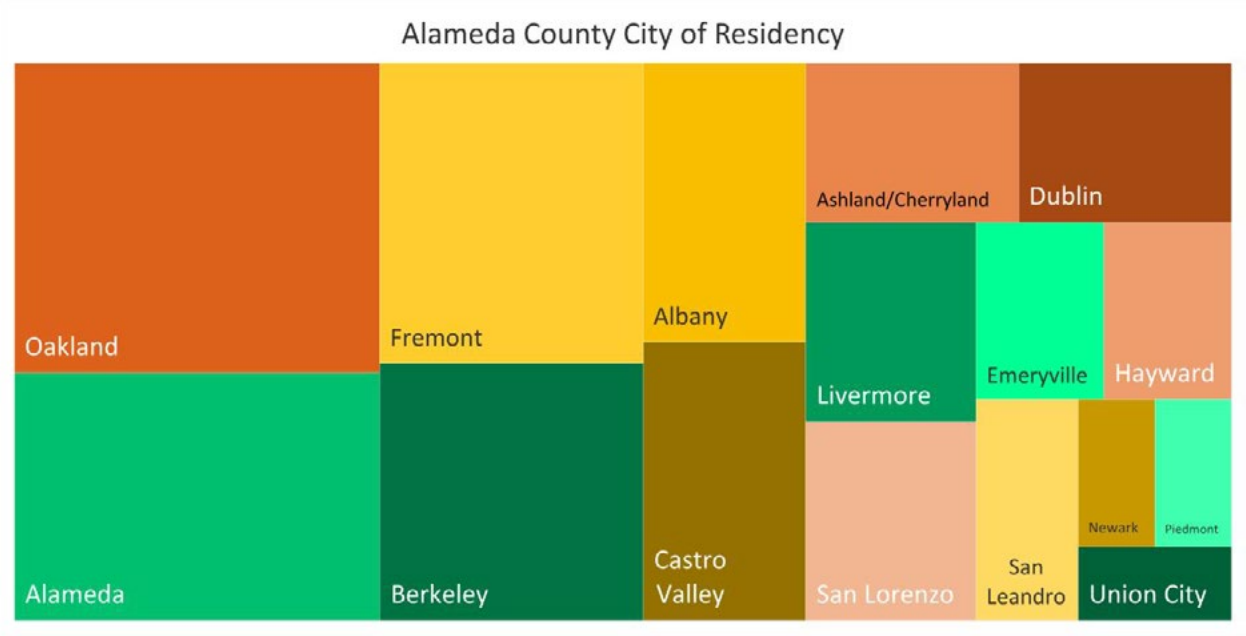
The intent of a listening session is not to provide services, advice, or solve systems issues; rather, these open avenues create a space for participants to be vulnerable, connect with others within their community, and participate in a facilitated discussion to add more context to issues and provide recommendations from direct sources. Similar to focus groups, facilitators aim to elicit specific narratives regarding stakeholders' experiences and observations of the existing mental health system. **Table 5** summarizes each listening session, identifies the stakeholder group, and quantifies the recommendations and issues presented during the discussion. In this process, a listening session **recommendation** is identified/quantified as a system improvement response provided during the discussion. The number of **issues** were identified based off any narrative regarding an experience or observation of barriers encountered by a stakeholder.

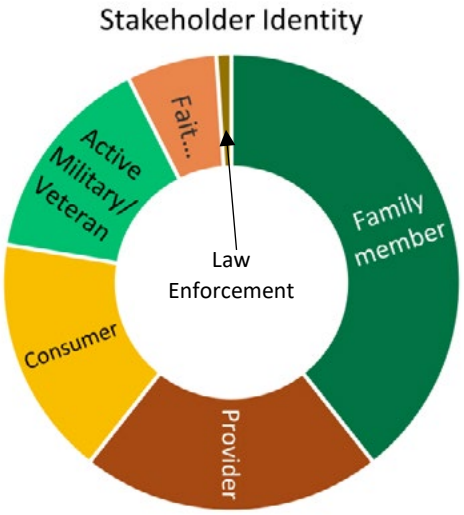
Table 5: MHSA Community Input Listening Sessions (**see** *Appendix B-3 for complete list of listening session recommendations*)

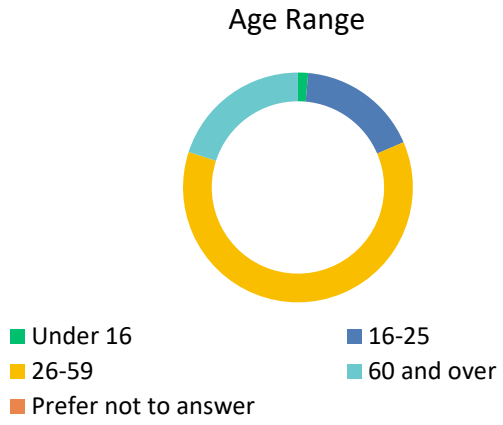
MHSA Listening Session	Description / # Participants
Alameda County Board of Supervisors (BOS) District 4	Special subcommittee for BOS District 4 (Oakland) held on 10/26/22 with 5 participants.
PEERS WRAP ® Program	PEERS WRAP® program for Latinx/Spanish-speaking cultures is a speakers' bureau providing a forum for members to live, grow, educate, and heal through story telling. held on 11/09/22 with 10 participants (age ranges 18-59).
API Reentry & System Impacted Populations	Collaborative courts involve a partnership with the District Attorney's Office, judges, defense attorney, Probation, social services, and other allied professionals. The court programs are 12-24 months and provide guided oversight and accountability with offenders. This session was held on 11/10/22, 10 participants age ranges 30-59.
Behavioral Health Collaborative of Alameda County – Part I & II (two sessions)	This session was held on 11/14/22 & 11/17/22, 23 participants total
Pacific Islander Wellness Initiative with RAMS, Inc.	This session was held on 11/18/22 with 6 participants, ages 18-59.
Mental Health Services Act Stakeholder Group (MHSA-SG)	15-member group consists of consumers, family members, and providers from each supervisorial district. The group reviews funded strategies, recommends priorities, and consults with ACBH held on 11/18/22, 7 participants
Transition Aged Youth (TAY)	Target membership reflects transitional aged youth (TAY) ages 18-24. Held on 11/29/22 with 10 participants.
Afghan Communities with Afghan Coalition	Held 12/1/22 with 8 participants.
African American Family Outreach Project (AAFOP)	Co-hosted with AAFOP, 12/8/22, 4 participants
Mental Health Association of Alameda County (MHAAC) – Family Education Resource Center (FERC)	Rescheduled to 12/19/22 with 17 participants (11 FERC staff)
Veterans, Active Duty, and Reservists with Swords to Plowshares	Rescheduled to 1/26/23 with 38 attendees.
Alameda-Contra Costa Medical Association (ACCMA)	Co-hosted in partnership with ACCMA, 1/19/23, 7 participants
13 completed listening session	**145 participants**

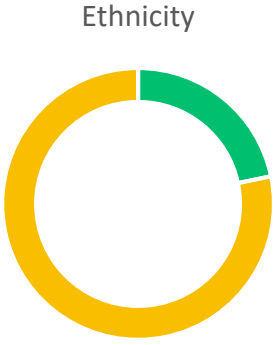
Summary of Listening Sessions

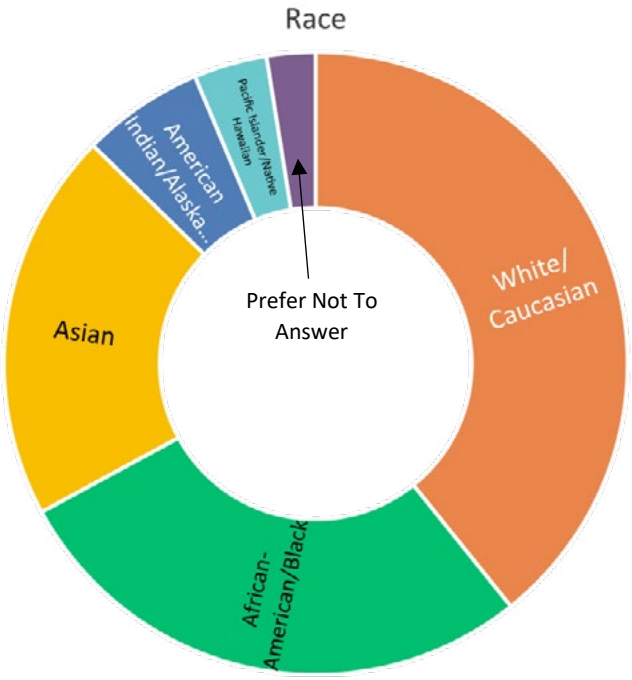
The CPPP solicitied input from 145 participants participating in thirteen MHSA listening sessions for the FY23/26 Three-Year Plan. MHSA collected demographic data on 70 particpants as reflected in the charts below:

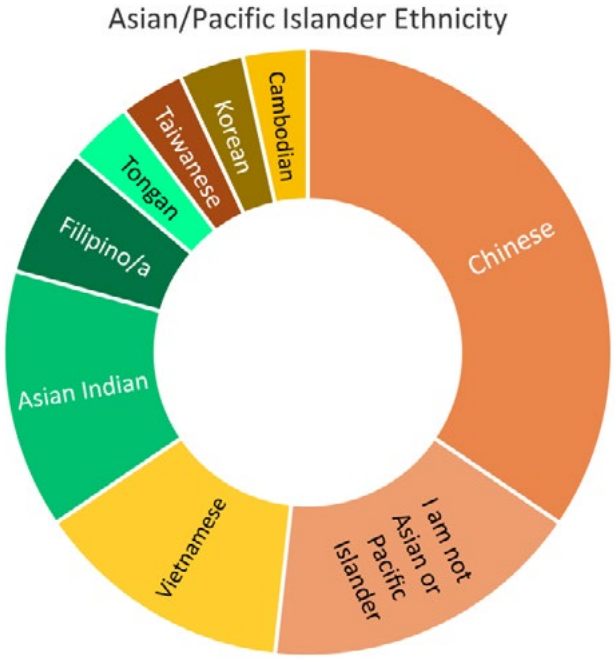


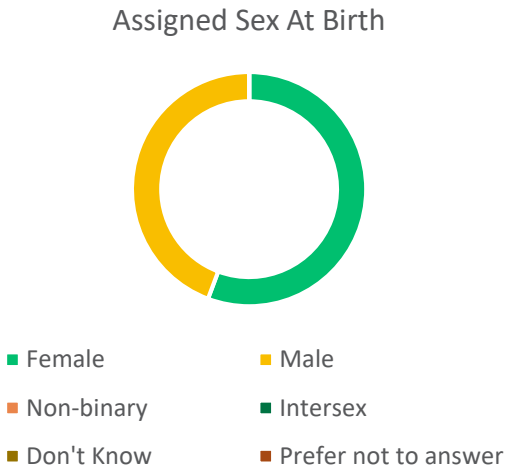


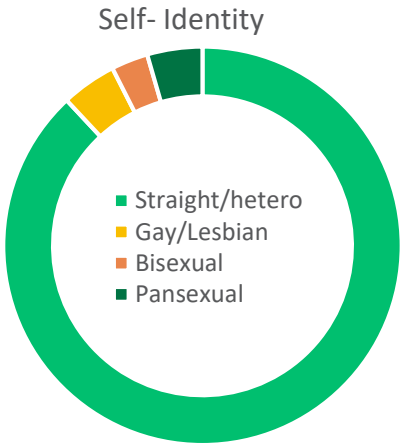


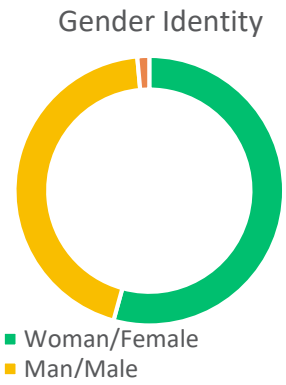



Race
White/ Caucasian
African-American/Black
Asian
American Indian/Alaska...
Pacific Islander/Native Hawaiian
Prefer Not To Answer


Asian/Pacific Islander Ethnicity
Chinese
I am not Asian or Pacific Islander
Vietnamese
Asian Indian
Filipino/a
Tongan
Taiwanese
Korean
Cambodian


Assigned Sex At Birth
Female
Male
Non-binary
Intersex
Don't Know
Prefer not to answer


Self- Identity
Straight/hetero
Gay/Lesbian
Bisexual
Pansexual


Gender Identity
Woman/Female
Man/Male

Community feedback was gathered through a series of scripted listening sessions facilitated by MHSA, HHREC, and trained co-hosts. The reoccurring themes identified across all listening sessions were:

- Address basic needs such as insecure housing
- Expand family reunification services and treatment courts
- Increase early intervention screenings and assessments
- Address the response time in systems such as ACCESS
- Isolation and lack of community
- Support the reentry community with diversion services
- Expand mobile crisis teams
- Address mental health workforce needs using non-traditional pathways
- More services for the African American community across the lifespan
- Supports and activities for the LGBTQ community, particularly the transgender community of color and sex workers
- Need for increased language capacity

The following sub-sections describe the specific community feedback collected during virtual CPPP listening sessions by unique stakeholder groups. A full listening session transcript of all reported needs and recommendations can be found in **Appendix B-3**.

Board of Supervisor's District 4 (Oakland) Listening Sessions

MHSA cohosted a listening session during a standing BOS 4 District meeting. The stakeholder group was identified as Oakland residents. Participants identified homeless/unhoused veterans and school-age youth as the most underserved populations within their community. It was also shared that increased isolation, fentanyl use, and issues with rate hikes for online therapy were pressing concerns. Participants suggested MHSA provide CFTN funds to update John George, and provide more outreach at local libraries as well as mental health first aid training.

PEERS WRAP ® Listening Session

MHSA cohosted a listening session with the Peers Envisioning & Engaging in Recovery Services (PEERS) WRAP ® program participants (a MHSA-funded project). Participants identified the African American, Latinx, LGBTQISA+, TAY, and Asian populations as groups that should be targeted for programming. Participants suggested MHSA address the needs of vulnerable groups with more peer support services, co-locating services where populations congregate and centralized resource hubs. Demographics included: 10 Hispanic/Latinx (Mexican, Puerto-Rican, Salvadorian, and Peruvian)

Asian-Pacific Islander Reentry & Systems Impacted Listening Session

MHSA cohosted a listening session with criminal justice involved and system impacted API communities. Participants identified the African American, Latinx, and substance user subgroups as the most underserved within their community. Reported concerns include a lack of culturally appropriate linguistic services, stigma in communities, and need for outreach to support Asian mental health. Participants suggested MHSA address the reentry process by using elderly API members and interpreters to provide services, technical support for API, and encourage those with lived experience to lead decision-making processes. Demographics included: 9 API (Vietnamese, Tongan, Chinese, Cambodian, Philipino), and Hispanic.

Behavioral Health Collaborative of Alameda County Listening Sessions I & II

MHSA facilitated two listening sessions with behavioral health providers who identified homelessness, a need for service integration, and safety nets for children as pressing mental needs. Participants reported many barriers for their agencies such as the shift to CalAIM which may impact their ability to travel/meet clients. The stakeholders suggested more pop-up services in mental health desert communities, and embedding services where community members meet such as churches and liquor stores.

Pacific Islander Wellness Initiative (RAMS, Inc.) Listening Session

MHSA cohosted a community engagement meeting RAMS, Inc. Stakeholder affiliation is largely comprised of pacific islanders. Participants reported the following barriers: PTSD/grief, family relations and stigma, anxiety, and telehealth. Participants identified at risk groups such as the undocumented communities, low-income, elderly, Micronesians, Palauan, Native Hawaiian, and Polynesians. Additional recommendations were made concerning the use of western medicine which may not be appropriate, the need to reduce funding to organizations that do not provide adequate services, and more funding around transportation. Demographics included: 6 Pacific Islanders (Samoan, Tongan) ages 18-59.

MHSA Stakeholder Group Listening Session

The MHSA Stakeholder Group is a diverse body that meets monthly. The MHSA-SG identified supportive housing and need for sub-acute beds as the most pressing mental health issues. Participants noted many barriers such as communication silos, workforce pay issues, and a need for more peer support specialists.

Transitional Aged Youth (TAY) Listening Session

MHSA cohosted a community input meeting with college-aged youth. The top mental health issues for this age group included parental consent for treatment, self-identity, basic needs, and anxiety. Stakeholders identified underserved groups as veterans, LGTBQIA+, Black students, immigrants/refugees, and people with cognitive disabilities. Participants identified solutions such as using personality tests to identify appropriate resources for youth, increasing university mental health resources, wellness centers, and one-stop shops for counseling young adults. Demographics included: 10 African American, Asian, Latinx, Vietnamese youth ages 18-24.

Afghan Coalition Listening Session

MHSA facilitated a listening session targeting the Afghan community. Participants identified a variety of barriers such as trauma, transportation, language barriers, school bullying, fear of harm, outreach, financial burdens, and need to address basic services first. Participants recommend establishing more Muslim schools/empowerment-focused educational centers, launching anti-stigma campaigns, establishing a basic needs distribution center, establishing elderly centers, and diversifying mental health teams with Pashto speaking providers.

African American Family Support Group (MHAAC) Listening Session

MHSA cohosted a community input meeting with African American family members who identified high needs groups as the poor communities, children and teens, and the unhoused. Specific recommendations for families included: more mental health counselors in schools, culturally competent screenings, addressing HIPAA issues and revisiting waiver policies, and using African American models in psychiatry.

MHAAC- Family Education Resource Center (FERC) Listening Session

MHSA cohosted a community input meeting with family members and their providers. Specific recommendations for families included: increasing supports in schools and IEPs, more 504,implementing NAMI end the silence programs in high schools, adding a line item to the MHSA budget to support AB2002.

Alameda-Contra Costa Medical Association (ACCMA) Listening Session

MHSA facilitated a listening session for a multi-county provider collaborative. ACCMA providers a variety of barriers such as the workforce shortage of mental health professions, appointment availability, narrow access to services, communication issues between providers, a need for care coordination and support. The group recommended intervention such as creating spaces adjacent to the emergency department for patient with psychiatric emergencies that are more clinically appropriate than keeping them in the ED.

Veterans, Active Duty, and Reservists Listening Session

MHSA cohosted an active military/veteran listening session with Swords to Plowshare. Participants identified Post-traumatic stress disorder (PTSD), anxiety, anger, and housing as major mental health challenges. Participants suggested MHSA dollars help provide mental health education in schools to destigmatize attitudes, and encourage mental health groups/therapy that meet in person to promote social connections.

Community Input Survey Results

During the community input period of October 28, 2022 – January 31, 2023, community members were asked to complete a 21-question survey that was hosted on SurveyMonkey and linked to the MHSA website. The survey was available in English, Chinese, and Spanish, three of Alameda County's threshold languages. A total of 581[1] unduplicated surveys were completed, while the survey was translated into 3 non-English languages over 99% of the surveys were English (**Table 1**). The following sections detail the demographics of survey participants and the results of the survey.

Table 1: Number of Survey Respondents by Survey Language[1]

Survey Languages	Number of Responses
1. English	576
2. Chinese	1
3. Spanish	4
Total	**581**

Note[1]: At time of writing, only the English-language surveys have been fully analyzed. The remaining 5 surveys will be updated and folded into the report as the MHSA Team completes these analyses.

Demographics

Survey participants were mostly adults aged 26-59 (59.55%), older adults 60 and over (31.08%), and 67.47% identified their gender as woman/female. (**Figures 1 and 2a/b**). Compared to the general Alameda County population these three groups are overrepresented among the survey participants (**Figure 1**). No data was obtained for persons 16 years or younger.

Figure 1: Participant's Age Groups (n=576)

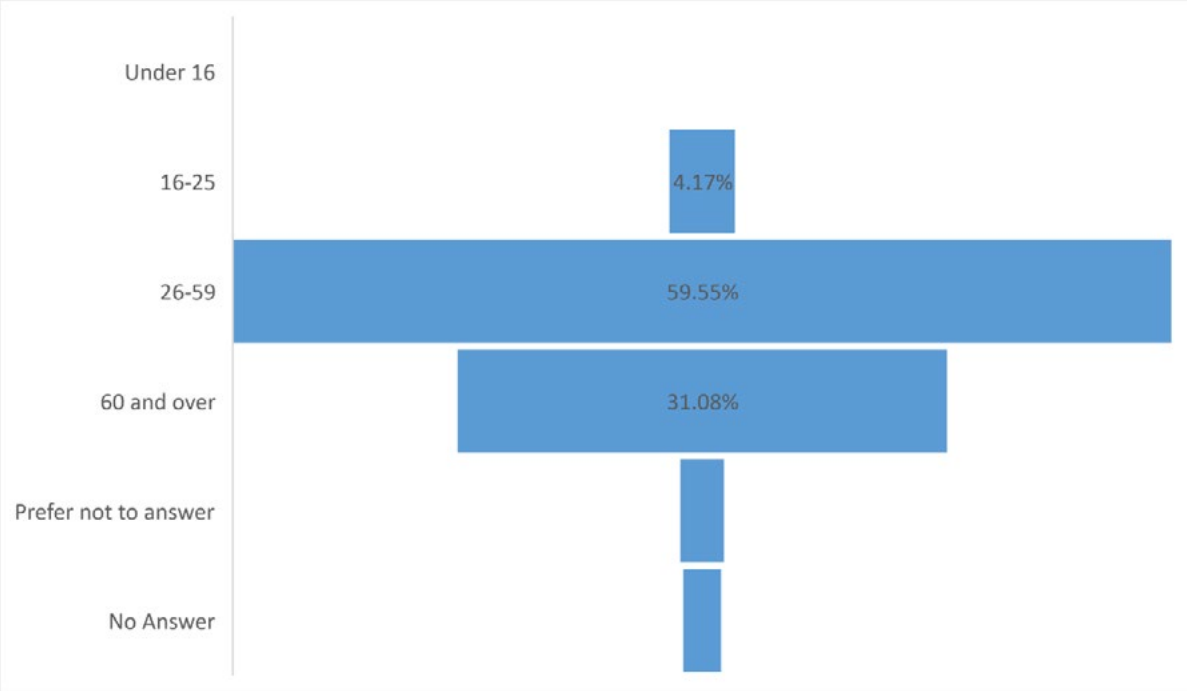


Figure 2a: Participant's Gender Identity (n=558)

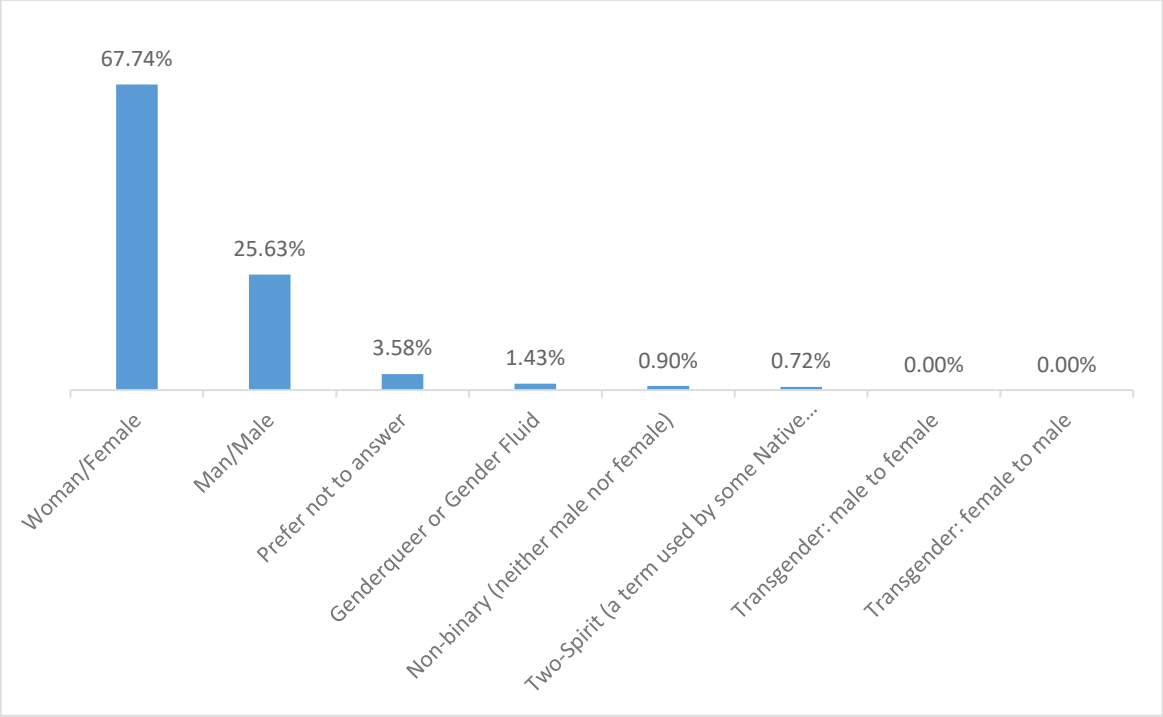
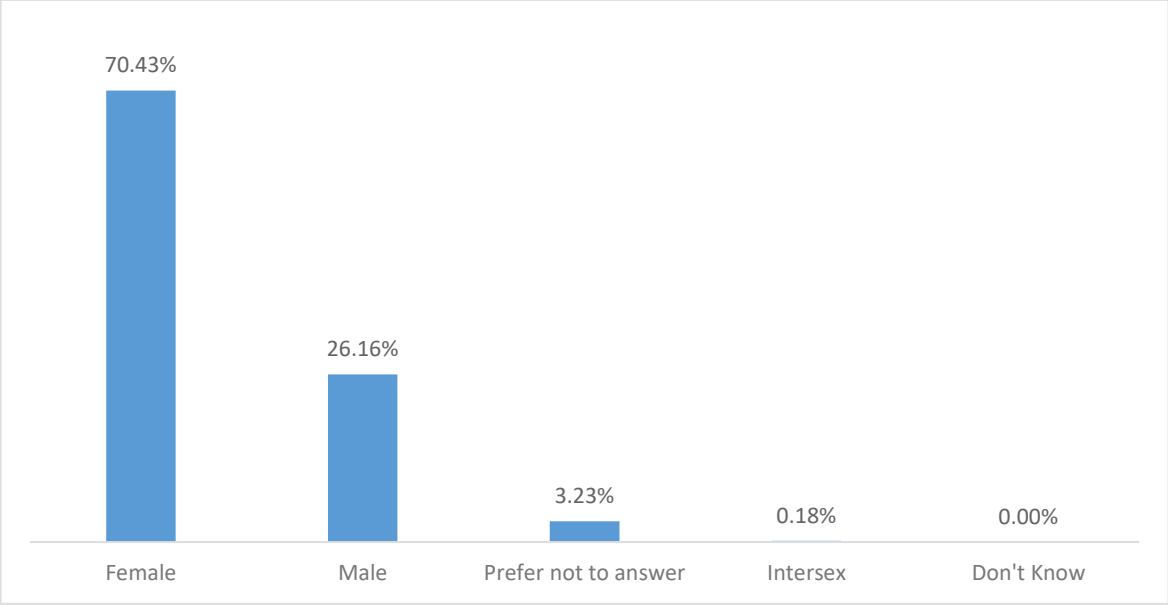


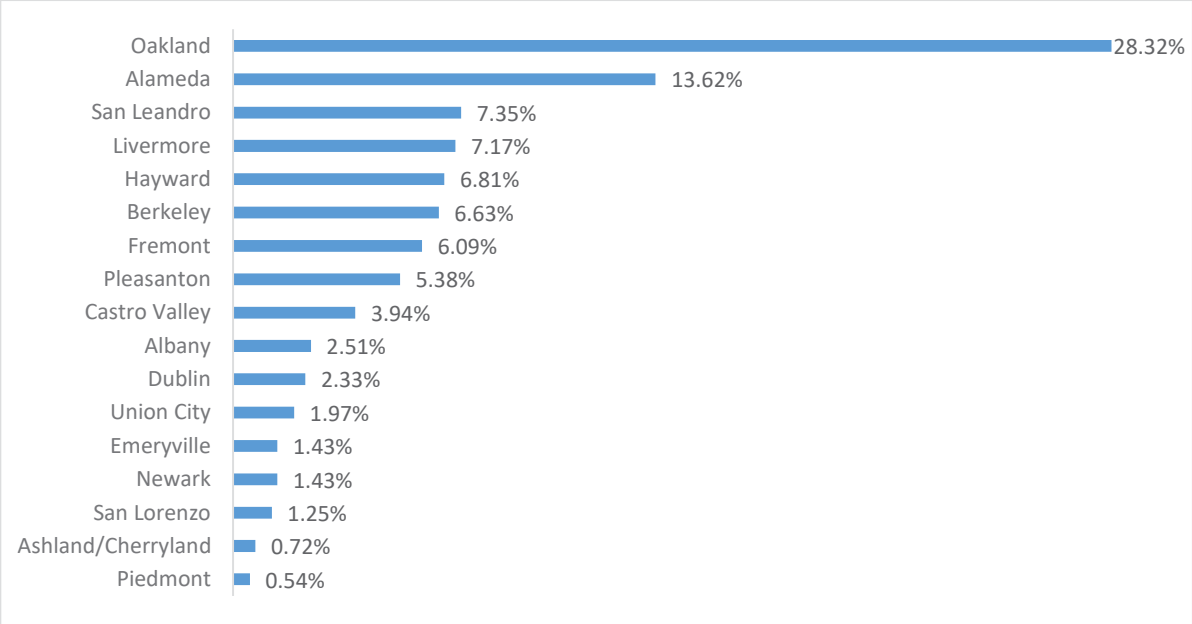
Figure 2b: Participant's Sex Assignment at Birth (n=558)



Outreach was conducted throughout various county cities. Oakland is 26.04% of the county's population, which is in close alignment with 28.32% of the respondents reporting that they live here.

Other cities that participants lived in were Alameda (13.62%), San Leandro (7.35%), and Hayward and Berkeley (6.81% and 6.63%, respectively). **Figure 3** below shows details of participant's city of residence.

Figure 3: Participant's City of Residence (n=544)



For this survey, respondents were asked to identify their race. Regarding this analysis, two points need to be considered: first, respondents were asked to indicate as many races as appropriate to describe their racial background. This differs from the US Census data, which handles multiple races by asking survey respondents to check a box labeled "Two or more races." Second, the CPPP survey treats race and ethnicity as independent facts from one another. A separate question for ethnicity asks respondents to identify themselves as being either Hispanic/Latinx or not Hispanic/Latinx; it is not considered a race in the CPPP survey. It would be possible, then, for a person to consider themselves both Hispanic/Latinx *and* white. This level of granularity for race and ethnicity would thus be captured in the CPPP survey but not in the US Census data, as the latter combines race and ethnicity into one question and does not allow for this granularity in its "Two or more races" selection.

Hispanic/Latinx is not considered a race for the CPPP County Survey, but it is for the US Census. This makes comparisons between the two data sets *with respect to this particular demographic slice* problematic, as they are not measuring the same categories. For the sake of clarity, the questions of race and ethnicity are presented as they appear in the CPPP survey only. Iterations of this plan in previous years contained such comparisons between survey and Census data, but they do not appear in the FY 23/26 plan.

552 respondents answered the question about their race. The racial selection with the highest number of respondent self-identification was White/Caucasian (49.09%), followed by Asian/Pacific Islander or Native Hawaiian (23.55%), African American/Black (16.85%), and American Indian/Alaskan Native (2.72%). 13.59% of the respondents chose to not answer this question. **See figure 4a**

For ethnicity, 86.56% of respondents identified themselves as not being of Hispanic/Latinx ethnicity, while 13.44 % of respondents identified themselves as being of Hispanic/Latinx ethnicity. 543 survey respondents answered this question. **See figure 4b**

Figure 4a: Race (n=552)

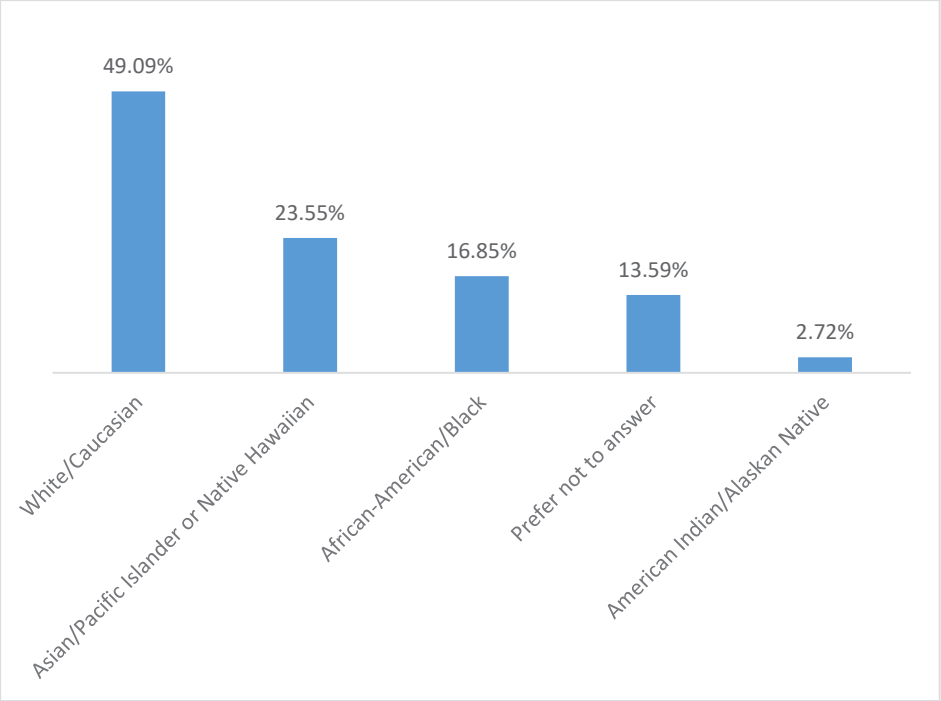
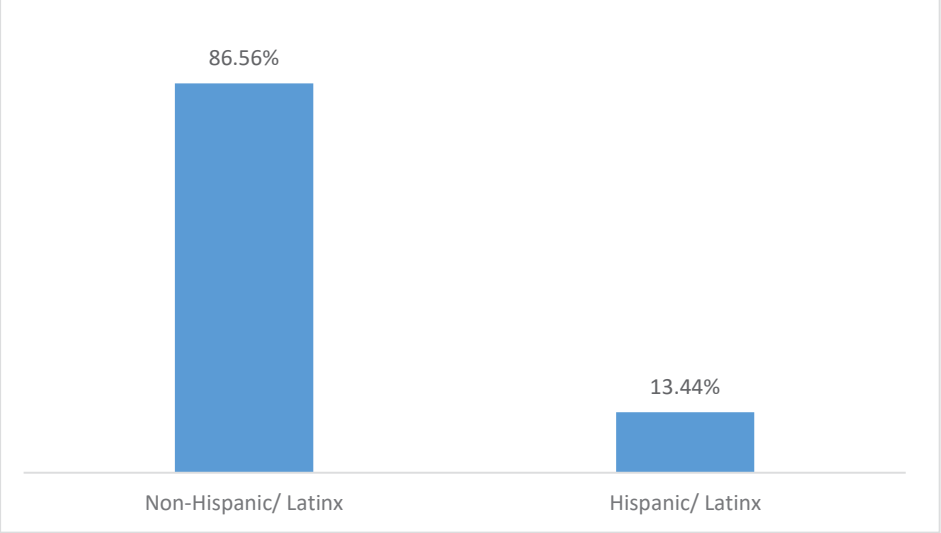
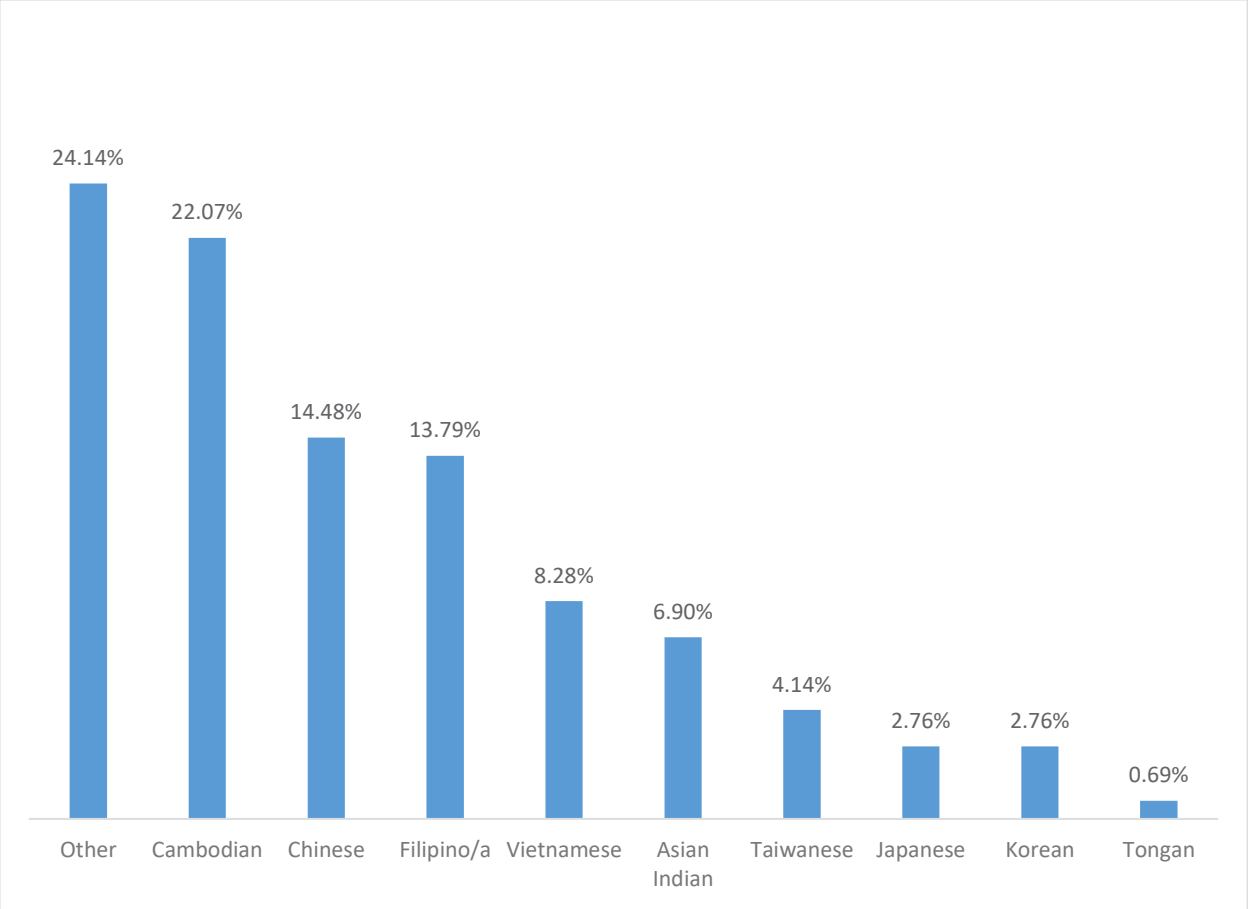


Figure 4b: Ethnicity (n = 543)



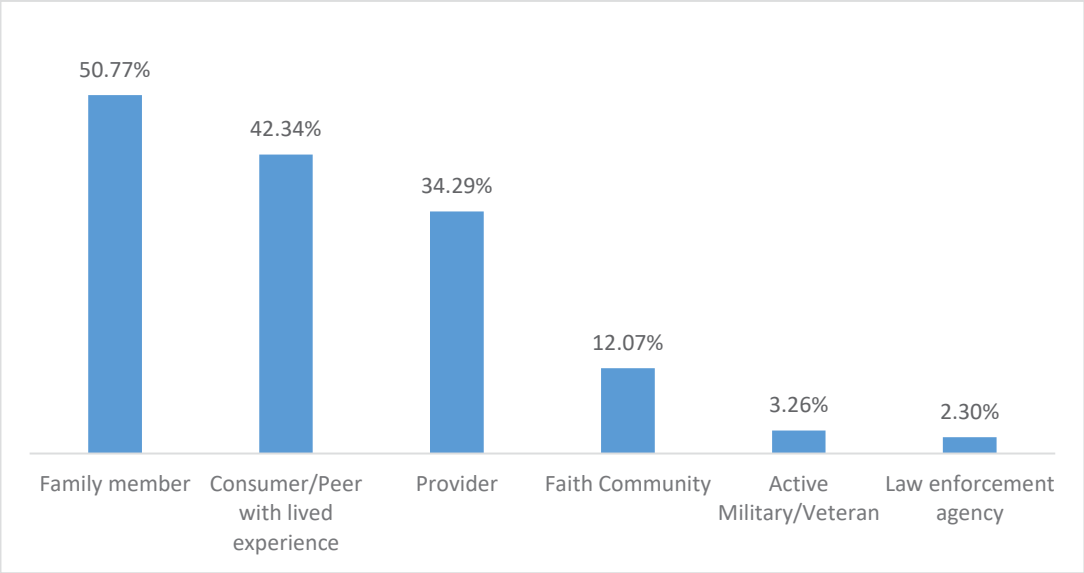
Among the 145 participants who chose an Asian or Pacific Islander nationality or country of origin, “other” was chosen the most (24.14%). The highest specified group was Cambodian (24.14%), followed by Chinese (14.48%) and Filipino/a (13.79%) (**Figure 5**).

Figure 5: Asian or Pacific Islander Participant's Nationality or Country of Origin (N= 110)



Participants were asked what stakeholder group they represented and most identified as a family member (50.77%), followed by consumer/peer with lived experience (42.34%). (**Figure 6**).

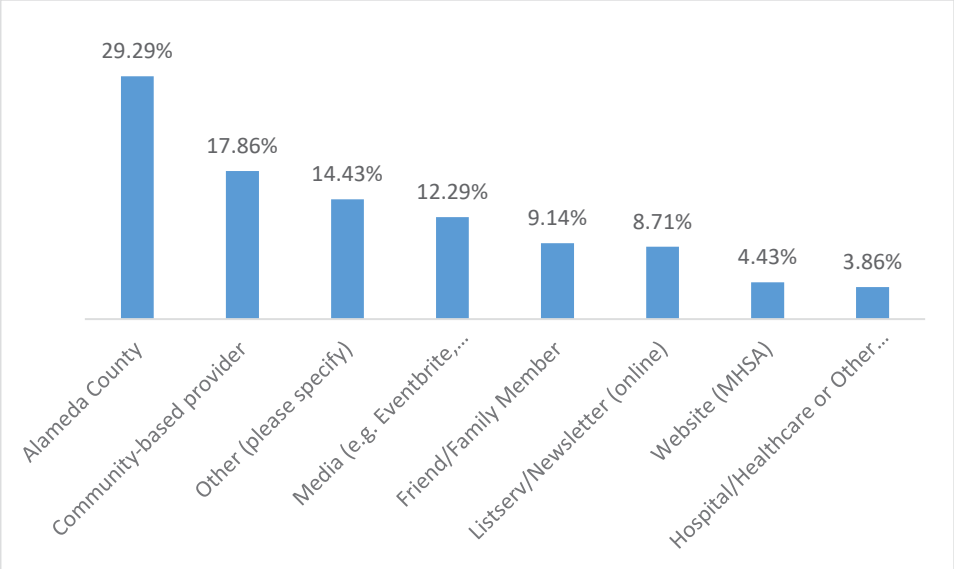
Figure 6: Participant's Stakeholder Group (n= 484)



*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. One-third of the answering participants reported that they learned about the survey through Alameda County (29.29%). The other ways that the participants learned about the survey were through community-based provider (17.86%), other (14.43%), media (12.29%), family/friend (9.14%), and listserv/newsletters (8.71%). Additionally, 86.81% 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 2**).

Figure 7: Learn about Community Participation and Feedback Survey (n=484)



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

Table 2: First Time Participating in MHSA Community Program Planning Process (n= 576)

Response	Count	Percent %
Yes	500	86.81%
No	33	5.73%
Not Sure	20	3.47%
No Answer	23	3.99%
Total	**576**	**100.00%**

MHSA Survey Results

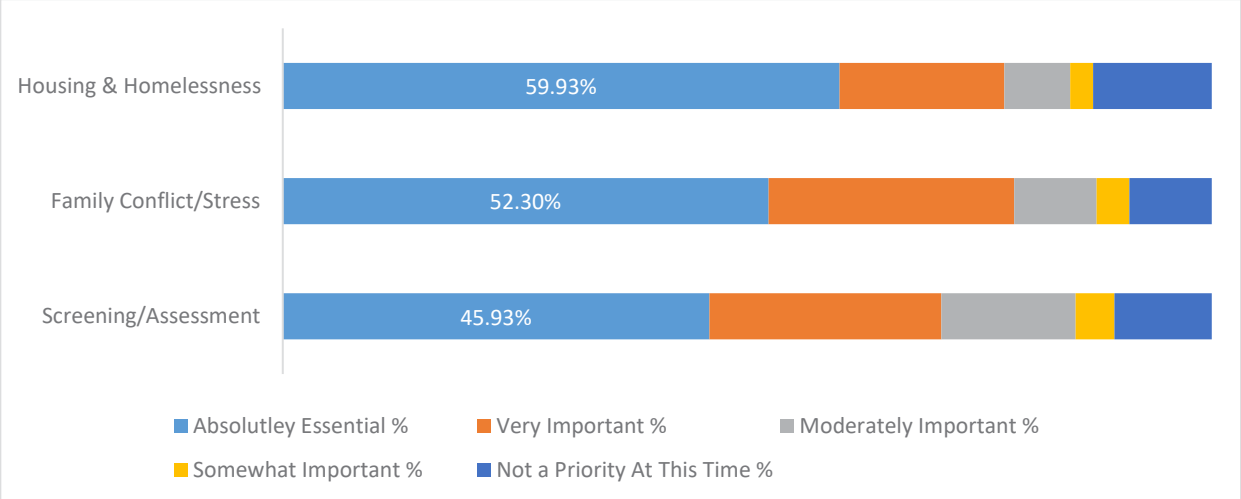
The following are the results of the MHSA Survey provided by 576 unduplicated individuals living and/or working in Alameda County. In response to the community input, ACBH has provided information on current programs and focus group recommendations that address each of the top identified needs.

Survey Question # 2: Mental Health Issues for Early Childhood Youth – Prioritized

Q2. What are the top or most pressing mental health challenges related to early childhood (ages 0-5) 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 Transitional Age Youth as: 1) Housing and Homelessness (59.93%); 2) Family Conflict/Stress (52.30%); and 3) Screening/Assessment (45.93%).

Figure 8a: Top Three Concerns Related to Early Childhood Youth [age 0-5] (n=564)



Analysis of Early Childhood Concerns

Table 3: Available Programs and Focus Group Recommendations for Early Childhood Youth

Prioritized Needs for Early Childhood Youth	**Available** (Programs in implementation)	**Future Opportunity** (for future consideration)
1. Housing & Homelessness	X	
2. Family Conflict/Stress	X	
3. Screening/Assessment	X	X

Early Childhood Youth: 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:

> "Children need a stable family environment in order to thrive. This can be difficult for children whose parents suffer from mental illness or substance abuse. The collaborative courts can provide resources to parents whose children have been removed due to these issues and help them to prevent their children from being placed outside the home."
>
> "All children should have a save and clean environment to live in. We need to prioritize affordable housing for all families."

Current Programs

To combat homelessness MHSA funded programs, help children and families find housing opportunities:

- Housing Solutions for Health
- No Place Like Home

Focus Group Recommendations

> *"*Increasing housing*."* — Peer Wrap Program Listening Session Participant

Early Childhood Youth Concern 2: Family Conflict/Stress

Survey participant expressed concerns about family stress and conflicts. Some thoughts and suggestions offered by the survey participants include:

> "Identification of abusive situations for young children is essential to protect them, especially those with disabilities and special needs. Screening, provision of services to the family for not only the child but parents and siblings so they can live together safely and caringly."
>
> ""The Family Treatment Court program is a strong collateral process that has been extremely helpful in addressing the underlying MH and substance abuse issues and help to reunify families in the dependency system by helping parents with co-occurring disorders."
>
> "Access to childcare, some trauma and family conflict could be alleviated if ALL families had access to quality childcare which has standards beyond babysitting. Require engagement activities, site visits and provide FREE training/certifications to childcare providers."

Current Programs

PEI funded programs help young children, and their families identify mental health illness and address childhood trauma:

- Fremont Healthy Start Program
- Early Childhood Mental Health Outreach & Consultation
- School-Based MH Consultation in Preschools-Blue Skies
- Unaccompanied Immigrant Youth Outreach
- Pediatric Care Coordinator Pilot program (WET)

Focus Group Recommendations

> "Culturally responsive, calming [or]…. meditation center for socialization opportunities or [to] get away from homes to reduce isolation." — Afghan Coalition Listening Session Participant

Early Childhood Youth Concern 3: Screening and Assessment

For many respondents, mental health screening and assessment ranked among the top 3 concerns identified in the survey answer. In the free response section, respondents called for wrap around services for both the children and their families, along with early intervention regarding mental health illnesses.

> "We must address the mental health, basic needs and offer wrap around services to the family and advocate early on if the child needs an IEP. Many immigrant communities may not have the language capacity or know about IEP services to request for this kind of assessment."
>
> "Early intervention with young children and their caregivers [is a concern facing young children]."

Current Programs

PEI funded programs help young children, and their families identify mental health illness through early screening:

- Fremont Healthy Start Program
- Early Childhood Mental Health Outreach & Consultation
- School-Based MH Consultation in Preschools-Blue Skies
- Unaccompanied Immigrant Youth Outreach

Focus Group Recommendations

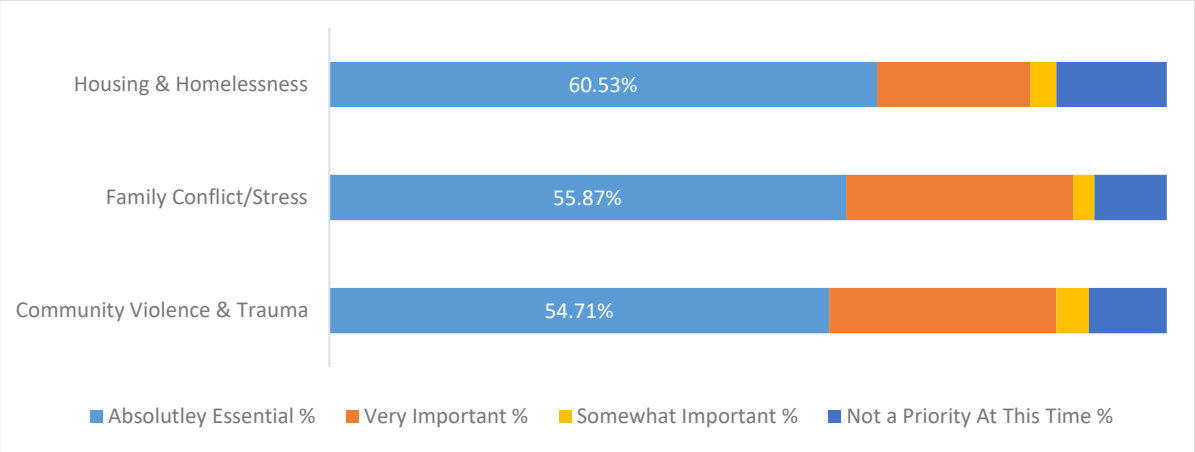
> "We need community response using trusted people to refer members of the community (e.g. faith based, school, nursery center) to address stigma [around accessing mental health services]. Embed services (screening level) in well-known/trusted/existing community orgs." — African American Family Outreach Project Listening Session Participant
>
> "Early identification [of mental health challenges] is difficult for African American Families. Framing mental health issues as the 'the family has deficits' is a deficit-based approach." — African American Family Outreach Project Listening Session Participant

Survey Question # 3: Mental Health Issues for Young Children – Prioritized

Q3. What are the top or most pressing mental health challenges related to young children (ages 6-12) that 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 Early Childhood Youth as: 1) Housing and Homelessness (60.53%); 2) Family Conflict/Stress (55.87%); and 3) Community Violence & Trauma (54.71%).

Figure 8b: Top Three Concerns Related to Young Children [ages 6-12] (n=568)



Analysis of Young Children Concerns

Table 4: Available Programs and Focus Group Recommendations for Young Children

Prioritized Needs for Young Children	**Available** (Programs in implementation)	**Future Opportunity** (for future consideration)
1. Housing & Homelessness	x	
2. Family Conflict/Stress	X	
3. Community Violence & Trauma	X	X

Young Children Concern 1: Housing & Homelessness

Survey respondents identified Housing and Homelessness as being a top concern for young children (those aged between 6 and 12 years of age). Writing in the free response section of this question, respondents emphasized that having a safe, stable home was a top priority for this age group.

> "These issues are exacerbated for children with disabilities and special needs to extra vigilance in identifying them in dangerous living situations, and the provision of services to them and their family so they can live in healthy ways. Child sexual abuse is a high concern."

> "Children need a stable family environment in order to thrive. This can be difficult for children whose parents suffer from mental illness or substance abuse. The collaborative courts can provide resources to parents whose children have been removed due to these issues and help them to prevent their children from being placed outside the home."

Current Programs

To combat homelessness MHSA funded programs, help children and families find housing opportunities:

- Housing Solutions for Health
- No Place Like Home

Focus Group Recommendations

> *"*Need to integrate services more (housing, medical, mental health treatment, and substance abuse disorder treatment)." — ACBH Collaborative (Providers)-Part 1 Listening Session Participant

Young Children Concern 2: Family Conflict and Stress

Family conflict and stress ranked as the second-highest concern regarding young children, according to survey response answers. A priority should be placed upon the use of programs, such as Family Treatment Courts, to aid in the maintenance or reunification of families facing such stressors.

> "Families connected to Family Treatment Courts have much higher rates of reunification and much lower rates of return to foster care. The strength of the Family Treatment Courts lies in getting parents into substance use treatment almost immediately. This reduces or even eliminates the need for children to come into foster care."
>
> "I am not as personally familiar with the family treatment courts, but I strongly believe in the value of reunification of families. If the parents can get assistance with their mental health and/or substance use concerns, they will be better equipped to parent their children - and the children will be better off. Early intervention with these children - and their families - is of the utmost importance."

Current Programs

PEI funded programs help young children, and their families identify mental health illness and address childhood trauma:

- Fremont Healthy Start Program
- Early Childhood Mental Health Outreach & Consultation
- Unaccompanied Immigrant Youth Outreach

Focus Group Recommendations

> *"*Education-more workshops emphasize healthy ways to respond to stress/trauma." —Afghan Coalition Listening Session Participant
>
> "More mental health programs for adults dealing with stress. [For example,] in San Jose, they had a program where if you were stressed out, you could bring your kids to a setting where they would be safe to reduce the risk of domestic violence." — African American Family Outreach Project

Young Children Concern 3: Community Violence and Trauma

Rounding out the list of top three concerns facing children ages 6 through 12 is the specter of community violence and the trauma that often accompanies it. Short, succinct responses in the survey speak to this reality:

"Human trafficking, domestic violence, and sexual assault."

"School safety, culture of peer-to-peer violence in schools."

Current Programs

PEI funded programs help young children, and their families identify mental health illness and address childhood trauma:

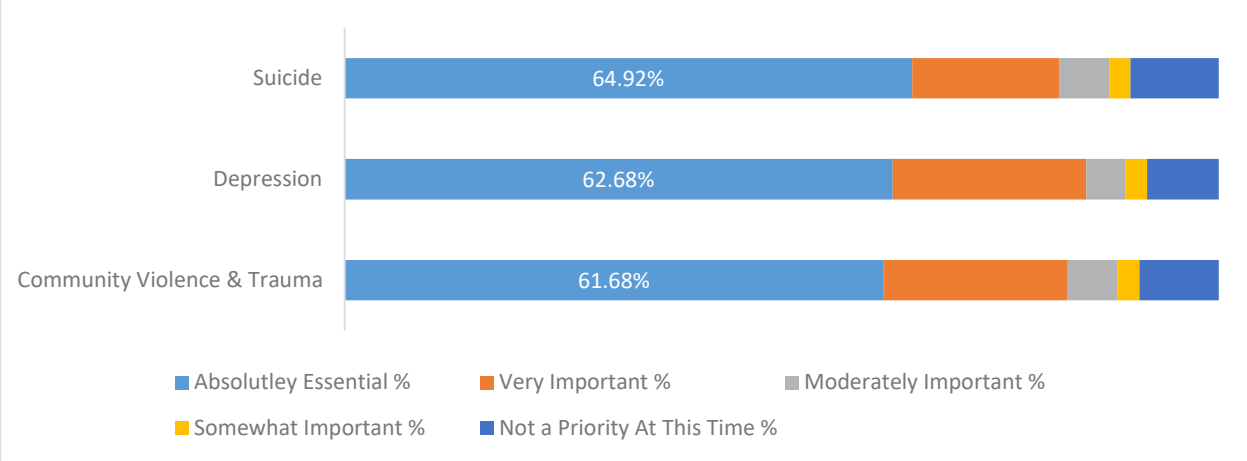
- Fremont Healthy Start Program
- Early Childhood Mental Health Outreach & Consultation
- Cultura Y Bienestar (La Clinica)
- Unaccompanied Immigrant Youth Outreach

Survey Question # 4: Mental Health Issues for Children, Middle/High School – Prioritized

Q4. What are the top or most pressing mental health challenges related to Children, middle/high school (ages 13-17) that 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 Transitional Age Youth as: 1) Suicide (64.92%); 2) Depression (62.68%); and 3) Community Violence & Trauma (64.94%).

Figure 8c: Top Three Concerns Related to Children, Middle/High School [Ages 13-17] (n=565)



Analysis of Children, Middle/High School Concerns

Table 5: Available Programs and Focus Group Recommendations for Children, Middle/High School

Prioritized Needs for Children, Middle/High School	**Available** (Programs in implementation)	**Future Opportunity** (for future consideration)
1. Suicide	X	X
2. Depression	X	
3. Community Violence & Trauma	X	

Children, Middle/High School (ages 13-17) Concerns 1 and 2: Suicide and Depression

There is a real concern for the mental well-being of children in this age group, according to the survey respondents. An overarching theme running through the collected free response submissions is that middle-and-high-school age children have little or no access for mental health care resources. If such resources are available, then there are often considerable barriers such as limited provider availability or long wait times to be seen by a clinician. Furthermore, respondents stated that the global events of the last three years related to COVID-19 and its aftereffects have created further strain on the minds of these children. In the respondents' opinions, this strain has led to an increase in mental illness and associated behaviors, such as anxiety, depression, violence, and suicidal thoughts and behavior.

> "There is a need for a lot more support at this age. Children dealing with mental illness are often rejected or ridiculed by peers and teachers. There is little help if any, through health insurance. Talk therapy seems to be the only support easily offered. Cognitive Behavioral Therapy and Exposure Response Prevention therapy for OCD are not readily available unless you have a lot of money to pay out of pocket. It is also extremely difficult to find therapists that do these therapies. Mindfulness could be included in the school day to help students with stress."
>
> "Covid has been devastating for this age group. Learning loss, but more importantly the increase in isolation, depression, anxiety, suicide, risk of violence. My son attends Berkeley High where in the last 6 months (including summer) there has been a lunch time suicide, thwarted attempt to bomb the school, two students recently shot and killed at a nearby party. Schools are NOT equipped to manage this level of stress, violence and mental health related issues. They need much more support."
>
> "Absolutely NO therapists available in Fremont area when there is a crisis situation! seems the County wants the ER's and hospitals to handle immediate crisis situations for this age group when a therapist or counselor can help! None were available!"
>
> "Not enough therapy options/providers."

Current Programs

PEI funded programs help youth, and their families identify mental health illness and address childhood trauma:

- Fremont Healthy Start Program
- Early Childhood Mental Health Outreach & Consultation
- Unaccompanied Immigrant Youth Outreach
- School-Based Mental Health Access and Linkage
- Crisis Support Services- Text Line
- Crisis Services: Mobile Response Teams
- ACBH Training Institute's Suicide Assessment & Intervention (WET)

Focus Group Recommendations

> "Teach kids to take care of mental health needs like how they are taught to take care of their physical health. [They should learn mental health challenge] signs, coping mechanisms, learning how to support peers." — TAY Listening Session Participant

> "They should have mental health counselors in the school. I believe kids have been out of school so young (suffering from depression due to quarantine) that this is needed." — African American Family Outreach Project Listening Session Participant

Children, Middle/High School (ages 13-17) Concerns 3: Community Violence and Trauma

Survey participants offered concerns around community violence and trauma, akin to those expressed regarding children in younger age brackets. Notable for this age group is the presence of concerns revolving around gender and sexual identity violence. Concern for bullying, in both physical and cyber settings, was also noted in these responses.

> "Many children have seen or experienced school violence. Anxiety and constant worry are their unfortunate companions. Tools for support this, such as music, meditation, etc. could be helpful. This is a good age for boys to learn how to treat women, so they can have happy families. Also, women need to learn self-defense... Also, education on cyberbullying and how to stop it, the importance of bystanders, etc."
>
> "Safe people and places."
>
> "Bullying."
>
> "Gender based violence such as human trafficking, domestic violence and sexual assault."

Current Programs

PEI funded programs help youth address trauma:

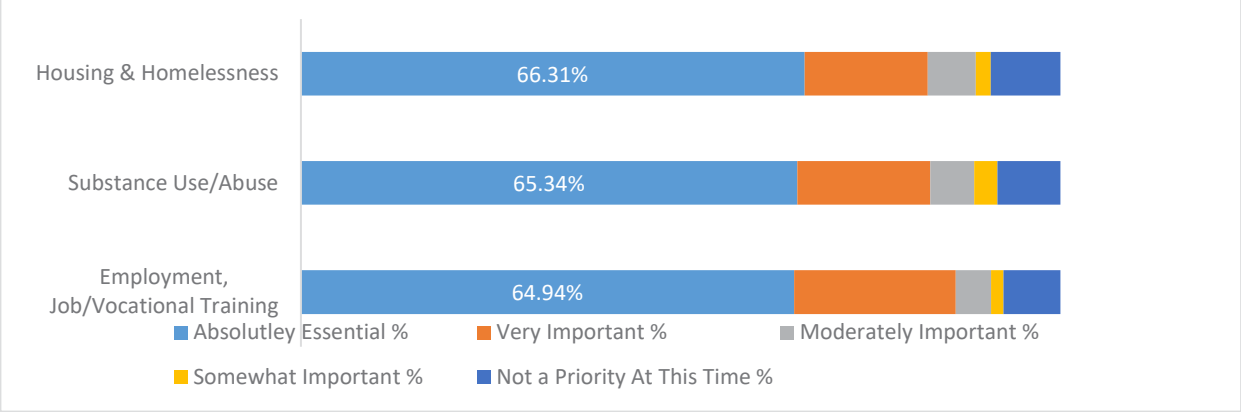
- Fremont Healthy Start Program
- Early Childhood Mental Health Outreach & Consultation
- Unaccompanied Immigrant Youth Outreach
- School-Based Mental Health Access and Linkage

Survey Question # 5: Mental Health Issues for Transitional Aged Youth (TAY) – Prioritized

Q5. What are the top or most pressing mental health challenges related to Transitional Aged Youth (TAY) (ages 18-24) that 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 Transitional Age Youth as: 1) Housing and Homelessness (66.31%); 2) Substance Use/Abuse (65.34%); and 3) Employment, Job/Vocational Training (64.94%).

Figure 8d: Top Three Concerns Related to Transitional Age Youth [Ages 18-24] (n=564)



Analysis of Transitional Aged Youth (TAY)

Table 6: Available Programs and Focus Group Recommendations for TAY

Prioritized Needs for TAY	**Available** (Programs in implementation)	**Future Opportunity** (for future consideration)
1. Housing & Homelessness	X	X
2. Substance Use/Abuse	X	
3. Employment, Job/Vocational Training	X	X

Transitional Age Youth (TAY) (ages 18-24) Concerns 1: Housing and Homelessness

Housing and homelessness were the top concerns for transitional-aged youth, according to survey respondents. As indicated through their free response, the lack of affordable housing coupled with limited income presents a very real threat to this age group.

> "As more and more children are in the throes of houselessness, all the above problems need to be addressed NOW not one year from now! Policies set in place. Yes, that is difficult but mandatory if there is to be a push on the needle towards success."

> "A lot of transition aged youth are working but have limited income and can't afford housing in the area, I've known a few that had to live in a vehicle. Having more homes for this group, or at least a place to legally park, would help."

> "Since the early 80's youth have been abandoned by the welfare system. A bus ticket, $50 and all their worldly possessions in a garbage bag. Trust, attachment and treatment for healing their trauma and substance use issues is key. Education & job training and adult placement that provide financial and day to day living skills would be amazing. Paying bills, cooking, cleaning etc. especially if the youth wasn't provided these skills. Provide safe housing and connecting activities to build communities that are based in trust and support."

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:

- Bay Area Community Services (BACS) Rental Subsidies and Landlord Liaison Program (RALE)
- Casa Maria Safe Haven Shelter
- Housing Solutions for Health
- No Place Like Home

Focus Group Recommendations

> "One-stop shops for counseling for young adults; paperwork and consultation meeting." — TAY Listening Session Participant

Transitional Age Youth (TAY) (ages 18-24) Concerns 2: Substance Use/Abuse

Quantitatively, the survey response data indicates that substance use and abuse rank as the second-highest concern for TAY youth. A review of the free response answers, however, reveals that this concern is coupled with a desire to utilize programs such the collaborative courts to help these young people avoid potentially deleterious interactions within the traditional criminal justice system. As their responses indicate, respondents posit that the ready availability and accessibility of such programs is a critical step in addressing substance use and abuse for this age group.

> "The collaborative courts are absolutely essential to helping system-involved TAY adults in Alameda County. The work they do to help people avoid the ongoing cycle of incarceration is invaluable - especially so early in adulthood. So many of the individuals they work with struggle with mental health and/or substance use concerns. What these individuals need is treatment, not further incarceration and marginalization. The collaborative courts are vital in ensuring that the mental health and substance use needs of these individuals are appropriately addressed."

> "Justice-involved TAY often need supports to allow them to become productive members of society. The collaborative courts help those with substance use and mental health issues to address these issues and achieve stability and sobriety. The collaborative courts can also assist with housing, education, and employment resources. Completion of a collaborative court program can also lead to charges being dismissed or removed from their record which also helps them to move forward in life."

> "Substance abusers need lots of help to turn habit. Too much freedom without responsibility for abusers. Need more residential treatment facilities and court should supervise."

> "Teaching programs on healthy relationships, respectful and healthy body image and view of sex. Solid Substance Use education to not promote drug use and tells truth about the effects of things like cannabis. Peer Support programs, Socio-emotional supports, and gearing up for transitions to Adult SOC or "Adulting" Case management."

> "Unfortunately, substance abuse can involve pre-teens, too, but becomes a serious problem most often in this age group. We desperately need more high-quality, affordable treatment centers and half-way houses."

Current Programs

MHSA CSS funds a variety of programs addressing co-occurring substance use amongst TAY:

- Bay Area Community Services (BACS) PAIGE program
- Building Opportunities for Self-Sufficiency (BOSS) Supported Independent Living
- Assisted Outpatient Treatment (AOT)
- Telecare CHANGES program
- Crisis Services: Mobile Response Teams

Focus Group Recommendations

> "Convince people to use resources, help people come to terms with their situations and eliminate the fear of opening up to people." — TAY Listening Session Participant

Transitional Age Youth (TAY) (ages 18-24) Concerns 3: Employment, Job/Vocational Training

Free or affordable job educational and job training opportunities are the third-highest concerns for the TAY age group, as reported by survey respondents. Written free response to this question indicate that educational and job training is seen as way to promote independent living and financial stability for TAY youth.

> "Long term financial stability and independent living is important at this stage. Providing the resources to make this possible is essential."
>
> "Emphasis on successful and meaningful educational support that includes job training and placement (like those provided by Cristo Rei) will help reduce the need for the many items listed as the youth will feel their success, be headed in a meaningful productive direction and feel good about themselves."
>
> "Real opportunities to obtain skills necessary to be self-sufficient."
>
> "This age group needs the most support with college and career readiness. They need access to free community college, grants, and scholarships, along with job training and paid internships."

Current Programs

To address job/vocational training needs, WET funds a variety of projects, including:

- Faces for the Future Mental Health Career Pathways and Bright Young Minds (BYM) Conference
- Ohlone Community College Mental Health Advocacy Program
- Mental Health Navigator Program with local community colleges
- Alameda County Behavioral Health Career Pipeline Scholarship and Mentorship Program
- Center for Empowering Refugees and Immigrants (CERI) Wellness in Action (WiA) workforce development program
- Beats, Rhymes and Life Mental Health Career Pathways
- Early Childhood Mental Health Postgraduate Certificate Program
- Korean Community Center of the east Bay Mental Health Asian Workforce Pipeline Program

Focus Group Recommendations

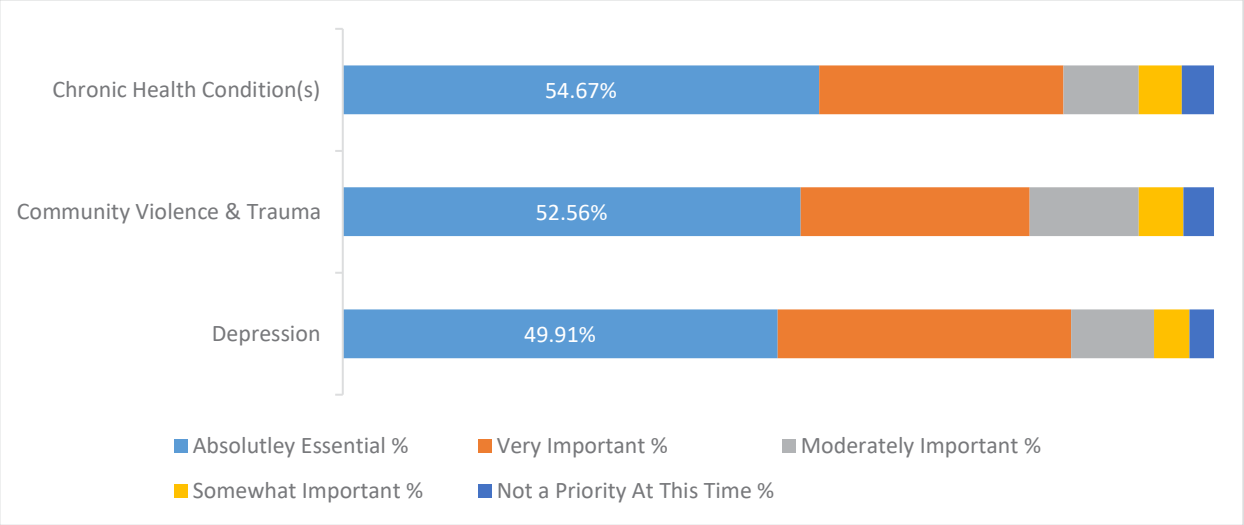
"Having a database; have resources reach out to people instead of vice versa. They can act as a guide." — TAY Listening Session Participant

Survey Question #1: Mental Health Issues for Adults and Older Adults – Prioritized

Q1. 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) Chronic Health Condition(s) (54.67%); 2) Community Violence & Trauma (52.56%); and 3) Depression (49.91%).

Figure 9: Top Three Concerns Related to Adults/Older Adults (n=573)



Analysis of Adults and Older Adults

Table 7: 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. Chronic Health Condition(s)	X	
2. Community Violence and Trauma	X	
3. Depression	X	

Concern 1: Chronic Health Condition(s)

Chronic health conditions top the list of concerns for adults and older adults, as measured by quantitative data in the survey. A review of the written comments indicates that access to healthcare resources, particularly mental health resources, is a driving concern. Mobile healthcare services would aid in accessing such resources, according to several responses.

severe mental illnesses, such as schizophrenia and dementia, is another major concern fond within the free responses for this question. This concern involves both a desire for readily available screening and ongoing treatment of such conditions.

> "SMI (Serious Mental Illness) needs to be taken seriously and the recognition on anosognosia as a real symptom of SMI needs to understood. We need serious change in our abilities to help adults with SMI who lack awareness about their disease."
>
> "Resources for the severely mentally ill (e.g. Schizophrenics)."
>
> "Mobile Mental Health Services - we really need them! As a standalone and as well as accompanying police, ambulance and fire emergency services. Dual diagnosis treatment centers for those without insurance or on Medi-Cal."
>
> "Serious mental illness: Schizophrenia, Schizoaffective, Serious Bipolar. Most of this population does not believe they are ill (anosognosia), and the system uses that as a reason to not help them."
>
> "Access to urgent Inpatient and Outpatient Psychiatry all days of the week."
>
> "In home treatment."
>
> "Mobile crisis teams, access to food, access to health care and mental health care"

Current Programs

PEI, CSS, and CFTN funded programs also helps Adult, Older Adult, and families with chronic medical conditions:

- Increased training and payment rates for locally contracted Board and Care homes
- Alameda Point Collaborative Senior Housing and Medical Respite Center (in development)
- Oak days Care Program

Focus Group Recommendations

> "More support (outreach and resource info) at libraries and for library staff." — Board of Supervisors, District 4, Supervisor Nate Miley (Unincorporated)
>
> "Embed mental health services in places where people already go, like church, liquor stores, et cetera. But need availability for treatment in these places, not just outreach." — ACBH Collaborative (Providers) Part I
>
> "…A lot of [County mental health services] are piecemealed and there needs to be a systematic model for a system of care. Each silo doesn't hand off to the next one. There's no connection, and it's difficult to access. A lot of calls, drop ins, hotlines, and traffic to access services. We need a 'shepherd' system that helps people; makes it easy to access services; makes it easy to connect; [and] makes it easy to follow up. We need to see that something is happening. For mental health care I have to follow up 3 months later. There's no insight into what is going on. We need a repository of information." — Alameda-Contra Costa Medical Association (ACCMA) Listening Group Participant

Concern 2: Community Violence and Trauma

Community violence and its associated trauma ranks as the survey respondents' second-greatest concern with respect to this age group. Domestic figures prominently in the free response section, along with calls for survivor support services such as PTSD counseling.

> "Gender based violence such as human trafficking, domestic violence and sexual assault"
>
> "Support Groups for PTSD"
>
> "Domestic violence. (If this is covered by family support then I would move the tick mark to 1) including verbal/mental and emotional abuse - it leads to depression, unemployment and homelessness. Some men are smart enough not to leave any marks. The abuser should be the one to have to find a new place to live. It's unbelievable how we still live with this issue."

Current Programs

There are multiple programs that work towards deescalating people in crisis and addressing trauma such as:

- Suicide Prevention Crisis Line and the Activating Hope Project
- In Home Outreach Teams
- Family Education and Resource Center (PEI)
- Crisis Response Program
- Older Adults Peer Support (PEI)

Focus Group Recommendations

> "Evaluate first and then expand MACRO[1] in Oakland [service] handles by fire department/clinicians. It's not as formidable as the police, and weapons aren't involved. Expand the CATT[2]/mobile response units." — African American Family Outreach Project Listening Session Participant
>
> "Have Crisis Intervention Trained (CIT) officer which exist in every jurisdiction who are experienced in de-escalation. Expand their availability. Promote awareness in trainings. Also increase the model with racial awareness and cultural competencies (I was pulled out of this training by a Police Officer Supervisor who didn't feel that racial awareness was important to the officers)." — African American Family Outreach Project Listening Session Participant

Note[1]: The Mobile Assistance Community Responders of Oakland (MACRO) Program is a community response program for non-violent, non-emergency 911 calls.

Note[2]: The Community Assessment and Transport Team (CATT) Program was developed in collaboration with Alameda County Behavioral Health Services, Alameda County Emergency Medical Services, Falck Ambulance Company, and Bonita House to provide assessment, crisis management, transportation and referral as appropriate to individuals presenting behavioral emergencies in the community.

Concern 3: Depression

Depression was a major concern in the previous community survey and continues this trend in the current one. Survey data indicates that this is the third-most pressing concern for adults and older adults; free responses, however, reflect a need for access to mental health interventions and services. Calls for accessible services and the removal of barriers to accessing them can be found throughout the body of free responses to this question. These responses also indicate a desire for culturally appropriate services to be made available as well.

> "Not getting enough resources of therapy/counseling"
>
> "Mental health services in appropriate language and relatable cultural providers"
>
> "With chronic illness and mental health, support with having easily accessible medications and support with taking meds as prescribed."
>
> "Access to mental health services that are African culture based"
>
> "Free and accessible quality psychiatric care (for by-polar individual and others with mental illness)."
>
> "Accessing mental health resources due to language barriers and transportation issues. Not enough bilingual and bicultural mental health providers that provide culturally responsive and holistic healing approach"

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

> "As part of the solution, I suggest making social connections, especially face-to-face, a priority. Phone calls and social networks have their place, but few things can beat the stress-busting, mood boosting power of quality seeing someone in person can have (Most veterans like to meet in person with their care providers versus meeting on Zoom)." — Active Military/Veterans Listening Session Participant

Survey Question #6: Unserved & Underserved Populations

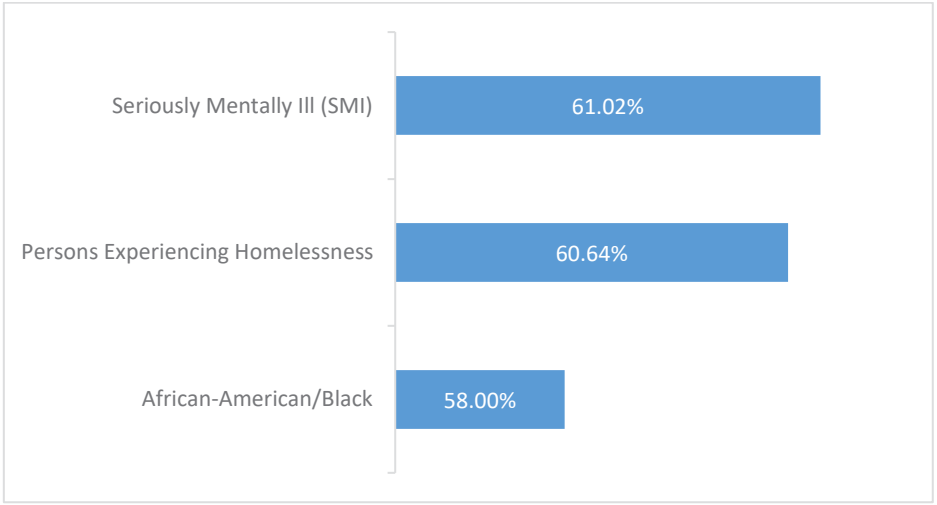
Q6. Are there any individuals, groups, and/or cultural communities whom you believe are not being adequately served by the behavioral health system of Alameda County? (Please select all that apply)

The seriously mentally ill were the most-identified group of people that survey respondents considered to be inadequately or underserved by the Alameda County behavioral health system (61.02%). Persons experiencing homelessness (60.64%) and African American/Black (58.00%) were the second and third highest group identified as being inadequately underserved or underserved.

Additionally, the free response comments indicate the sentiment that the population as whole within the County is not being adequately served by the behavioral health system. Concerns around language also surfaced repeatedly through this section. Participants also indicated a perceived lack of services around women, and pre-, peri-, and postnatal care.

> "People who do not speak English."
>
> "I say all groups because we are not doing enough across all groups."
>
> "Honestly, I don't see anybody getting the care that they need."
>
> "Pregnant/perinatal individuals are definitely underserved. I don't know about others."
>
> "Pregnant and postpartum women
>
> "I'd include Women as group to acknowledge domestic violence, gender discrimination, sexual harassment issues."
>
> "All of these populations have a chance of falling through the cracks. It's not easy to get info about resources."

Figure 10: Top Three Populations or Groups Not Adequately Served by System (n=515)



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

Table 8: Available Programs and Focus Group Recommendations for Underserved Populations

Prioritized Underserved Populations	Available Services	Focus Group Recommendations
1. Seriously Mentally Ill	X	X
2. Persons Experiencing Homelessness	X	X
3. African American/Black	X	X

Underserved Population 1: Seriously Mentally Ill (SMI)

Survey respondents indicated through their free response issues that access to County infrastructure is limited. Additionally, certain groups of SMI individuals, such as young adults, do not receive adequate behavioral healthcare.

> "Persons experiencing mental illness/substance abuse that don't qualify for services at John George."

> "Young adults, particularly those with more serious disorders."

Current Programs

For MHSA programs serving the seriously mentally ill, see CSS section: Full Service Partnership (FSP) section in this Plan.

Focus Group Recommendations

Listening group input indicates a need for greater family input to treatment concerns regarding a given individual. Additionally, a better understanding of what HIPAA (Health Insurance Portability and Accountability Act) is and how family of SMI individual can work within this framework to help their loved one get the care they need.

> "To address HIPAA issues: there is a protocol developed by ACBH OFA and FERC where agencies should know that you can encourage people to talk to you. You can still listen to a family member and hear complaints even if you can't disclose information." — African American Family Outreach Project Listening Session Participant

> "Day-long trainings for families with lunch served where they discuss mental health issues and have workshops, especially if taught by other African Americans in areas where African Americans live (for example, some groups based in Marin County, et cetera where people have different resources) — African American Family Outreach Project Listening Session Participant

Underserved Population 2: Persons Experiencing Homelessness

As noted previously in this section, persons experiencing homeless were the demographic group that survey respondents rated as the second highest group that they felt were not receiving behavioral healthcare services.

Current Programs

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

Focus Group Recommendations

"Resource hubs that [are in] a centralized location where CBO's (Community Benefit Organizations) who specialize in a specific resource or service come to weekly to screen triage and /or enroll potential clients into their program or agency to be able to obtain further support." — Peer Wrap® Program-Spanish Listening Group Participant

Underserved Population 3: African American/Black

Identified as the third of the top three groups where individuals within it are not getting their behavioral health needs met, African American persons were also identified during listening group sessions as being underserved.

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.
- African American Wellness Hub

Focus Group Recommendations

"Culturally competent mental health screening. Often times certain diagnoses are overlooked, like bipolar depression is overlooked in favor of schizophrenia. We need to use black psychiatrists or models developed by African Americans or using [behavioral health assessment] instruments where African Americans were majority respondents." — African American Family Outreach Project Listening Session Participant

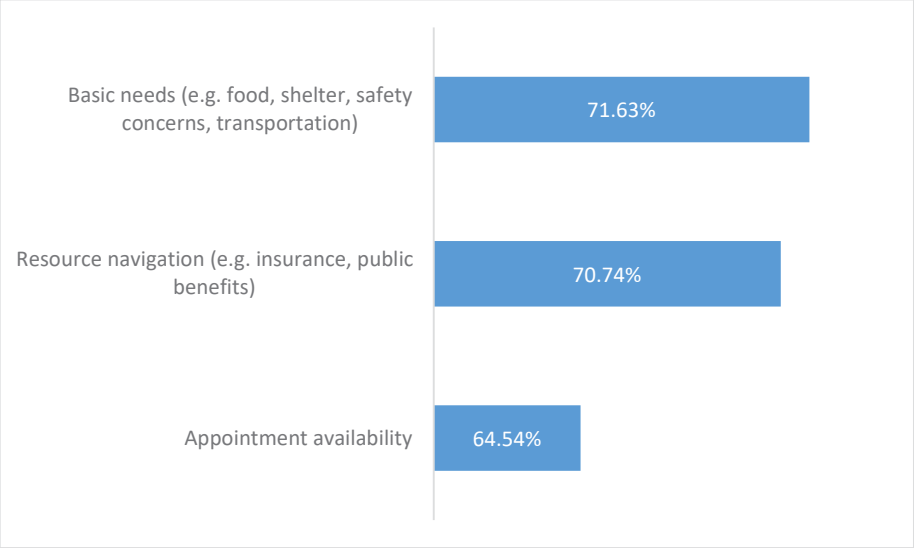
"We need African American clinics that include psychiatry in the model when psychosis exists." — African American Family Outreach Project Listening Session Participant

Survey Question #7: Barriers towards Accessing Mental Health Services

Q7. What are the barriers and gaps for people to get mental health resources and appropriate treatment needed for their recovery? (Please select all that apply).

Respondents prioritized the top three barriers to accessing mental health services as: 1) Basic needs (e.g. food, shelter, safety concerns, transportation) (71.63%); 2) Resource navigation (e.g. insurance, public benefits) (70.74%); and 3) Appointment availability (64.54%).

Figure 11: Top Three Barriers to Accessing Mental Health Services (n=557)



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

Table 9: MHSA Programs to Address Barriers to Mental Health Services

Barriers to accessing services	Available Programs	Focus Group Recommendations
1. Basic needs (e.g. food, shelter, safety concerns, transportation)	X	X
2. Resource navigation (e.g. insurance, public benefits)	X	X
3. Appointment availability	X	X

Barriers to Accessing Mental Health Services

The survey participants' concerns can be distilled as such: resources, ranging from basic need such as food and housing to behavioral and mental healthcare treatment, are in short supply. If these resources are somehow available, then accessing them can be an arduous and difficult process. Their responses speak to an overloaded, unfriendly system that does not currently meet their needs; they also speak to a desire for a more friendly, efficient, and transparent method to access care.

> "No beds, can't navigate a system that has no boats. Need to double the number of beds at Villa and at the units at John George, and take money out of Santa Rita to do that."

> "Difficulty getting connected to services, change in providers once connected. Who to contact and how to get connected to different teams. More outreach efforts required, can be difficult to reach people via phone."

"The difficulty navigating systems prevents people from going and the way people are disrespected when accessing services."

"Cost - many providers are not accepting insurance. Also, many sites have you talk to 3-4 people before meeting your clinician, this commonly results in re-traumatization, frustration, and hopelessness."

"Provider follow through, provider availability during evenings/nights/weekends/holidays; more responsive system and less hoops to go through (e.g. enhance 211)."

Current Programs

A majority of MHSA funded programs across CSS and PEI incorporate wrap around services to address basic needs and support with resource navigation. MHSA has addressed appointed availability by providing funding to expand crisis line service hours and providing a COLA to MHSA contractors to address workforce shortages. Please read program summaries located in these sections for more information.

Focus Group Recommendations

"Pop-up service. Pay attention to [resource] deserts and get services where they're needed." — ACBH Collaborative (Providers) Part I- Listening Session Participant

"I think for TAY (Transitional Aged Youth), who tend to be more dependent on technology, having online resource hubs would be helpful. For example, having one social media account for Alameda County mental health resources would allow teens to easily find more resources." — TAY Listening Session Participant

"Efforts in other parts of the state to create spaces adjacent to emergency departments (ED) for patients with psychiatric emergencies that are more clinically appropriate than keeping them in the ED without needing to build another psychiatric hospital or to expand John George. There's a desire to have the ED be the place where [behavioral healthcare patients] are cared for and recognizing that there's a limit." — Alameda-Contra Costa County Medical Association Listening Session Participant

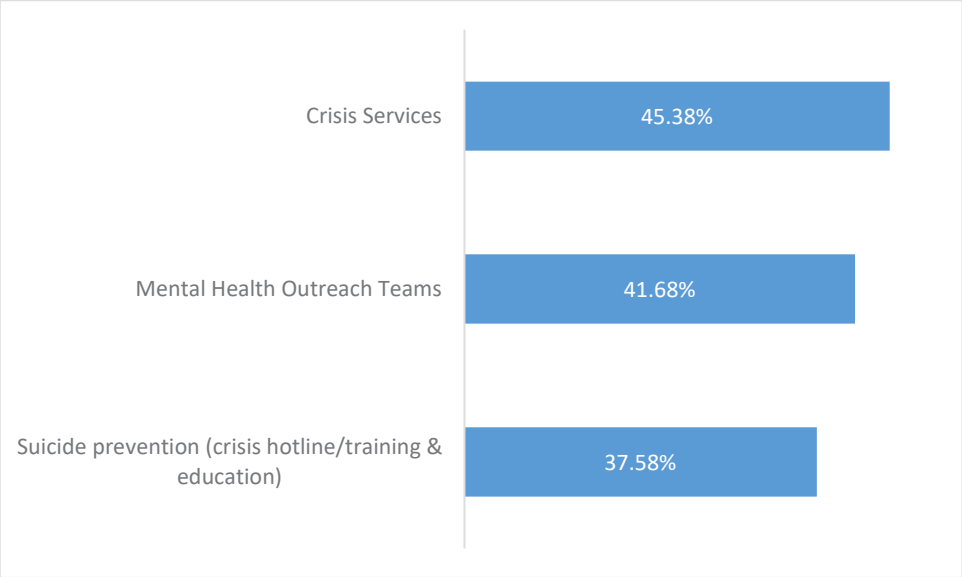
"The County thinks of focusing on a portion of the population, and that those who have commercial insurance will be taken care of. This is a problem that impacts all patients, even those with "good" insurance. Create a system of care for these patients." — Alameda-Contra Costa County Medical Association Listening Session Participant

Survey Question #8. Effectiveness of MHSA Services

Q8. Which of the following MHSA Service areas do you feel have been effective in addressing our local mental health concerns? (Please select all that apply).

Respondents ranked top three effective programs: 1) Crisis Services (45.38%); 2 Mental Health Outreach Teams (41.68%); and 3) Suicide prevention (crisis hotline/training & education) (37.58%).

Figure 12: Top Three Most Effective MHSA Service Areas (n= 436)



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

Most Effective MHSA Service Area: Free Response

Crisis services were identified by survey respondents as the most effective MHSA service area with respect to addressing mental health concerns; this sentiment was also reflected in some of the free response submissions for this question. When asked which other areas were effective in addressing mental health concerns, respondents expressed satisfaction with court and court-adjacent programs. Additionally, services providing or promoting peer support services were also viewed as being effective in addressing local mental health needs.

> "The MACRO team has been helpful in responding to people in a mental health crisis."
>
> "Peers Organizing Community Change [POCC]."
>
> "Office of Peer Support Services
>
> "Local police department alternative response team."
>
> "I think the police are becoming more aware of human mental health and taking it into account. this is awesome."
>
> "Alameda CASA program for foster youth (court appointed special advocates) volunteers."
>
> "Collaborative courts."
>
> "I believe our treatment courts have been effective in address justice involved mental health."
>
> "I believe the collaborative courts address "dual diagnosis services," and "mental health services for reentry populations."

"Collaborative Courts."

Focus Group Recommendations

Along similar lines, focus group participants were asked which programs from which they or their loved ones had accessed services, or that they would be comfortable recommending. Their responses reflect an awareness, if not an appreciation, of crisis and mobile outreach; support and education programs; and alternative courts.

- MACRO (Mobile Assistance Community Responders of Oakland)
- CATT (Community Assessment and Transport Team)
- IHOT (In-Home Outreach Teams)
- FERC (Family Education Resource Centers)
- Behavioral Courts
- Collaborative Courts

Survey Question #9. Innovative Services

Q9. MHSA funds INNOVATIVE SERVICES such as the proposed Consumer Empowerment Using Recovery Oriented Cognitive Therapy (CT-R). The framework of this peer training project will not change. What innovative ideas do you have to improve mental health services?

Of the 576 survey respondents, 265 responded to this question, while 311 did not. These were bucketed into 8 broad categories related to innovating mental health services. Access and availability were the most frequent theme of these responses (21.89%), followed by screening, assessment, and/or treatment ideas (20.00%). Innovative ideas related to community-, school-, and peer-based programs were the third-highest idea category for this question.

Table 10: Top Three Innovative Ideas

Innovative Idea Recommendations	Available	Focus Group Recommendations
1. Access and availability	X	X
2. Screening, assessment, and/or treatment	X	X
3. Community-, school-, and peer- based programs	X	X

Innovative Idea 1: Access and availability

As noted above, innovation ideas regarding access to and availability of behavioral healthcare represented the most frequent idea category in this part of the survey. Included in this category ideas that sought to remediate or remove demographic, cultural, or linguistic barriers to accessing care.

"More services in East County that are culturally diverse."

"Provide adequate pay and train CBOs to serve community via support groups for various cultures/communities-[for example] African American and youth over 5 years old."

"More low-cost/free counseling services offered by the county, mental health campaign specifically reaching out to immigrants and refugees in the community, mental health education for young children (age 6-12)."

"Culturally- and community-based initiatives that are run by people from that community and grounded in the values and approaches that resonate for that community. We need to support young leaders from these culturally specific communities with skills to facilitate wellness programs that are responsive to their communities' needs."

"Portable mental health stations… like the mobile command centers that do health checks. Maybe have one where people can have mental health checkups?"

Current Programs

The current programs that are funded to decrease stigma and advertise services are listed under question 7, barriers 3 above.

Focus Group Recommendations

"Making a "one stop shop" where services are located, including mental health services." — Peer Wrap Program- Spanish Listening Session Participant.

"Create support plans that will reimbursement veterans out-of- pocket medical expenses to include physical and mental cognitive psychotherapy." — Active Military/Veterans Listening Session Participant

"Most workshops are Latinx or African American led - work on something Asian led."—API Re-entry & Systems Impacted Population Listening Session Participant

"Pop up services, pay attention to desserts and get services where they're needed." — ACBH Collaborative (Providers)-Part I Listening Session Participant

Innovative Idea 2: Screening, assessment, and/or treatment

Respondents generated innovation ideas related to the specific mechanisms of care delivery: screening, assessment, and diagnosis of behavioral health conditions. For the purposes of this analysis, these were categorized on the affirmative inclusion within a clinical setting, or where the direct application of care was involved. Many such ideas included the deployment of non-traditional therapeutic techniques, as well as the establishment of non-traditional sites for care delivery for specific populations of individuals facing major behavioral health challenges.

"Restorative practices, narrative therapy practices, other indigenous and non-western practices not rooted in colonization."

"Staffed all day daily drop-in appointments seven days a week."

"A dual diagnosis "community" where they can live, supervised, and receive treatment. Like an apartment building similar to a retirement home where they have access to medical care, cognitive treatment, meals and medication; but with "security" to keep them there in order to prevent them harming themselves or others or the community."

"3 Team approach for homeless - give them same medical person, social worker, and peer counselor for 5-year period. Think it UCSF that did this as a pilot with South Bay population. Very successful."

"Have a mental health assessment at every primary care or ED visit. Educate and hire more mental health professionals. Give funds to companies like Telecare and programs like STRIDES to help these high resource users in need…"

Current Programs

The current programs that are funded to screen, assess and provide treatment as listed under question 1 above and through all CSS OESD programs.

Focus Group Recommendations

"A program to expand awareness among MD's and other providers so that they can have a higher degree of referrals for families." —MHAAC/Family Members Listening Session Participant

"Communication between providers is an issue. I know the state is attempting to work on that with the requirements, but we should work on this now. Especially on communication between mental health providers, hospitals, emergency room, acute/psych facilities. There's a problem when pediatricians receive children back from the ER and not knowing what's been done and what their role is. On the tech part for MHSA there is a need to help facilitate communication and break down barriers around confidential/privileged information." — Alameda-Contra Costa Medical Association Listening Session Participant

Innovative Idea 3: Community-, school-, or peer-based programs

To reach a larger swath of the population, survey respondents recommended the working with various community, school, and peer-based groups to achieve this goal. Such groups would leverage their relationships with local communities to better advocate for mental health service advocacy, education, and access. Many of the responses indicated that developing a sustainable funding pipeline would be a vital step in developing and maintain these programs. Additionally, these suggestions reflect a desire to fill the program workers from within the population they serve. There are also proposals to create relationships between existing service providers — such as clinicians and community benefit organizations — and the communities that they serve.

"More long-term funding for nonprofit and community organizations who are already providing these services to improve quality and quantity. More free training."

"More community involvement in restorative practices and mental health awareness. May develop a mental health mobile that travels around Alameda County informing the public about free mental health services and agencies that offer support in their neighborhoods."

"... Funding programs not based on numbers would change the focus and actually more people would be reached because programs would have the time and energy to build the relationships people need."

"Peer support groups. Easier accessibility, variation in languages offered, and a diverse group of people offering those services for a low-cost fee or no fee at all."

"Having students support other students within school systems. This "support" would from an allocated group of students who would find resources that fit a student's particular set of needs."

Current Programs

There are a variety of community, school, 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)

Focus Group Recommendations

"Destigmatize/help eliminate stigma associated with medical community, transportation, and work; create co-ops between agencies, organizations, and corporations to create community with veterans." — Active Military/Veterans Listening Session Participant

"Resource Hubs that [are] a centralized location where CBOs who specialize in a specific resource or service come weekly to screen, triage and/or enroll potential clients into their program or agency to be able to obtain further support." — PEER Wrap ® Program – Spanish Listening Session Participant

"Wellness centers and counselors in each school, group therapy." — TAY Listening Session Participant

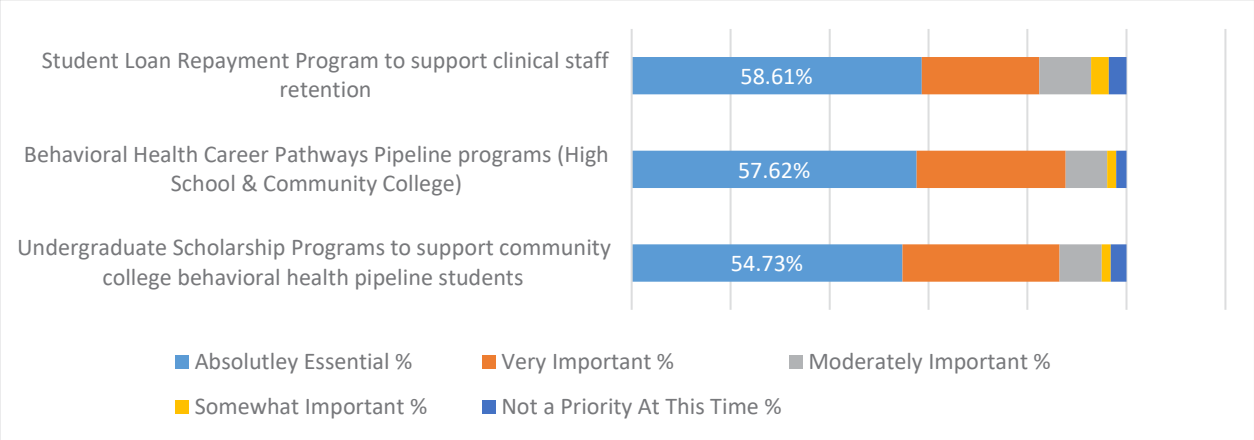
Survey Question #10. Workforce, Education & Training Activities - Prioritized

Q10. MHSA funds WORKFORCE, EDUCATION & TRAINING (WET) 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) Student Loan Repayment Program to support clinical staff retention (58.61%); 2) Behavioral Health Career Pathways Pipeline programs (High School & Community College) (57.62%); and 3) Undergraduate Scholarship Programs to support

community college behavioral health pipeline students (54.73%). Additionally, participants left 66 comments describing suggestions and improvements to these WET activities and training offers. See **Appendix G** for details on the other WET activities.

Figure 13: Top Three Absolutely Essential WET Activities (n= 546)



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

Table 11: MHSA WET Activities Available Programs and Future Opportunities

Prioritized Needs for WET	**Available** (Programs in implementation)
1. Student Loan Repayment Program to support clinical staff retention	X
2. Behavioral Health Career Pathways Pipeline programs	X
3. Undergraduate Scholarship Programs to support community college behavioral health pipeline students	X

<u>Workforce, Education, and Training Activities</u>

In the free response section of this question, survey respondents expressed a need to adequately fund the mental health services workers' education and training. Additionally, respondents suggested recruiting and funding practitioners from non-traditional pathways, such as the older adult population or those without formal graduate education. Survey respondents also expressed paying or funding the mental work health in a way that reflects the realities of living in a high cost-of-living area such as the San Francisco Bay Area.

> "Pay students and interns for their work."
>
> "PAID internships are essential! Students and interns cannot afford to go into the behavioral health field if they are struggling to meet their own basic needs."
>
> "Are there workforce development programs for people outside the school system? I think that is the major gap in our community, for those who do are not enrolled in school or who have full- or part- time jobs already, how do we get them to the next level? How do they get better paying

jobs with benefits? It is very hard for our community members to stop working to enroll in school if they are the only providers for their families."

"I still think the older persons (avoid family member contact) will do a better job. Use adult day school program to teach the older people so they feel good to do community work and also the young people or the older people feel comfortable. Comfortable and relaxed atmosphere is very important to them - nonthreatening person to the behavior persons."

"Improve older adult workforce development strategies."

"Better pay, housing stipends for those who work in mental Healthcare. Better benefits for staff so they can afford to live in the city that they work in, especially those who work in crisis intervention."

Current Programs

WET currently funds all these recommendations, please visit the WET section in this Plan to learn more.

Focus Group Recommendations

"More educational opportunities/incentives." — API Reentry & Systems Impacted Populations Listening Session Participant

"Health and art funding. Alameda County [should] partner some online social work school [to offer] full ride scholarships to MHRS (Mental Health Rehabilitative Services) and [funding for] peers paid internships and a peer pipeline." — ACBH Collaborative (Provider) Part II Listening Session Participant

Integrating Feedback Into MHSA

The CPPP is an ongoing effort of Alameda County Behavioral Health Care Services Department (ACBH) and the MHSA Division to guide continuous program improvements.

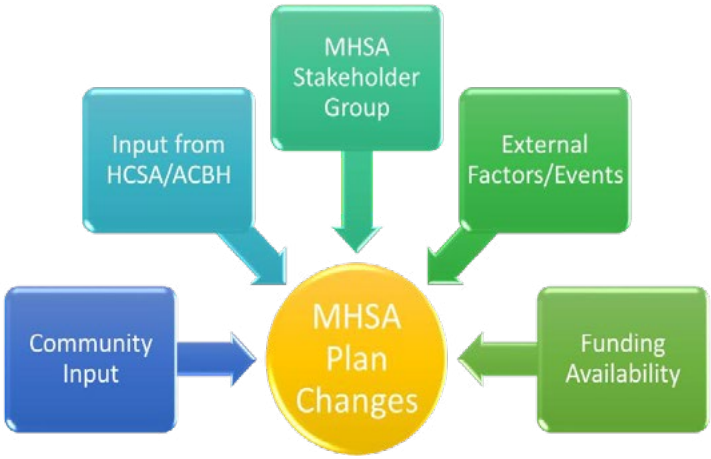


Figure 14: MHSA Plan Change Process

Program ideas are funded by MHSA based on the ongoing available funding in each MHSA component area, and community need which is expressed through a variety of ways including, but not limited to:

- The Community Program Planning Process and Public Comment
- Information gathered through the ongoing MHSA Stakeholder Group
- Needs expressed directly to the Alameda County Health Care Services Agency (HCSA)/ACBH Directors,
- External events such as a surge in a population (such as the Afghan community), increase in justice involved populations, COVID-19, etc.
- Alignment with county, agency and departmental mission, vision, and values
- Organizational structure and service delivery

As described throughout this report, MHSA engages the community, including mental health service peers with lived experience, their families, service providers, ACBH staff, and other community stakeholders in the development and refinement of all our programs. We aim to involve the community at every level of programming, from program development with consumers and service providers at the time of contracting, to developing program goals and objectives, evaluation metrics, and program improvements.

The County is currently evaluating public input presented during the CPPP and 30-Day Public Comment periods. These discussions have been narrowed to a number of possible activities and are summarized in the Summary of Changes section of the FY23/26 MHSA Three-Year Plan which is publicly available at https://acmhsa.org. All community need information is shared with the ACBH Leadership and analyzed against the known budget information. After this review, the ACBH Director makes the final decisions on how to move forward with any new or expansion programming.

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 & systems and wellness & recovery. CSS uses funds for direct therapeutic services and supports to adults with severe mental illness (SMI) and children with severe emotional disturbance (SED).

As of FY 22/23, Alameda's CSS component funds 13 Full Service Partnerships (FSP) programs (1,045 slots), including our Community Conservatorship and Assisted Outpatient Treatment (AOT) programs. Additional FSP slots will become available as the ACBH Service Teams (case management/medication support) are transformed into FSPs later in FY 23/24. The CSS component also funds 27 Outreach Engagement/System Development (OESD) *workplans.*

CSS programs are implemented through ACBH's multiple Systems of Care including:

- The Crisis System of Care;
- Forensic, Diversion, and Re-entry System of Care, as well as
- The two ongoing 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 engagement teams. 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 21/22 AGGREGATED FSP DEMOGRAPHICS & PERFORMANCE INDICATORS[1]

FY 21/22 FSP Demographic Data

During FY 21/22, 1,206 individuals were served in one of ACBH's FSP programs. The FSP service utilization trend continues to incrementally increase year over year by anywhere from 2% to 15%. Below are demographics on partners served between July 1, 2021 and June 30, 2022.

RACE/ETHNICITY

Fiscal Year	Ethnic Group	Clients	% of Clients
FY 2021-2022	Alaska Native or American Indian	10	1%
	Asian	94	8%
	Black or African American	569	47%
	Hispanic or Latino	97	8%
	Other	83	7%
	Pacific Islander	13	1%
	Unknown	9	1%
	White	331	27%
		1,206	100%

GENDER IDENTITY

Fiscal Year	Gender Identity	Clients	% of Clients
FY 2021-2022	Male	495	41%
	Missing	392	33%
	Female	295	24%
	Multiple Gender Identities	8	1%
	Non-Conforming	5	0%
	Prefer Not to Answer	3	0%
	Male to Female	2	0%
	Other	2	0%
	Queer	2	0%
	Female to Male	1	0%
	Intersex	1	0%
		1,206	100%

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

SEXUAL ORIENTATION

Fiscal Year	Sexual Orientation	Clients	% of Clients
FY 2021-2022	Missing	740	61%
	Heterosexual	404	33%
	Bisexual	16	1%
	Gay	14	1%
	Multiple Sexual Orientations	9	1%
	Other	7	1%
	Lesbian	6	0%
	Prefer Not to Answer	6	0%
	Queer	2	0%
	Questioning	2	0%
		1,206	100%

LANGUAGE

Fiscal Year	Language Group	Clients	% of Clients
FY 2021-2022	Arabic	3	0%
	Chinese	4	0%
	English	1,152	96%
	Farsi	1	0%
	Other	5	0%
	Spanish	38	3%
	Tagalog	2	0%
	Unknown	1	0%
		1,206	100%

AGE

Age	Clients	% of Clients
0-8 yrs.	20	2%
9-17 yrs.	44	4%
18-24 yrs.	152	13%
25-59 yrs.	766	64%
59+ yrs.	224	19%
	1,206	100%

COUNTY REGION OF RESIDENCE

Fiscal Year	Region	Clients	% of Clients
FY 2021-2022	1. North	640	53%
	2. Central	417	35%
	3. South	75	6%
	4. East	27	2%
	5. Out of County	47	4%
		1,206	100%

FY 21/22 FSP Performance Indicators

FSP providers are continually working with ACBH to develop and/or refine performance indicators in order to document and highlight the impact of FSP services. Below are a number of indicators ACBH is tracking for the FSP partners. This is data from clients served from July 1, 2021 to June 30, 2022.

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

All FSP 1 Episodes*	Pre Year: FSP Episodes with At Least 1 Hospital Admit	Year 1: Eligible Episodes**	Year 1: Episodes with Decrease in Hospital Admits	Year 1: Percent with Decrease	Year 2: Eligible Episodes	Year 2: Episodes with Decrease in Hospital Admits	Year 2: Percent with Decrease	Year 3+: Eligible Episodes***	Year 3+: Episodes with Decrease in Hospital Admits	Year 3+: Percent with Decrease
1,116	558	433	311	72%	290	217	75%	197	175	89%

*Total number of FSP episodes considered for the metric

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

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

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

All FSP Episodes*	Pre Year: FSP Episodes with At Least 1 Hospital Day	Year 1: Eligible Episodes**	Year 1: Episodes with Decrease in Hospital Days	Year 1: % with Decrease	Year 2: Eligible Episodes	Year 2: Episodes with Decrease in Hospital Days	Year 2: % with Decrease	Year 3+: Eligible Episodes***	Year 3+: Episodes with Decrease in Hospital Days	Year 3+: % with Decrease
1,116	565	436	343	79%	292	241	83%	199	179	90%

*Total number of FSP episodes considered for the metric

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

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

3. **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.

Fiscal Year	Eligible Clients	Clients with Primary Care Visit During this FY	% with Primary Care Visit During this FY
FY 2021-2022	723	468	65%

* Data Source: Anthem/Alliance/CHCN

4. **FSP Acute Follow up within 5 Days:** The percent of FSP partners who were seen (face-to-face) by their FSP staff within five days of: discharge from a hospital for a mental health diagnosis, discharge from an institution of mental disease, receiving crisis stabilization (CSU), discharge from psychiatric health facility, and/or discharge from the County Justice System. The lower end benchmark is 70% and the high-end benchmark is 90%.

Hospital/Crisis Episodes	Follow-Up in 5 Days	Success Rate
1,697	1,229	72%

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

5. **FSP Average of 4+ Visits per Month:** The percent of FSP partners who have been open to a provider for at least 30 days who have had 4 or more face to face visits with FSP staff. The lower end benchmark is 70% and the high-end benchmark is 90%.

Fiscal Year	Clients with Episode(s)*	Clients with Average of 4+ Visits Per Month	Success Rate (%)
FY 2021-2022	968	613	63%

6. **No Gaps in Service over 30 days:** The percent of child-focused 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.

Fiscal Year	Clients	Clients with No Gap Over 30 Days	% No Gap Over 30 Days
FY 2021-2022	39	34	87%

*Children's focused FSP metric only

7. Incarceration[2]: Do the number of incarcerations decrease for FSP partners in the years that they are in an FSP, when compared to the year prior to FSP admission?

All FSP Episodes*	Pre Year: FSP Episodes with At Least 1 Incarceration	Year 1: Eligible Episodes**	Year 1: Episodes with Decrease in Incarcerations	Year 1: % of Episodes with Decrease	Year 2: Eligible Episodes	Year 2: Episodes with Decrease in Incarcerations	Year 2: % of Episodes with Decrease	Year 3+: Eligible Episodes***	Year 3+: Episodes with Decrease in Incarcerations	Year 3+: % of Episodes with Decrease
994	398	302	239	79%	206	179	87%	115	95	83%

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

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

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

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

All FSP Episodes*	Pre Year: FSP Episodes with At Least 1 Homeless or Institutional Setting Day	Year 1: Eligible Episodes**	Year 1: Episodes with Increase in Community Living Days	Year 1: % with Increase	Year 2: Eligible Episodes	Year 2: Episodes with Increase in Community Living Days	Year 2: % with Increase	Year 3+: Eligible Episodes***	Year 3+: Episodes with Increase in Community Living Days	Year 3+: % with Increase
1,116	419	419	187	45%	404	180	45%	323	130	40%

*Total number of FSP episodes considered for the metric

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

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

Housing Types Considered "Community Living":

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

Client Vignette (Success Story)

Here's an inspiring success story about a young 20-year old woman who participates in the Transition Age Youth (TAY) FSP called Prevention, Advocacy, Innovation, Growth, and Empowerment (PAIGE), run by the agency Bay Area Community Services (BACS).

PAIGE staff began working with this young woman in late 2020; she struggled with severe PTSD and multiple attempts of suicide since childhood. She had been admitted to psychiatric hospitals well over 20 times since 2013.

When opened with PAIGE, she had difficulties meeting with staff for long periods as she struggled with symptoms of social anxiety, hypervigilance, and overwhelm. She experienced extreme isolation and difficulty with being out in the community on her own, leaving her bedroom due to fear of bumping into roommates, and daily suicidal ideation.

The PAIGE team engaged her at a slow pace to ensure she felt safe and comfortable to express herself and engage in treatment. She was slowly introduced to more staff members who engaged her in creative activities to build rapport. Throughout the course of treatment, she exhibited courage and pushed herself out of her comfort zone countless times to engage in groups, social events, and has done tremendous work around processing her trauma.

She is extremely insightful, motivated to be engaged in her treatment, and one of the biggest accomplishments this year was completing a vocational program and internship to pursue her career as a vet assistant. She was able to identify *hope for her future* and is also now in a healthy relationship.

CHILDREN & YOUTH FSPs

FULL SERVICE PARTNERSHIP (FSP) REPORT

FSP #: FSP 16

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 0-10) who are experiencing difficulties in school and/or may need intensive support services to stabilize.

How Much Did We Do?

I. FY 21/22:

a. **Number of Unique Clients Served:** 23. **Cost per client:** $31,938

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. Throughout the pandemic, we have continued to offer in person meetings at a family's preferred location as long as we are able to do so safely.

III. Language Capacity for this Program: We provide services in the families' preferred language. This year, we served 19 English-speaking families and 4 Spanish-speaking families.

IV. FY 21/22 challenges: As we continue to navigate through the COVID 19 pandemic, we worked very hard to conduct 90% or more of our services in person. This proved challenging during times of COVID spikes and we quickly had to pivot back to virtual services. For some families, that continued to be challenging. We worked hard to get our clients re-engaged in school, in person. This proved to be challenging because many of our clients had never been to school in person. Additionally, finding qualified and talented staff to fill vacancies was challenging. As an agency we have worked hard to recruit and retain our staff by increasing base wages wherever we can and emphasizing wellness and sustainability in this work.

Is anyone better off?

V. FY 21/22 Client Impact: Here are two stories submitted by our Care Coordinators that highlight some of the interventions provided by Connections and the successes the youth and family were able to achieve during the course of treatment. **(Clients' names have been changed to protect identity.)**

We received a referral for a 6-year-old boy named "Tice" who had experienced significant early trauma and attachment disruptions. His biological parents struggled with addiction and mental health diagnoses. He was being cared for by his maternal grandmother who struggled greatly to cope with his intense behaviors which included destroying things in the home, leaving the house unsupervised, making verbal threats, and expressing suicidal ideation. He exhibited aggression and dysregulation while at school and had been kept in a psychiatric hospital for a week prior to being referred to our program. At the time of referral, his grandmother regularly made verbal threats to "give him up" and would call the police when he acted out.

Our care coordinator immediately began to develop a team of professional and natural supports to help Tice and his grandmother. They conducted regular meetings with the school staff, school therapist, Kinship therapist, grandmother, and several other family members. We also helped the primary therapist to make a referral to TBS to ensure even greater support for Tice's daily needs. Our WRAP support counselor worked closely with the TBS coach and school staff to develop interventions for Tice, including teaching him coping skills, practicing skills in triggering situations, increasing self-esteem, and increasing Tice's ability to accept limits and use social skills. Our support counselor worked with Tice in the home with his caregiver and siblings, as well as at school. Our care coordinator worked with other professionals to support Tice's grandmother with strategies to use in the home and provided psycho-education about trauma and attachment. Tice's grandmother utilized our crisis phone several times to receive coaching and support when struggling with Tice's behaviors.

Although Tice continues to struggle with some dysregulating moments, reports from his grandmother and school staff indicate that he is much more successful at accepting limits and using coping skills. His grandmother no longer threatens to give him up and he appears much more secure at home. His oldest adult sister and her partner provide daily support to his grandmother which has relieved grandmother's stress and helped Tice feel more connected and supported by family. He expresses pride in being the "man of the house" and expresses motivation to help his grandmother. Tice has not been hospitalized for

over a year and his grandmother has not needed the crisis line in several months. We are working on a sustainability plan with Tice's grandmother to help her envision what she has learned and how she can continue to receive support when WRAP service close.

We received a referral for a 4-year-old girl named "Naomi" who was struggling significantly with transitions to her preschool placement. During drop-off, Naomi would scream, thrash, bite, scratch, and spit on her mother and school staff in an attempt not to separate from her mother. School staff described her as being terrified and the stress experienced by Naomi's mother decreased the consistency of Naomi's attendance at school. Naomi's mother was very young and had three other children all under the age of 8 years. Naomi and her family experienced homelessness during the first 2.5 years of Naomi's life, moving from shelters to families' homes without any stability or predictability.

Our care coordinator worked with the preschool staff and Naomi's family to develop some targeted strategies to support Naomi's transitions, including trying to have a preferred staff meet her in the mornings, providing her with space away from others and preferred activities/comfort objects to use when upset, and creating two different social stories to support Naomi's transitions. One book was focused on the teachers, friends, and routines that Naomi had at school. This book reinforced that her family thought about her during the school day and would always come back to get her at the end of the day. The second book was a family book devoted to photos of Naomi with her immediate family and large extended family to reinforce how many people love and care for Naomi. Regular team meetings with school staff, Naomi's mother, grandmother, and aunties helped the team focus on how to support Naomi feel secure and Naomi's mother to increase predictability and consistency at home.

The care coordinator also worked weekly one-on-one with Naomi to identify and practice coping skills, develop feeling language and communication skills, and navigate peer interactions. The care coordinator worked one-on-one weekly with Naomi's mother to develop organizational strategies (visual calendar, using a planner, chore charts) and on being the parent that Naomi's mother really wanted to be, which included validating her children's feelings, rewarding positive behaviors, and doing things as a family. The care coordinator worked with Naomi's mother to identify practical challenges, such as transportation, a working phone, and financial stresses, using ancillary funds to address immediate needs and to consider how to meet the needs once WRAP closes.

Naomi has been much more successful at school and is able to transition safely without throwing tantrums. Although Naomi's mother still struggles to cope with the needs of all her children, she is working to implement more structure in the home and we are currently preparing for Naomi to start Kindergarten.

VI. FY 21/22 Additional Information: N/A

VII. FY 22/23 Projections of Clients to be Served: 20

VIII. FY 22/23 Programs or Service Changes: N/A

Metrics	% of FY 21/22 FSP clients that achieved the metric
Reduction in Hospital Admits*	100%
Reduction in Hospital Days*	0
Reduction in Psychiatric Emergency Services (PES)*	100%
Reduction in Incarceration Days*	0
Increase in the number of days Stably Housed*	0
Primary Care visit within the previous year	90%
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	0
Average of four or more visits per month per client	91%

*The metrics above measuring "reductions" are looking at FSP clients served in FY 21/22 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 #: FSP 17
PROVIDER NAME: Fred Finch Youth and Family Services

PROGRAM NAME: East Bay Wrap

Program Description: Founded on the Principles of Wraparound, East Bay Wrap provides unconditional care that is family centered, individualized, culturally responsive, and strengths-based. Our approach focuses on supporting youth and their families by providing services in the youth and family's natural environment, including in the home, at school, and 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 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 21/22:

a. **Number of Unique Clients Served:** 25. **Cost per client:** $29,423

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

a. **Reduce Mental Health Stigma:** Our Parent Partner and our Youth Partner are staff with lived experience. As they partner with and support the youth and families referred, they share some of their own stories about struggling with, addressing, and learning to meet their goals despite having/or having a child with a mental health disability. This helps to de-stigmatize mental health and foster hope for youth and families.
b. **Create a Welcoming Environment:** By having a multi-racial and gendered team with different life experiences, education, skills and abilities, this helps to create a welcoming environment for youth and families, however they identify. Staff are trained in using a trauma-informed approach and are skilled at implementing family engagement strategies. They work to meet with youth and families at times and locations that are most convenient for the youth and family.

III. Language Capacity for this Program: The Parent Partner is bi-lingual Spanish speaking.

IV. FY 21/22 challenges: Challenges for this year included the Covid-19 pandemic, staffing and documentation. While the staff team is very flexible and adapted quickly to a hybrid service delivery model, delivering telehealth services when Covid rates spike or a family/youth/staff tested positive for Covid, we have found that overall with this population in-person services are very much needed. The pandemic has also caused a workforce shortage and this year there has been staff turnover and unfilled positions. Currenly we are working to hire a Clincal Supervisor who left in May. Lastly, the documentation demands of Medi-Cal can be time consuming and take away from service delivery time,

particularly for the Care Coordinators. Some of the upcoming documentation reductions as a result of CalAIM should help staff spend less time on paperwork and more time meeting with youth and families.

Is anyone better off?

V. FY 21/22 Client Impact: In surveys parents/caregivers have shared how much they have felt supported as a family with the wraparound services. The program is meeting bench marks for the number of monthly services and response/follow up to crisis. Here are some examples of client impact:

A 17-year-old African American young man was homeless with his mother when services began. He struggled with psychosis and was inconsistent with his medication. The wrap team worked with the family to find stable housing in San Leandro and helped him then enroll in high school. With these life changes he was able to stabilize and then transitioned to TAY services after he turned 18.

A 16-year-old Latino young man with a history of trauma was referred when he was struggling during the pandemic, not attending school, sneaking out, becoming involved in stealing and other illegal activity. He was living with his grandparents. The wrap team partnered with the family to help the grandparents feel less overwhemed and to support the youth to get the needed supports at school and into extracurricular activities like boxing. Through wrap services, he learned to use healthier outlets for his anger and to develop goals for the future.

A 15-year-old African American young woman was referred for services due to her running away and having suicical thoughts and behaviors while living with her mother. Her mother was struggling with substance abuse and that was triggering her daughter's sense of safety. Through a series of Child & Family Team meetings and collaboration with the staff team and family, a decision was made for the young woman to move into a home with her aunt. The mother was in support of this plan. Once in a more stable living environment, the young woman's behaviors decreased, she wasn't experiencing sucicidal ideation or running away, and she started to improve at school and to develop healthy peer relationships.

VI. FY 21/22 Additional Information: Fred Finch Youth & Family Services is continuing to implement the Racial Equity Initiative and this is a priority for the agency. We currently have staff participate in racial affinity groups to learn more about privilege for White-identified staff and to help provide a voice for staff who identify as BIPOC. East Bay Wrap staff use individual and group supervision as well as staff meetings and trainings to discuss and address issues of culture and to ensure the delivery of culturally responsive services.

VII. FY 22/23 Projections of Clients to be Served: We are contracted to serve 20 youth concurrently. We currently have a new Care Coordinator and an opening for a Clinical Supervisor who carries half a caseload so there are only 13 youth open. We hope to get the new staff up to capacity and fill the opening so we can reach the target of 20.

VIII. FY 22/23 Programs or Service Changes: N/A

Metrics	% of FY 21/22 FSP clients that achieved the metric
Reduction in Hospital Admits*	60%
Reduction in Hospital Days*	80%
Reduction in Psychiatric Emergency Services (PES)*	0
Reduction in Incarceration Days*	100%
Increase in the number of days Stably Housed*	0
Primary Care visit within the previous year	75%
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	93%
Average of four or more visits per month per client	67%

*The metrics above measuring "reductions" are looking at FSP clients served in FY 21/22 who experienced one of these negative events (crisis, hospital admission, and incarceration) prior to enrollment in an FSP compared to the first year of FSP enrollment.

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

TRANSITION AGE YOUTH FSPs

FULL SERVICE PARTNERSHIP (FSP) REPORT

FSP #: FSP 3
PROVIDER NAME: Fred Finch Youth and Family Services

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

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 21/22:

a. **Number of Unique Clients Served:** 71. Cost per client: $ $41,817

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

a. **Reduce Mental Health Stigma:** All staff are trained in Cognitive Behavioral Therapy for psychosis, and one large component of this strategy is to destigmatize psychosis through direct support to participants.

   The program's value of person-centered language, prioritizing the stated preferences of the participants themselves, and collaborating to create goals and set priorities helps to destigmatize mental health support access as it reduces reliance on traditional systems which may prescribe a one-size-fits-all approach.

   The program completes outreach and engagement to family supports and loved ones as well as the participants' themselves, providing psychoeducation about mental health, and supporting with skills building as it relates to addressing mental health needs in the home and engaging in crisis management.

b. **Create a Welcoming Environment:** The STAY facility has an open-door policy for participants and encourages participants to come to campus to rest and recuperate. There is a 'participant room' with couches and hygiene supplies for participants in the office space.

   STAY utilizes flexible funding to increase access to wellness opportunities, enjoy meals, and celebrate accomplishments, particularly when someone has a work, school, or housing milestone, or to celebrate anniversaries and birthdays with participants.

III. Language Capacity for this Program: English is the primary language for most program participants, but we have participants who are monolingual in Spanish and Punjabi. One bilingual Spanish-speaking Peer Mentor and one bilingual Spanish-speaking Clinical Supervisor remained on staff. When in collaboration with participants and families telehealth and language line interpreters were involved.
IV. FY 21/22 challenges: Hiring: The STAY team has been understaffed for all of FY21-22. For most of the year, the team had the following staffing: 4 of 7 Clinicians, 1 of 2 Employment Specialists, 2 of 2 Peer

Mentors, 0.4 of 1 Family Partner, 0.5 of 1 Registered Nurse, 0.5 of 1 medication provider. Also, during multiple occurrences in the last year, during stretches of time of three weeks or more, at least three staff were on extended leave, impacting the level of services the team were able to provide to participants. In FY 20-21, there were more applicants for non-clinical positions than clinical positions, which impacted the programs' capacity to fill important positions which provide case management to participants. In order to creatively address staffing, STAY will be filling case manager positions with a combination of Bachelors, Masters, and pre-licensed case managers.

Housing: Participants in STAY are often experiencing acute mental health crises, and the current system of Coordinated Entry, in which a participant must complete an often hours-long interview, creates a barrier for participants to access this resource. Multiple participants in the program do not access shelter or other forms of housing until they are stable enough in their symptoms to be able to complete the required forms and interviews.

COVID restrictions: Although there has been no stay at home orders in the FY 21-22 year, certain placements frequently accessed by STAY participants, such as hospitals, jails, sub-acute placements, and shelters, have had to take measures to reduce spread of COVID during outbreaks. This has impacted the STAY teams' ability to meet with participants in these placements and continue work on case management tasks. Also, when shelters have had outbreaks, they have had to limit the number of intakes, thus impacting participants' available housing opportunities.

Extended/Delayed Discharges: Referrals to adult system of care and coordinating with next providers were delayed at times, impacting participant outcomes and capacity to bring on new participants. The reasons being that the new provider was unable to take on the participant in a timely manner, medication provider appointment was not set, participant was difficult to locate, referral was not done in final quarter prior to 25th birthday.

Is anyone better off?

V. FY 21/22 Client Impact: "Improve the ability of clients to secure and maintain stable permanent housing in the least restrictive and most integrated living situation appropriate to meet their needs and preferences" - While the ultimate goal is to secure permanent housing, in the current housing climate of the Bay Area, STAY continues to be creative in helping to secure and maintain housing for participants in the program. In the last year, between 52 and 65% of participants in any given month had been in a stable living situation for at least three months. These include usage of family and loved ones supports, shared housing, longer-term transitional housing, board and cares, and various treatment facilities.

"Reduce client hospitalizations and utilization of emergency health care services for mental health and physical health issues" - The STAY program was able to support reduction of hospitalization for 81% of participants in the program in FY 21-22. Strategies for doing so are targeting the symptoms and resources which promote mental health crisis through education, coaching, modeling, and psychotherapy. The team also collaborates with family members to increase their awareness of presentations which meet criteria for 5150 hold and promote least invasive mental health environments and resources when someone is subthreshold for psychiatric hospitalization. STAY also increases contact with participants who present with increased risk, which often helps to reduce likelihood of going to the hospital. Extensive safety planning is done with all participants who are at risk of hospitalization due to harm to self, others, or grave disability.

"Connect clients with ongoing primary healthcare services and coordinate healthcare services with clients' primary care providers" - The STAY program was able to connect 67% of eligible participants to primary care providers in FY 21-22. When a participant comes in without an identified provider, linkage is offered and attempted, and steps are taken to attempt to reduce barriers to connecting to primary care. These include working through anxiety management and trauma-response as it relates to medical settings, increasing skills in transportation, increasing awareness of physical health and wellness, and using motivational interviewing to address motivation and interviewing as it relates.

Personal Client Story: Over the course of the last year, one participant, who was initially referred to the program from an early psychosis program and was attending school, had a relapse of mental health experiences, housing insecurity, and stopped college. Through ongoing services around stabilization, linkage, and CBT for psychosis, this participant was able to set appropriate and health boundaries with family members, re-engage in own mental health recovery, reduce hospitalizations, and return back to school. This fall, due to the work in FY 21-22, this participant is prepared to move in to campus housing and resume their studies at university.

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

VII. FY 22/23 Projections of Clients to be Served: 75

VIII. FY 22/23 Programs or Service Changes: The ACT Clinician role (previously 7 FTE) will now be set up with a combination of BBS-registered ACT Clinicians, Masters-level non-BBS registered Mental Health Counselors, and Bachelor-level Care Facilitators. Each participant will be assigned a clinician to provide guidance for care interventions, crisis management, and annual clinical assessments and a case manager who will be responsible for regular linkage and care facilitation. This change in staffing will hopefully help increase staffing in the case manager role so that more participants may be served in the program. Participants will have a case manager to address immediate needs, and when the need arises for traditional therapy in addition to case management and care facilitation, an assigned clinician will be able to meet more regularly with them for this purpose.

In order to streamline bringing referred participants into the program, the Lead Clinician became the Referral Coordinator for STAY in FY 21-22. Within two days of referral, this person contacts referral source, gathers information about best ways to engage, and attempts to schedule intake. They also complete most intakes for the STAY program. It is likely that this strategy has helped to increase the annual client number from 67 in FY 20-21 to 71 in FY 21-22.

The Family Partner role (previously filled by 0.4 FTE) has been combined with the Care Facilitator role for a full-time direct care position. Part of the caseload for this person will be specifically for the purpose of providing services to families and loved ones as well as providing direct case management and care facilitation directly to participants themselves.

Metrics	% of FY 21/22 FSP clients that achieved the metric
Reduction in Hospital Admits*	71%
Reduction in Hospital Days*	88%
Reduction in Psychiatric Emergency Services (PES)*	80%
Reduction in Incarceration Days*	57%
Increase in the number of days Stably Housed*	28%
Primary Care visit within the previous year	61%
With an educational goal who are enrolled in school	0
With a vocational goal who are employed	17%
Received a follow up visit within five days after a mental health hospitalization or crisis	82%
Average of four or more visits per month per client	69%

*The metrics above measuring "reductions" are looking at FSP clients served in FY 21/22 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 #: FSP 21
PROVIDER NAME: Bay Area Community Services (BACS)

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

Program Description: Provides 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 21/22:

a. **Number of Unique Clients Served:** 65. **Cost per client:** $22,838.

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

a. **Reduce Mental Health Stigma:** PAIGE team uses a client-centered approach to meet partners where they are at in terms of stage in their recovery and normalize their experiences. We ensure that treatment goals are developed collaboratively and we value our partner's autonomy to make decisions for themselves. Team provides psychoeducation and works collaboratively with families and their natural supports to improve understanding of mental health challenges and develop strategies to better support their loved ones. One way we do this is by connecting them to family resources such as FERC and NAMI. We also encourage TAY to link to resources in the community such as peer groups to reduce stigma and increase social supports as part of their recovery.
b. **Create a Welcoming Environment:** The PAIGE team values respect and the comfortability and safety of our partners. PAIGE is flexible and offers services in settings where participants feel most comfortable such as in their home, at the park, the office, of their preferred location in the community. Team takes safety precautions for COVID-19 and have provided PPE to our participants throughout the pandemic. PAIGE also offers telehealth visits including psychiatry through MS teams for partners who do not feel comfortable or safe meeting in person due to COVID-19 risks. PAIGE team members practice a person-centered approach and utilize Harm-Reduction and Trauma-Informed Care principles to meet the participant where they are at and to allow a safe place for self-expression. PAIGE also embodies a multicultural approach as a we serve a diverse population and understand the importance of how cultural aspects may influence mental health, especially when working with families.

III. Language Capacity for this Program: Spanish, English, and access to the county Language Line.

IV. FY 21/22 challenges: PAIGE team experienced increased staff turnover rates and low staff capacity this FY year, in addition to staff periodically missing work due to COVID-19. PAIGE team onboarded total of 4 new staff members, 3 who joined in the second half of the FY. Team experienced challenges with onboarding/training new staffing, supporting staff adapt to new work environment, and focusing on strengthening team culture to reduce turnover rates. Another challenge for PAIGE was balancing a large caseload with low staff capacity and ensuring partners were still being seen at least 4 times a month. Team did well in utilizing ACT meetings to track visits with partners and prioritizing those in acute crisis. However due to short staffing, PAIGE endured challenges with street outreach to partners experiencing homelessness or those who have patterns of declining services. These are partners who often need the most support but can be difficult to locate or engage.

Team also experienced periodic challenges with outreaching to partners in in/out of county jail and inpatient psychiatric facilities as result of COVID-19 outbreaks, lockdown of facilities as well as technical difficulties with video visits. Despite these barriers, team did well with collaborating with providers to develop discharge plans to prepare and support partners for reentry into the community.

Is anyone better off?

V. FY 21/22 Client Impact: Many of our partners are isolated, lack social and natural supports, and identify PAIGE team as an important resource and support they can depend on during their worst moments. PAIGE team participants have endured, overcome a lot of challenges, and several have made progress in their recovery in the past year including at least 4 who graduated to a lower level of care. Majority of partners were seen regularly by our psychiatrist this year as we have been able to offer telehealth visits, which increases accessibility for our partners who struggle with severe isolation and difficulties meeting at the clinic or office. Through IPS services, many of partners obtained competitive employment and enrolled into school for GED, vocational programs, or college courses. During this FY we have also observed reduced number of re-hospitalizations and improvement with drawing in families and natural supports as vital contributors to their treatment. Team has also been able to increase social events and support groups for our partners to increase their peer network as more barriers have been reduced around COVID-19 regulations. This allows the team to continue develop creative engagement strategies, for example we had an Oakland A's baseball outing for our partners and their families, which allowed them a space to foster a connection in their community.

One success story is about a 20-year-old participant who we began serving in late 2020 who struggled with severe PTSD and multiple attempts of suicide since childhood. She had been admitted to psychiatric hospitals well over 20 times since 2013. When opened with PAIGE, she had difficulties meeting with staff for long periods as she struggled with symptoms of social anxiety, hypervigilance, and overwhelm. She experienced extreme isolation and difficulty with being out in the community on her own, leaving her bedroom due to fear of bumping into roommates, and daily suicidal ideation. PAIGE team engaged her at a slow pace to ensure partner felt safe and comfortable to express herself and engage in treatment. We slowly introduced her to more staff members and engaged her in creative activities to build rapport. Throughout the course of treatment, she exhibited courage and pushed herself out of her comfort zone countless times to engage in groups, social events, and has done tremendous work around processing her trauma. She is extremely insightful, motivated to be engaged in her treatment, and one of the biggest accomplishments this year was completing a vocational program

and internship to pursue her career as a vet assistant. She was able to identify hope for her future and is also now in a healthy relationship.

VI. FY 21/22 Additional Information: PAIGE team members biggest strength is their comradery, work ethic, and passion for serving our TAY group. We have been successful at implementing an efficient style of collaboration using the ACT model which can be observed during our daily meetings to ensure team is following up on important tasks, that our partners are being met at least 2 times a week, and prioritizing those who are in acute crisis. Team works cohesively and eager to jump in to support partners and their colleagues.

VII. FY 22/23 Projections of Clients to be Served: 70

VIII. FY 22/23 Programs or Service Changes: Paige team would like to focus on increasing the facilitation of team decision meetings (TDMs). Due to challenges with low staffing, onboarding and ongoing pandemic regulations, PAIGE did not provide TDMs as often as we would have liked. PAIGE team would also like to focus on supporting our partners who struggle with homelessness or housing stability to connect to coordinated entry and help them become "doc ready" such as making sure they have a copy of their ID, social security card, verification of income, and verification of homelessness. We would also like to focus on scheduling at least 1 social and peer group each month and develop monthly calendar with events and resources to share to participants to encourage building connections in the community.

Metrics	% of FY 21/22 FSP clients that achieved the metric
Reduction in Hospital Admits*	93%
Reduction in Hospital Days*	93%
Reduction in Psychiatric Emergency Services (PES)*	81%
Reduction in Incarceration Days*	65%
Increase in the number of days Stably Housed*	52%
Primary Care visit within the previous year	69%
With an educational goal who are enrolled in school	0
With a vocational goal who are employed	31%

Received a follow up visit within five days after a mental health hospitalization or crisis	79%
Average of four or more visits per month per client	73%

*The metrics above measuring "reductions" are looking at FSP clients served in FY 21/22 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 #: FSP 4

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: Greater HOPE provides services for chronically homeless adults.

How Much Did We Do?

I. FY 21/22:

a. **Number of Unique Clients Served:** 137. **Cost per client:** $32,107

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

a. **Reduce Mental Health Stigma:** Greater Hope staff work continuously to help reduce mental health stigma in the community. This year, some staff participated in a community Town Hall where they were given the opportunity to provide some education to community members on the impacts of mental health and how we can all come together to support those that are experiencing mental health challenges and the resources available to help. Staff that are working with participants on housing, job search and other community activities work to educate the general community on mental health impacts to try and support participants as they work to integrate in to their local communities. Lastly, Staff continued with monthly Consumer Advisory Board meetings to allow for participants to have a voice in their care and program development.
b. **Create a Welcoming Environment:** For the second half of this fiscal year, starting in January 2022, our Greater HOPE team was able to come back to the office full time and start providing some in person services again after several months of COVID restrictions. Participants have been invited back to the office for therapy sessions, Consumer Advisory Board meetings, meetings with partner providers. Additionally, participants have access to crisis services daily where they can stop by the office for needed resources in the moment that are provided by triage staff.

III. Language Capacity for this Program: Greater HOPE team has access to a language line that can be used to provide services in any needed language. We also have limited number of staff that are bilingual Spanish.

IV. FY 21/22 challenges: As in years past, hiring continues to be a challenge for the Greater HOPE team. Specifically there has been a small pool of applicants applying for Managament, Clinician and Employment Specialist roles. Leadership team is continuly brainstorming creative ways to recruit staff for vacant postions.

Is anyone better off?

V. FY 21/22 Client Impact: Greater HOPE team has been excited to see several participants graduate to a lower level of care. One success story to note is a participant who was working with our team for 4+ years. When participant was referred to Greater HOPE, they were experiencing significant mental health symptoms and presented as very unstable in the community, and a high utilizer of local emergency services. Through help of team and wrap around services, participant has been able to gain insight into his mental health, become stable on medication and also is employed at this time. Participant has been able to graduate to lower level of care in 2022 and now has skills and tools to navigate in the community with light touch case management support and medication management.

VI. FY 21/22 Additional Information: N/A

VII. FY 22/23 Projections of Clients to be Served: 150

VIII. FY 22/23 Programs or Service Changes: N/A

Metrics	% of FY 21/22 FSP clients that achieved the metric
Reduction in Hospital Admits*	74%
Reduction in Hospital Days*	77%
Reduction in Psychiatric Emergency Services (PES)*	65%
Reduction in Incarceration Days*	80%
Increase in the number of days Stably Housed*	52%
Primary Care visit within the previous year	62%
With an educational goal who are enrolled in school	20%
With a vocational goal who are employed	11%
Received a follow up visit within five days after a mental health hospitalization or crisis	74%
Average of four or more visits per month per client	69%

FULL SERVICE PARTNERSHIP (FSP) REPORT

FSP #: FSP 10

PROVIDER NAME: Abode Services

PROGRAM NAME: Rental Subsidies and Landlord Liasion Program

Program Description: The Rental Assistances and Landlord Engagement (RALE) (formerly called Landlord Liaison) Program is designed to cultivate and sustain relationships with property owners and property management companies (landlords) with the goal of encouraging them to accept additional tenants who are referred through the Coordinated Entry System when vacancies occur, and to recruit new landlords who are willing to make rental units available to homeless people with disabilities who are participating in scattered site PSH programs. The Rental Assistances and Landlord Engagement (RALE) Program works to identify available rental housing units, educate property owners and managers about the benefits of making housing available through the scattered site PSH program, offer incentive payments to property owners for entering into lease agreements with participants, and helps owners and property management companies navigate paperwork and relationships with Public Housing Authorities or Lead Agencies. The program also facilitates communication and coordination between landlords and tenants and/or service providers as needed to assist with problem-solving. The Rental Assistances and Landlord Engagement (RALE) Program operates a 24/7 hotline available to all owners and property management companies in the program that may be utilized for crisis needs, property management needs, and problem solving.

Target Population: Abode Services' assist very low and low-income, unhoused people, including those with special needs and at risk of becoming unhoused to secure stable, supportive housing. A sub population served are landlords and property managers who accept clients with a range of rental assistance subsidies managed by Abode.

How Much Did We Do?

I. FY 21/22:

a. **Number of Unique Clients Served:** Maintained 331 units with subsidy management and 71 units without subsidy management for a total of 402. Client subsidy costs vary, total subsidy budget is $2.25M for 2 contracts with Abode and Bay Area Community Services (BACS).

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

a. **Reduce Mental Health Stigma:** Abode understands that many participants feel judged, frustrated, or humiliated as they navigate complex, bureaucratic systems of care, and have given up on receiving services altogether. Abode Services' strives to reduce mental health stigmas by providing landlords with educational resources and tools to support participants who are in a mental health crisis. We also assist in educating our landlords on Fair Housing Laws and tenancy rights when signs of direct and indirect discrimination or discriminatory language is observed or reported. Abode also prioritizes lived experience in our staffing decisions, hiring people with similar experiences, who can relate to and understand client challenges and provide a compassionate and non-judgmental source of hope and support. In addition, all employees

receive cultural humility training to increase their ability to reflect upon culture, privilege, and power dynamics in service provision.

b. **Create a Welcoming Environment:** Most of the work Abode Services provides in this program is field based or over the phone. We create a welcoming space by employing staff who have lived experience and/or who have a similar racial/cultural/ethnic background to those we serve. This makes our team very diverse. We use a Trauma Informed approach to engage with tenants. We strive to promote safety, build trust, be transparent and work collaboratively with tenants by providing choices whenever possible. We are also responsive to tenants and property managers and seek to utilize a solution focused approach when issues arise. Abode strives to provide supportive services that are relevant, supportive, and focused on building upon participants' strengths, skills, and gifts.

III. Language Capacity for this Program: Across Abode Services' serves people who represent a wide variety of cultures, who speak multiple languages, and whose understanding and interpretations of services and program options can vary quite widely. To ensure that participants can access all services even if they do not speak English, Abode implemented a 2-year Language Access Plan to address any linguistic barriers that participant households might face. Actions taken thus far include identification of threshold languages and translation of vital documents. We also utilize the Alameda County Language ACCESS Line

IV. FY 21/22 challenges: Difficulty in securing units under the changing Fair Market Rates (FMR). There was a decline in available and viable units within Alameda County. Landlords unwillingness to work with subsidized housing was also a challenge, discriminatory language or behaviors with landlords towards subsidized housing recipients was a contributing factor. Difficulty connecting to resources for clients experiencing mental health crisis, and resources for clients struggling with addiction. Finally, we faced challenges in finding employment opportunities for participants.

Is Anyone Better Off?

V. FY 21/22 Client Impact:
Clients are mostly stable in their housing through Landlord Liaison Project:

- 88% of units in portfolio maintained for 6-11 months
- 77% of units in portfolio maintained for 12+ months
- 77% of units in portfolio maintained for 36+ months
- No evictions from PSH during FY21-22

Success story: An Abode participant in this program has been housed since July of 2018. Unfortunately, due to the global pandemic and County shutdowns, this participants' mental health was severally compromised and ability to maintain his housing was impacted.

Leading into 2021, the landlord contacted our Housing Team to inform us that she would be terminating his lease due to his living conditions and ongoing lease violations. In response to the landlord complaint, our Housing Specialist immediately scheduled a case conference call with his service team to discuss the violations, develop a housing success plan and identify resources which would support the participant in cleaning and repairing his unit.

After several conference calls with the landlord and intensive case management support for the participant, the Housing Team was able to successfully resolve the tenancy violations and support the

participant with adhering to the terms of the lease. This participant is one of our highlighted success stories for FY 21-22, because he continues to utilize the tools outlined in his housing success plan, he is actively engaged with his services team to address his mental health and medical needs and is successfully maintaining his housing with zero lease violations.

VI. FY 21/22 Additional Information:

- 88% of landlords rated Abode as 3 (out of 5) stars or higher.
- Increase in communication and education with landlords and landlord engagement, to widen the network of landlords.
- Securing and maintaining units by actively searching for units within Alameda County. and leveraging existing relationships with landlords to sources new units.
- Successful Housing Placement for all active referrals.
- Coordination of Services and resources for clients.
- Resolution of tenancy violations with landlords to reduce housing exits.
- There has also been an increase in Services Providers to provide effective and consistent wrap-around services that leverage more weekly contact with clients and address life skills support and coaching as well as an increase in resources to provide landlords when clients are experiencing a mental health crisis.
- Abode has developed an improved system for tracking staff response time to Housing Providers and regular reminders to staff for building and retaining communication efforts with landlords.

VII. FY 22/23 Projections of Clients to be Served: 290 units with subsidy management and 700 units of landlord liaison support without subsidy management

VIII. FY 22/23 Programs or Service Changes: Expansion of Housing Specialists to help maintain landlord relationships and promote housing stability.

FULL SERVICE PARTNERSHIP (FSP) REPORT

FSP #: FSP 10

PROVIDER NAME: Abode Services

PROGRAM NAME: Project Hope Mobile Van Program (Tri City Area)

Program Description: The mobile clinic delivers medical and social services to the unsheltered population at highly trafficked locations such as churches, local showers and meal sites. Services include coordinated entry assessments, assisting unhoused individuals with getting document ready for housing, supporting with matches to permanent supportive housing, linkage and referrals, access to mail, mobile medical treatment, prescribing medication, and providing medical supplies, vaccinations and testing.

Target Population: Unsheltered individuals in the Tri-City, Mid County and East County areas.

How Much Did We Do?

I. FY 21/22:

a. **Number of Unique Clients Served:** 562. **Cost per client:** $645

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

a. **Reduce Mental Health Stigma:** The mobile clinic serves people from all walks of life and with varying needs. Staff is trained to utilize strengths-based language, harm reduction and housing first to allow anyone to access services despite their level of need. Staff use person first language to build rapport with participants who are hesitant to engage in formal services. Staff remain very positive and support people of different background and needs.
b. **Create a Welcoming Environment:** Staff provide water, snacks, clothing, hygiene kits, referrals, transportation tickets and assistance with documentation. Staff are very open and friendly when speaking to people who come to the mobile clinic which has become a hub for resources over the years. Staff also help participants become document ready by addressing barriers to mail access.

III. Language Capacity for this Program: Hope staff primarily speak English and were able to utilize staff within the organization who speak Spanish and Farsi. Staff also had access to the Interpretation and Language Line.

IV. FY 21/22 Challenges: Due to emissions law changes and mileage restriction criteria, the Mobile Clinic van no longer serve Castro Valley and Livermore.

Is Anyone Better Off?

V. FY 21/22 Client Impact: The staff provided 31 of the 56 individuals with safety net service referrals and housing problem solving. 82% of the participants have received Coordinated Entry Assessments. 40% of clients were assisted with non cash benefits, 83% exited with health insurance.

VI. FY 21/22 Additional Information: N/A

VII. FY 22/23 Projections of Clients to be Served: N/A

VIII. FY 22/23 Programs or Service Changes: Despite the challenges posed by the emission law and mileage restriction, HOPE outreach will continue to serve in the Tri-City area via street outreach and will utilize the mini-van to deliver mail, clothing, and other supplies to participants.

FULL SERVICE PARTNERSHIP (FSP) REPORT

FSP #: FSP 10

PROVIDER NAME: Alameda County Health Care Services Agency Office of Homeless Care and Coordination (OHCC) Housing Services Office (HSO) and multiple subcontractors

PROGRAM NAME: Housing Solutions for Health

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

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

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

Specific program categories that operate under the OHCC include:

1) Long-term housing subsidy programs and housing partnership support contracts that make it possible for individuals with serious mental illness to live in permanent supportive housing and licensed 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.

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

No Place Like Home (NPLH): The OHCC worked collaboratively with cities, other county departments, and affordable housing developers to secure $65 million from the statewide No Place Like Home (NPLH) Program (Round 4 funds) for creating more supportive housing for homeless individuals with a serious mental illness. This funding will help create and support 199 new housing units set aside for the target population in buildings with 553 total affordable units. Counties must commit to providing supportive services to NPLH tenants for a minimum of 20 years. Each project will have rents restricted as affordable to the NPLH target population for a minimum of 55 years. This allocation is in addition to the $129 million round 1-3 allocations. In total, 562 NPLH units will be added within Alameda County and will support expansion of units dedicated to those experiencing homelessness and SMI.

How Much Did We Do?

I. FY 21/22: *Data reflected in individual program summaries*

FY 21/22 challenges: The pandemic continued to add challenges to those experiencing homelessness and serious mental illness and accompanying household members. Due to risk mitigation efforts, temporary shelters operated within decompressed capacity limits to support social distancing and health measures. Additional on-going challenges facing include rapidly rising costs of housing within the County. The number of individuals experiencing homelessness has increased over 20% between 2019 and 2022 with an **estimate of over 9,747 people experiencing homelessness on any given night** (Alameda County 2022 Point-In-Time Count Summary). 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.

FULL SERVICE PARTNERSHIP (FSP) REPORT

FSP #: FSP 10

PROVIDER NAME: Alameda County Health Care Services Agency Office of Homeless Care and Coordination (OHCC) Housing Services Office (HSO) and multiple providers

PROGRAM NAME: Housing Support Program (HSP)

Program Description: The Housing Support Program (HSP) provides housing subsidy payments, services coordination and consultation, and training and technical support for Commuity Care Licensed board and care operators that serve individuals, 18 and over with serious mental illness, acute medical and housing needs.

HSP contractors will provide tier level of care and supports as approved/included in their Exhibit A-Scope of Work (SOW). The program offers a range of servics from basic board and care services to intensive support with activities of daily living ADLs, injection medication administration and non ambulatory designated beds and, transition age youth programming within three primary tiers. Tier level of care: Tier #1 is the basic rate care services; Tier #2 – basic board and care services, plus 1 or more supported services; and Tier # 3 basic board and care service plus two or more supported services

Target Population: HSP serves adults, ranging from 18-64 years old, with serious mental illness referred to the Housing Services Office (HSO) from designated referral programs, including sub-acute facilities, crisis residential treatment, state hospitals, community conservatorship programs, Conditional Release Program (CONREP) and outpatient behavioral health teams. HSP is the highest level of supported housing and priority is given to individuals with long histories of inpatient care who will need medication management and 24/7 care and supervision.

How Much Did We Do?

I. FY 21/22:

a. **Number of Unique Clients Served:** 312 Clients
   - HSP increased its portfolio adding 2 Adult Residential Facilities (ARFs) that included a 42-bed new home and 2 Residential Facilities for the Elderly (RCFEs) in locations with limited supported housing.
   - FY 21/22 operations supported 84% capacity at our highest (350 Clients), and on average, we operated at 79% full capacity. **Cost per client:** $13,904 (at highest capacity)

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

a. **Reduce Mental Health Stigma:** HSP provide a network of services throughout Alameda County to enhance resident's choice. HSP providers offer supported care in home like environment and offer roommate matching when possible. HSP operators receive annual training on Mental Health First Aid, Crisis Planning and Prevention, and privacy training. County liaisons provide coaching and support on best practice on housing problem solving and retention.
b. **Create a Welcoming Environment:** HSP promote client preference by working with referring agencies and applicants to find best match fit within the agency portfolio. Applicants are offered

in person and virtual tour of facilities. Applicants are introduced to staff and current tenants on tour and sometimes lunch or snacks are provided. When available applicants are offered room selection. At move in, residents are given storage space, bedding, and toiletries. Residents receive a calendar of events, access to electronic devices and privacy to meet with visitors and their care coordinators. Birthdays, holidays, and special events are honored at most sites.

III. Language Capacity for this Program: Services provided in a variety of languages, English, Spanish, Tagalog, Mandarin, Portuguese, and the Alameda County's Language Translation Line. Signage and flyers are in Alameda County threshold languages.

IV. FY 21/22 challenges: The pandemic impacted staffing at licensed homes. Many homes lost long term staff due to family and health concerns. Applicants referred to HSP had a higher rate of complex medical and behavioral needs. The pandemic outbreak slowed down the referral process, admissions and discharges from the home. HSP providers received guidance from the local public health agency on how to address outbreaks and re-open their facility to new tenants. HSP saw an increased in crisis episodes for medical and psychiatric services as the usual access to care coordinators, clinics and social programs were decreased in some cases ceased due to COVID outbreaks.

Is Anyone Better Off?

HSP experienced a higher volume of referrals. Of the 16 congregate facilities with shared rooms, only four homes experienced a COVID 19 outbreak. Only 1 known death was attributed to COVID 19. HSP had five positive discharges: four to family and one to a studio apartment. Six HSP participants are working or going to schoool. Flexibility within HSP allow for transfers when a home cannot meet the need of residents. Eight individuals transferred from one HSP home to another. 40% of the Clients, have benefited from HSP services for over a decade, and there are 12% with over 2 decades stay.

V. FY 21/22 Client Impact: HSP consist of owners and operators who have been in business on average over 10 years. Their dedication and commmittment to working with Alameda County Behavioral Health Care (ACBH) participants has help reduced severity of mental health symptoms; improved daily functioning; improved overall health status; promoted housing stability increased community connections/social networks; increased sense of purpose and meaning in life; reductions in mental health service costs and utilization of crisis, inpatient, and locked facilities; reduced tobacco use.
98 of 246 of the clients, have benefitt from HSP services for 10+ years. 29 residents in HSP has lived at their current housing for over 2 decades.

VI. FY 21/22 Additional Information: As board and care owners retire or transition out of residential care business, this has led to closure of facilities and decreased in supported housing options. HSP experience the closure of 3 RCFEs after the sole owner retired.

VII. FY 22/23 Projections of Clients to be Served: 20 additional Tier 2 and Tier 3 slots, that constitutes for a 6.67% growth on slots that will serve our most important and vulnerable population with higher levels of care.

VIII. FY 22/23 Programs or Service Changes: HSP will recruit new owners twice a year through the Request for Proposal Questionairre (RFPQ).

FULL SERVICE PARTNERSHIP (FSP) REPORT

FSP #: FSP 10

PROVIDER NAME: Bay Area Community Services (BACS)

PROGRAM NAME: North County Housing Connect, Housing Navigation Program

Program Description: Contractor's Housing Navigation (BACS Oakland Project Connect - OPC) Program provides an intensive, housing-focused, care coordination role within Alameda County's health and housing services provider networks. Housing Navigator's support clients with obtaining permanent, safe, and supportive homes as quickly as possible. Navigators shall also work to ensure that appropriate resources and supports are in place for individuals to maintain their housing. Annually, the program is targeted to serve 50-75 clients.

Target Population: Individuals who are unhoused and meet criteria for speciality mental health.

How Much Did We Do?

I. FY 21/22:

a. **Number of Unique Clients Served:** 85. **Cost per client:** $8,134

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

a. **Reduce Mental Health Stigma:** BACS Oakland Project Connect (OPC) utilizes a *whatever it takes* program model and approach to housing navigation. The services are low barrier and community based. Staff receive onboarding and ongoing training around privacy, best practices for mental health scenarios and recovery-oriented services.
b. **Create a Welcoming Environment:** BACS Oakland Project Connect (OPC) provided majority of their services in the community but when clients visit their site, they will enter a building with a home-like quality with warm colors, comfortable furniture, and refreshments. There is always a peer or staff on site to greet and support an individual who walks through the door.

III. Language Capacity for this Program: English is the primary language utilized in service provision, however OPC staff have access to agency staff who speak Spanish and availability to utilize the Language Line. The agency posts signs in Alameda County threshold languages.

IV. FY 21/22 challenges: The pandemic has made it difficult to recruit and maintain staff, while the need to support more individuals with housing navigation efforts, continues to increase.

Is Anyone Better Off?

V. FY 21/22 Client Impact: Throughout the year new referrals were enrolled in the program. Individuals who were ready to step down from services were appropriately linked to available resources. And in partnership with housing locators, majority of those discharged secured transitional and permanent supportive housing.

Census of those served increased, and program graduation rate has remained steady. The agency continued to build strong networking relationships with owners of transitional housing and housing locators.

VI. FY 21/22 Additional Information: OPC staff are field based and maintain contact with OPC participants throughout the pandemic. 89% of their partners were matched to housing and other viable community resources including benefits support, legal consultation and health care services. OPC met or exceeded its contract deliverables for the FY 21/22.

VII. FY 22/23 Projections of Clients to be Served: 50-75 clients.

VIII. FY 22/23 Programs or Service Changes: N/A

FULL SERVICE PARTNERSHIP (FSP) REPORT

FSP #: FSP 10

PROVIDER NAME: Bay Area Community Services (BACS)

PROGRAM NAME: Rental Subsidies and Land Lord Liasion Program

Program Description: The Rental Assistances and Landlord Engagement (RALE) (formerly called Landlord Liaison) Program is designed to cultivate and sustain relationships with property owners and property management companies (landlords) with the goal of encouraging them to accept additional tenants who are referred through the Coordinated Entry System when vacancies occur, and to recruit new landlords who are willing to make rental units available to homeless people with disabilities who are participating in scattered site PSH programs. The Rental Assistances and Landlord Engagement (RALE) Program works to identify available rental housing units, educate property owners and managers about the benefits of making housing available through the scattered site PSH program, offer incentive payments to property owners for entering into lease agreements with participants, and helps owners and property management companies navigate paperwork and relationships with Public Housing Authorities or Lead Agencies. The program also facilitates communication and coordination between landlords and tenants and/or service providers as needed to assist with problem-solving. The Rental Assistances and Landlord Engagement (RALE) Program operates a 24/7 hotline available to all owners and property management companies in the program that may be utilized for crisis needs, property management needs, and problem solving.

Target Population: BACS' serves under-served individuals and families including chronic and literal homeless adults with Severe Mental Illness (SMI) and housing insecure individuals including encampment communities. Specific target populations include Transition Age Youth, older adults, individuals with forensic background, zero income and who have active substance use disorder in addition to co-occurring mental health conditions.

How Much Did We Do?

I. FY 21/22:

a. **Number of Unique Clients Served:** 200 Client subsidy costs vary, total subsidy budget is $2.25M for 2 contracts with Abode and Bay Area Community Services (BACS).

b. **How Well Did We Do?**

II. Please Describe Ways that the Program Strives to:

a. **Reduce Mental Health Stigma:** Several BACS Providers in this program have lived experiences which is valuable in engaging and supporting our participants. BACS also educates landlords about the population we serve and to be sensitive to their life experiences and backgrounds in order to be non-judgmental and unbiased. BACS promotes Housing First philosophy and holds up the ability for high needs participants with mental health conditions to live normal lives.

b. **Create a Welcoming Environment:** BACS maintains a client centered approach that is non-judgmental and meets them where they're at. We dress casual understand that each individual we serve comes from a different life experience and culture and it takes time to build rapport and relationship. We promote a trauma informed approach with harm reduction which respects

individual's choices in response to the conditions in their lives. BACS also views culture as strength not a barrier and we remain open to learning from those we serve.

III. Language Capacity for this Program: BACS staff speak Spanish staff, and we use various interpretation applications and services via phone

IV. FY 21/22 challenges: Those who have dropped out of case management and need to be referred to tenancy sustaining services or elsewhere. Difficult to support those who choose not to engage with services.

Many clients not paying rent portion due to pandemic and eviction moritorium. These outstanding rent amounts need to be paid and our program has limited ability to support this need

Is Anyone Better Off?

V. FY 21/22 Client Impact:

- 191 units maintained in portfolio for 6 months = 96%
- 183 units maintained in portfolio for 12 months or more = 92%
- 179 units maintained in portolio for 36 months or more = 89.5%
- **Among the clients in this program:**
  - 68 clients entering from literal homelessness
  - 3 Veterans
  - 72 Female, 34 Male, 1 Transgender
  - 37 Seniors (62+)
  - 106 with disabilities
  - 46 receiving non-cash benefits
- Only 6 exits: 2 to permanent housing, 1 incarcerated, 2 deceased, 1 other.

Success Story: A 2 ½ year client was living at The Lakehurst until a fire occurred in his unit rendering it uninhabitable. These individual experienced ongoing active delusions, disorganized thoughts and significant paranoia. All of which were barriers to transitioning into permanent housing.

Program staff collaborated with his mother for an extended period support this individual in attending unit viewings. However, this individual felt too paranoid to move forward with the application process with all of the units viewed. This individual finally felt comfortable and safe with a studio unit at Mark Twain Apartments. He ultimately moved into the unit in November 2021. Since being housed, he has been more successful with managing his mental health symptoms and has been more consistent with accessing support from community providers. He has complied with Landlord Liaison program expectations and has not been issued any lease violations."

Success Story: Shortly after being housed, a partner with acute stress and severe anxiety and was not able to remain in their unit. Program staff held a client centered approach and openly received daily calls with the distressed partner every day, for a month. This time was spent drawing out her strengths and interests, housing and overall health needs in order to relocate her successfully. Staff were able to get this partner and service animal rehoused in a beautiful community that offers regular walks to the beach, a pool, gym and open outside space. Anxiety levels have decreased tremendously, per her doctor. Staff now receive calls from the partner on a positive note and full of gratitude and there has been a positive shift in and in her level independence.

VI. FY 21/22 Additional Information: N/A

VII. FY 22/23 Projections of Clients to be Served: Total Minimum Units to be Maintained 175 Landlord Liaison units maintained without subsidy 80.

VIII. FY 22/23 Programs or Service Changes: Expansion of Housing Specialists to help maintain landlord relationships and promote housing stability.

FULL SERVICE PARTNERSHIP (FSP) REPORT

FSP #: FSP 10

PROVIDER NAME: Building Opportunities for Self-Sufficiency (BOSS)

PROGRAM NAME: Berkeley Housing: USV/Harrison House Singles

Program Description: Emergency shelter serving adults who are literally unhoused with moderate to severe mental health conditions. Shelter guests are eligible for housing navigation, linkages to community services and benefits support.

Target Population: Harrison House has 10 designated beds for guests 18+, who are literally unhoused and eligible for Alameda County Behavioral Health (ACBH) services. Operating under decompression in alignment with pandemic risk mitigation efforts, the number of available set-aside ACBH beds during this fiscal year was 5.

How Much Did We Do?

I. FY 21/22:

a. **Number of Unique Clients Served:** 21. **Cost per client:** $15,447

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

a. **Reduce Mental Health Stigma:** Ursula Sherman Village (USV)/Harrison House maintain confidentiality and privacy for its guests. Guests with behavioral health diagnoses are fully integrated into the program. The project utilizes a person-centered approach for intakes and discharges. Staff and guests share meals and breaks in a common space. Alameda County's Shelter Standards Guiding Principles informs the service delivery throughout an individual's stay.
b. **Create a Welcoming Environment:** USV staff, shelter coordinator, program aides, and housing navigator welcome new guests, offer tours, and introduce new guests to existing residents. USV staff provide a space for privacy at intake and pace the onboarding process per guests' needs. New guests are issued a welcoming package with toiletries, linens, and other personal items and assigned a laundry slot. Guests are provided with a calendar of events for the site. Guests are assigned a housing navigator who will provide case management services and housing resources. Guests are provided opportunities to give feedback to USV staff directly or use the suggestion box.

III. Language Capacity for this Program: Staff on site speak English and Spanish. Within the agency, staff also speak Vietnamese, Mandarin and Cantonese. Interpretation and Language Line is available for guests and staff. Signages are in Alameda County threshold languages: Spanish, Cantonese and Farsi.

IV. FY 21/22 challenges: USV is on its third year of decompression due to risk mitigation efforts combatting pandemic challenges. USV staff are following local mandate for congregate setting, there are only 5 of the 10 beds available to serve the community. USV experienced several closures to addmission, due to COVID 19 outbreaks. During COVID outbreaks there was a higher number of exits to streets, because the quaratine protocols impact their abilities to move around freely. In addition, USV experienced staffing shortages for the 21-22 fiscal year.

Is Anyone Better Off?

V. FY 21/22 Client Impact: USV ensure residents complete a Coordinated Entry Assessment (CEA) within 7 days of admission and registered for the housing queue if qualified. Out of 21 individuals served: 1 secured permanent supportive housing, 2 move in with family and/or friend, and 1 secured market rate apartment. This particular individual was unhoused, for over 7 years, she also obtained employment while at USV. She made cold calls to local landlords and secured her own housing paying market rate rent. 18 of the 21 leavers secured income prior to discharge increasing their chances of housing and financial stability.

VI. FY 21/22 Additional Information: USV staff have collaborative relationships with Soul Space and Samuel Merritt Nursing School program to meet the unique needs of individuals who struggled with access to basic care. Soul Space OnTrack, offers consultation to USV staff on ways to provide a culturally responsive, strength-based service delivery for unhoused individuals with a focus on African American guests. Samuel Merritt Nursing School provide nursing interns for 6 weeks at USV. These nursing inters, provide health education and linkages to health care services for individuals who are not connect to a health clinic.

VII. FY 22/23 Projections of Clients to be Served: 21-30 range based on compression status.

VIII. FY 22/23 Programs or Service Changes: N/A

FULL SERVICE PARTNERSHIP (FSP) REPORT

FSP #: FSP 10

PROVIDER NAME: Building Opportunities for Self-Sufficiency (BOSS)

PROGRAM NAME: Casa Maria Safe Haven Shelter (Interim and Emergency Housing)

Program Description: Casa Maria is a supported interim/emergency shelter (Safe Haven) for unhoused individuals who are hard to reach while on the streets. There are 17 private or semi-private units for adults experiencing homelessness with disabilities. Participants can stay up to 6 months; individuals receive housing navigation, SSI/benefits advocacy, linkages to community resources and life skills development, while seeking permanent housing.

Target Population: Adults 18+, unhoused with a serious mental illness (SMI) and eligible for Housing Disability Advocacy Program (HDAP). Qualified individuals must be within the Coordinated Entry System, housing queue for permanent supportive housing and receive Social Security Income (SSI) Advocacy from one of Alameda County-funded benefits advocate entities.

How Much Did We Do?

I. FY 21/22:

a. **Number of Unique Clients Served:** 23. **Cost per client:** $13,682

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

a. **Reduce Mental Health Stigma:** Using the Housing First Model, Casa Maria is a low barrier Safe Haven, using a person-centered approach to keep residents safely "housed," without requiring treatment or sobriety. Linkages to care and treatment are available upon client request.
b. **Create a Welcoming Environment:** Casa Maria staff consists of shelter coordinators and program aides who work within a collaborative network of housing navigators, care coordinators, and benefits advocates to enroll eligible applicants into Safe Haven. Applicants are greeted by Casa Maria staff and offered a tour and same-day enrollment. The units have private rooms and shared common living spaces. Residents have storage space on site and offered off-site storage for items unable to fit in the designated area. Residents have access to staff 24/7, one hot meal a day, and access to a kitchen and microwave. Staff support residents to connect with the Casa community and community members in the neighborhood, major holidays are celebrated, and personal expression were honored.

III. Language Capacity for this Program: Casa Maria staff speaks English, Cantonese, Mandarin, and Vietnamese. Staff at Casa Maria can access other BOSS staff who speak Spanish. Casa Maria staff have access to the Alameda County Language Line for languages not spoken at the agency.

IV. FY 21/22 challenges: Casa Maria has been operating under decompression (COVID risk mitigation efforts) capacity which has sometimes been challenging to secure enough health and safety cleaning and disinfectant supplies. Test kits were not always available when needed and admissions were on pause when there was a noted outbreak. The pandemic also impacted staffing at Casa Maria as well with collaborative partners which made it a challenge to support residents fully.

Is Anyone Better Off?

Of the 23 unique individuals served, 21 exited to PSH; most were housed within 6.5 months of entering Casa Maria, and 88% exited from Casa Maria with one or more non-cash benefits and ongoing support from benefits advocates.

V. FY 21/22 Client Impact: Shelter staff noted a shift in the community for FY 21/22. They cited that increased collaboration with community partners has led Casa guests to participate in community building and networking. Shelter staff participating in weekly provider meetings and training provided by Alameda County Health Care for the Homeless (ACHCH) has increased problem-solving, engagement and communication with agency partners.

VI. FY 21/22 Additional Information: A Casa Maria long-stayer secured permanent supportive housing after 3 years of trying to find a good fit. Casa Maria community is so strong that a guest who experienced an insurmountable tragedy back-to-back cited that Casa Maria staff and guests got him through a dark period and kept him focused on his goal of long-term housing.

VII. FY 22/23 Projections of Clients to be Served: 17 point-in-time count.

VIII. FY 22/23 Programs or Service Changes: Addition of program aides, enhancement, and development of life skills to support independent living.

FULL SERVICE PARTNERSHIP (FSP) REPORT

FSP #: FSP 10

PROVIDER NAME: Building Opportunities for Self-Sufficiency (BOSS)

PROGRAM NAME: South County Homeless Housing (A Street Shelter)

Program Description: South County Homeless Project (SCHP) is an interim emergency housing for adults who are unhoused and meet eligiblity requirements for speciality mental health serivces. Residents stay up to 6 months (with extensions as needed while people are seeking permanent housing) and have access to housing navigation, benefits eligibility, employment, health, wellness, and peer support services.

Target Population: Individuals 18 years and older who are literally homeless, and who meet eligibility requirements for specialty mental health services. These are individuals who are identified by Alameda County Behavioral Health (ACBH) as individuals with high needs who are hard to find and engage while on the streets.

How Much Did We Do?

I. FY 21/22:

a. **Number of Unique Clients Served:** 38. **Cost per resident:** $16,128

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

a. **Reduce Mental Health Stigma:** SCHP uses Alameda County Shelter Standard's as a guide for intake, service coordination and discharges while being person-centered. BOSS staff refer to shelter residents as participants or guests. BOSS staff receive annual training on privacy and confidentiality regulations. BOSS uses Housing First model not requiring sobriety and treatment adherence as a condition for admission or remaining at site. Staff and residents share space for lunch and breaks. Participants have access to a private room to meet with guests. Holidays, birthdays and other milestones are celebrated.
b. **Create a Welcoming Environment:** Residents at SCHP have access to community garden and patio area which blends into the neighborhood. For potential residents, BOSS staff and current resident offer a tour of the facility, answers questions about program rules and structure. Once enrolled into SCHP, residents are provided linens and toiletries and storage area for personal belongings. Residents have access to showers and laundry. Hot meals and snacks are also provided. BOSS staff provide intensive, housing-focused, care and coordination and assist to obtain and retain permanent housing as soon as possible.

III. Language Capacity for this Program: SCHP staff speak English and Spanish. Staff have access to colleagues within the agency who speak Cantonese, Vietnamese and Mandarin. Staff also have access to the Interpreters and Language Line. Signages and flyers are posted in Alameda County threshold languages Spanish, Chinese and Farsi.

IV. FY 21/22 challenges: SCHP is a 24-bed facility, but the agency has been operating at a decompression level of 12 beds due to COVID-19, which impacted bed availability for unhoused individuals. In addition,

the agency had to pause admissions multiple times due to the COVID-19 outbreak. COVID-19 impacted residents' ability to remain on site due to quarantine restrictions. In addition, the agency struggled to recruit and maintain staff. Due to a decrease in housing opportunities, the length of stay for SCHP increased for some participants. Finally, COVID-19 limited the agency's ability to facilitate groups and host community events.

Is anyone better off?

V. FY 21/22 Client Impact: SCHP met its contract deliverables of serving at least 24 unduplicated guests for the FY 21/22. Of the 27 served, 22 guests exited to permanent housing and known destinations. 4 of the SCHP guests obtained employment. Sixteen were able to secure public benefits.

VI. FY 21/22 Additional Information: SCHP reported two longer stayers (over 2 years at the shelter) were able to find permanent housing. 1 of the long stayers obtained employment and secured market rate room to rent. Per SCHP staff, “It was rewarding seeing his hope, dignity, and love of life restored.”

VII. FY 22/23 Projections of Clients to be Served: 24-48 based on decompression levels.

VIII. FY 22/23 Programs or Service Changes: N/A

FULL SERVICE PARTNERSHIP (FSP) REPORT

FSP #: FSP 10

PROVIDER NAME: Building Opportunities for Self-Sufficiency (BOSS)

PROGRAM NAME: Supported Independent Living

Program Description: Contractor shall serve formerly unhoused individuals living in permanent supportive housing units designated for individuals with histories of serious mental health issues (SMI) at Meekland, Pacheco Courts and Rosa Parks.

Target Population: Transition-Aged Youth (18-24), adults and families with a member with SMI.

How Much Did We Do?

I. FY 21/22:

a. **Number of Unique Clients Served:** 32. **Cost per client:** $9,220

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

a. **Reduce Mental Health Stigma:** BOSS upholds Housing First Model with low barriers to permanent supportive housing. Staff are provided with Mental Health First Aid and Harm Reduction trainings to increase awareness of stigmatizing behavior, language, and response and to reinforce client centered practice and to respect resident's self-determination in reaching their goals. Treatment and Substance Use Disorder services are voluntary and offered on an as needed basis. BOSS staff utilizes evidence-based practices such as guiding principles of Trauma Informed Care and Motivation Interviewing to build upon the strength of tenants. BOSS also provides groups that focus on community building, property maintenance and health and safety.
b. **Create a Welcoming Environment:** BOSS' team of property managers, on-site clinical staff and program aides offer site tours for potential residents. On-site services establish rapport with potential new residents and their network of support at intake and throughout their stay at BOSS properties. At move in, BOSS teams invite existing tenants to meet with new tenant. BOSS teams host care coordination meetings at site, offer use of community room for events and computer room for residents.

III. Language Capacity for this Program: Primary language at all three properties is English. Supportive housing staff have access to agency's staff who speak Spanish, Cantonese, Vietnamese and Mandarin. BOSS staff also have access to language line. Agency post information and referrals in Alameda County threshold languages.

IV. FY 21/22 Challenges: The pandemic impacted services available to residents. The agency offered limited groups and community building activities. Individual services were provided via computer and phone apps and minimal face to face contact. Residents became more disconnected and isolative. The agency is working to rebuild these connections. Many residents face economic hardship which impacted their ability to pay rent. Residents were referred to programs with Emergency Rental Assistance Program (ERAP) to help retain their housing. As pandemic federal and local mandates were lifted, residents noted a decrease in housing alternatives as rent increased in Alameda County. There are also

limited resources for people who are currently housed but are looking for other affordable housing opportunities.

Is Anyone Better Off?

V. FY 21/22 Client Impact: Four of the original 15 tenants are still housed at Meekland. One former tenant secured his own apartment. Three of the original tenants are still at Rosa Parks. Two residents secured affordable housing and a housing voucher. Eleven of 12 residents at Pacheco Court have remained housed. One resident left after securing housing within his/her network of support. Increased collaboration with community partners has been beneficial to housing retention.

VI. FY 21/22 Additional Information: As federal and local pandemic mandates are lifted; BOSS is in the process of increasing face to face contact and establishing a schedule of groups and events with tenants.

VII. FY 22/23 Projections of Clients to be Served: 32-38

VIII. FY 22/23 Programs or Service Changes: N/A

FULL SERVICE PARTNERSHIP (FSP) REPORT

FSP #: FSP 10

PROVIDER NAME: East Oakland Community Project

PROGRAM NAME: Crossroads

Program Description: East Oakland Community Project's (EOCP) Crossroads Emergency Housing supports singles and families, including people living with HIV/AIDS, to receive the necessary skills to obtain employment and permanent housing in a dignified and healing environment. EOCP offers individualized support through case management, which helps homeless people advocate for themselves and connects them to services to assist them in becoming self-reliant.

Target Population: Individuals 18 years and older who are literally homeless, and who meet eligibility requirements for specialty mental health services. These are individuals who are identified by Alameda County Behavioral Health (ACBH) as individuals with high needs who are hard to find and engage while on the streets.

How Much Did We Do?

I. FY 21/22:

a. **Number of Unique Clients Served:** 48**. Cost per client:** $6,916

How Well Did We Do?

II. Please Describe Ways that the Program Strive to

a. **Reduce Mental Health Stigma:** East Oakland Community Project (EOCP) is located in the heart of Oakland. The agency is known for providing dedicated care to individuals and families who are under-served and under resourced. 10 of the shelter beds are for adults who are enrolled in ACBH system of care. All single adults share a common space without distinction. Families have separate entry/exit points as well as separate sleeping quarters. EOCP staff build personalized and trusting connections with each of their guests and use person first language to focus on individual strengths and resiliency. EOCP staff receive annual trainings on confidentiality and privacy. In alignment with Alameda County's Shelter Standards, EOCP is low barrier and with quick entry shelter program.
b. **Create a Welcoming Environment:** Guests are offered a tour and introduction of personnel and current residents. Intakes are arranged at snack and mealtime so guests can have a hot meal and connect with other residents. At admission, guests receive standard supplies of linens, personal storage, and toiletries. EOCP staff provide a space for privacy at intake and pace the onboarding process per guests' needs. A welcoming letter with staff contact information and calendar of events are given to new enrollees. Community meetings are weekly and pre-COVID 19, a buddy system was in place for new residents.

III. Language Capacity for this Program: Staff at EOCP speak English, French and Spanish. Staff also have access to the Interpreter and Language Line. Signages and flyers are in Alameda County threshold languages.

IV. FY 21/22 challenges: EOCP served fewer individuals due to COVID-19 decompression requirements. COVID-19 outbreaks triggered quarantining, and isolation protocols at the site that led to early exit for

residents who could not follow public health recommendations. An uptick in residents with high psychiatric and medical acuity, which increased crisis episodes and contributed to high number of discharges from the facility. EOCP experienced a high turnover of personnel in key roles at the agency. Significant delays with certifying new staff documentation requirements. Access to quality and affordable housing was scarce.

Is anyone better off?

V. FY 21/22 Client Impact: EOCP serves many individuals and families needing urgent spaces of safety or accommodation. Many guests are fleeing violence, have physical and mental health diagnoses, are foster care youth, or are discharged from an institution (e.g., hospital, jail) with no available resources to obtain housing. Despite these barriers, the agency has built connections and relationships with Alameda County to connect EOCP guests with the proper support when needed. Of the 48 served, 46 left with income, including non-cash benefits, and three individuals obtained employment. Thirty-eight exited with health insurance. The most common exit from the program was with family/friends, temporary situations, and transitional housing.

VI. FY 21/22 Additional Information: EOCP staff shared that a long stayer with a subsidy to find the right home for her and her children, after a year and multiple extensions from the local public housing authority, this long stayer moved into her first apartment after 10 years of living on the streets and in shelters.

VII. FY 22/23 Projections of Clients to be Served: Between 10 and 22 individuals served.

VIII. FY 22/23 Programs or Service Changes: Historically EOCP has used a behavioral health clinician as a consultant. That contract was not renewed for the FY 22/23. EOCP has brought that position in-house.

FULL SERVICE PARTNERSHIP (FSP) REPORT

FSP #: FSP 10

PROVIDER NAME: Housing Authority of the County of Alameda (HACA)

PROGRAM NAME: Flexible Housing Subsidy Pool - Rental Assistance Program

Program Description: A program in effect since 2009, which seeks to expand affordable housing resources and supports for adults with serious mental illness currently served by ACBH adult mental health service team providers. The project provides monthly housing subsidies for eligible ACBH clients with serious mental health issues. The Housing Authority of the County of Alameda (HACA) is responsible for quality housing subsidy administration supporting clients, timely rental payments to landlords, performance of housing inspections, verification of contracts, and review of rental agreements, while OHCC Housing Services Office (HSO) staff facilitate connections to an expanded array of supportive services to clients in the program. MHSA funds are utilized to cover the monthly housing subsidy payments and the costs of managing the subsidy program. As part of this collaboration, a lottery system supports the availability and transition to Section 8 Housing Choice Vouchers to program participants, every three years. The primary goal of the program is to expand the number of ACBH adult service consumers living less restrictive and more integrated housing settings.

Target Population: Focus on helping adults (18 and older) with serious mental illness in Alameda County to live in the least restrictive and most integrated setting appropriate to meet their needs. Rental Assistance Program efforts focus primarily on helping individuals experiencing homelessness and those with prolonged stays in institutional settings.

How Much Did We Do?

I. FY 21/22

a. **Number of Unique Clients Served:** 32. **Cost per client:** $18,750

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

a. **Reduce Mental Health Stigma:** As housing continues to be identified as a significant unmet met need among persons experiencing homelessness, with serious mental health issues, this program supports reduction of mental health stigma by integrating the essential tenet *housing is health* and focusing on securing and retaining permanent supportive housing in the community. Further, the program utilizes Housing First principles and referrals through the Coordinated Entry System (CES).
b. **Create a Welcoming Environment:** Collaboration with natural supports focusing on an individual's preference and selection of housing including coordination with landlords and service providers.

III. Language Capacity for this Program: English and use of County Language/translation services, if needed.

IV. FY 21/22 challenges: Project partners continue to experience staff shortage and retention difficulties

related to the pandemic; communication continues to be an integral component to ensuring expediency in intiating housing subsidies.

Is anyone better off?

V. FY 21/22 Client Impact: Number of unduplicated individuals served, who have retained housing: 32.

VI. FY 21/22 Additional Information: N/A

VII. FY 22/23 Projections of Clients to be Served: This program will continue to expand and support more individuals with housing assistance subsidies.

VIII. FY 22/23 Programs or Service Changes: During FY22/23, a lottery will be held for the transition of a limited number of Section 8 Housing Vouchers for eligible CHOICES partners who meet the following eligibility criteria: utilization of housing subsidy and maintained successful tenancy for at least 15 consecutive months, initial and annual follow-up Housing Quality Standards (HQS) inspections, in good standing and participation within the CHOICES program, and meet eligibility criteria for Section 8 Housing Choice Vouchers.

FULL SERVICE PARTNERSHIP (FSP) REPORT

FSP #: FSP 11

PROVIDER NAME: Telecare Corporation

PROGRAM NAME: Community Conservatorship Program

Program Description: Community Conservatorship Program is a full-service partnership program based on the Assertive Community Treatment model. It is civil court overseen due to the conservatorship status.

Target Population: CC program serve individuals with severe mental illness who have a history of long hospital stays including Napa or other state hospitals, are high utilizers of mental health services and who are considered to be at great risk for psychiatric hospitalization and grave disability.

How Much Did We Do?

I. FY 21/22:

a. **Number of Unique Clients Served:** 28. **Cost per client:** $10,775

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

a. **Reduce Mental Health Stigma:** We address internalized stigma by treating clients as individuals, getting to know them as humans through direct conversations and whole person assessments, learning their psychosocial histories, understanding the reasons behind their challenges, learning their strengths and creating individualized treatment goals that come from client's hopes and dreams. We provide clients with education about their mental health and substance use symptoms that can increase understanding and a sense of control over their lives. We educate about ways that stigma from society may impact their own self perceptions.

   We are with clients side-by-side in the community which allows us to advocate for fair treatment, as well as model for community members, how to interact with people who are experiencing symptoms of mental health diagnoses in real time.

   We work with family members and other loved ones to provide psychoeducation and skill building about how to interact with clients in ways that minimize stigmatization.

   We provide ongoing training and support to help staff recognize own internalized biases and minimize potential microaggressions towards clients.

b. **Create a Welcoming Environment:** Almost all of our services are provided in the community, where are clients are located. We have a receptionist who answers calls with respect and ensures that clients' stated needs are forwarded to their team. We have a 24/7 Crisis Line answered by a live staff member, which allows clients to receive support when they feel the need. We have staff on-site all day, every day (M-F) to address the needs of clients who come to the office looking for support. We host client-focused events that honor and welcome our clients, to help them feel like integral members of society.

III. Language Capacity for this Program: English, Spanish, access to a Language Line for any additional language needs.

IV. FY 21/22 challenges: FY21/22 was a time of great uncertainty due to the stressors of the global pandemic, housing insecurity, increased risk of substance use, increase of hate crimes directed towards vulnerable populations, increased cost of livng, especially for housing and food. While all these factors impacted our clients, the most challenging of the past year were the shortage of safe, affordable housing, increased cost of living due to inflation, and the dangerous risk of overdose and death due to the easy accessiblity of fentanyl and other street drugs.

Is anyone better off?

V. FY 21/22 Client Impact: "Dave" is a 65 year old, African American man. He was enrolled in the CC program in 2021 after a subacute stay. Prior to joining the CC program and returning to the community, Dave had spent nearly 5 years in state or subacute hospitals. He was able to step down from a Murphy conservatorship to a Community Conservatorship. He was initially very anxious and excited to return to the community. He worked with the CC team to ensure his symptoms and medications were managed closely. He connected with primary care for referral around his vision issues to ensure he would maintain his sight. His identified priorities were around medical care, good housing, and help maintaining his sobriety. Dave has been stabily housed at his board and care home since leaving the hospital and has not reoffended or returned to the hospital. He attends out-patient substance treatment 3 times a week and has developed supportive relationships in his home and in the community. He engages 3-4 times a week with CC team staff to get his needs met and ensure he is maintaining the success he has acheived.

VI. FY 21/22 Additional Information:

- 89% of CC Partners received a follow up visit within 7 days of discharge from a mental health hospitalization
- 100% of CC Partners received a follow up visit within 30 days of discharge from a mental health hospitalization

VII. FY 22/23 Projections of Clients to be Served:

- CC program currently has 19 unique partners open to service, 2 referrals in outreach status, and 2 being evaluated by PGO for eligibility
- We project that we will reach census of 25 partners throughout the FY22-23 year

VIII. FY 22/23 Programs or Service Changes: There will be ongoing evaluation and changes in practices to follow the federal, state and local guidelines about COVID as they develop. If the global pandemic allows, we plan to reinstate all in-person partner events, including Partner Summer Picnic, Thanksgiving Event and Holiday party

Metrics	% of FY 21/22 FSP clients that achieved the metric
Reduction in Hospital Admits*	75%
Reduction in Hospital Days*	89%
Reduction in Psychiatric Emergency Services (PES)*	0
Reduction in Incarceration Days*	67%
Increase in the number of days Stably Housed*	50%
Primary Care visit within the previous year	63%
With an educational goal who are enrolled in school	0
With a vocational goal who are employed	4%
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	0

*The metrics above measuring “reductions” are looking at FSP clients served in FY 21/22 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 #: FSP 12

PROVIDER NAME: Telecare Corporation

PROGRAM NAME: Assisted Outpatient Treatment (AOT)

Program Description: AOT is a full-service partnership program based on the Assertive Community Treatment model. The program is overseen by civil court order for treatment. It consists of 3 potential court terms of 6 months, allowing participants the opportunity to voluntarily engage with treatment.

Target Population: AOT serve individuals with severe mental illness who have a history of poor treatment engagement, are high utilizers of mental health services and who are considered to be at great risk for psychiatric hospitalization, grave disability or danger to others.

How Much Did We Do?

I. FY 21/22:

a. **Number of Unique Clients Served:** 51. **Cost per client:** $20,708

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

a. **Reduce Mental Health Stigma:** We address internalized stigma by treating clients as individuals, getting to know them as humans through direct conversations and whole person assessments, learning their psychosocial histories, understanding the reasons behind their challenges, learning their strengths, and creating individualized treatment goals that come from client's hopes and dreams. We provide clients with education about their mental health and substance use symptoms that can increase understanding and a sense of control over their lives. We educate about ways that stigma from society may impact their own self perceptions. We encourage partners to engage in community and develop relationships which foster independence and empowerment.

   We are with clients side-by-side in the community which allows us to advocate for fair treatment, as well as model for community members, how to interact with people who are experiencing symptoms of mental health diagnoses in real time.

   We work with family members and other loved ones to provide psychoeducation and skill building about how to interact with clients in ways that minimize stigmatization.

   We provide ongoing training and support to help staff recognize their own internalized biases and minimize potential microaggressions towards clients.

b. **Create a Welcoming Environment:** Almost all of our services are provided in the community, where are clients are located. We have a receptionist who answers calls with respect and ensures that clients' stated needs are forwarded to their team. We have a 24/7 Crisis Line answered by a live staff member, which allows clients to receive support when they feel the need. We have staff on-site all day, every day (M-F) to address the needs of clients who come to

the office looking for support. We host client-focused events that honor and welcome our clients, to help them feel like integral members of society.

III. Language Capacity for this Program: English, Spanish, access to a Language Line for any additional language needs.

IV. FY 21/22 challenges: FY21/22 was a time of great uncertainty due to the stressors of the global pandemic, housing insecurity, increased risk of substance use, increase of hate crimes directed towards vulnerable populations, increased cost of livng, especially for housing and food. While all these factors impacted our clients, the most challenging of the past year were the shortage of safe, affordable housing, increased cost of living due to inflation, and the dangerous risk of overdose and death due to the easy accessiblity of fentanyl and other street drugs.

Is anyone better off?

V. FY 21/22 Client Impact: "Bill" is a 36 year old African American man, referred for AOT investigation after a series of incarcerations, mobile crisis encounters and hospitalizations. He was court ordered to the AOT program in Febrary 2021 and the team began engagement. Working with Bill to identifying several areas of including housing, substance treatment, employment, benefits and ways to manage his troubling thoughts. AOT supported Bill with short-term housing using MHSA funds to provide a safe space for him to connect with his team and develop independence and self care skills. During his first term with AOT, Bill worked on securing benefits, reconnecting with his primary care provider and exploring housing options. He started taking medications to manage his thoughts and began to make improvements around his sumbstance use disorder. Into his second term, he began exploring harm reduction strategies to his substance use and secured housing in a independent living home. He also started focusing on his goals for employment. He applied several places but failed the drug testing portion of the application process. He was invited to re-apply in 6 months if he was able to pass the test. He worked on his sobriety and continued taking his medications, working with his psychiatrist to improve symptom management. In his third term with AOT, he was successful in secure the job he really wanted and passed his pre-employment tests. He started working full time initially, but determined that was really challenging when also trying to balance his self care and relationships. He was able to reduce his schedule and stay employed. He has maintained his housing, completed his criminal court diversion program, maintained his medication and symptom management and his sobriety. He has reconnected with his family and is repairing some of those relationships. Bill has graduated from the AOT program, completing all 3 terms (18 months) and continues to move forward with his next team around his hopes and dreams.

VI. FY 21/22 Additional Information: AOT metrics:

- 80% of AOT Partners received a follow up visit within 7 days of discharge from a mental health hospitalization
- 100% of AOT Partners received a follow up visit within 30 days of discharge from a mental health hospitalization

VII. FY 22/23 Projections of Clients to be Served: AOT currently has 25 unique partners open to service, with 3 partners being investigated by our county liaison.

There have been some changes to the AOT laws, which has grown to include individuals with 1,370 charges as a possible diversion to custody stays. The court, county liaisons and county counsel are currently exploring how the AOT program would handle 1370 referrals.

We project that we will remain at full census of 30 partners throughout the FY22-23 year.

VIII. FY 22/23 Programs or Service Changes: There will be ongoing evaluation and changes in practices to follow the federal, state and local guidelines about COVID as they develop. If the global pandemic allows, we plan to reinstate all in-person partner events, including Partner Summer Picnic, Thanksgiving Event and Holiday party.

Metrics	% of FY 21/22 FSP clients that achieved the metric
Reduction in Hospital Admits*	80%
Reduction in Hospital Days*	73%
Reduction in Psychiatric Emergency Services (PES)*	0
Reduction in Incarceration Days*	71%
Increase in the number of days Stably Housed*	0
Primary Care visit within the previous year	69%
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	0
Average of four or more visits per month per client	0

*The metrics above measuring “reductions” are looking at FSP clients served in FY 21/22 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 #: FSP 13

PROVIDER NAME: Telecare Corporation

PROGRAM NAME: CHANGES

Program Description: Telecare CHANGES is an adult Full Service Partnership located in the Eastmont Town Center in Oakland, CA. The CHANGES FSP provides comprehensive 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: 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 21/22:

a. **Number of Unique Clients Served:** 120. **Cost per client:** $24,784

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

a. **Reduce Mental Health Stigma:** At Telecare, we talk openly about mental health and respond to misperceptions or negative comments by sharing facts and experiences. We address internalized stigma by treating clients as individuals, getting to know them as humans through direct conversations and whole person assessments, learning their psychosocial histories, understanding the reasons behind their challenges, learning their strengths and creating individualized treatment goals that come from client's hopes and dreams. We provide clients with education about their mental health and substance use symptoms that can increase understanding and a sense of control over their lives. We educate about ways that stigma from society may impact their own self perceptions.

   i. We are with clients side-by-side in the community which allows us to advocate for fair treatment, as well as model for community members, how to interact with people who are experiencing symptoms of mental health diagnoses in real time

ii. We work with family members and other loved ones to provide psychoeducation and skill building about how to interact with clients in ways that minimize stigmatization.

iii. We provide ongoing training and support to help staff recognize own internalized biases and minimize potential microaggressions towards clients

b. Create a Welcoming Environment:

i. Almost all of our services are provided in the community, where are clients are located. We have a receptionist who answers calls with respect and ensures that clients' stated needs are forwarded to their team. We have a 24/7 Crisis Line answered by a live staff member, which allows clients to receive support when they feel the need. We have staff on-site all day, every day (M-F) to address the needs of clients who come to the office looking for support.

ii. We host client-focused events that honor and welcome our clients, to help them feel like integral members of society.

III. Language Capacity for this Program: English (119 clients served) and Spanish (1 individual served). We also have the capacity to serve Samoan speakers.

IV. FY 21/22 challenges: The amount of information needed to track with FSP's is overwhelming and challenging. Collaborating with other providers due to all around staffing challenges is a barrier as well. Staffing, retention and hiring has been a major challenge. Not having clinical case managers on FSP is difficult as we don't have enough staff who can do therapy versus the clients who are requesting it, and caseloads are near 25 clients.

Is anyone better off?

V. FY 21/22 Client Impact: Nearly half of CHANGES members have a chronic medical condition and we have made a commitment to make sure they get the medical care they need and deserve. Changes had a client who had sciatica pain, suicidal ideation, chronic homeless, and prominent drug and alcohol abuse. With the work of case managers, this client has maintained housing and sobriety for almost one year and has been regularly seeing a doctor and physical therapist for treatment of his sciatica. His overall risk has dramatically decreased and has been an excellent self-advocate and graduated behavioral health work.

VI. FY 21/22 Additional Information: Changes has seen an increase of employment and school attendance for clients.

VII. FY 22/23 Projections of Clients to be Served: 110

VIII. FY 22/23 Programs or Service Changes: In October 2022, the Changes Clinical Director will transfer to another Telecare program, and her replacement will begin early November 2022. Additionally, the program will welcome a new Administrator. The Changes Program expects to be fully staffed by January 2023. There will be ongoing evaluation and changes in practices to follow the federal, state and local guidelines about Covid as they develop. If able, we plan to reinstate all in-person partner events.

Metrics	% of FY 21/22 FSP clients that achieved the metric
Reduction in Hospital Admits*	64%
Reduction in Hospital Days*	71%
Reduction in Psychiatric Emergency Services (PES)*	74%
Reduction in Incarceration Days*	68%
Increase in the number of days Stably Housed*	49%
Primary Care visit within the previous year	59%
With an educational goal who are enrolled in school	0
With a vocational goal who are employed	25%
Received a follow up visit within five days after a mental health hospitalization or crisis	67%
Average of four or more visits per month per client	47%

*The metrics above measuring “reductions” are looking at FSP clients served in FY 21/22 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 #: FSP 14
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 21/22:

a. **Number of Unique Clients Served:**
-105 unique clients were served by STRIDES in FY21/22, Cost per client: $28,324
-5 new partners joined during this year
-6 partners transitioned as part of our efforts to transition them to an appropriate level of care and to open up STRIDES new admissions

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

a. **Reduce Mental Health Stigma:** We address internalized stigma by treating clients as individuals, getting to know them as humans through direct conversations and whole person assessments, learning their psychosocial histories, understanding the reasons behind their challenges, learning their strengths and creating individualized treatment goals that come from client's hopes and dreams. We provide clients with education about their mental health and substance use symptoms that can increase understanding and a sense of control over their lives. We educate about ways that stigma from society may impact their own self perceptions.

   We are with clients side-by-side in the community which allows us to advocate for fair treatment, as well as model for community members, how to interact with people who are experiencing symptoms of mental health diagnoses in real time.

   We work with family members and other loved ones to provide psychoeducation and skill building about how to interact with clients in ways that minimize stigmatization.

   We provide ongoing training and support to help staff recognize own internalized biases and minimize potential microaggressions towards clients.

b. **Create a Welcoming Environment:** Almost all of our services are provided in the community, where our clients are located. We have a receptionist who answers calls with respect and ensures that clients' stated needs are forwarded to their team. We have a 24/7 Crisis Line answered by a live staff member, which allows clients to receive support when they feel the need. We have staff on-site all day, every day (M-F) to address the needs of clients who come

to the office looking for support. We host client-focused events that honor and welcome our clients, to help them feel like integral members of society.

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

IV. FY 21/22 challenges: FY21/22 was a time of great uncertainty due to the stressors of the global pandemic, housing insecurity, increased risk of substance use, increase of hate crimes directed at vulnerable populations, increased cost of living, especially for housing and food. While all these factors impact our partners, the most challenging in the past year include the shortage of safe, affordable housing, increased cost of living and the dangerous risk of overdose and death due to fentanyl and other street drugs.

Is anyone better off?

V. FY 21/22 Client Impact: "Jasmine" is a 62-year-old, AA female, referred to STRIDES in 2010. She has had 30+ years history of psychiatric (acute and subacute) and medical hospitalizations within Alameda County. In 2020-2021, Jasmine's physical health deterioriated significantly. She was diagnosed with renal failure and kidney disease, with a recommendation by PCP and medical hospitals for 3x/week dialysis treatments. Jasmine was highly paranoid about medical treatment, not adherent to psychiatric medications to manage her psychosis symptoms, continued to engage in illicit drug use, and consistently refused psych/medical care. Our only resolution was to strongly encourage/support her to Highland Hospital Emergency Department for acute dialysis treatment approximately once every two weeks – which was what she tolerated and only sometimes agreed to, and which was not anywhere near the level of treatment she needed for the severity of her medical condition. Ultimately, this led to life-threatening complications and an extensive medical hospitalization between Nov 2021 – Feb 2022 for stabilization. Upon discharge, STRIDES supported her transition to Assisted Care Living home (for which we supplement her housing rent using MHSA housing funds). Since the transition there, Jasmine has consistently engaged with treatment team visits multiple times per week, during which we provided extensive support to 3x/week dialysis treatments, along with scheduled outings throughout the week to further reward her engagement in medical care. Currently, she has demonstrated improved insight and strong motivation to manage her medical care condition and attend all treatment appointments, has been in recovery from substance use, and has had no psychiatric or medical rehospitalizations.

VI. FY 21/22 Additional Information: STRIDES met partial or full achievement on all performance metrics as required in our contract with Alameda County Behavioral Health.

- 84% of STRIDES Partners received a follow up visit within 7 days of discharge from a mental health hospitalization
- 83% of STRIDES partners experienced a reduction in jail days compared to the prior year
- 79% OF STRIDES partners received follow up within 5 days after mental health hospitalization or crisis visit
- 77% of STRIDES partners had at least one visit with Primary Care Provider *After corrections are made based on STRIDES PCP Corrections submission
- 75% of STRIDES partners received a minimum of four visits per month
- 65% of STRIDES Partners experienced a reduction in psychiatric emergency, inpatient and crisis stabilization days as compared to the prior fiscal year

VII. FY 22/23 Projections of Clients to be Served: STRIDES currently has 100 unique partners open to service and 2 referrals in outreach status. We project that we will remain at or above full census of 100 partners throughout the FY22-23 year. Projection that we will be able to inactivate up to 10% of our partner census due to graduation and moving out of county during the 22-23 year, making room for 10 new partners to join and benefit from our services.

VIII. FY 22/23 Programs or Service Changes: Ongoing flexibility with service provision during rapidly changing directives during COVID-19 pandemic. Instituting virtual / in-person (socially distanced) groups; such as art group, family support group, Seeking Safety, Co-occurring education group, etc. Increasing housing flexibility with the use of partner housing funds to ensure that partners can access housing at a variety of levels of care depending on their needs.

Metrics	% of FY 21/22 FSP clients that achieved the metric
Reduction in Hospital Admits*	78%
Reduction in Hospital Days*	93%
Reduction in Psychiatric Emergency Services (PES)*	65%
Reduction in Incarceration Days*	90%
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	100%
With a vocational goal who are employed	13%
Received a follow up visit within five days after a mental health hospitalization or crisis	80%
Average of four or more visits per month per client	75%

*The metrics above measuring "reductions" are looking at FSP clients served in FY 21/22 who experienced one of these negative events (crisis, hospital admission, and incarceration) prior to enrollment in an FSP compared to the first year of FSP enrollment.

FULL SERVICE PARTNERSHIP (FSP) REPORT

FSP #: FSP 18

PROVIDER NAME: Bay Area Community Services (BACS)

PROGRAM NAME: Homeless Engagement Action Team (HEAT)

Program Description: Provides 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 21/22:

a. **Number of Unique Clients Served:** 162. Cost per client: $27,152

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

a. **Reduce Mental Health Stigma:** HEAT works with participants by using a client-centered approach to collaborate with their families and/or any natural supports to meet participants where they are at in terms of recovery, insight, and ability to manage symptoms. HEAT provides psychoeducation to families and other natural supports to support them in being part of the treatment team to help their loved ones, provide linkage support to receive much needed support (NAMI, Towne House Wellness Center, HEDCO Wellness Center). 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.
b. **Create a Welcoming Environment:** HEAT is flexible in location, meeting time, and engagement style to support participants and natural supports to feel comfortable in a wide range of settings. The HEAT meets with participants at parks, their homes, any one of our wellness centers or other BACS locations, or anywhere in the community that they prefer. HEAT ensures safety by taking steps during COVID-19 to both wear and provide PPE to participants during meetings and take temperatures before entering buildings. HEAT staff are trained in Crisis De-escalation, 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 team was designed with Culturally and Linguistically Appropriate Services (CLAS) standards in mind.

III. Language Capacity for this Program: Spanish, English, access to the county Language Line.

IV. FY 21/22 challenges: As the pandemic continued into this year, HEAT continued to go above and beyond to meet participants in the community, at the wellness centers, and via digital platforms to ensure their needs were being met. One of the biggest challenges continued to be accessing and outreaching in psychiatric care settings and jail. Historically locked settings are an opportunity for intensive engagement and trust building to prepare for reentry and support in the community. However, this year continued to have some barriers to outreach and engagement efforts with many facilities going into lockdown due to COVID-19 outbreaks; though HEAT team was able to use unique and collaborative strategies to continue to meet our partners where they were at in their recovery and goals.

Another challenge was low staffing on HEAT. The COVID-19 Pandemic greatly impacted our staffing, which impacted HEAT's ability to engage with all HEAT partners at least 4x a month. However, the HEAT Team began to strategize and staff began meeting with folks in the same area on the same day to maximize their time and outreach attempts. The HEAT team also had the addition of several new staff who were experienced in the field and from the community, which helped with partners' engagement.

Is anone better off?

V. FY 21/22 Client Impact: HEAT participants have overcome a lot in the past year. Entering into another year of the pandemic, participants identified HEAT as one of the few resources they could continue to rely on during the ongoing pandemic chaos. The pandemic increased barriers to resources folks previously connected to independently; such as: social services, DMV, social security, food pantries, and employment resources. HEAT team was able to minimize barriers and enroll/transfer Medi-Cal, SSI, and access to DMV services for participants, when they were otherwise unable to follow through. Primary care and medication management were also great accomplishments of HEAT this year—with many clinics struggling with staffing shortages due to the increase in COVID-related illnesses, HEAT was able to offer advocacy, support, collaboration, and medication services to ensure participant needs were addressed.

HEAT had a truly monumental success story this year. This participant was originally from San Diego and in her mid-late 60's when we began to outreach her in 2019. She struggled managing psychotic symptoms, she was homeless in Alameda, and was in and out of John George. The team had outreached her several times in the community only to be met with hostility and aggression. Eventually she was referred to Villa where the team had an opportunity to build rapport with her; with some patience, she finally agreed to services with HEAT. She spent the better half of her 3 years with the team working on getting her benefits, housing, and staying on her medications. She eventually was awarded SSI, moved into a licensed board and care and all psychotic symptoms, hostility, and aggression completely went away. She then began focusing on bigger goals: reconnecting with her family in San Diego. She spent over 10 years without any contact with her sister and elderly mother. With some patience and a lot of help from HEAT, she was able to locate and reunite via phone with her sister in San Diego. She was informed that her mother was battling a lot of different medical issues, which then sparked her new goal to move down to San Diego to be close to her family. During this period, though it came with some added stressors, this partner was able to stay on medications and continue managing her symptoms successfully; in fact, when she discharged from Villa, she never went back to JGP, CSU, or a CRT. This partner was a fierce advocate for her move and worked collaboratively with the HEAT staff in figuring out how to make the move happen. It was with great pleasure that the HEAT team was able to transfer her Medi-Cal, her sub-payee, find her a new board and care down the street from her sister in San

Diego, and connect her with a new case management team. This partner's success does not end at her move to San Diego to be close to her mom and her sister; she often stated that she felt like herself again after finding the right medication regiment and sticking with it was made her goals a reality.

Overall HEAT reduced the number of partners that were re-hospitalized, by providing wraparound services 7 days a week with a passionate and dedicated team. HEAT exemplifies what it means to provide collaborative wraparound care, coordinating with family, friends, landlords, hospitals, and clinics from the start of services with participants and timely in the event of crisis or support needs. The Wellness Centers have also been an asset to the team, working closing with the wellness center staff to link participants and their families to the support resources they are interested in. As COVID-19 regulations begin to lift, HEAT has supported participants in accessing vaccines, covid tests, and began to offer groups for participants to support with their symptoms/symptom management. HEAT recently had a field trip to an A's game where participants were invited to attend in order to enhance their connection to the community.

VI. FY 21/22 Additional Information: HEAT had some fluctuations in staff during this year. HEAT was able to continue supporting 125+ participants. The team was able to onboard, train, and integrate new staff utilizing the opportunity to reengage participants that had been struggling to meet. HEAT has great comradery as a program and all members are passionate about serving adults with severe mental illness and homelessness and embracing the Whatever it Takes model. HEAT is collaborative and supportive of one another and the partners we serve and has been able to successfully implement the daily schedule in ACT model, ensuring participants meet with 2-5 different staff monthly, and typically no less than 1 meeting a week. The team is not afraid to step in or step up when needed and the participant outcomes demonstrate this success.

VII. FY 22/23 Projections of Clients to be Served: 150

VIII. FY 22/23 Programs or Service Changes: HEAT would like to increase the number of visits clients receive per month and increase the number of TDM's each partner has each month. Increasing visits with clients was a goal for this year; however, the ongoing pandemic and staffing shortages got in the way. We would like to get more natural supports involved and engaged in each partners treatment plan. HEAT has exemplified response to emergency hospitalizations and will continue to build relationships and reduce barriers to collaborative discharge planning by working very closely with John George Psychiatric Pavilion, Villa Fairmont, Jay Mahler, Woodroe, Amber House, and HSP board and care to be involved in all steps of discharge planning and will continue to do so during this fiscal year. HEAT would like to move back towards a model where groups are planned and a calendar is produced monthly to encourage participant attendance and voice in groups. HEAT will work this year to implement at least 2 groups per month and one social event to encourage community building, interdependence and support.

Metrics	% of FY 21/22 FSP clients that achieved the metric
Reduction in Hospital Admits*	80%
Reduction in Hospital Days*	84%
Reduction in Psychiatric Emergency Services (PES)*	67%
Reduction in Incarceration Days*	80%
Increase in the number of days Stably Housed*	28%
Primary Care visit within the previous year	74%
With an educational goal who are enrolled in school	0
With a vocational goal who are employed	17%
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	50%

*The metrics above measuring "reductions" are looking at FSP clients served in FY 21/22 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 #: FSP 20

PROVIDER NAME: Bay Area Community Services (BACS)

PROGRAM NAME: Lasting Independence Forensic Team (LIFT)

Program Description: Provides 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 rehospitalization 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 21/22:

a. **Number of Unique Clients Served:** 118. **Cost per client:** $25,161.

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

a. **Reduce Mental Health Stigma:** LIFT 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. LIFT 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 group outings in the community such as hikes and going to the beach. 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:** LIFT is flexible in location, meeting time, and engagement style to support participants and families to feel comfortable in their desired setting. LIFT will meet participants at parks, at their homes, at our office or anywhere in the community that they prefer. LIFT ensures safety by taking steps during COVID, as needed as the pandemic fluctuates, to wear and provide PPE to participants during meetings and take temperatures before entering buildings. To further increase ease of access during pandemic MS Teams is utilized for medication appts and other visits as appropriate. 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: English, Spanish. We have provided psychiatry services in Tai Chinese and Cantonese through the Language Line.

IV. FY 21/22 challenges: As the pandemic continued this year, LIFT staff continued to go above and beyond to meet participants in the community, in office spaces, and via digital platforms to ensure their needs were being met. One of the biggest challenges continued to be accessing and outreaching in psychiatric care settings and jail. Historically locked settings are an opportunity for intensive engagement and trust building to prepare for reentry and support in the community. However, this year continued to have many barriers to outreach and engagement efforts; though LIFT was able to use unique and collaborative strategies to continue to meet our partners where they were at in their recovery and goals.

LIFT also experienced substantial staff turnover and the lack of a nurse for most of the year (transferring internally, medical leave, and leaving the agency) which put a strain on the program as a whole. Though the team banded together and participant & programmatic needs continued to be met.

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.

Finally, the additional stressors of the pandemic have resulted in increased relapse of substances, and the availability of substance treatment has been challenging. Many of our participants do not have the ability to call Centerpoint every day for a week or more in the hopes of finding a facility, and often relapse before a connection can be made.

Is anyone better off?

V. FY 21/22 Client Impact: LIFT participants have overcome a lot in the past year. Entering the second year of the pandemic, participants identified LIFT as one of the few resources they could continue to rely on during the chaos. The pandemic created increased barriers in the system for participants to access resources that they could previously manage independently, such as social services, DMV and social security. LIFT was able to minimize barriers and enroll/transfer Medi-Cal, SSI, and access to DMV services appointments for participants, where they otherwise were unable to follow through. LIFT was able to support participants with employment with IPS throughout pandemic and had success stories linking participants to job training and to visit school graduations in order to inspire them and provide hope. Primary care and medication management were also great accomplishments of the LIFT program this year—as many clinics remain closed to in-person services, LIFT was able to offer advocacy, support, and our medication services to ensure participant needs were addressed.

We have worked hard in the last year to promote budgeting skills and encourage our partners to contribute 30% of their income towards rent in order to promote independence and accountability. Two of our participants initially reported they would rather be homeless than pay towards their rent, however, they hesitantly agreed and now it is a source of pride that they pay their rent!

One incredible success story is about a participant who we began serving in 2019 who struggled with managing psychosis symptoms, substance use, and was in and out of John George frequently. The

participant served 8 years in prison, and was referred to LIFT while he was in Santa Rita Jail where he spent over a year. The participant lost his father to suicide when he was 6 and he attempted suicide the same way, by hanging, the year he was referred to LIFT. He had difficulty managing severe psychosis symptoms, agitation, assaultive behaviors which resulted in recidivism in these crisis and criminal justice settings for most of his life. The participants mother had a stay away order, he was estranged from his siblings, he was homeless and needed daily doses of methadone. The participant took his medications, but continued to use crisis services and crave substances. After a lot of rapport building, consistency in meeting with LIFT, the participant began to improve his relationship with his mother. In the spring of 2021 he began to decrease methadone, was living with his mother and attending substance treatment groups. This participant began to feel more confident and his self-esteem grew as he rebuilt and built relationships and he began to feel more hopeful about the future. He has a face tattoo that is a reminder of his old life and he requested help with removal as it affects his feelings of self-worth and self-esteem. LIFT has supported him with three treatments and the participants confidence is building as his tattoo recedes, it will be gone after two more treatments. The participant began to meet with LIFT IPS and recently completed forklift training and is actively interviewing and seeking employment. The participant has a permanent supportive housing match and will have his own home in a couple of months. He is saving up for a car and feeling very hopeful about his future. This participant has had *zero* interactions with emergency, forensics or any kind of crisis services in one year. He has been able to successfully manage his psychosis symptoms, cravings for substances and learn and use coping and communication skills. We look forward to his graduation from LIFT to a lower level of service!

LIFT was able to graduate three partners to a lower level of care, either psychiatric outpatient treatment or a Level 1 community-based program. LIFT has had two partners that moved into Permanent Supportive Housing. We continue to make a positive impact in the lives of the partners we serve. LIFT has worked tirelessly to decrease reliance on emergency psychiatric services to promote independence, community, and self-esteem.

Another LIFT partner had not been able to maintain housing (clogging toilets or becoming aggressive with neighbors due to fears people were entering his room by various means) due to paranoia. With consistent engagement and rapport building, the participant agreed to see LIFT psychiatrist and began to take medication and has been learning to tolerate distress. Participant has maintained housing for more than six months, meets with various staff and participates in community outings. poor medication compliance and aggression, incarceration, homelessness, and violence, was able to maintain stable housing for 5 months. This is the longest he has maintained housing outside of an institution.

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

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

VI. FY 21/22 Additional Information: LIFT had some fluctuations in staff during this year, which they were able to take on with stride. LIFT was able to continue supporting 90+ participants with three quarters of the staff deemed appropriate in the RFP. The team was able to onboard, train, and integrate new staff utilizing the opportunity to reengage participants that had been struggling to meet. LIFT has great camaraderie as a program and all members are passionate about serving formerly incarcerated people and embracing the Whatever it Takes model. LIFT is collaborative and supportive of one another and the adults they serve and has been able to successfully implement the daily schedule in ACT model, ensuring participants meet with 2-5 different staff monthly, and typically minimally 1 meeting a week. The team is not afraid to step in or step up when needed and the participant outcomes demonstrate this success.

VII. FY 22/23 Projections of Clients to be Served: LIFT has a program goal and projects to serve 105-110 individuals.

VIII. FY 22/23 Programs or Service Changes: LIFT would like to increase primary care linkage and increase the number of TDM's each partner has each month. Increasing TDMS was a goal last year, however ongoing pandemic and staffing got in the way. We would like to get more natural supports involved and engaged in each partners treatment plan. LIFT has exemplified response to emergency hospitalizations and will continue to build relationships and reduce barriers to collaborative discharge planning by working very closely with John George Psychiatric Pavilion, Villa Fairmont, Jay Mahler, Woodroe, Amber House and HSP board and care to be involved in all steps of discharge planning and will continue to do so during this fiscal year. LIFT hopes to increases engagement with our incarcerated participants and we look forward to in person meetings at the jail so that we can build rapport with our participants that are hard to connect with when they are in the community. LIFT would like to move towards a model where groups are planned and a calendar is produced monthly to encourage participant attendance and voice in groups. LIFT staff have developed a DBT skills group curriculum and we plan to begin the group in August 2022. We will add Sunday outings our monthly "Saturday outdoor outings" due to the success and positive feedback from our Saturday group outings. PAIGE will work this year to implement at least 2 groups per month and one social event to encourage community building, interdependence and support.

Metrics	% of FY 21/22 FSP clients that achieved the metric
Reduction in Hospital Admits*	64%
Reduction in Hospital Days*	70%
Reduction in Psychiatric Emergency Services (PES)*	77%

Reduction in Incarceration Days*	85%
Increase in the number of days Stably Housed*	24%
Primary Care visit within the previous year	69%
With an educational goal who are enrolled in school	50%
With a vocational goal who are employed	17%
Received a follow up visit within five days after a mental health hospitalization or crisis	79%
Average of four or more visits per month per client	68%

*The metrics above measuring "reductions" are looking at FSP clients served in FY 21/22 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 #: FSP 22
PROVIDER NAME: Telecare Corporation

PROGRAM NAME: Justice and Mental Health Recovery (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 21/22:

a. **Number of Unique Clients Served:** 108. **Cost per client:** $27,538.

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

a. **Reduce Mental Health Stigma:** We address internalized stigma by treating clients as individuals, getting to know them as humans through direct conversations and whole person assessments, learning their psychosocial histories, understanding the reasons behind their challenges, learning their strengths and creating individualized treatment goals that come from client's hopes and dreams. We provide clients with education about their mental health and substance use symptoms that can increase understanding and a sense of control over their lives. We educate about ways that stigma from society may impact their own self perceptions.

   We are with clients side-by-side in the community which allows us to advocate for fair treatment, as well as model for community members, how to interact with people who are experiencing symptoms of mental health diagnoses in real time.

   We work with family members and other loved ones to provide psychoeducation and skill building about how to interact with clients in ways that minimize stigmatization.

   We provide ongoing training and support to help staff recognize own internalized biases and minimize potential micro-aggressions towards clients.

b. **Create a Welcoming Environment:** Almost all of our services are provided in the community, where our clients are located. We have a receptionist who answers calls with respect and ensures that clients' stated needs are forwarded to their team. We have a 24/7 Crisis Line answered by a live staff member, which allows clients to receive support when they feel the need. We have staff on-site all day, every day (M-F) to address the needs of clients who come to the office looking for support. We also host client-focused events that honor and welcome our clients, to help them feel like integral members of society.

III. Language Capacity for this Program: English, Spanish and Urdu

IV. FY 21/22 challenges: FY21/22 was a time of great uncertainty due to the stressors of the global pandemic, housing insecurity, increased risk of substance use, increase of hate crimes directed towards vulnerable populations, increased cost of livng, especially for housing and food. While all these factors impacted our clients, the most challenging of the past year were the shortage of safe, affordable housing, increased cost of living due to inflation, and the dangerous risk of overdose and death due to the easy accessiblity of fentanyl and other street drugs.

Is anyone better off?

V. FY 21/22 Client Impact: "Dante" is a 27 year-old man, referred to JAMHR in 2019, when he aged out of the TAY FSP Program. In the previous 2 years, he has been in and out of jail and psych emergency services, making it difficult for the team to meet with him and build rapport. When he was available to meet with staff he presented as angry, aggressive, demanding, with poor impulse control and often inebriated. Staff were often afraid of his responses, and provided minimal services due to safety concerns. In the past year, he has finally begun to build rapport with the JAMHR team. This rapport has allowed for more in-depth and honest conversations about Dante's hopes and dreams for the future, his challenges with substance use and his history of trauma. Dante is now able to interact with JAMHR staff in an open and honest way, he is able to participate in harm reduction regarding his substance use, he asked for and has been able to maintain housing. He demonstrates insight into his need for a higher quality and more structured home environment going forward and is participating in planning for a move to a more supportive environment soon. He is able to identify the benefits of meaningful activity and has a plan with the JAMHR team to help him move towards positive and creative use of his time. He still has moments of frustration but demonstrates an ability to manage the frustration and avoid falling back into destructive or threatening behaviors. Dante is now someone that the JAMHR team looks forward to working with!

VI. FY 21/22 Additional Information: JAMHR met partial or full achievement on all performance metrics as required in our contract with Alameda County Behavioral Health.

- 92% of JAMHR Partners received a follow up visit within 7 days of discharge from a mental health hospitalization
- 75% of JAMHR Partners experienced a reduction in psychiatric emergency, inpatient and crisis stabilization days as compared to the prior fiscal year
- 75% OF JAMHR partners received follow up within 5 days after mental health hospitalization or crisis visit
- 71% of JAMHR partners received a minimum of four visits per month
- 62% of JAMHR partners had at least one visit with Primary Care Provider
- 60% of JAMHR partners experienced a reduction in jail days compared to the prior year

VII. FY 22/23 Projections of Clients to be Served: JAMHR currently has 100 unique partners open to service and 4 referrals in outreach status. We project that we will remain at or above full census of 100 partners throughout the FY22-23 year. Projection that we will be able to inactivate up to 10% of our partner census due to graduation and moving out of county during the 22-23 year, making room for 10 new partners to join and benefit from our services.

VIII. FY 22/23 Programs or Service Changes: There will be ongoing evaluation and changes in practices to follow the federal, state and local guidelines about COVID as they develop. If the global pandemic allows, we plan to reinstate all in-person partner events, including Partner Summer Picnic, Thanksgiving Event and Holiday party.

Metrics	% of FY 21/22 FSP clients that achieved the metric
Reduction in Hospital Admits*	61%
Reduction in Hospital Days*	71%
Reduction in Psychiatric Emergency Services (PES)*	75%
Reduction in Incarceration Days*	83%
Increase in the number of days Stably Housed*	57%
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	22%
Received a follow up visit within five days after a mental health hospitalization or crisis	75%
Average of four or more visits per month per client	71%

*The metrics above measuring "reductions" are looking at FSP clients served in FY 21/22 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 #: FSP 19

PROVIDER NAME: Bay Area Community Services (BACS)

PROGRAM NAME: Circa60

Program Description: Provides 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 21/22:

a. **Number of Unique Clients Served:** 101. **Cost per client:** $28,762

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

a. **Reduce Mental Health Stigma:** Circa60 works collaboratively with our clients, their family and friends, and other service providers and supports from a person-centered approach to support partners with increased wellness and to strive for their goals. Circa60 makes an effort to meet clients where they are at and normalizes and validates their experiences; additionally, Circa60 works to provide clients with opportunities to connect with other clients at social and other events to decrease the stigma and isolation common with people struggling with their mental health.
b. **Create a Welcoming Environment:** Circa60 works to support clients and those involved in their care wherever they are, whether that be at home, at a hospital or other medical or mental health facility, in jail, at the office, at an outdoor location, by phone, or anywhere else. Circa60 additionally seeks to be collaborative and flexible in all interactions and to embody the principle of cultural humility for both clients and each other. Finally, Circa60 encourages clients to come to the Towne House wellness center where Circa60 has its office to feel more at home with the agency, and has also been diligent in following health guidelines regarding COVID-19 to ensure the safety of our clients.

III. Language Capacity for this Program: English and Spanish, access to the county Language Line.

IV. FY 21/22 challenges: The COVID-19 pandemic continued to greatly impact the older adults which make up Circa60 clients, and often led to barriers for Circa60 to serve clients, as many in our program reside in facilities such as hospitals, skilled nursing facilities, and board and cares which have at times

limited or refused visitation due to outbreaks and/or high risk levels. Nonetheless, Circa60 worked hard to continue to serve our clients through flexibility, creativity, and collaboration, whether that meant speaking to clients through a fence at the property line, frequent phone check-ins, collaborating with facility staff to do video calls, or through other means. COVID-19 also contributed to some staff turnover at Circa60, though Circa60 was able to hire some incredibly strong new staff as well. Furthermore, the impacts of the COVID-19 pandemic also contributed to the isolation of our clients which of course negatively impacts their mental health, but Circa60 did as much as possible to continue to link clients to COVID-safe community events, resources, and their families.

Additionally, a lot of residential programs are not available to Circa60 clients due to their medical needs and so our clients are (often unintentionally) being discriminated against via not having equitable access because of their disabilities; in the last year we have had clients turned down from unlicensed room and boards, crisis stabilization units, crisis residential treatment, and residential substance treatment programs due to our clients' conditions such as being blind, not being fully ambulatory, using an oxygen tank, or otherwise having "too complex" medical needs. This has at times resulted in our clients ending up hospitalized, not receiving needed care, or ending up on the streets whereas without their medical needs they would have had additional options. Nonetheless Circa60 continued to support our clients however possible as well as to advocate for additional services and decreased barriers.

Is anyone better off?

V. FY 21/22 Client Impact: Circa60 has been working to ensure all willing clients have regular primary care visits and to reconnect isolated clients to family/friends. Circa60 supported a man in his early 70s with re-connecting with family who he hadn't had much contact with in years, supporting him to visit one of his children on multiple occasions which in turn allowed him to furthermore see his former spouse. Additional, Circa60 helped him this year in getting back on track with his medical care, with his primary case manager paying close attention to his changing medical needs and being a strong advocate to ensure he gets the care he needed, including after a terrible incident where he was hospitalized for days after a stranger drugged him; the Circa60 team, led by his primary case manager, supported him throughout his stay in the hospital, advocated for his needs with hospital staff and his housing staff, keeping his child informed, and ensuring follow-ups after hospital discharge. Circa60 is looking forward to continuing to support this client to stay connected to his family and receive all needed medical care, as well as to help other isolated clients in re-connecting with lost family members and all our clients with their medical needs.

VI. FY 21/22 Additional Information: Circa60 worked hard to support clients with taking precautions against COVID-19 given their increased risk due to their age and medical concerns.

VII. FY 22/23 Projections of Clients to be Served: 100+

VIII. FY 22/23 Programs or Service Changes: Almost all willing clients have been connected to primary care at this point, and Circa60 will continue to attempt to connect any remaining clients (as well as new clients) to primary care. Circa60 will also build on its initiative to re-connect isolated clients to lost family members and is excited for the reunions that are envisioned. Additionally, as the COVID-19 pandemic allows Circa60 will build towards increased community events and starting groups to support clients in connecting to each other and the larger community.

Metrics	% of FY 21/22 FSP clients that achieved the metric
Reduction in Hospital Admits*	61%
Reduction in Hospital Days*	70%
Reduction in Psychiatric Emergency Services (PES)*	73%
Reduction in Incarceration Days*	86%
Increase in the number of days Stably Housed*	51%
Primary Care visit within the previous year	39%
With an educational goal who are enrolled in school	0
With a vocational goal who are employed	9%
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	49%

*The metrics above measuring "reductions" are looking at FSP clients served in FY 21/22 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/SYSTEM DEVELOPMENT PROGRAMS

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. Increased number of clients losing their mobility leading to increased falls as well.

How Much Did We Do?

I. FY 22/23:

a. **Number of Unique Clients Served:** 63. **Cost per client:** $10,611

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

a. **Reduce Mental Health Stigma:** The mission of the City of Fremont's Human Services Department is to deliver excellent and culturally sensitive services to all consumers in a caring, nurturing, and respectful environment while improving their quality of life free of stigma and discrimination.

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

   - Senior Mobile Mental Health Program and all other City programs continues to see the need to conduct anti-stigma program presentation to community partners to increase their awareness about mental illness and to join forces/capacity to decrease stigma and discrimination against people with mental health challenges.
   - The program takes the lead in educating other City of Fremont's staff abut mental illness to increase their awareness of their attitudes and behaviors towards clients suffering from mental illness.
   - Educating our client and their families about mental health needs/issues and to help them maximize their learnings about their experiences, will motivate and prepare them to make good decision about different aspects of their lives. Our clients will have the opportunity to shift role from a role of service recipient to an expert of their own lives and to educate other

clients, staff and the community of their own mental health perspective in order to decrease stigma and discrimination.

- Program encourages all clients to actively engage in various community networking, services and programs, will contribute to de-pathologize/decrease stigma about mental illness in the community at large. The community then can give clients the opportunity to have a more meaningful community experience and vice versa, thus giving them hope and motivation to fully participate in community living.
- We support NAMI's motto "all members to become stigma "busters"
- Program administrator plays an active role as she participates in addressing and reducing stigma on the macro level influencing changes in mental health policies and legislatures.

b. Create a Welcoming Environment: City of Fremont provides the following protective factors for our clients: sense of belonging, positive work climate and easy access to needed services.

- Human Services Department provides mental health training to staff and other department's staff in order to help create and support mental health friendly environment.
- City of Fremont promotes mental health friendly events to generate increased awareness in the creation of workplace of culture of tolerance, acceptance, respect and inclusion.
- Posters supporting mental health can be found in many areas in Human Services Department building.
- City of Fremont is ADA compliant.

III. Language Capacity for this Program: English, Spanish, Farsi, Dari, Mandarin, Cantonese, Tagalog and other Philippine dialect, Hindi and American Sign Language. We also have other language capacity provided by our student interns. This year we have Vietnamese language capacity. We utilize language line for other languages we don't have the capacity for.

IV. FY 22/23 challenges: Pandemic has put major hardhips on both clients and service providers re: service delivery. Re-structured program delivery was implemented to meet client's needs. We implemented a hybrid system of in-person, telehealth and phone interface with clients consistent with their wishes and compliance with the Alameda County Safety Response Protocol. Undoubtedly, the public health crisis (pandemic) has contributed to client's worseing of their symptoms and increased in isolative behaviors.

All program clients have co-occuring medical and physical conditions leading to treatment cancellation thus trigger increase in their mental health symptoms. In addition, due to medical issues, they take so many medication and some clients prefer not to consider adding psychiatric medication to their on-going medication regimen. Individual therapy becomes ineffective if client's mental health symptoms are not lifted at some level.

Losing some level of independence ie: decline in mobility, increase falls, decline in vision, losing family and friends.

<u>Is anyone better off?</u>

V. FY 22/23 Client Impact: Madeline is a 70-year-old divorced Caucasian female. She was referred to Senior Mobile Mental Health program last year. However, it took one of the program counselor 10 months to actually engaged her in treatment. Madeline struggled homelessness for more than 20 years. She has long history of mental health challenges leading to psychiatric hospitalizations on a number of occasions. When she was referred to the program, she presented with severe depression, immobilized

Disorder (OCD) where she has to have everything perfect, takes on a lot of small projects and doesn't complete any of them. She also reported her traumatic experiences when she was homeless and as a child.

- A male stranger exposed his genitals to her while she was living in her car.
- A male stranger attempted to get into her car at night while she was sleeping.
- As a child, she recalled an incident where a male stranger had rubbed up against her in a sexual manner.

During COVID 19, she agreed to be temporarily housed at the Islander Motel with the help of the City of Fremont – Homeless Housing Coordinator. Being housed in a safer and decent place, she started to show motivation to engage in receiving outpatient mental health services with positive outcome. Counselor's initial focus of treatment was to develop a trusting therapeutic relationship. She continues to show progress as she increased her stability and functioning. After a year, she was offered a more stable and better housing arrangement at Parc Medallion Apartment where she will have her own apartment unit. Initially client has struggled to commit to this type of housing but with the support of her counselor, City of Fremont case manager, homeless advocate and Homeless Housing Coordinator, she agreed to sign the lease. She has been successfully living in her own apartment the last 10 months. She has a very nice and comfortable apartment and stated she feels "at home". Client said she loves to sew so City of Fremont-Personal Urgent Need fund program bought her a sewing machine. Client decorated her apartment by sewing all her curtains and sewed tablecloths she gave away to family and friends during the holiday. Late last year, she agreed to re- start medication. She was seen by the program psychiatrist with positive results. Anxiety and Depressive symptoms are now manageable. She has signed her paperwork for her permanent Section 8 housing.

With her stability and functioning, she has now reconnected with her sister and now part of her life. Sister visited her many times and many more to come as they spend quality time together reminiscing time when they were growing up. Her future plan is to have a boyfriend who will understand and support her. Lastly, she adopted a kitten named Jasmine, daily companion.

VI. FY 22/23 Additional Information: N/A

VII. FY 23/24 Projections of Clients to be Served: 55 clients for the Senior Mobile Mental Health. We have now 23 clients in our step-down program (Recovery and Resiliency) indicative that more Senior Mobile Mental Health clients are improving and not needing more intensive mental health services.

VIII. FY 23/24 Programs or Service Changes: N/A

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 5A

PROVIDER NAME: Alameda County Behavioral Health

PROGRAM NAME: Crisis Services: Mobile Crisis Team (MCT), Mobile Evaluation Teams (MET), and Outreach & Engagement Teams

Program Description: Currently the Crisis Services Teams, 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 Teams (MET and HMET), partnerships with Oakland and Hayward Police Departments. 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.

Target Population: We serve residents of Alameda County along the entire lifespan who are experiencing a mental health or substance use crisis. Outreach and engagement teams focus on indidiuals with pesistant and severe mental health conditions.

How Much Did We Do?

I. FY 21/22:

a. **Number of Unique Clients Served:** 1,430. **Cost per client:** $2,022

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. Crisis Services has worked closely with ACBH's Office of Peer Support Services 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. All of our teams can transport consumers to a variety of settings whenever appropriate and safe to do so. We only involve law enforcement when necessary.

b) **Create a Welcoming Environment:** Since 2019, Crisis Services has been providing field and phone-based crisis intervention, outreach and engagement services to individuals across the lifespan throughout Alameda County. Crisis Teams respond within a few minutes to a few hours depending on team availability and the type of crisis intervention needed. Our Outreach and engagement teams provide essential items (transportation, food, toiletries, clothing, PPE) to

individuals in need. Crisis Services staff provided nearly 50 presentations to a wide range of stakeholders who benefit from our services. We have also strongly encouraged callers to contact Crisis Services directly when needed.

In regards to our work environment, Crisis Services has developed a comprehensive training and on-boarding program including a manual and at least two weeks of shadowing and training with more experienced staff. Although not funded via MHSA, we also implemented a yearly staff retreat and appreciation station with self-care items to assist with morale during these difficult times. We hope that these activities will assist with staff recruitment and retention.

III. Language Capacity for this Program: Currently, Crisis Services language capacity is English, Spanish, Vietnamese, 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. The ACBH Office of Ethnic Services has assisted with the translation of Crisis Services brochures and resource materials for all threshold languages in Alameda County. Crisis Services staff also provide consent forms and informing materials in threshold languages.

IV. FY 21/22 challenges: Similar to the previous fiscal year, Crisis Services' on-going expansion and services have been impacted by COVID-19 and other events that have affected staff and residents of Alameda County including, but not limited to, political unrest, racial/ethnic disparities in communities of color accessing and or utilizing mental health and substance use treatment, and now a recession. The global pandemic in addition to environmental factors, have resulted in an increase in mobile crisis team calls for services especially for children, transitional age youth, and older adults. Requests for wellness checks have also increased. We have also experienced significant challenges in staff recruitment. Many professionals are leaving the Bay Area due to the high cost of living. Furthermore, many public and private entities are competing for the same mental health providers.

Is anyone better off?

V. FY 21/22 Client Impact: Focused marketing of Crisis Services via presentations and participation in many community events have resulted in an average of 600 direct calls to Crisis Services per month.These calls include referrals to our mobile and outreach teams, information, care cordination and follow up.

Coordination between Crisis Services and voluntary crisis stabilization, crisis residential treatment, sobering and detox facilities has resulted in a reduction of involuntry psychitric holds. All of our teams can transport individuals directly to these services.

Staff are in field more than 75% of their shift. This ensures that services are provided in settings that are most convient to the community.

ACBH Crisis Services, in collaboration Crisis Support Servicesof Alameda County (CSS), has implemented AB988. This partnership includes a monthly stakeholder meeting, coordination of warm handoffs from CSS to Crisis Services on-duty clinicians, and same day response form our mobile crisis teams when needed. So far approximately 2% of callers to CSS require community response which highlights the expertise of the CSS staff in providing de-escalation and support.

Outreach and engagement teams provide in-reach at Psychiatric Emergency at John George Psychiatric Hospital in an effort to reach consumers before they discharge to the community. Staff provide information and referral for voluntary mental health, SUD, and other community services. We have found that the face to face contact has helped to develop rapport with the community and increase the likelyhood of consumers agreeing to care.

Mobile crisis staff have spent more time at local board and care homes to support consumers at risk of losing placement due to decompensation and other issues related to mental health symptoms. Our goal is to help consumers maintain housing and reduce calls to law enforcment by these homes. Mobile team staff discuss safety plans, and de-escalation / diversion strategies with staff and provide care cordination with assigned mental health providers. Outreach teams will visit consumers newly or temporarily placed in these homes.

Outreach and engagement teams collab with Healthcare for the Homeless, other street health teams, and the public libraries to provide resources and linkage to mental health and SUD services.

Crisis Services staff have also provided at least 5 de-escalation and crisis risk assessment trainings to community partners. We hope that these trainigs will better equipt providers with the necessary tools t better serve those with mental health and SUD chllenges.

VI. FY 21/22 Additional Information: N/A

VII. FY 22/23 Projections of Clients to be served: We anticipate serving an additional 170 consumers bring our unduplicated consumers served to 1,600.

VIII. FY 22/23 Programs or Service Changes: ACBH Crisis Services will transition to a System of Care, which will result in further expansion of Crisis Services, increase collaborations with community partners, and require the creation of additional administrative and clinical positions. We also plan to implement an internship program to help increase our overall capacity. We hope interns will considering joining our teams permanently. We will continue our efforts to recruitment and retain, staff and hope to revamp our clinical staff classification to allow for the hiring of license eligible clinicians. We will also partner with the Office of Peer Support Services to develop a crisis specific peer/family training program. Finally, we hope to pilot bilateral referrals between 911 and 988. 988/CSS already refers callers experiencing an emergency to 911. However local 911 dispatch centers will need to change their protocols to allow transfers from 911 to 988.

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 cooccurring 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.

How Much Did We Do?

I. FY 21/22:

a. **Number of Unique Clients Served:** ACBH received 149 referrals for Behavioral Health Court during FY 21/22. Approximately 145 clients were served during FY 21/22. As the program typically lasts 12-24 months, the total number of clients served may include individuals referred prior to FY21/22. Approximately 25 individuals successfully graduated during the FY21/22 period
– this number reflects individuals who were referred and admitted during prior fiscal years, including clients admitted during FY18/19. **Cost per client:** $2,080

How Well Did We Do?

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' in person Language Services are able to accommodate almost any language needed, including sign language, and

have specialized training for legal terms. The Language Phone Line contracted through ACBH is medically certified and confidential.

IV. FY 21/22 challenges: BHC is one of many court programs available to clients who are justice involved including: Drug Court, Informal Court, Veterans Court, Homeless and Caring Court. The differentiation between the many programs, their requirements and limitations is often confusing even for those who are direclty involved in the programs. ACBH and representatives of Drug court offered a presentation at the beginning of FY21/22 in hopes of clarifying some of the key differences between our programs, and improve the appropriateness of referrals being made.

As with many other programs, there has been a regular shift of staff with Behavioral Health Court. ACBH hired a new Mental Health Specialist to fill a vacant position. There was also a rotation of council and bench with new Deputy Public Defender, new Deputy District Attorney, and new judge for Behavioral Health Court.

Because of the way BHC was originally set up, BHC did not previously track data for referrals being made, and only tracked data for individuals after they were admitted. Starting in 2019, BHC began documenting and collecting data for all referrals received. Because of the multiple systems/stakeholders that hold various aspects of the information, there is no centralized agency identified, nor full time funded person to collect, mangae, and analyze this data. It is our hope that ongoing negotiations with the MOU will allow us to identify resources to improve this in the years to come.

Is anyone better off?

V. FY 21/22 Client 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.

VI. FY 21/22 Additional Information:
Alameda County Behavioral Health Court is unique from many other Behavioral Health Courts throughout California in that Alameda County BHC 1) is predominantly pre-plea, 2) Probation is not involved in program administration or funding, and 3) client's charges are waived or reduced or records sealed upon successful completion of the program.

Behavioral Health Court additionally accepts clients with STRIKE charges, in which case they are admitted to BHC post plea with a deferred entry of judgement. BHC continues to accept a range of charges from misdemeanor to felony including (but not limited to): trespassing, theft, grand theft, assault, and assault with a deadly weapon. The District Attorney and judge are careful to take into consideration the desire of the identified victim(s), when considering violent charges. Family members often play a key role in advocacy for their loved ones.

Whether the charges are permitted is typically negotiated between the defense council and district attorney of the originating court of referral. Each member of the BHC Team (Judge, District Attorney, Defense Council, and ACBH) must approve of the admission in order for the individual to participate.

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.

VII. FY 22/23 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. At that time BHC was to serve a total of 30 clients, all centrally located with one specialty forensic full service partnership.
Many changes have evolved with BHC since that time including an expansion of the number of clients that can be served.

- Clients may be connected to either intensive community services or full service partnerships. Individuals needing less intensive services are referred to Informal Court or other court programs.
- To maintain the high quality of engagement with current staffing available for assessments and collection of court reports, BHC clinicians maintain a 1 to 30 staff to client ratio, and can accommodate a total census of 100 clients at any point in time.
- For FY 2022/2023, 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.

VIII. FY 22/23 Programs or Service Changes: The agreement between ACBH, The Superior Court, Alameda County Public Defender's Office and District Attorney's Office is currently under review for revision to reflect the current laws and work flow practices, and ensure health equity for all clients referred. Additionally, the Forensic Diversion and Reentry Services System of Care anticipates continued changes throughout the system related to alignment with our "True North Metrics", the implementation of CalAIM, and in response to other mandates.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 7

PROVIDER NAME: Alameda County Collaborative Courts

PROGRAM NAME: Mental Health Court Specialist

Program Description: The MHSA-funded mental health navigator position works in the Office of Collaborative Court Services (OCCS) which manages eight treatment courts in Alameda County. These treatment courts serve approximately 180 justice involved clients who need substance abuse and mental health treatment services. The mental health navigator coordinates mental health services within the Alameda County Behavioral Health system of care. This includes contacting clients to coordinate service linkage, completing written referrals, supporting warm handoffs to new providers, maintaining contact with clients and providers as needed, initiating treatment team meetings, engaging in court hearings and pre-court staffing meetings, and assisting clients with discharge planning. The mental health navigator participates in weekly clinical check-ins with collaborative court case managers to track clients' needs and progress in treatment.

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 21/22:

a. **Number of Unique Clients Served:** 123 individuals were served between January 3, 2022 (the day the mental health navigator began work) and June 30, 2022. **Cost per client:** $621

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

a. **Reduce Mental Health Stigma:** The Mental Health Service Act (MHSA)-funded mental health navigator ensures that treatment court participants are quickly linked to mental health services in Alameda County. He approaches clients using Telecare's recovery-centered clinical system (RCCS) which emphasizes client empowerment to make changes that promote recovery.

   Immediate client-centered contact and supported linkage- The mental health navigator connects with clients to discuss their mental health treatment options and to ask and answer questions. He approaches treatment clients as partners and acts as an advocate for their care. He makes referrals through ACCESS and maintains contact with clients to support warm handoffs to their new providers. He ensures that clients engage with services and provides ongoing service connections as needed. He also provides interim services such as linkage to crisis residential programs and community programs.

Utilizes effective screening – The mental health navigator utilizes information from the evidence-based mental health screen form (MHSF III) administered by a licensed clinician. The MHSF III identifies the court clients' most pressing mental health needs.

Client-centered referral process- Through the recovery-centered clinical system (RCCS) lens, the mental health navigator engages clients in conversations about their recovery journey and supports them with plans for treatment linkage that advance their goals. Prior to calling or submitting a written referral for services, the client is consulted about what information she or he would like to be shared (or not to be shared) and what they hope to gain from the referral.

Bridging treatment teams- The mental health navigator introduces drug treatment and mental health providers to one another and assists with coordinating treatment team meetings to support a more holistic health experience for the treatment court clients.

Language- The mental health navigator uses person-centered empowering language to describe clients' substance use and mental health needs. The RCCS model which the mental health navigator utilizes focuses on culture and conversation and in interviews with clients he is sensitive to how language shapes relationships, supports a wellness culture, and how it can reduce stigma around health needs. The influence of the mental health navigator and Telecare team has changed the way our justice partners speak about (and with) this population. Conversations are more health-focused with less judgmental and stigmatizing language.

b. Create a Welcoming Environment:

Trauma informed court setting-The mental health navigator supports a trauma informed court culture in which the environment is stable and predictable, and he is present, so clients feel supported. The hearing process is ritualized to reduce any anxiety or trauma related to the court environment. For example, clients are welcomed, the mental health navigator introduces himself, and explains his role at each hearing.

Pre-court staffing meetings- Before each court session, the mental health navigator participates in a pre-court meeting in which each client and their needs are discussed. The navigator presents a goal plan that the Judge can use to help the client engage in services, including medication support if necessary. This includes making accommodations for those that may have emotional and/or behavioral challenges to ensure that they feel supported within the court setting. The navigator updates the Judge and partners on client progress since the last court session so the team can collaborate to develop a plan for court interventions as needed. For example, if a client has recently relapsed, this information can be discussed before the hearing, so the judge is prepared to request increased treatment engagement. The mental health navigator may for example, share that the client, though struggling, has recently reached out for more assistance and this can be praised by the judge as well.

Modifications within court setting- "Breakout" rooms are built into virtual court hearings in which clients may meet with their attorneys, the mental health navigator, or other team members for private discussions if needed. The mental health navigator may offer follow-up services to any clients expressing mental health service needs within the court space or may

check in with anyone who seems distressed. The mental health navigator is also available for check-ins with clients before court to offer support and reduce any court-related anxiety.

III. Language Capacity for this Program: English and the services of an interpreter as needed.

IV. FY 21/22 challenges: A mental health staffing shortage occurred during this fiscal year, at the same time that mental health issues increased in severity. Co-occurring treatment facilities-imposed quarantines that limited available beds. Some available providers were less experienced, which increased the tasks performed by the mental health navigator to include medication management, housing referrals, and referrals to other services such as benefit advocacy. The number of justice-involved individuals referred to the collaborative courts with high mental health level-of-care needs increased substantially.

Is anyone better off?

V. FY 21/22 Client Impact: Every client with mental health needs with whom the mental health navigator interacted was referred to services and admitted to a provider offering the appropriate level of care within two weeks or less.

Testimonial: "I was having a really tough time and within a day I got support which helped save my life. I got into an SLE from the help of my case manager and the mental health team helped me and got on a call with a psychiatrist and my primary care physician. My medication got set right up. Sometimes I get overwhelmed with setting up appointments and all the 'adulting stuff' and they made it successful and were really supportive. The team is really down-to-earth, and I feel no stigma at all from you guys." – treatment court participant.

VI. FY 21/22 Additional Information:

Received MHSA Services by Department				
Department		Received MHSA Services		Total
		No	Yes	
Misdemeanor Drug Court 104	Count	23	27	50
	%	46.0%	54.0%	100.0%
Felony Drug Court 703	Count	11	30	41
	%	26.8%	73.2%	100.0%
Family Treatment Court 403	Count	16	20	36
	%	44.4%	55.6%	100.0%
Family Treatment Court 404	Count	25	5	30
	%	83.3%	16.7%	100.0%
Family Treatment Court 405	Count	6	26	32
	%	18.8%	81.3%	100.0%
Parole Reentry Court	Count	9	4	13
	%	69.2%	30.8%	100.0%

PRCS Reentry Court	Count	3	4	7
	%	42.9%	57.1%	100.0%
Veterans Treatment Court	Count	19	7	26
	%	73.1%	26.9%	100.0%
Total	Count	112	123	235
	%	47.7%	52.3%	100.0%

This table shows that overall, 123 of 235 (52.3%) of the collaborative court participants active at any point between January 3 (the date the mental health navigator began work) and June 30, 2022, received his services. Note that this includes just one half of fiscal year 2021-22.

Also depicted here is a statistically significant difference between departments in the proportions of participants receiving these services, ranging from 81.3% in Family Treatment Court Department 405 to 16.7% in Family Treatment Court Department 404. The low proportion of parents served by the mental health navigator in this department is likely due to the fact that the Case Manager is a licensed therapist. The second lowest proportion (26.9%) in the Veterans Treatment Court is due to the fact that this court transitions people out of county mental health services and into federally funded mental health services provided by the Veterans Administration.

The Office of Collaborative Court Services monitors its operations to identify and mitigate any disparity related to participants' race/ethnicity, gender, age, and co-occurring disorders. The table at right reflects no statistically significant differences between racial/ ethnic groups in the proportions of persons served by the mental health navigator. "All Other Races" includes 13 Asians, seven Native Hawaiian/Other Pacific Islanders, five Native American/Alaska Natives, and four persons who identified as "Some other race."

Received MHSA Services by Race/ Ethnicity

Race/Ethnicity		Received MHSA Services: No	Received MHSA Services: Yes	Total
African American	Count	30	41	71
	%	42.3%	57.7%	100.0%
Latino/ Hispanic	Count	31	25	56
	%	55.4%	44.6%	100.0%
Multi-Racial	Count	5	11	16
	%	31.3%	68.8%	100.0%
White	Count	31	32	63
	%	49.2%	50.8%	100.0%
All Other Races	Count	15	14	29
	%	51.7%	48.3%	100.0%
Total	Count	112	123	235
	%	47.7%	52.3%	100.0%

- Fifty-six of 105 (53.3%) participants identified as females at birth and 67 of 130 (51.5%) of persons identified as males at birth were served by the mental health navigator; nearly equivalent proportions.
- Four of eight (50%) Older Adults (61 to 72 years of age at program entry), 107 of 196 (54.6%) Adults (26 to 59 years of age at program entry), but just twelve of 30 (40%) Transition Age Youth (19 to 25 at program entry) were served by the mental health navigator.

VII. FY 22/23 Projections of Clients to be Served: Alameda County's emphasis upon placing justice-involved persons with mental health needs in the least restrictive environments is expected to increase

participation in the collaborative courts. Since the mental health navigator did not commence service delivery until January 2022, the 235 collaborative court participants active at any time during this six-month period is likely to double in fiscal year 2022-23 to 470. Similarly, the 123 participants served is expected to double to 246 during the full fiscal year 2022-23.

VIII. FY 22/23 Programs or Service Changes: It is important to increase mental health infrastructure, particularly for justice-involved individuals with co-occurring mental health and substance use disorders. The mental health navigator will increase in-person visits with clients in SUD treatment settings. The mental health navigator will also coordinate the participation of treatment providers as members of collaborative court teams.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 7

PROVIDER NAME: Court Advocacy Program (CAP)

PROGRAM NAME: Mental Health Court Specialist

Program Description: CAP increases access to community mental health services and reduces recidivism through advocacy and release planning and includes 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 21/22:

a. **Number of Unique Clients Served:** 68. **Cost per client:** $2,080

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 is 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 and psychosocial rehabilitation. CAP holds hope for recovery, even if someone has lost it for themselves. CAP empowers individuals with choice and the right to self-determination.

   Overall, CAP reduces recidivism to jail by successfully engaging people with welcoming and trauma informed practices, connecting people with serious mental health conditions to outpatient mental health services, and crafting mental health dispositions for re-entry back into the community.

III. Language Capacity for this Program: The CAP program is able to utilize ACBH Language Phone Line and in person Language Interpretation Services that are available to the court. The courts' in person Language Services are able to accommodate almost any language needed, including sign language, and have

specialized training for legal terms. The Language Phone Line contracted through ACBH is medically certified and confidential.

IV. FY 21/22 challenges: The Court Advocacy Project experienced a marked increase in referrals for enrollment throughout the fiscal year. While there are many factors that may contribute to this, it coincided with intermitent staff absences due to Covid-19 related needs – similar to staffing shortages experienced across California.

Is anyone better off?

V. FY 21/22 Client Impact:
As a result of CAP services:

- Clients were offered an opportunity to connect with treatment at the right-matched level of behavioral health care support
- Criminal Justice Professionals were better able to recognize, understand, and address the underlying issues leading to recidivism
- Families and community treatment providers were better able to navigate the court system and advocate for their loved ones/partners

VI. FY 21/22 Additional Information: The Court Advocacy Project has had a steady increase in referrals in this past FY. There are may factors that may be affecting this:

1) Covid Restrictions lifting. Previously ongoing Covid precautions for safety affected the ability for forensic alienists contracted by the court to complete assessments, which led to a decrease in referrals. In this past year, sevearl of the judges met with the alienists and ACSO to resolve these issues and smooth their ability to initiate the referral process to CAP.
2) The end of the COVID-19 Emergency Bail Schedule. We previously saw a decrease in referrals under the Emergency Bail Scheduled. Many individuals were released from custody, or cited and releasd, without first being connected to services. We have seen an increase in referrals since the end of the emergency bail schedule, and also received referrals for those who were previously released and then re-arrested.
3) The implementation of SB317. In September 2021, Senate Bill 317 was passed to revise the existing Penal Code 1370.01 which affects individuals who are considered incompetent to stand trial for misdemeanor charges (Law section (ca.gov)). As a result, the court has new options for referrals to clients who are affected by this revised law including mental health diversion, Assisted Outpatient Treatment, and Conservatorship. While there are new legal options for the criminal court, ACBH continues to work with representatives of Alameda County's Superior Court, Public Defender, and District Attorney's office to clarify procedures and eligibility for services.
4) Conserved clients being arrested from hospital settings. At times we have seen referrals for clients who assault a staff person while inpatient at an acute hosptial and are arrested and taken to the jail despite the conservatorship. All mental health services at the jail are voluntary and once there, may choose to cease taking medications.

VII. FY 22/23 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. 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 and offer voluntary services and linkages to individuals eligible for our county mental health plan.

VIII. FY 22/23 Programs 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. Many criminal courts now use a hybrid model for meeting in person and holding online hearings and we expect this to continue for the forseeable future. We additionally anticipate the implementation of "Care Courts" throughout California, and the possible passage of AB 2275 (affecting 5150 holds, due process, and LPS conservatorships) may also have the potential to affect CAP services. 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 12-25 years old who are involved in the juvenile justice system and their families.

How Much Did We Do?

I. FY 21/22:

a. **Number of Unique Clients Served:** 346. **Cost per client:** $478

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 continued to implement its new process to have a GC clinician meet with every youth upon their detainment into Juvenile Hall. As indicated in last year's report, this 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.

   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.

   New for the FY 21/22 are the addition of groups and the Juvenile Institutional Officer (JIO) guides. This year, GC clinicians offered groups, one premised on the Seeking Safety model and another called "The Don't Call It a Grief Group" group. The groups ran regularly, interrupted only by public health circumstances or crisis. The groups reduced stigma by providing the benefit of increased social support and reducing isolation. Participants were able to co-develop and reinforce adaptive coping skills, something particularly salient to the disenfranchised grief that youth may be experiencing in the custodial environment.

   This year, GC also created Behavioral Health guides for all juvenile institution officers (JIOs) to support their understanding of behavioral health conditions, how such conditions can manifest

in a juvenile custody setting, and what they can do in response. The guides, totaling more than 60 pages, will be placed into Care Coordination binders that sit at the unit desks on each unit.

Appreciating the content of the JIO guides, probation leadership offered GC team members four-to-five hours to provide behavioral health-related training for participants in probation's required Core training. The guides and correspondent training will reduce stigma by providing information that is easy-to-read, relatable, normalizing, and actionable.

b. **Create a Welcoming Environment:** The GC continues to work with our Probation partners to make several changes in order to create a more welcoming environment for our youth.

With the momentum from the prior year's redesign of the detention units, the GC and partners from JJC Medical successfully advocated for all youth in the facility to receive sleep masks. The team also updated the sleep protocol. The protocol was premised on standards from the National Commission on Correctional Healthcare (NCCHC) and clarified roles for the JJC's pediatrician; nurse manager; psychiatrists; behavioral health clinicians; and juvenile institution officers. Importantly, the protocol removed the need for youth with sleep disturbances to await follow-up after the weekly Care Coordination meeting. Instead, all parties now have a flowchart that can be acted upon as soon as youth or staff report sleep difficulties. Sleep masks and the updated, streamlined sleep protocol are inextricably linked to creating a welcoming and nurturing environment, as sleep is essential for human existence and survival.

The afore described JIO guides are also integral to facilitating a welcoming environment. JIOs with awareness of behavioral health presentations and conditions may be able to regulate their verbal and non-verbal communication as well as spatial and physical orientation when interacting with youth affected by ADHD, mood disruption, post-traumatic stress injury, etc. Increased JIO awareness and regulation could lead youth to feel less stigmatized and isolated and to be more open to participating in behavioral health interventions, formal or informal, and offered by behavioral health professionals or other JJC partners.

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

III. Language Capacity for this Program: The GC has one Spanish speaking clinician.

IV. FY 21/22 challenges: This year, challenges related to staffing and ongoing COVID-19 policy and practice adjustments. As with other behavioral health clinics, the Guidance Clinic lost staff to out-of-state moves and family/personal-related transitions. Also as with other clinics, GC staff members had to adjust to multiple unit composition shifts to accommodate public health needs.

Is anyone better off?

V. FY 21/22 Client Impact: Client impact is best shared through the stories of GC clinicians. Here are two:

1. A youth came into custody for the second time this year. During the follow-up meeting with a GC clinician, the youth was able to self-reflect and showed a different level of maturity and accountability than before. For example, he was able to identify family challenges that were detrimental to his growth and in turn communicate with his mother some of the things he

talked about with his clinician. He was also able to share things he had not shared with her before. In the end, he was able to get some closure and gain a different level of understanding he didn't have before.

2. A youth had originally been detained for shooting at an occupied vehicle and was initially resistant to mental health services. Eventually the youth participated in individual therapy, though he was opposed to family therapy. Over time, the youth changed his perspective and became open to family therapy, however the youth's parent's attendance was inconsistent. Through therapy, the youth learned the significance of being able to identify his triggers for anger, verbally express when he was experiencing uncomfortable emotions and feelings, utilize effective coping interventions, and understand that depression in young men can present in the form of anger. This youth graduated high school, completed Camp Sweeney, and is now gainfully employed in Alameda County.

VI. FY 21/22 Additional Information: The number of youths served was lower than in past years due to lower arrest and detention rates.

VII. FY 22/23 Projections of Clients to be Served: Probation leadership projects that the census will rise this year, and therefore we anticipate serving around 500 youth in the next fiscal year. This is due to factors including the closure of the Division of Juvenile Justice (DJJ) and recent legislation increasing the age to which young adults on juvenile probation can be held in juvenile detention facilities.

VIII. FY 22/23 Programs or Service Changes: Guidance Clinic clinicians are providing services to youth on the "secure track" unit, or the unit providing services for youth who returned from the soon-to-close Division of Juvenile Justice (DJJ) or who would otherwise have been referred there.

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 21/22:

a. **Number of Unique Clients Served:** 34. **Cost per client:** $26,687

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 are 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: We provide services in the families' preferred language. This year, we served 23 English-speaking families and 11 Spanish-speaking families.

IV. FY 21/22 challenges: The ongoing COVID 19 pandemic continued to have an impact on the youth and families we serve. Youth struggled to get re-engaged with school and families struggled to find stable work and housing coupled with the rising costs of living in the Bay Area. Our team continues to work creatively to find as many supports and resouirsces possible to support families during this challenging time.

Is anyone better off?

V. FY 21/22 Client Impact: Here is a case story submitted by one of our MST Clinicians that highlight some of the interventions provided by MST and the successes the youth and family were able to achieve during the course of treatment. **(Client's name has been changed to protect identity.)**

Jayde was 17 years old and was referred to the Seneca MST program by her Probation Officer for behaviors of aggression and school truancy. Jayde had been on Juvenile Probation since she was 13 years old, having over a dozen violations and arrests that were impacting her safety and functioning in her home, community, and school settings. She had been referred to the MST program prior to the pandemic in 2019, although services could not remain open and continue after 30 days given the lack of engagement of her parent at the time. Flash forward to late 2021, Jayde was now re-referred and residing with her Aunt, and she had become a mother to a sweet and healthy baby that was under 1 year old. During the course of MST, Jayde and her Aunt actively engaged in the program, meeting with the Clinician twice per week to target her mental health and Probation conditions. She had expressed sincere motivation to address her Probation status and desire to be dismissed. Jayde was able to also begin engagement in a youth program where she became a paid Intern Youth Coordinator, as well as engage in weekly parenting courses to help her navigate motherhood and connect with other young mothers, and at the same time she maximized her educational goals by taking courses through independent studies. Jayde worked diligently in these areas for several months, while her Aunt remained a steadfast advocate and support in influencing her positively in all areas. The persistent efforts of the family were extremely fruitful, Jayde was able to meet her graduation requirements a month ahead of schedule, and she completed her internship at the youth program. Jayde continued to sustain her progress after walking the stage at graduation, and was dismissed from the Probation Department as she had gone above and beyond to meet her expectations, and had no instances of engagement in her referral behaviors for 5 consistent months. Jayde successfully completed all of her overarching MST goals and desired outcomes, and at case closure she was happily transitioning into independent and sustainable housing with her son and preparing to apply for community college.

VI. FY 21/22 Additional Information: N/A

VII. FY 22/23 Projections of Clients to be Served: 40

VIII. FY 22/23 Programs or Service Changes: N/A

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 11

PROVIDER NAME: Bay Area Community Services (BACS)

PROGRAM NAME: Crisis Stabilization Unit (CSU): 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 serves adults 18 years or older (18-59 years) experiencing a mental health crisis.

How Much Did We Do?

I. FY 21/22:

a. **Number of Unique Clients Served:**

Amber CRT:178. **Cost per client:** $12,513 **Amber CSU:** 357. **Cost per client:** $13,217

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

a. **Reduce Mental Health Stigma:** Amber CRT and CSU collaborate with community stakeholders, families, and friends of referring partners in crisis to determine the dimensions contributing to the presenting problem, allow space for partners and friends/family to process thoughts and feelings related to the problem, and collaboratively formulate an action plan to address the problem. Through our effort to make crisis stabilization an inclusive process where possible, Amber CSU staff strive to increase understanding and reduce fear of those with mental illness. Amber CRT aims to support the client population through a dynamic approach, including medication management, strength building, fostering development of activities of daily living, while collaborating with existing care teams
b. **Create a Welcoming Environment:** Amber House seeks to eliminate barriers to access to mental health services while prioritizing the safety of our partners. Amber CSU embraces a “no wrong door” philosophy for those seeking our assistance with linkage to ongoing mental health, substance use, housing services, including referrals to the two-week CRT programs. Amber House provides a safe containing environment for partners in distress, allowing space for developing treatment goals and processing trauma.

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. FY 21/22 challenges: The ongoing COVID-19 pandemic has impacted staffing for our referring partners, and reduced the number of referrals received for the FY. COVID-19 has also impacted our ability to fill clinician, nursing, and managerial staff positions. Average occupancy rate objectives were not met due to limited number of referrals from community partners.

Is anyone better off?

V. FY 21/22 Client Impact: Amber CSU has exceeded targets for the following quality measures: Over 64% of partners have been connected to outpatient behavioral health services within seven days of discharge, and over 78% within 30 days of discharge. The number of partners served increased by 43% in the 4th quarter as compared to the third quarter for FY 21/22. Amber CRT maintained an approximate number of AMA discharges at 20% (from 21% the previous year) and saw a 70% rate of successful completion of programming.

VI. FY 21/22 Additional Information: In an effort to increase our census, community partners are encouraged to come to Amber CSU in order to gain more information on the program and our referral process. Previous CRT clients are welcomed back to treatment as needed to support with continued stabilization needs.

VII. FY 22/23 Projections of Clients to be Served: Amber CRT aims to maintain an average daily census above 85% occupancy. Amber CSU aims to admit a minimum of 3 clients per day.

VIII. FY 22/23 Programs or Service Changes: N/A

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 11

PROVIDER NAME: STARS Behavioral Health Group

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 21/22:

a. **Number of Unique Clients Served:** 564 unduplicated CSU youth served during 363 combined CSU hours; and 31 outpatient clients/youth received a combined total of 163.8 outpatient hours. **Cost per client:** $5,702.

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

a. **Reduce Mental Health Stigma:** All clients/caregivers tour the facility at admission, are fully informed of patient's rights (including for holds as needed), and staff educate clients/caregivers about how the youth may voluntarily transfer to a higher level of care.
b. **Create a Welcoming Environment:** The CSU has identified rooms for clients and families. Thus, family members have private space and they are welcomed to stay and ask questions. The environment is kept clean and safe by the team throughout their shift. Additionally, Willow Rock monitors the quality of the setting and service experience by continuously surveying client & caregiver perceptions.

III. Language Capacity for this Program: The program continually recruits staff to offer multi-lingual services that meet the county threshold languages. The CSU currently has Spanish speaking staff, Korean-speaking staff, and an available language line for other non-English speaking clients. Written materials are translated into the county threshold languages. Additionally, a language line is posted in every room and is accessible to families at any time.

IV. FY 21/22 challenges: Challenges addressed this last year included: a) sustaining staffing at regulated levels in light of Bay Area healthcare labor shortages; b) clarifying and managing expectations with the county and the provider community about the optimal use of the services, to facilitate streamlined

referral and intake processes; and, c) standing up SBHG's infrastructures including facility management, security and safety protocols.

Is anyone better off?

V. FY 21/22 Client Impact: Stars CSU and Outpatient cliniciansmeasure risk behaviors, symptoms, functioning and coping using the standardized Brief Psychiatric Rating Scale (BPRS-Child). During FY 21-22, there were N=318 matched pairs (intake to discharge), that demonstrated statistically significant desirable reductions (less risk, less symptoms, improved functioning, better coping) in total and subscale scores. A full outcome analysis is available upon request.

VI. FY 21/22 Additional Information: The CSU surveys clients, caregivers, and agency partners to improve program services.

VII. FY 22/23 Projections of Clients to be Served: The CSU aims to keep building utilization to 100 clients/month.

VIII. FY 22/23 Programs or Service Changes: Explore after-service transportation and continue to respond to feedback from community partners.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 14

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

PROGRAM NAME: Language ACCESS Asian (AHS ACCESS)

Program Description: AHS ACCESS operates a designated Intake and Referral phone line to provide AAPI language speaking/cultural screenings, evaluate medical necessity, and determine service levels for community members requesting mental health services. Community outreach, psychoeducation, and home/field visist are provided to promote mental health awareness, help seeking, and service participation amongst AAPI populations. The Program also provides short-term crisis stabilization outpatient treatment and reduces utilization of higher levels of care via medication support, individual therapy, individual rehabilitation, group rehabilitation, collateral, and case management services.

Target Population: AHS ACCESS provides services to consumers living in Alameda County, with primary focus on individuals and families who identify themselves as Asian Americans and Pacific Islanders. Consumers range in age from Children/Youth (0-15), TAY (16-25), Adults (26-59) to Older Adults (60+).

How Much Did We Do?

I. FY 21/22

a. **Number of clients served:**
   - Screening/linkage – served 449 unduplicated intake clients with 1,460 service contacts
   - Crisis stabilization outpatient treatment - served unduplicated 41 clients
   - Outreach/psychoeducation – served 1,878 community members. **Cost per client:** $617

How Well Did We Do?

II. Please describe ways that the program strives to:

a. **Reduce mental health stigma:**
   - Conducted tabling and screening at community events to foster trust building with community members through leveraging AAPI holistic health concept.
   - Partnered with AAPI-focused CBO's to conduct community education to address MH stigma and promote help seeking behaviors.
   - Launched YouTube channel and Mental Health Awareness website with audiovisual/infographic materials to reach out community members 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.
   - 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 AAPI languages including but not limited to Cantonese (797), Mandarin (328), Vietnamese (274), Khmer (84), Korean (41), Japanese (11), Mien (7), and English (774). Interpretation for other AAPI languages (33) and other languages (19).

IV. FY 21/22 Challenges: In response to COVID pandemic, social instabilities, anti-Asian hate crimes, intake staff continued to primarily provide mental health screening and service linkage on phone. Necessary telehealth or in-person screening sessions were scheduled per intake clients' needs.

Besides in-person outreach and treatment sessions, online psychoeducation and telehealth treatment services were provided to accommodate some community members' safety concerns. Due to AAPI limited technology access and help-seeking pattern, extra efforts were recruited to expand the scope of outreach and enhance treatment participation.

Owing to untimely service seeking, a good number of AAPI clients suffered from S/I, H/I and severe psychiatric symptoms upon the receipt of referrals, difficulties were encountered making urgent arrangement of psychiatric services with the limited resources in a short time frame.

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

Is Anyone Better Off?

V. FY 21/22 Client Impact:

- Provided culturally and linguistically responsive screening and service linkage services to 449 unduplicated intake clients with 1,460 services/contacts, connected with appropriate level of services, conducted safety planning for S/I and H/I.
- Delivered in-person sessions and Telehealth services to 41 unduplicated ACCESS treatment clients with assessment, treatment planning, medication support, individual therapy/rehab, group rehab, collateral, and case management services.
- Partnered multiple AAPI PCP and CBO's to conduct in-person outreach events and online wellness/psychoeducation sessions to reach out 1,878 community members.
- Launched AHS ACCESS YouTube Channel and MH Awareness website "ahsaccess.org" with infographic wellness materials and videos around interconnected themes of Self-care, Relationships, and Mental Health to raise AAPI MH awareness and promote help seeking.
- Coordinated with AAPI-focused Prevention Programs to foster trust building/working partnership and promote 2-way referral processes.
- Piloted Service Delivery Decentralization to have clinical staff to deliver treatment services at a welcoming community cultural center in mid county.
- A case study "Ms. Y is a 47-year-old Chinese woman who was born and grew up in China. In her late 20s, she experienced postpartum depression and started taking psychiatric medications to manager her mood. After immigrating to the U.S. with her family in 2008, she had several depression relapses in the face of multiple difficulties, such as language barriers, lack of employment opportunities, and loss of close family member. The most recent relapse occurred in the midst of pandemic and led to psychotic symptoms and hospitalizations. Through AHS

ACCESS and the family's care and support, Ms. Y's recovery has been going smoothly as she has regained stable mood, sleep, and appetite. In addition, with ACVP's assistance, she recently found a full-time job in clothing industry surrounded by many Chinese-speaking colleagues. In therapy, she continues to learn coping skills to address life and work stressors in the hope of passing trial period at work and living a more meaningful life."

VI. FY 21/22 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 22/23 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
- The service was significantly affected by the pandemic in the past one and half years. Due to the uncertainty and unpredictability, the same projections are currently used for the coming year.

VIII. FY 22/23 Program or Service Changes: Mobile "ACCESS" Screening and Service Linkage through culturally/linguistically responsive channels:

- Resume mobile outreach and pre-treatment case management to help clients address life stressors, remove help-seeking barriers, and prioritize mental health needs
- Resume 3rd party site screening/service referral to leverage holistic health concept and help seeking pattern at AAPI-focused health clinics and community service centers

Audience-targeting Outreach Mobilization to build trust and promote AAPI help-seeking:

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

Mental Health Awareness Campaign to address shame/stigma and raise mental health awareness:

- Further build on AHS ACCESS YouTube channel and MH Awareness website to disseminate audience-targeting materials (recovery stories, videos, infographic materials, etc.) on social media

Service Delivery Decentralization to increase case openings and service utilization rate:

- Leverage Telehealth to deliver treatment services by addressing client's preference, limited staff availability, and mobility/transportation challenges
- Allocate clinical staff by geographic clusters to deliver mobile/field-based treatment services at welcoming community spots or clients' places

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 15

PROVIDER NAME: La Familia Counseling Center

PROGRAM NAME: ACCESS Staffing to Latinx 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 Counseling Center 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 Latinx Population receives call from consumers and family members of consumers of mental health services who identify as Latinx 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 21/22:

a. **Number of Unique Clients Served:** 90. **Cost per client:** $9,502

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

a. **Reduce Mental Health Stigma:** Our ACCESS staff and La Familia MPTI trainees provide psychotherapy to clients. The team strives to support clients while also reducing mental health stigma. 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.

The Access Team of staff and practicum trainees, strives to reduce mental health stigma for the clients. One way the program achieves this, is to help make services accessible for the clients,

providing the client knowledge about their symptoms, and about resources they can use (internal) coping skills or external (community resources) to improve their mental health symptoms. La Familia's Spanish Language ACCESS does serve a large number of Spanish speaking clients (monolingual) or (bilingual). Having the services accessible in the clients' preferred language helps promote their mental health wellbeing.

b. **Create a Welcoming Environment:** La Familia's value of belonging speaks to creating the welcoming environment to our clients. This value along with the other ones noted above, are integrated into the organization to remind staff of the values, such as at All Agency Staff meetings. The ACCESS Program staff and trainees provide unconditional positive regard, empathy, compassion and respect to the program clients to help the clients feel welcomed. The staff and trainees receive supervision and guidance in ways to best support the clients using a variety of approaches. The La Familia MPTI practicum trainee program provides a vast array of training and supervision to its interns in topics pertaining to the client populations the intern is service. Our interns/trainees are focused on serving the Adult population and receive an adequate amount of training to support their learning and growth as a therapist. Additionally, staff and trainees learn about the importance of cultural sensitivity in working with Latino culture. Staff and trainees provide services to clients and their families in the Spanish language helping them receive support in their native language or their preferred language. All of the programs staff are bilingual Spanish and English and many are also bi-cultural. La Familia respects and values their staff and clients' for their variety of cultural diversity and provide culturally sensitive services.

III. Language Capacity for this Program: Spanish and English. All our staff (Program Manager) and interns are bilingual Spanish and English speaking. Our prior staff this past fiscal year were Spanish and English speaking and intern trainees this past fiscal year were also bilingual Spanish and English speaking.

IV. FY 21/22 challenges: One of the main challenges the program faced this year is staff. This is an ongoing delemma since the Covid pandemic began. It has become challenging to find Spanish Speaking applicants for the Staff therapist positions. The programs practicum trainee La Familia MPTI interns have helped to mitigate the absence of staff therapists, in their ability to provide services. Another challenge is that there are a large number of Spanish clients that need mental health services or are requesting psychotherapy, and there are not very many providers to help support them. Although the program numbers for psychiatric medication managment visits is inceasing, there are still challenges to increase numbers as some clients may arrive already receiving psychotropic medications through their primary care provider, other chose not to select medication services.

Is anyone better off?

V. FY 21/22 Client Impact: Many of the clients we serve do report improvement in their symptoms, gaining a better awareness abouts their symptoms and having learned ways to better manage their symptoms. We were able to serve 90 plus clients and support them in bettering their lives through the mental health therapy support and community referrals.

VI. FY 21/22 Additional Information: N/A

VII. FY 22/23 Projections of Clients to be Served: 90 plus.

VIII. FY 22/23 Programs or Service Changes: Currently, the program is short staffed with no staff therapists in the program besides the program manager. For this next fiscal year we will have 3-4 interns practicum trainees provide therapy services and plan to continue to recruit to fill the two vacant Staff therapist positions.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 18

PROVIDER NAME: Bay Area Community Services (BACS)

PROGRAM NAME: Wellness Centers: HEDCO House

Program Description: Wellness Centers provide a welcoming entry point for outpatient services for individuals who are unserved or underserved by the mental health system. They provide step-down service for individuals transitioning from ACBH specialty mental health services in an environment of inclusion and acceptance in facilities that are commonly managed and staffed by consumers who provide or arrange for peer support. Wellness Centers are contracted providers who perform outreach and engagement; offer outpatient services such as mental health services, case management/brokerage, crisis intervention, medication support/dispensing; provide peer support and wellness services; and Tenant Support Services (TSP) for those with housing insecurity. Wellness Center personnel are trained in HarmReduction and Trauma-Informed Care principles to meet the participant where they are at in a wholeperson 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: The BACS Wellness Centers provide services to adults (ages 18+) experiencing mental health challenges. These individuals may or may not be currently enrolled in ACBH specialty mental health programs (such as Service Teams, Full Service Partnerships, etc.). * There is also a Wellness Center provided by BACS that provides services to TAY (ages 16-24).

How Much Did We Do?

I. FY 21/22:

a. **Number of Unique Clients Served:** 22, does not include outreach/engagement activities. The budget for this program is: $730,942.

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

a. **Reduce Mental Health Stigma:** Some ways Hedco has been able to reduce stigma is through psycho-education. Hedco has been hosting internal and external groups focused on mental health, signs and signals of severe mental disorders, Survivors of Suicide Attempt, etc. Another way to reduce mental health stigma is by an open dialogue through informal groups. The program manager often engages with participants and small groups and shares his knowledge, normalizes mental health, and openly discuss it.
b. **Create a Welcoming Environment:** The program manager has been offering a more structured (calendar) and decluttered center. He was able to create spaces where participants can rest and sleep if needed (rest area), a welcoming shaded furnished patio (including some games for participants enjoyment), and by coaching staff members to provide quality service on a person-centered approach. Everyone who comes at Hedco hungry finds food. If they are looking for resources, staff will do whatever it takes to leave the center satisfied with their visit.

III. Language Capacity for this Program: Hedco has access to the county language line for an interpreter and is able to use the language line as needed. On site staff can provide services in English and Spanish.
IV. FY 21/22 challenges: The program was able to have a mental health clincian only for a few months of the fiscal year. It made difficult to meet goals and expectation. We could have done better job linking more participants to mental health services. Our numbers were lower than expected. Hedco has a robust Native Spanish-speaker team members, and we could have engaged participants who only speak Spanish.

Is anyone better off?

V. FY 21/22 Client Impact: Many of the participants working with the clincian have been able to find permantent housing (some still on transition), employment, and regain independency. And most importanly, they are treated with respect and dignity.

VI. FY 21/22 Additional Information: N/A

VII. FY 22/23 Projections of Clients to be Served: It is expected that by the end of this fiscal year, the number of unduplicated participants to be over 140.

VIII. FY 22/23 Programs or Service Changes: It is expected that Hedco will continue to have a person-center approach, reduce crisis calls, engage with participants in a more meaningful way.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 18

PROVIDER NAME: Bay Area Community Services (BACS)

PROGRAM NAME: Wellness Centers: South County

Program Description: Wellness Centers provide a welcoming entry point for outpatient services for individuals who are unserved or underserved by the mental health system. They provide step-down service for individuals transitioning from ACBH specialty mental health services in an environment of inclusion and acceptance in facilities that are commonly managed and staffed by consumers who provide or arrange for peer support. Wellness Centers are contracted providers who perform outreach and engagement; offer outpatient services such as mental health services, case management/brokerage, crisis intervention, medication support/dispensing; provide peer support and wellness services; and 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: The BACS Wellness Centers provide services to adults (ages 25+) experiencing mental health challenges. These individuals may or may not be currently enrolled in ACBH specialty mental health programs (such as Service Teams, Full Service Partnerships, etc.). * There is also a Wellness Center provided by BACS that provides services to TAY (ages 16-24). Additional Requirements for IPS Supported Employment: Contractor shall work with individuals who have expressed interest and motivation in pursuing competitive employment, regardless of their employment readiness, diagnoses, symptoms, substance use history, psychiatric hospitalizations, homelessness, level of disability, or legal system involvement.

How Much Did We Do?

I. FY 21/22:

a. **Number of Unique Clients Served:** 46, does not include outreach/engagement activities. The budget for this program is: $603,114.

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

a. **Reduce Mental Health Stigma:** Our program reduces mental health stigmas by normalizing conversations surrounding mental health. During our groups, we take time to educate our partners about mental health and provide resources for seeking help when needed. We build bonds with our partners so they know that if they are in need of help, they can pull us aside at any time to talk. We practice active listening skills so our partners know that we are listening and that we genuinely care about what they are telling us and going through.
b. **Create a Welcoming Environment:** When our partners come to our center, they are welcomed with colorful art, a warm meal, and a welcoming community. Our staff tells our partners “Make yourself at home” as they prepare to start their day here at the center. New partners are

greeted with a tour of the facility, told of the internal resources provided, and prompted on how to access one-on-one support from staff to work on goals toward self-sufficiency.

III. Language Capacity for this Program: Translation services are available as needed.

IV. FY 21/22 challenges: Hiring a Clinician late in the fiscal year made it difficult to meet the goals outlined in the contract. COVID also made it difficult due to fewer people visiting the Wellness Centers during the surges as well as outbreaks occurring onsite. Onsite outbreaks led to a staff shortage over a span of a few weeks. Another challenge was staff turnover. For our partners, meeting a new staff member and having to build rapport again takes time. Most of our staff at the SCWC were new as of this fiscal year so it took quite a bit of training to get up to par with writing notes and providing services.

Is anyone better off?

V. FY 21/22 Client Impact: Clients were positively impacted by feeling improved self-esteem, increased knowledge, gaining coping tools, building community, socializing, and removing barriers to move forward toward self-sufficiency.

VI. FY 21/22 Additional Information: N/A

VII. FY 22/23 Projections of Clients to be Served: 40+ unduplicated clients.

VIII. FY 22/23 Programs or Service Changes: N/A

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 18

PROVIDER NAME: Bay Area Community Services (BACS)

PROGRAM NAME: Wellness Centers: Towne House

Program Description: Wellness Centers provide a welcoming entry point for outpatient services for individuals who are unserved or underserved by the mental health system. They provide step-down service for individuals transitioning from ACBH specialty mental health services in an environment of inclusion and acceptance in facilities that are commonly managed and staffed by consumers who provide or arrange for peer support. Wellness Centers are contracted providers who perform outreach and engagement; offer outpatient services such as mental health services, case management/brokerage, crisis intervention, medication support/dispensing; provide peer support and wellness services; and 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: The BACS Wellness Centers provide services to adults (ages 25+) experiencing mental health challenges. These individuals may or may not be currently enrolled in ACBH specialty mental health programs (such as Service Teams, Full Service Partnerships, etc.). * There is also a Wellness Center provided by BACS that provides services to TAY (ages 16-24). Additional Requirements for IPS Supported Employment: Contractor shall work with individuals who have expressed interest and motivation in pursuing competitive employment, regardless of their employment readiness, diagnoses, symptoms, substance use history, psychiatric hospitalizations, homelessness, level of disability, or legal system involvement.

How Much Did We Do?

I. FY 21/22:

a. **Number of Unique Clients Served:** 46. does not include outreach/engagement activities. The budget for this program is: $976,274

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

a. **Reduce Mental Health Stigma:** Towne House Wellness Center revamped the monthly calendar of activities and shifted the focus to a more holistic approach to mental wellness and heavily incorporated elements of mindfulness into group programming. Towne House Wellness Center uses mindfulness for its ease of instruction delivery and as a tangible resource and skill that partners could take with them, draw upon, and incorporate into their personal wellness plans when experiencing a personal crisis. Throughout the week partners are encouraged by staff to participate in groups that introduce yoga, breathing exercises, art visualization, mindfulness, and community wellness walks all while providing ongoing psycho-education around the benefits of practicing being present and mindful.

b. **Create a Welcoming Environment:** Towne House Wellness Center actively solicits partner feedback and utilizes their input in the creation and implementation of ongoing groups. The intent here is to foster a sense of community, partnership, collaboration, and buy-in by having partners suggest what groups they would like to have and why. Towne House Wellness Center amasses clothes through in-house donations and developed a plan to create a clothes pantry where partners can access clean clothes that would be appropriate for interview/employment attire or just casual daily wear can change into. Towne House is proud to have established partner volunteers to support the wellness center as well. Towne House Wellness Center creates an environment that the partners appreciate and take account of as well.

III. Language Capacity for this Program: Towne House Wellness Center has access to the county language line for an interpreter and is able to use the language line as needed.

IV. FY 21/22 challenges: Staffing has been the major challenge for Towne House Wellness Center. Towne House Wellness Center has not had a clinician for the majority of the fiscal year and is currently hiring for a clinician.

Is anyone better off?

V. FY 21/22 Client Impact: Towne House has become the sole place our partners get to experience a safe haven due to the lack of social support; natural, community, or both. As we continue to adjust to post Covid-19 the need for assistance and resources is evident. But often a familiar welcoming face, a meal with a cup of coffee, and human interaction are what our partners are seeking the most. Post Covid-19 partners have returned to the Towne House Wellness Center with joy and relief to be able to come to Towne House again. Partners have transparently shared the common negative impacts on their mental health as feelings of isolation, depression, and hopelessness while living through the pandemic and the challenges in trusting that things will get better. Partners are demonstrating increased insight into how they can meet their personal needs by participating in our weekly groups and engaging in 1:1 interaction with staff. Offering and holding a space where community partners can congregate and engage in meaningful conversation and wellness activities, reflects an alleviation of the negative impact that catastrophes have on a person's mental health.

VI. FY 21/22 Additional Information: Towne House Wellness Center is brainstorming new and innovative ideas that have enhanced the services of the wellness center. Staff continues to have a willingness to thoughtfully incorporate the feedback around service delivery adaptations and partner support. Each team member has taken on the task of developing activities and/or groups that align with our focus on mental wellness and each has risen to the challenge and conquered it. Staff is claiming ownership and pride in the activities and groups they develop embodying the "Whatever It Takes" spirit and attitude that we nurture in all staff here at BACS.

VII. FY 22/23 Projections of Clients to be Served: 50 clients projected to be served.

VIII. FY 22/23 Programs or Service Changes: N/A

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: The BACS Wellness Centers provide services to adults (ages 25+) experiencing mental health challenges. These individuals may or may not be currently enrolled in ACBH specialty mental health programs (such as Service Teams, Full Service Partnerships, etc.). * There is also a Wellness Center provided by BACS that provides services to TAY (ages 16-24). Additional Requirements for IPS Supported Employment: Contractor shall work with individuals who have expressed interest and motivation in pursuing competitive employment, regardless of their employment readiness, diagnoses, symptoms, substance use history, psychiatric hospitalizations, homelessness, level of disability, or legal system involvement.

How Much Did We Do?

I. FY 21/22:

a. **Number of Unique Clients Served:** 68, does not include outreach/engagement activities. The budget for this program is: $553,347

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

a. **Reduce Mental Health Stigma:** Valley Wellness strives to reduce mental health stigma by discussing mental health openly. Clients are encouraged to participate in group activities that encourage and support different ideas. Valley supports the idea that there is no wrong way to feel only different ways to address feelings.
b. **Create a Welcoming Environment:** Clients are offered food, supplies and asked to make themselves at home upon arrival. Staff ensure that client's basic needs are met to the best of our ability, in an attempt to establish a rapport and create a welcoming atmosphere.

III. Language Capacity for this Program: All staff have access to the county translation line.

IV. FY 21/22 challenges: Valley has faced challenges with staffing.

Is anyone better off?

V. FY 21/22 Client Impact: Clients have found housing, recieved supplies, providing a communmity center for mental health support. Focusing on wrap around services for client support.

VI. FY 21/22 Additional Information: N/A

VII. FY 22/23 Projections of Clients to be Served: Valley is projected to serve at least 300 clients this quarter for services and 25 for case management.

VIII. FY 22/23 Programs or Service Changes: N/A

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 18

PROVIDER NAME: Bonita House

PROGRAM NAME: Wellness Centers: Berkeley

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

Target Population: The Bonita House Wellness Centers provide services to adults (age 25+) experiencing mental health challenges. These individuals may or may not be currently enrolled in ACBH specialty mental health programs (such as Service Teams, Full Service Partnerships, etc.). Additional Requirements for IPS Supported Employment: Contractor shall work with individuals who have expressed interest and motivation in pursuing competitive employment, regardless of their employment readiness, diagnoses, symptoms, substance use history, psychiatric hospitalizations, homelessness, level of disability, or legal system involvement.

How Much Did We Do?

I. FY 21/22:

a. **Number of Unique Clients Served:** 21, does not include outreach/engagement activities. The budget for this program is: $491,037

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

a. **Reduce Mental Health Stigma:** The Berkeley Wellness Center is a unique, strength-based program that strives to improve access to mental health support and care. We are a community in which people are accepted for who they are. We help people with hidden disabilities navigate through the often-overwhelming health care system so they can get the appropriate care and treatment they need.
b. **Create a Welcoming Environment:** Clients are encouraged to develop their own wellness program through expressions of personal interests, needs, and goals in their unique recovery journey. BWC provides a safe, welcoming place where clients can increase socialization, reduce isolation, and increase peer contact. Our program includes creative programs such as art therapy groups, writing workshops, and music groups.

III. Language Capacity for this Program: English

IV. FY 21/22 challenges: Staffing at BWC continues to be a challenge; we have experienced some turnover in the PSS positions. At the time of this writing, BWC is fully staffed and the new Program

Manager is in place. COVID health concerns presented a challeng to clients and staff regarding offing in-person services. BWC offers services both in-person and via Zoom, however most still prefer in-person participation.

Is anyone better off?

V. FY 21/22 Client Impact: 91% of clients who completed the quarterly satisfaction surveys reported that they agreed or strongly agreed with the statement, "I like the services that I received here." 70% agreed or strongly agreed with the statement, "I am engaged in a meanigful role in my life." 74% agreed or strongly agreed with the statement, "I am able to manage my physical and mental health needs." 81% of the clients surveyed reported that the agreed or strongly agreed with the statement, "I deal more effectively with daily problems" as a result of the services they received.

VI. FY 21/22 Additional Information: N/A

VII. FY 22/23 Projections of Clients to be Served: 21

VIII. FY 22/23 Programs or Service Changes: We hired a new Director of Wellness Programs and Program Manager at BWC in May; they are focusing on streamlining operations, program development, and community outreach. BWC has added peer-led support groups, writing workshops, and open studio music groups. We have resumed taking clients on monthly outings beginning with a well-attended visit to the Berkely Art Museum. The open studio art program led by our Associate MFT continues to be a highlight of the week for many clients.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 18

PROVIDER NAME: Bonita House

PROGRAM NAME: Wellness Centers: Casa Ubuntu

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

Target Population: The Bonita House Wellness Centers provide services to adults (age 25+) experiencing mental health challenges. These individuals may or may not be currently enrolled in ACBH specialty mental health programs (such as Service Teams, Full Service Partnerships, etc.). Additional Requirements for IPS Supported Employment: Contractor shall work with individuals who have expressed interest and motivation in pursuing competitive employment, regardless of their employment readiness, diagnoses, symptoms, substance use history, psychiatric hospitalizations, homelessness, level of disability, or legal system involvement.

How Much Did We Do?

I. FY 21/22:

a. **Number of Unique Clients Served:** 40. does not include outreach/engagement activities. The budget for this program is: $823,324

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

a. **Reduce Mental Health Stigma:** The Casa Ubuntu Creative Wellness Center is a supportive, strength-based program that strives to help members achieve wellness and self-sufficiency. We are a community in which people are empowered to create lives of personal meaning in which they develop and manage their own supports to live, work, and play in a community of their choice.
b. **Create a Welcoming Environment:** Clients are encouraged to develop their own wellness program through expressions of personal interests, needs, and goals in their unique recovery journey. We provide peer-driven support, individual counseling, daily wellness groups, fieldtrips, social and recreational activities to help clients develop the skills and resources they need for better life satisfaction.

III. Language Capacity for this Program: English and Spanish

IV. FY 21/22 challenges: Casa Ubuntu's IPS specialist resigned in August 2021, and we have not been able to fill the position, therefore IPS services have been discontinued for the time being. Staff turnover

has been a challenge and the uncertainty of new COVID variants has presented a complex barrier to those who desire to attend in-person services. We continue to provide group and individual services both in-person and via Zoom to support accessibility to our services.

Is anyone better off?

V. FY 21/22 Client Impact: 86% of clients who completed the quarterly satisfaction surveys reported that they agreed or strongly agreed with the statement, "I like the services that I received here." 86% agreed or strongly agreed with the statement, "I am engaged in a meanigful role in my life." 86% agreed or strongly agreed with the statement, "I am able to manage my physical and mental health needs." 88% of the clients surveyed reported that the agreed or strongly agreed with the statement, "I deal more effectively with daily problems" as a result of the services they received.

VI. FY 21/22 Additional Information: N/A

VII. FY 22/23 Projections of Clients to be Served: 40

VIII. FY 22/23 Programs or Service Changes: In May 2022 we onboarded a new Director of Wellness Programs and one Student MFT Trainee. We lost one PSS in June and are currently looking to fill the position. We have added a Mindfulness group to the weekly program and opened the center for recreational and social activities in the afternoons. Casa Ubuntu staff has resumed taking clients on monthly outings; the first outings were to a movie and to the USAOC Convention. The Director is focusing on streamlining operations, building the program services offered, and community outreach activities.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 18

PROVIDER NAME: National Alliance on Mental Illness (NAMI) Easy Bay Chapters – NAMI for Chinese Communities – Mental Health Association for Chinese Communities (MHACC)

PROGRAM NAME: Capacity Building & Family Empowerment

Program Description: The Covid-19 pandemic and anti-Asian hate crimes have devasted our community. As a result, the need for mental health services in our community has skyrocketed. The funds from Alameda County were used to increase our capability to serve. Aside from our traditional Family support groups and NAMI Family to Family classes, we also started many more services, such as online Zumba, Yoga, Tai Chi, Singing and Dancing classes to help combat the loneliness and stress of our communities.

Our Family Caregiver Support Group is for the people who have family members suffering from mental health issues. The purpose of this program is to provide support to those caregivers. It is offered once each month in both Cantonese and in Mandarin.

Our Cantonese and Mandarin Mental Health Warmline, along with volunteer manned WeChat Support Groups also provided quick support to the people who have urgent needs.

Target Population: We specialize in support of the first and second generation of ethnic Chinese who are suffering from mental health issues or whose family members are suffering from mental health issues. We provide language and culturally appropriate services to the populations we serve as the key strengths of MHACC.

How Much Did We Do?

I. FY 21/22:

a. **Number of Unique Clients Served:** In the fiscal year of 21/22, MHACC has served more than 2,000 families. We let our community know that we are here for them. More importantly, we demonstrated that we have the knowledge and the will to help them. They see hope as long as we are around them. Program budget: $10,580

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

a. **Reduce Mental Health Stigma:** Mental Health Stigma is the major obstacle for us to fully address mental health issues in our community. We have been battling stigma since day one of MHACC by translating mental health materials from reputable sources into Chinese and holding seminars, webinars and workshops in our communities.

   We also hold monthly Peer to Peer support groups and Family Caregiver support groups to fight against these stigmas through education and awareness. Dedicated Mental Health WeChat groups made a great difference in reaching out to a larger population.

b. **Create a Welcoming Environment:** Creating a welcome environment is critically important. We have singing and dancing classes to make people feel comfortable and welcomed. This gives people a safe and funs space while interacting with others. We organized multiple activities,

such as a Spring Festival event and Walking for a Healthy Body event. Of course, the major purpose of our variety of support groups is to let people feel welcomed, feel like and family, and have something to look forward to.

III. Language Capacity for this Program: The Chinese language, Mandarin and Cantonese dialects are our specialties. We are also providing services in English. We can meet clients needs by providing them with the language or dialects they feel most comfortable with.

IV. FY 21/22 challenges: The greatest challenges we faced are the lack of awareness and knowledge about mental health in our community. We spent a great amount of time and effort to educate and re-educate the people. We try to convince them that mental health issues are like any other physical health issues which require medical care and should not be ignored. The other challenges resulted from the deep-rooted shame withint the Asian culture and immigrant backgrounds. Most of the clients we serve are the first-generation immigrants and their American born children. Due to the vastly different cultural and educaitonal backgroudns, the two generations often do not understand each other well, especially when mental health issues arive withint the family. We need to pay special attention to this.

The pandemic also created a big challenge for us. The traditional physical gatherings and face to face meetings became impossible. We had to build up our virtual meeting capacity.

Is anyone better off?

V. FY 21/22 Client Impact: What MHACC has done and continues to do has saved many lives and many families. People thanked us when they or their family members overcame their mental health situations.

Person A said: “We just sent my husband to a mental health hospital. He didn’t object this time. The police were well trained and nice. Me and my husband’s mother accompanied him to the hospital. Thanks to what I learned from MHACC, we were able to let my husband stay at the hospital a couple of days longer, which is very helpful.”

Person B said: “Hi Elaine, thank you so much for your care of my daughter and my family. My daughter has recovered from a severe mental health issue. Now, she is health both mentally and physically. She has become a teacher. She is happy everyday about her life and her career. It is a real blessing for us to have a caring MHACC family.”

Person C said: “Hi Elaine, I would like to tell you some good news. My younger brother is willing to take the shots now. Given time, he should recover, I am sure. Thank you for your guidance over the time. And many thanks to the support groups.”

Many of the people we helped became passionate volunteers for our organization. For the younger people, we not only try to help them recover, but also help them become productive member in society. For example, Mr. Lo had suffered from mental health issues for many years. Last year, he participated in our mental health facilitator training class. After the class, he became a leader in our Peer-to-Peer support group and then went on to help us with writing reports and grant applications.

VI. FY 21/22 Additional Information: Thanks to the support of Alameda County Behavioral Health and the Office of Family Empowerment, we have greatly increased our capacity to serve. As a result, we

secured a major grant, the Stop the Hate grant. This, in turn will greatly help us to better serve Alameda County. We look forward to continuing working with ACBH.

VII. FY 22/23 Projections of Clients to be Served: Due to increased capacity, we are planning to serve even more clients in the fiscal year of 22/23. We will put extra effort in peer support and greatly expand our bandwidth to help Anti-Asian hate crime victims.

VIII. FY 22/23 Programs or Service Changes: For the fiscal year of 22/23, we will continue our mission and our battle tested programs. At the same time, we will utilize our newly developed mobile mental health apps, MiSunshine and UrSpace to serve even more people and make mental health resources more accessible.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 18

PROVIDER NAME: National Alliance on Mental Illness (NAMI) NAMI EAST BAY -East Bay Chapters

PROGRAM NAME: Capacity Building & Family Empowerment

Program Description: NAMI EastBay has as its mission goal to support, educate, advocate, promote research, network, explore alternative perspectives and to overcome the stigma surrounding mental illness.

We attempt to accomplish this through a weekly support group, every other month speaker meeting where a general relevant topic is presented, every other month 5-page newsletter, Mail Chimp (bulk mail) alerts, website and responsively to phone calls and email inquiries and requests.

Target Population: Our programs are geared towards the needs of families or friends of loved ones with mental illness. Although there is generally no direct intervention with the individuals with lived experience, hopefully the improvement in the family's understanding of and knowledge of the illness and appropriate resources, along with communication strategies and the knowledge that the family is not alone with their challenges will help alleviate the accompanying challenges and frustrations.

How Much Did We Do?

I. FY 21/22:

a. **Number of Unique Clients Served:** Estimated 108 unique clients. This is a bit tricky since oftentimes we're dealing with a family rather than a single individual. This last year, we offered a weekly support group. Of the participants, there were generally 7 or 8 attendees who have attended on a weekly basis and each meeting brought in 2-3 newcomers. A follow-up note is sent after each meeting with elaboration of acronyms, book recommendations, specific phone contact numbers, website addresses and descriptions of services. Program budget: $10,580

   In addition, our newsletter is sent via email to approximately 1,110 recipients and the paper newsletter is mailed to 350 recipients. Our office receives approximately 3-5 inquiries and requests a week via email or phone calls.

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

a. **Reduce Mental Health Stigma:** We rely heavily on the concept that stigma is based on a lack of knowledge about or misunderstanding of mental illness. The very fact of being in a group where problems are shared and understood seems to be a solid first step. We use some humor where appropriate and share insights or comments from our ill relatives which help to develop empathy in those families who are totally distressed and unable to use that perspective. Oftentimes, where appropriate, we learn to identify predictable emotions and normalize such issues as a consumer feeling frightened and scared when internal demons and voices are

threatening. Via a comfortable relaxed process, we become familiar with cultural differences in how families deal with crisis.

b. **Create a Welcoming Environment:** Before the pandemic, we'd greet support group attendees with coffee and cookies. That's not possible these days since we work on Zoom, but the intent is there. Realizing that for many family members, coming to a group and sharing one's struggles is a daunting task so we give extra attention and welcome to new attendees. Seasoned group members kindly reach out and speak to the benefits of coming to group and this message is conveyed repeatedly in the chat room. Folks are encouraged to unmute on Zoom so everyone is free to interact.

III. Language Capacity for this Program: Our groups and printed materials use English but we freely give out the contact information for groups where Spanish or Mandarin/Cantonese is used. Our website provides onscreen translation.

IV. FY 21/22 challenges: It goes without saying that these last two years have been heavily impacted by Covid. We transferred over to the Zoom process but realize that still leaves many families unable to access us. Another challenge has been the underlying presence of general societal anxiety and depression due in part to Covid but also to geopolitical issues. These are tough times.

Is anyone better off?

V. FY 21/22 Client Impact: We do not currently offer direct services to clients. Instead, in our quest to have the system view our families as part of the support team, we feel that bringing our folks up to steam on what mental illness is, community resources and how the system works, our families can become more credible team members. And this benefits the clients, as do the communication skills and coping strategies we teach.

VI. FY 21/22 Additional Information: N/A

VII. FY 22/23 Projections of Clients to be Served: We imagine we will maintain a similar base number of client/family participation but anticipate offering direct consumer groups, which will increase numbers. We are seeing an increasing number of support group referrals coming to us from Kaiser and private and county clinicians.

VIII. FY 22/23 Programs or Service Changes: We are anticipating a change in the affiliate long-term leadership and we are contemplating some changes to the organization but will still be offering our support and education outreach. Because of the labor intensity of producing the newsletter, we will be stopping the production of hard copies. We will be relying on electronic bulk mail and intend to use that more with paper accommodations made for those members who are not comfortable with technology. We will be hiring a part time tech person who will maintain and troubleshoot our zoom, website, social media and mail processes. We will also be increasing the hours and responsibilities of our part time office manager. Lastly, we will be expanding our board and putting in place an advisory board of subject/resource specialists.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 18

PROVIDER NAME: National Alliance on Mental Illness (NAMI) Easy Bay Chapters- NAMI Tri-Valley.

PROGRAM NAME: Capacity Building & Family Empowerment

Program Description: NAMI Tri-Valley is an independent 501(c)3 organization. Our Mission, in collaboration with other community agencies and organizations, is dedicated to improving the quality of life for those whose lives are affected by mental illness, by providing support, resource information, education programs, and advocacy.

Target Population: Family members and others who have loved ones living with a mental illness, and peer support.

How Much Did We Do?

I. FY 21/22:

a. **Number of Unique Clients Served:**
   Family to Family Education Class – 41
   Suicide Prevention Workshop for Caregivers – 88
   NAMI Connections Recovery Support Group – 44 Repeat, 4
   Unique Family Support Group – 305 Repeat – 26 Unique
   Program budget: $10,580

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

a. **Reduce Mental Health Stigma:** NAMI Tri-Valley provides information, support, advocacy, resources and the time to listen to any person who seeks any or all of these services, which are all important factors in dispelling stigma. We have received comments from participants that have attended some of the programs listed in this report, which is testimony to the dedicated services we provide:

   Family-to-Family Education Class: "This class offered an environment that felt safe to share our raw emotions and situations and felt supported and not judged."
   "It was comforting to see we are not the only ones dealing with these types of issues in our family."
   "Because I have been attending support groups for quite a while I would not say I have had an 'aha' moment. But one thing that did stand out was the exercise where many people were reading at the same time, while we were to listen to and follow directions. That really gave me a better understanding of the chaos that can be going on in the mind of my loved one with mental illness."
   "I have shared much of the information with other family members hoping to help them educate themselves and put some of this into practice= understanding and empathy being the key."

   Suicide Prevention Workshop for Family Caregivers: "I'm pretty sure we are zooming for the long haul – and I look forward to this workshop next year."

"Awesome job! Thank you!"
"[Provide] Crisis and more suicide prevention workshops, the information around this topic is worth reviewing. Thank you!!"

NAMI Connections Recovery Support Group: "Finding a community of people who understand mental health that's been judgment free has helped me immensely especially during the pandemic."

One long-time attendee said "It was the social interactions that have helped."

Family Support Group: "You are such a gem and lifeline for all of us in our challenges, with your mother hen wing over us, guiding and supporting us all through our journeys! You should know you make a world of difference to lots and lots of people including me! Bless you for doing what you do and being who you are. People matter. It shows in your heart."

"Thank you, Marsha for this email and all the thoughtful support you, Lisa and Mark provided us. It helped us so much. Being with members who truly understand… very grateful!"

b. **Create a Welcoming Environment:** We greet and treat all participants in all of our programs with dignity and respect. Often the initial contact with NAMI Tri-Valley is a phone call. We promptly answer most all calls and many have commented that we are the only organization that has picked up the phone right away.

   Zoom video conferencing has been our main source of delivery of our services during FY 21-22. Not all are comfortable with this venue, but most work around the various challenges. Since we have recently rented office space for the first time, we are able to safely conduct small support groups in the conference room that is available for our use, which has made a world of difference for those who do not do as well using Zoom.

III. Language Capacity for this Program: English language is the primary language used, however, we are in the process of starting a Spanish language Family Support Group in October of 2022.

IV. FY 21/22 challenges: Living with COVID-19 through FY21-22 has converted all of our activities to Zoom video conferencing, which has had its challenges as well as its successes such as the ability for NAMI

Tri-Valley to continue helping people. One challenge for us is in accurate tracking of who is a repeat participant and who is there for the first time. Often a person will call in on a support group but prefer to listen only, no audio, no video and does not wish to introduce themselves. That is fine with us, but for tracking purposes, we are starting to make a note of that. Soon, we plan to hold one (1) support group per month on Zoom and 1 support group per month in person. We will test out how that will work including looking at hybrid set ups (in-person & Zoom).

Is anyone better off?

V. FY 21/22 Client Impact: NAMI Tri-Valley's service areas include Livermore, Dublin and Pleasanton. These areas are historically underserved when it comes to psycho-social programs for peers and their families. NAMI Tri-Valley has developed multiple support groups in order to strengthen the support of

We are also exploring housing possibilities for mental health clients in East Alameda County, as well as increasing public awareness on suicide prevention. All of these projects improve lives in our communities.

VI. FY 21/22 Additional Information: The programs listed under Section I. have differences. For example, the support group count for return participants and new participants, however the Suicide Prevention Workshop for Family Caregivers is a once a year event and must register in advance. Equally so for the Family-to-Family class, all attendees must register and all are unique clients.

VII. FY 22/23 Projections of Clients to be Served: We anticipate increased attendance when we resume in-person meetings.

VIII. FY 22/23 Programs or Service Changes: In October, 2022, we will be starting a Family Support Group in Spanish. This group is projected to be held every 3rd Monday evening. This has been a long-time dream to provide a group for the Hispanic community in East Alameda County. We are slowly transitioning to meetings in person, and that will give us more accurate data.

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.

How Much Did We Do?

I. FY 21/22:

a. **Number of Unique Clients Served:** 2,790. Does not include outreach and engagement activities. Total program budget is $960,331

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

a. **Reduce Mental Health Stigma:** ACNMHC provides active peer support through peer- ran groups focusing on a wide range of wellness topics including life skills and wellness tools such as WRAP, community engagements through presentations hosted by consumers active in their recovery journey, meaningful work activity through volunteer and employment opportunities. Housing advocacy and intensive case management provided by individuals who have lived experience receiving mental health services and/or has experienced homelessness.

b. **Create a Welcoming Environment: ACNMNHC** maintains a welcoming environment by having front desk staff who are trained Peer Support Specialist, a safe space to connect with other peers. We provide a warm presentation by offering casual seating; a program volunteer is there

to greet consumers when they arrive and a safe and clean waiting space. All of our sites provide water, coffee, snacks and a listening ear. A variety of brochures about ACNMHC individual programs, we provide a variety of mental health recovery-oriented materials and a Navigation Specialist to help peers find what they need. We maintain a clean/sanitized environment. We provide up to date resources related to Pandemic supports.

III. Language Capacity for this Program:

a. ACNMHC primary language capacity is English
b. ACNMHC BestNOW provides services in Spanish
c. ACNMHC BDIC has developed a peer services assistant who focuses on increasing service access in Spanish

IV. FY 21/22 challenges:

- Increasing Staffing capacity and retention. We are experiencing high staffing turn over
- Realignment of services and staffing to meet the new servisse shifts

Is anyone better off?

When we don't engage some of our members, its because they have made shifts in their lives. We provide vital, emergency services, peer support and training. Everyone we serve at some point is in of support. Occasionally, we have members return just to tell us what has happened since we last saw them. Many move on to becoming housed and employed. Others tell stories of how the reunited with their children. All of them share how the program and its staff impacted their lives. We have one program that visits locked facilities. Often we see our members out in the community and they also share how they are doing (better) and how much our support helped them improve the quality of their lives.
We are currently implementing a reporting system that will allow the programs to record the feedback from our members.

Across our programs, we can: ensure a peer focus approach to services including support groups lead by peers, housing and employment support.

V. FY 21/22 Client Impact: we increased access to the BN training program with supports to help individuals prepare for employment. We increase access to support groups by adding more topics virtually and incfreased housing supports to include case management assistance

VI. FY 21/22 Additional Information: ACNMHC is in a rebranding transition. The agency is planning to expand peer services in additional populations such as Latinx, TAY, and Re-entry.

VII. FY 22/23 Projections of Clients to be Served: 3500

VIII. FY 22/23 Programs or Service Changes: BDIC has expanded services to include Peer Respite and response. This service includes more community outreach. These services are currently funded by the City of Berkeley.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 18

PROVIDER NAME: PEERS

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

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

Target Population: These services predominantly serve adults (ages 25+) experiencing mental health challenges. These individuals may or may not be currently enrolled in ACBH specialty mental health programs (such as Service Teams, Full Service Partnerships, etc.).

How Much Did We Do?

I. FY 21/22:

a. **Number of Unique Clients Served:** 206 **Cost per client:** $1,675

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

a. **Reduce Mental Health Stigma:** Every aspect of the PEERS WRAP program is designed to eliminate stigma. The program is peer led, so all staff involved in the program have lived experience, serving as models of recovery and resilience. A key principle of WRAP is to avoid clinical or diagnostic language, so no one needs to identify with stigmatizing diagnostic categories in order to participate. Moreover, the program is strengths based and emphasizes participants' agency and capacity for recovery.
b. **Create a Welcoming Environment:** Communicating warmth and welcoming participants is a priority for PEERS. Through our annual Peer Program Participant survey, 96 percent of respondents agreed or strongly agreed with the statement "Staff greet me warmly when I attend the program," a figure that remained consistent since before we began remote programming during the pandemic.

III. Language Capacity for this Program: Two of our WRAP groups are conducted in Spanish and the rest are in English.

IV. FY 21/22 challenges: Our major struggle with our WRAP deliverables this past year was low attendance. We tried many outreach strategies, from email to Instagram to reaching out to personal connections to encourage participation. We are sensing fatigue with remote groups. In FY 22-23, we plan to resume in-person WRAP groups with some of our longstanding partner agencies, including South County Homeless Project, La Familia Counseling Center, and East Bay Community Recovery Project. We hope that this increases the number of participants, though ongoing pandemic concerns might make people reluctant to gather in larger groups.

Is anyone better off?

V. FY 21/22 Client Impact: Ninety-four percent of WRAP participants reported that the group was useful to them, 90% reported that the group helped them understand more about their mental health and wellness, and 91% reported that the group helped them have hope. A sample comment on our evaluation survey is "I like hearing others' answers – helps me feel normal." An example of impact on a single participant is that an older adult African American man with mental health and substance use challenges shared on several occasions how the WRAP key recovery concepts (hope, personal responsibility, education, self-advocacy, and support) helped him through some difficult challenges. He expressed gratitude that PEERS was providing this group at the site and often shared that out in his everyday life he could always remember the recovery concepts and that thinking about them helped him to not drink, or reminded him he was welcome even if he had been drinking over the weekend.

VI. FY 21/22 Additional Information: N/A

VII. FY 22/23 Projections of Clients to be Served: 250

VIII. FY 22/23 Programs or Service Changes: We expect to resume in-person WRAP groups at some of our partner agencies, including South County Homeless Project, La Familia Counseling Center, and East Bay Community Recovery Project, and perhaps even the East Oakland Senior Center.

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 based on the acuity client of needs to promote successful transition of patients to primary care; 1. Medication Support Services including initial assessment and follow-up assessment; 2. Issuing medication prescription(s) for the right drug therapy for client; 3. Administration of injectable medication, when applicable; 4. Evaluation and monitoring including consultations with physicians, clients and family members as authorized by the client. Face-to-face evaluation and monitoring for possible drug interactions, contraindications, adverse effects, therapeutic alternatives, allergies, over/under dosing, polypharmacy, side effects, dietary conflicts or any other medication related issues; 5. Mental Health Services including assessment, collateral, plan development, individual rehabilitation, brief individual and/or group therapy, case management/brokerage and crisis intervention services, and 6. Outreach efforts made in the field by a psychiatric nurse specifically in North County to meet that client demand

Target Population: Pathways to Wellness provides services to children (5-9 years old), adolescents (10-17 years old), and adults (18-59 years old) who have moderate to severe mental illness impairments resulting in at least one significant impairment in an important area of life functioning. All clients must meet specialty mental health criteria with impairments in the moderate to severe range. All clients are referred by Alameda County Acute Crisis Care and Evaluations for System-Wide Services (ACCESS). Services are provided in North County, South County and East County, located in Oakland, Union City and Pleasanton.

How Much Did We Do?

I. FY 21/22:

a. **Number of Unique Clients Served:** 2,762 **Cost per client:** $693

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

a. **Reduce Mental Health Stigma:** We reduce mental health stigma by hiring diverse staff that is culturally competent, and who understand, embody, and implement the standards of the MHSA model of care. This includes a commitment to reduce mental health stigma through utilizing client-centered assessment, strength-based services, trauma-informed care, and culturally competent training within the psychiatric and social-behavioral frameworks of mental health care. We had several recruitment strategies and processes which encouraged more diverse providers to apply to work for Pathways, despite the decrease in available providers in community mental health. *[In July 2021 it was reported that there were approximately 30,312 psychiatrists in the U.S. About half of the psychiatrists in the U.S. to maintain private practices and many psychiatrists work in multiple settings leaving massive shortages for psychiatrists per state.]* Pathways continues to be dedicated to reducing mental health stigma through utilizing

client-centered assessment, strength-based services, trauma-informed care, and culturally competent training. We were also able to continue to improve our engagement services and show rates with our African American mentally ill clients. This group also continues to be the largest ethnic group that we serve each month.

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

III. Language Capacity for this Program: We have several staff who speak different languages including: Spanish, Farsi, Tagalog, Hindi, and Arabic.

IV. FY 21/22 challenges: We have been still providing services to our clients despite being in a national pandemic for over 2.5 years. Clients are feeling the burden of being in a pandemic and a higher level of suicidality is being expressed among clients. Client referrals have increased in intensity and severity. More time and attention were required with existing open cases as anxiety, depression, substance use and overall acuity levels increased during the pandemic.

Staffing shortages, unexpected COVID spreads and adherence to the COVID reimbursement requirements for all staff (especially professional level staff) while recover from COVID has definitely impacted our fee for service contract especially with the fixed costs associated with the running the program.

Another challenge was the need for Pathways Providers to take on higher caseloads sporadically throughout the year to ensure that all clients were properly cared for until staff recovered from COVID.

Is anyone better off?

V. FY 21/22 Client Impact: During the year 2021-2022, we impacted clients by serving them throughout the entire year by utilizing telemedicine services. We continue to provide services despite the pandemic and have reduced rates of no-shows and timeliness with appointments due to our telemedicine outreach. We have been able to accommodate all referrals with appointments within 7 days or under who are discharged from the hospital. This year our referral to admission time has improved due to hiring an Intake physician.

We have continued to provide ongoing services to patients using telemedicine and in-person services. These services continue to reach clients who are struggling with serious mental health. We continued to encourage and provide protection to clients with risk to COVID19 including offering a health fair

providing vaccinations, anti-bacterial and hand sanitizer products, masks, health check-ups, and health education.

Throughout the year, we increased client access to vaccinations which contributed to less exposure to COVID19. We increased our outreach to outside providers coordinating medical records and health objectives. We connected 82% of our total clients connected with a Primary Care Physician. We reduced the number of psychiatric hospitalizations of clients enrolled in Pathways by 80%+ this fiscal year compared to last year. We reduced hospitalizations by offering more therapy, case management, extra appointments, and providing assessments for higher levels of care as needed. Clients who are of a higher acuity are increasing through the referral process.

Client-Centered Psychiatric Assessment is an ongoing service activity of gathering and analyzing collaborative information with the client. Together we help the client build community resources by using tertiary interventions to reduce harm and increase resiliency. Assessments incorporate a review of medical necessity, mental status determination, and analysis of the client's clinical history by gathering relevant cultural issues, analysis of behaviors and interpersonal skills, and a review of family dynamics and diagnosis. Our assessments capture the client's comprehensive social cultural lens by recognizing the daily stressors a client may go through especially 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 symptoms and we ensure that clients are diagnosed correctly. We account for the impact of how these qualifiers can drive diagnosis including African Americans being disproportionally diagnosed with schizophrenia and other psychotic disorders when instead they have a trauma disorder. We at Pathways to Wellness differentiate between cultural and functional paranoia in symptoms and encourage an accurate portrayal of client symptoms. By focusing on what the client is experiencing in the world as who they are, we can differentiate between what is 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 institutions which they continually encounter.

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, and 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.

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

We provide ongoing culturally responsive trainings for our staff and our communities at large to better engage and serve African American consumers which represents the largest client population at

Pathways. These trainings are provided to both our staff and to our community. We train providers about the complexity of trauma within the African American population and how to best serve their psychiatric and biopsychosocial needs.

VI. FY 21/22 Additional Information: We were able to improve the number 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 levels of care due to the inability of PCPs to take our clients.

VII. FY 22/23 Projections of Clients to be Served: 2,800 [if based on current capitated contract]**.**

VIII. FY 22/23 Programs or Service Changes: We are providing ongoing telemedicine and in-person services. We will continue to provide services within 10 days or less for all new referrals and less than 7 days for all clients coming out of the psychiatric hospital. In addition, we will operate under the new guidelines of "No Wrong Door". Nevertheless, under our existing capitated reimbursement structure, Pathways anticipates serving 2,800 clients next fiscal year. However, Pathways believes that without the capitated contract and with appropriate rates for our outpatient specialty health program, the county would see an increase in capacity and improvements in overall care from Pathways.

In addition, as clients increase in severity our community, we will continue to see an increase in behavioral health needs which will result in demand for immediate access for psychiatry, therapy and case management services in an effort to keep clients out of crisis. Proactive planning, accessibility and resources will be needed by all providers who are able to deliver quality care to higher numbers than usual.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 19

PROVIDER NAME: Telecare Corporation

PROGRAM NAME: STEPS Program

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

Target Population: Adults (ages 18-59) diagnosed with a severe mental illness. STEPS' goal is to serve high utilizers of Alameda County mental health services. Members referred to STEPS will have utilized at least three psychiatric emergency room visits and/or at least one month of inpatient psychiatric care within the past year. Priority will be given to members who have met these criteria for 2 years in a row.

How Much Did We Do?

I. FY 21/22:

a. **Number of Unique Clients Served:** 55. **Cost per client:** $12,008

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

a. **Reduce Mental Health Stigma:** We address internalized stigma by treating clients as individuals, getting to know them as humans through direct conversations and whole person assessments, learning their psychosocial histories, understanding the reasons behind their challenges, learning their strengths and creating individualized treatment goals that come from client's hopes and dreams. We provide clients with education about their mental health and substance use symptoms that can increase understanding and a sense of control over their lives. We educate about ways that stigma from society may impact their own self perceptions.

   We are with clients side-by-side in the community which allows us to advocate for fair treatment, as well as model for community members, how to interact with people who are experiencing symptoms of mental health diagnoses in real time

   We work with family members and other loved ones to provide psychoeducation and skill building about how to interact with clients in ways that minimize stigmatization.

   We provide ongoing training and support to help staff recognize own internalized biases and minimize potential microaggressions towards clients

b. **Create a Welcoming Environment:** Almost all of our services are provided in the community, where our clients are located. We have a receptionist who answers calls with respect and

ensures that clients' stated needs are forwarded to their team. We have staff on-site all day, every day (M-F) to address the needs of clients who come to the office looking for support.

We host client-focused events that honor and welcome our clients, to help them feel like integral members of society.

We provide training to staff around ways to create a welcoming environment and ways to provide support with welcoming attitudes.

III. Language Capacity for this Program: STEPS program uses a language line to provide services in the language our partners require or prefer. 53 Clients were served in English and 2 served in Mandarin/Cantonese.

IV. FY 21/22 challenges: FY21/22 was a time of great uncertainty due to the stressors of the global pandemic, housing insecurity, increased risk of substance use, increase of hate crimes directed towards vulnerable populations, increased cost of livng, especially for housing and food. While all these factors impacted our clients, the most challenging of the past year were the shortage of safe, affordable housing, increased cost of living due to inflation, and the dangerous risk of overdose and death due to the easy accessiblity of fentanyl and other street drugs.

We have also continued to struggle in FY21/22 with our referral flow. Traditionally the majority of STEPS referrals came from Villa Fairmont, however, Villa has seen an increase in FSP partners coming to Villa and those individuals are ineligible for STEPS services. We have increased our admissions through community referrals (direct from Alameda County service teams) which has led to a increase in LOS for partners in STEPS over the last year due to housing instability.

Is anyone better off?

V. FY 21/22 Client Impact: "Jane" is a single mother of spent two years with the STEPS program due poor symptom management, complex medical needs and barriers to engaging in treatment. She struggled with frequent suicidal thoughts, depressive symptoms, voices, and PTSD, which made it difficult for her to maintain treatment engagement with her primary case management team, manage ADLs, or manage her medical needs. She was pregnant and had diabetes at the time of admission. With the help of STEPS case management service, she was able to reach a place of medication stability with her primary CM team and improve consistency on attending medical follow up appointments. When Jane struggled to maintain treatment engagement with psychiatry, STEPS support her in attending treatment meetings and accessing services. STEPS assisted Jane with advocating for a change in treatment teams due to some very triggering events near her CM clinic, which were creating an additional barrier to engaging in treatment. Eventually her Service Level CM services were transferred to another program closer to where she lived and away from the triggering location. STEPS assisted Jane with building rapport and establishing consistency in engagement and treatment with her new treatment team. Due to her symptoms and history of trauma, Jane struggled to engage in community supports, struggled to trust providers, and struggled to maintain engagement with her treatment teams. STEPS CM team consistency, longevity, and approach to service helped build a strong connection, which fostered trust and openness with Jane.

During her time with STEPS, Jane successfully completed pregnancy and gave birth to a healthy baby. STEPS assisted Jane with transportation, managing her medication, supported her in attending her

medical appointments, provided psychoeducation around the importance of medical care for both her and the baby, and provided coaching on grounding skills to reduce symptoms of anxiety, suicidal thoughts, healthy coping for triggering thoughts, and paranoia. Jane was also connected to CM services for her baby and STEPS was able to support her in maintaining treatment engagement with this CM as well. Jane is a section 8 housing recipient and needed support with communicating her needs with her landlord to support a healthy and safe environment for her family. STEPS supported Jane in advocating for service and maintenance at her home. STEPS also supported Jane in moving to a new, larger home after the birth of the baby. STEPS was able to support Jane's housing stability when she fell behind on rent using the housing subsidiary funds provided by MHSA funding.

VI. FY 21/22 Additional Information: STEPS was provided a housing budget this past year in response to the need from many new referrals who were either homeless, at risk of homelessness, or not connected with benefits resulting in a barrier for discharge to the comunity from inpatient settings. In FY 21/22, STEPS supported 7 partners with securing and maintaining stable, supportive, long-term housing. This reduced their risks of rehospitalization, homelessness, risks to safety, and grave disability.

Member satisfaction surveys 7/1/21-6/30/22

Recovery Oriented Questions			
	Strongly Agree/ Agree	Neutral	Disagree/ Strongly Disagree
Staff were willing to see me as often as I felt was necessary	91%	6%	3%
I felt comfortable asking questions about my treatment and medications	88%	9%	3%
Staff believed that I could grow, change and recover	100%	0%	0%
I felt safe to raise questions or complain	90%	3%	7%
Staff helped me obtain the information I needed so that I could take charge of managing my illness	94%	6%	0%
	Strongly Agree/ Agree	Neutral	Disagree/ Strongly Disagree
Member Satisfaction with Services			
I liked the services I received here	97%	3%	0%
Given other choices, I would still choose to get services from this agency	88%	6%	6%
Services were available at times that were good for me	91%	9%	0%
I was able to get all the services I thought I needed	94%	3%	3%
I would recommend this program to a friend or family member	85%	12%	3%

VII. FY 22/23 Projections of Clients to be Served: Our intention is to provide services to approximately 75 distinct partners per year and keep our median LOS around 90-180days in order to provide for optimal flow.

VIII. FY 22/23 Programs or Service Changes: STEPS will continue to work with Alameda County around referral streams and ways STEPS can support both our at-risk populations and the larger ACBHCS system flow. We are exploring providing support for partners during their transition from FSP level services to Service team levels of service, as this transition time can be challenging and a critical linkage time. We are also continuing to explore ways to support individuals transitioning from TAY services to the adult system of care.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 20

PROVIDER NAME: Alameda County Behavioral Health, Vocational Services Division

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

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

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

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: Alameda County Specialty Mental Health Clients - Assisting youth (16-17 years old), Transitional Age Youth (TAY- 18-24 years old), Adults (18-54 years old) and Older Adults (55+ years old) in finding and keeping competitive work, utilizing the evidence-based practice of Individual Place and Support (IPS) - Supported Employment. IPS services span across all of Alameda County.

How Much Did We Do?

I. FY 21/22:

a. **Number of Unique Clients Served:** 260, **Cost per client:** $15,984

How Well Did We Do?

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 (SMI) receiving specialty mental health services express a desire to work, yet within the ACBH 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 according to June 2022 Bureau of Labor Statistics reporting). To compound matters, an even smaller fraction of employed consumers with SMI 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 have historically been 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.

   Fortunately, in September 2021 CA Senate Bill 639 was signed into law, which will phase out the use of Section 214 (c)(1)(A) of the Fair Labor Standards Act (FLSA) (i.e. certificate for allowance of subminimum employment wages for people with disabilities) and ultimately prohibit paying workers with disabilities less than the $15.00 California minimum wage. These workers will be transitioned to competitive, integrated employment. ACVP staff were members of a workgroup headed by the CA State Council on Developmental Disabilities, whose goal was to raise awareness and support to SB 639 prior to it being signed into law.

   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 program participants' self-esteem, 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.

   Lastly, ACVP Leadership has been asked to participate on a state facilitated Workforce and Employment Committee to discuss best practices for employment services for the SMI population. This will provide an opportunity for advocacy and promotion of competitive job development strategies, using IPS evidenced based approaches, for all mental health clients in the state.

b. **Create a Welcoming Environment:** ACBH Vocational Services strives to create a welcoming environment and promote the idea that work supports recovery. Pre-COVID, ACVP would host annual gatherings with program participants, mental health workers and natural supports 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, catered lunch, raffle prizes, and inspiration stations are all typically 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 21/22 challenges: Maintaining adequate staffing levels continues to be a universal challenge across our system of care. As of FY end, 10 out of 19 (over 50%) direct service and supervisory permanent positions in ACVP were vacant. Of these 10 vacant positions, the unit was able to utilize non-permanent employees from the HRS "TAP" (Temporary Assingment Pool), Provisional, Retiree-Annuitant, and Clinical Intern groups while the parallel civil service process for hiring permanent employees advanced. In addition to this, the ongoing effects of COVID have also negatively affected service penetration rates among referring partner programs, as the general focus on employment and education as a key intervention and service has diminished with many case managment services being offered on the phone and clients having more concerns of leaving their homes and getting infected.

Is anyone better off?

V. FY 21/22 Client Impact: On a monthly average ACVP has a 38% job placement rate (up from 28% prior year). Competitive employment rate percentage is the number of clients in the IPS program who worked a competitive job in the community (monthly average working n=42) divided by the total number of people in the IPS program (monthly average n=112). Benchmarks set by the Westat IPS Collaborative include 30% fair standard, 40% good standard, and 50% exemplary standard. ACVP helped consumers start 95 new jobs during the FY 21/22 as well as maintain 49 positions with existing employers, for a total of 144 jobs (see list of employers and positions at the end of report).

VI. FY 21/22 Additional Information: N/A

VII. FY 22/23 Projections of Clients to be Served: ACVP is projected to serve 280+ clients in FY22/23. In July 2022, 112 unique clients were served. On average over the past 6 months, there have been 10 new enrollments each month (projected enrollments: 11 months remaining x 10 enrollments = 110). In addition, ACVP anticipates hiring 2 vacant ES positions, increasing capacity for at least 60 more clients. Total projected: 112 served + 110 new enrollments + 60 additional ES capacity =282.

VIII. FY 22/23 Programs or Service Changes: ACVP hopes to fully staff all direct service vacancies by FY3Q and introduce services into the ACBH Substance Use Disorder (SUD) system of Care and within the ACBH Specialty Mental Health Forensic Division, and to expand service capacity into the supported housing programs under Health Care Services Agency. Certain partner providers have also demonstrated high levels of interest and demand for service – For example, the Lifelong Supported Housing program has generated enough interest and potential client pipeline to justify assigning two employment specialists to the program, doubling capacity from serving 10 to 20 at any given time. There are also plans to coordinate "Kick-off," lunchtime, events at all partnering teams to boost enthusiasm of going to work or school among clients and referring clinicians.

ACVP Program Participants' Employers

7-ELEVEN
99 CENT STORES
ABC SECURITY INC
ABILITY NOW BAY AREA
ABSOLUTE PLUMBLING & DRAIN
AC TRANSIT
AIRPORT TERMINAL SERVICES
ALL WAYS CARING
ALLEY KITCHENS
AMAZON
AMC BAY STREET MOVIE THEATERS
ANIMAL INTERNAL MEDICINE & SPECIALTY SERVICES
ARAMARK
BAY TUBE & MACHINING
BC FORWARD
BERKELEY BOWL
BEST BUY
BETTY'S PIER 29 RESTURANT
BJ'S RESTAURANT
BLOCK BY BLOCK PROGRAM
BLUE CREW
BURGER KING
BURLINGTON COAT FACTORY
CABULANCE COMFORT
CHAWK TECHNOLOGY
CHILI'S RESTAURANT
CHUCK E. CHEESE
CITY OF OAKLAND
CONTEMPORARY SERVICES CORP
COSTCO
DD RETAIL STORE
DIABLO CAR WASH
DNA PIZZA
DOLLAR TREE
DOMINOS PIZZA
DOWNTOWN TOYOTA
EMERALD PACKAGING
E-WASTE & SOLAR RECYCLING CENTER
FAMILY SUPPORTIVE HOUSING, INC
FEDERAL EXPRESS
FELTON INSTITUTE
FIVE GUYS BURGERS AND FRIES
FRED'S FLOWERS
FRONT ROW DISPLAY
GLS WAREHOUSE
GOODWILL
GROCERY OUTLET
HENRY MILLER
HOME DEPOT
HOMESTEAD SENIOR CARE
IN-N-OUT BURGER
JERRY HO'S MEAT COMPANY
JIFFY LUBE
JUN HAUNG COMPANY
K&G FASHION SUPERSTORE
KENTUCKY FRIED CHICKEN
KINETIC EVENTS
LANDMARK EVENT SERVICES
LAUNDRY LAND
LITTLE CEASARS PIZZA
MACY'S
MCDONALD'S
MEAT COMPANY INC
MERRILL GARDENS
MICHAEL'S
NEW OAKLAND PHARMACY #1
OAKLAND UNIFIED SCHOOL DISTRICT
OD SIGNS
PALAMERICAN SECURITY SERVICES
PAPASAN ROLLS AND BOWLS
PARTNER'S PERSONNEL AGENCY
PARTY CITY
PET SMART
PHO TY #1
PORT OF OAKLAND
PORTRAYOU PHOTOGRAPHY
PUP TOWN DOG DAYCARE & BOARDING
RAGO & SONS METAL STAMPING
RAHI SYSTEMS
RAINBOW FASHION
REGAL THEATERS
RGIS INVENTORY
RICH CITY RIDES
ROSS DRESS FOR LESS
SAFEWAY
SALLY BEAUTY SUPPLY
SALLY'S PEER RESPITE HOME
SALVATION ARMY
SECURITY EYE PATROL
SHAKE SHACK
SIDESTREET PHO
SIGNWORKS OF AMERICA
SMART AND FINAL
SONIC DRIVE IN
SUBWAY
TARGET
TESLA MOTORS
THE CANTEEN RESTAURANT
THE EDUCATION TEAM
THE ORIGINAL MEL'S DINER
TIRE CHOICE
TJ MAXX
TRADER JOES
U-HAUL
UNDER ONE WOOF
UPS
USPS
VECTOR MARKETING
WALMART
WESTEC PLASTICS CORPORATION
WILD CAT CONSULTING
WINDSOR POST ACUTE CARE CENTER OF HAYWARD
YOUNG'S AUTOMOTIVE

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 20

PROVIDER NAME: Bonita House

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

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

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

How Much Did We Do?

I. FY 21/22:

a. **Number of Unique Members Served:** 8.

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

a. **Reduce Mental Health Stigma:** Psychoeducation to inform members and/or family members to decrease stigma. Psychoeducation to employers to foster an inclusive environment for potential candidates/members.
b. **Create a Welcoming Environment:** Good communication and meeting members where they are, finding out what the member's needs are, helping to develop skills for members to be better equipped for employment.

III. Language Capacity for this Program: English

IV. FY 21/22 challenges: Supported Independent Living Program (SIL) could better integrate employments services and IPS principles into program. There has been much turnover in staff and the IPS provider is constantly working to reduce stigma around staff's perceptions of who is "ready" to work; more education needed for the team to udnerstand the "zero exclusions" principle of IPS. Referrals from team, need more vetting of appropriate candidates for the IPS program; staff need to make sure that the members are aware of the referrals being made and are motivated to obtain secure work. Better communication between SIL staff and IPS staff to encourage collaborative efforts in helping members to reach employment goals.

Is anyone better off?

V. FY 21/22 Member Impact: One member secured work, working two jobs and transitioned from IPS caseload; due to scheduling and inactivity with IPS staff. Two other members were able to secure work while recieving support from IPS. IPS is impactful to those participants who are actively engaged and also proactive in job search independently.

VI. FY 21/22 Additional Information: IPS steering committee and workgroup needed to understand and/or develop ways to better integrate IPS work into programs. Need more intentional collaborative efforts between upper management and IPS department to build/develop IPS program.

VII. FY 22/23 Projections of Members to be Served: SIL is currently at capacity, need more movement of participants through IPS to allow room for larger capacity. May need to hire additional support with IPS to elicit more interest in the program and increase capacity.

VIII. FY 22/23 Programs or Service Changes: N/A

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 20

PROVIDER NAME: Center for Independent Living (CIL)

PROGRAM NAME: Individual Placement Services (IPS)

Program Description: Work incentives, benefits counseling. By working collaboratively with the ACBH Vocational Program, we offer training and technical support resources, training events, strategize

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

How Much Did We Do?

I. FY 21/22:

a. **Number of Unique Clients Served:** 56. Cost per client: $1,141

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

a. **Reduce Mental Health Stigma:** CIL is an independent living center whose "programs provide people with skills, knowledge and resources that empower them to eliminate damaging and stereotypical notions of disability so that they can strive toward reaching their full human potential." In this contract with ACBHC, we assist people with mental disabilities obtain knowledge about Social Security disability work incentives that can help them improve their financial well-being, protect their necessary public benefits, and build self-confidence.
b. **Create a Welcoming Environment:** The CIL Work Incentive Benefits Counselor provides friendly and welcoming services. The counselor provides information about Social Security work incentives and rules and can meet multiple times with the consumer if needed. We believe each person is their own best decision-maker, so do not dictate what consumers should do, but provide information, resources and support to them. A consumer can have an in-office appointment with the WIB counselor or meet via phone or video, whichever is their preference.

III. Language Capacity for this Program: Although all services were provided in English, CIL's Work Incentive Benefits counselor can utilize Language Line to provide support in multiple languages. The counselor can also provide links to and/or copies of Work Incentive benefits information in Spanish.

IV. FY 21/22 challenges: The ongoing pandemic has continued to impact the numbers of IPS program participants actively seeking employment in 21-22 and the varying degrees of social-distancing protocols throughout the year have also impacted the numbers of in-person service provision.

The numbers and program were also affected by Geoff Evans leaving his WIB position at CIL in mid-April for another position within ACBHC. Robin Earth, a CIL program manager, took over Geoff Evan's position, on a temporary basis, while CIL searched to hire a new WIB counselor for the ACBHS position. The hiring search was challenging and took longer than expected due to the pandemic and due to the specific skills required for this position. CIL hired a new WIB counselor, Caolan Hyland, for this ACBHC contract position in July. (Robin is currently assisting Caolan during this transition period.) The quarterly numbers decreased in

the 4th quarter, as well as the number of contacts with wellness centers, due to the loss of WIB counselor Geoff Evans and the length of time required to hire a new WIB counselor.

Is anyone better off?

V. FY 21/22 Client Impact: While significant numbers of participants are engaged in employment, all participants who have received Work Incentives Benefits Counseling have learned important information about how Social Security Disability benefits and Medi-Cal programs function and learned the rules and regulations surrounding earned income, asset limits, best practices for reporting income and asset management strategies. These learned skills are important for navigating the interface between employment and benefits and help to reduce a reluctance to pursue employment due to fear of losing benefits, and encourage confidence towards building an increased independence and ability to manage personal responsibilities.

Here are 2 typical outcomes of WIBC services:
A participant who was not working yet was referred to the WIB program by an Employment counselor from one of the wellness centers. He had SSI and Medi-Cal and was thinking about working, and was worried about possibly losing his SSI and Medi-Cal if he worked. I (Robin Earth) informed him that approximately only half of his monthly earnings would be deducted from his SSI monthly payment, the importance of reporting to SSA when you start or stop work and the amount of monthly earnings by the 6th of each month, how to do report earnings, and that he ultimately would have a combined higher total income. I also informed him that his Medi-Cal could continue under 1619b if his SSI payment went to zero due to work earnings, as long as he still had the same medical condition, and kept his resources under $2000. I let him know that he could contact me again if he had questions. Although he said he was only at the "gathering information" point, and wasn't sure yet about working, he said the information was helpful, especially about Medi-Cal. He also knew he could contact me again if he had more questions. A participant was working part-time, and wanted to know how many more hours he could work before his SSDI benefits would be affected. He did not want to lose his benefits. He had already used all his Trial Work Period. I informed him that the 2022 SGA limit was $1,350 and that as long as he stayed under SGA, and was still medically eligible, his benefits should continue. I also informed him about the "Expedited Reinstatement" 5-year safety net, for recipients who lose their benefits due to earnings above SGA, and then have to stop working or work less due to the same impairment. I also informed him about best ways of reporting his monthly earnings to SSA. The outcome is that he became more knowledgeable about the SGA limit and reporting his earnings to SSA to avoid overpayments, which will allow him to better determine whether and how much to increase his work hours.

VI. FY 21/22 Additional Information: The CIL does not yet capture client demographic information for the ACHC position. We plan to start collecting this information for 22/23.

VII. FY 22/23 Projections of Clients to be Served: We expect the numbers of clients to be served in 2022-2023 to increase, and project between 75-100 unduplicated clients. Due to the ongoing changing nature of the COVID-19 pandemic and its impacts on economics, jobs, social distancing protocols, housing stability and availability, etc., it is difficult to be certain of how things will unfold**.**

VIII. FY 22/23 Programs or Service Changes: Caolan Hyland was hired in July 2022 as the new Work Incentives Benefits counselor for the ACBH contract. Robin Earth is still the contact at this time.

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 21/22:

a. **Number of Unique Clients Served:** 37. **Cost per client:** $41,088

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

a. **Reduce Mental Health Stigma:** By normalizing their experiences by letting them grow in an environment where they are not alone. Allowing them to make mistakes and assisting them with making better choices.
b. **Create a Welcoming Environment:** In a residential setting we create a mini family where they can ask peers as well as staff for support.

III. Language Capacity for this Program: Spanish and English.

IV. FY 21/22 challenges: We are facing challenges in keeping the youth engaged in daily group. When they begin to spiral into their symptoms it becomes extremely hard getting them to re-engage in treatment. We have tried to send them to the CRT for stabilization, unfortunately we are unable to hold their beds for the 30 days that they need to stabilize.

Is anyone better off?

V. FY 21/22 Client Impact: Being in a therapeutic environment where they can experience their mental health symptoms and get help in the moment has been very useful for our clients to the point where

they are doing better at Refuge then they have at any placement that they have in the past. A lot of clients return to visit or even be readmitted.

VI. FY 21/22 Additional Information: We are grateful for our outsider Provider teams.

VII. FY 22/23 Projections of Clients to be Served: We hope to serve 40 clients.

VIII. FY 22/23 Programs or Service Changes: CalAim is making adjustments to all programs in the state of California.

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 21/22:

a. **Number of Unique Clients Served:** 49. **Cost per client:** $7,467

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

a. **Reduce Mental Health Stigma:** The Schreiber Center works to reduce mental health stigma by regularly partnering with other departments, providers, care staff, and family members to collaborate, consult, and provide education on mental health symptoms and presentations, specifically in the IDD population. The Schreiber team participates in the Health and Wellness Committee within the Developmental Disabilities Council of Alameda County to help support and promote mental health services for the IDD population.
b. **Create a Welcoming Environment:** We provide a welcoming environment by greeting our clients in the front reception area and escorting them to our meeting rooms when sessions are in person. For telehealth services we provide support and assistance for clients to navigate entrance into our virtual meeting rooms and we collaborate with clients on ensuring their home environments have the privacy and comfort necessary to be able to participate freely in sessions.

III. Language Capacity for this Program: Schreiber Center utilizes translation services offered by ACBH. Due to the precautions taken related to the ongoing COVID-19 pandemic, ongoing clients are receiving services telephonically, in which case a translator is available by phone if needed. The Schreiber Psychiatrist is bilingual in English and Spanish.

IV. FY 21/22 challenges: Schreiber Center has been and continues to be impacted by COVID-19 in that clients are receiving telehealth, to ensure the safety and health of both clients and staff. During this FY;

however, new intakes have transitioned to in person, with safety precautions in place. During this FY a change in clerical support took place and now Schreiber is fully staffed, with necessary clerical support in place.

Is anyone better off?

V. FY 21/22 Client Impact: Schreiber Center clients are noted to benefit from services anecdotally as well as evidenced by improvements in measurable treatment results. Our clients who engage in our mental health counseling are offered skills to help prevent future mental health distress and crises and report benefiting from our services. Schreiber clients report developing personal insight into their diagnosis and often improve relational and life skills. Our interventions also are noted to increase feelings of hope and resiliency. Schreiber also collaborates with other parts of our system and this benefits clients who may have an intellectual or developmental disability and are receiving services in other areas of our system.

VI. FY 21/22 Additional Information: As mentioned previously in this report, Schreiber is impacted by the ongoing COVID-19 pandemic and continues to provide primary telehealth services, although new intake appointments re in person, with necessary safety precautions in place.

VII. FY 22/23 Projections of Clients to be Served: The Schreiber Center continues to be impacted by the COVID-19 pandemic and is providing telehealth services to ongoing clients. With the easing of the pandemic restrictions during this FY we have been able to schedule new intake appointments in the clinic, which ensures a comprehensive assessment. We also plan to continue to expand in-person services throughout the next FY year. During this FY we have been able to review and address all wait list referrals in a timely manner. We anticipate providing services to at least 60 clients during the next FY.

VIII. FY 22/23 Programs 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: Alameda County Health Care for the Homeless (ACHCH)/LifeLong Medical Care

PROGRAM NAME: Behavioral Health - Primary Care Integration Project: TRUST Clinic

Program Description: The TRUST Clinic is a multi-service clinic designed to improve the health status of people who are homeless, including providing assistance with housing and income supports.

Target Population: Homeless, low-income adults, with chronic mental and physical health disabilities and/or clients of an Alameda County Behavioral Health Care service team; and not currently engaged in primary care elsewhere or have would be better served by the integrated primary care at the Trust Clinic.

How Much Did We Do?

I. FY 21/22:

a. **Number of Unique Clients Served:** 1,516. **Cost per client:** $1,418

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 low barrier walk-in and scheduled care.
b. **Create a Welcoming Environment:** The Trust Clinic provides a welcoming environment by offering the following:
   - Accessible location, near public transit.
   - Walk-in appointment availability.
   - Health coaches available to support patients with non-medical needs, e.g., case management, food assistance.
   - Behavioral health clinicians available in the primary care setting.

   The Trust Clinic staff works closely with Street Health Outreach teams that proactively support patients with navigation and accessing care at the clinic; these are patients who have unmet physical and mental health needs, and who are residing in encampments and other unsheltered settings.

III. Language Capacity for this Program: The TRUST Clinic has staff who are fluent in English and Spanish. For individuals with other translation needs, TRUST utilizes a language line to ensure language needs are not a barrier to services.

IV. FY 21/22 challenges:
Staff retention, turnover. Trust Clinic staff turnover and retention continues to be a challenge; LifeLong Medical Care as a non-profit community health center has to compete for staff in the current competitive health care job market. LifeLong is constantly filling vacancies due to retirements, and staff leaving for other higher paying, less stressful positions. The most recent staff who have left have take postions at Kaiser and Children's Hospital.

Community violence. Ongoing violence occurs in the downtown Oakland area. In November 2021 next to the Trust Clinic, a KRON4 security guard was fatally shot. The following month, two cars raced down 14th Street, with the drivers shooting at each other in front of the Trust Clinic, traumatizing both patients and staff. A separate, unrelated shooting resulted in a a bullet hole in an ACHCH office window. Staff continue to receive threats, and cars are broken into. While these events are not daily, they occur often enough to create a high level of stress for everyone. As a precaution, LifeLong installed a bulletproof barrier around the perimeter of the clinic.

Continued need to social distance due to COVID-19. Trust Clinic patients have to wait outside, with the waiting room and showers continuing to be closed off due to COVID-19 precautions. During 2021-22, LifeLong began allowing more people into the clinic at one time, although there continue to be lines outside. ACHCH is working with LifeLong to support expanded capacity to see more patients, i.e., adding an exam room, opening more offices for patient visits. Additionally, patients are also seen via telehealth for behavioral health visits.

Is anyone better off?

V. FY 21/22 Client Impact:
COVID-19 Response: LifeLong Trust Clinic leadership and staff collaborate closely with ACHCH and continue to be on the forefront of providing COVID-19 vaccines, testing and referrals to isolation/quarantine for people experiencing homelessness.

SUD Services. This year, LifeLong expanded Medication Assisted Treatment (MAT) for substance use services onsite, and how has a staff team of social workers to support patients with SUD services.

Clinic Services: In FY21-22 TRUST served 1,516 patients, providing 18,607 visits including 9,877 enabling services. One notable area of success was the addition of new staff positions to expand MAT and SUD services.

Patient Story: The collaboration between behavioral health and primary medical care continues to be critical for patients seeking care at the Trust Clinic. In the spring of 2022, a 52-year-old Latinx woman with a history of Opioid Use Disorder- in remission and stable on Buprenorphine, Major Depressive Disorder, Post Traumatic Stress Disorder and Hypertension complained of bugs living in her ear that would crawl out at night and bite her. She first reported this to her psychiatrist during a telemedicine visit. She denied self-harming to remove the bugs and denied methamphetamine use. The psychiatrist connected her to a walk-in appointment with a PCP the next day to rule out possible infection vs. delusional parasitosis. She was seen the next day and given Ivermectin to treat a possible scabies infestation, although no bugs were observed. The treatment was unsuccessful, and the patient reported that her hair was now falling out due to the bugs.

The case was presented at the TRUST Clinic weekly case conference during which best practices for the treatment of delusional parasitosis was discussed and an integrated approach to treating this patient was developed. This included a co-visit with her psychiatrist and PCP. At this visit, her urine drug screen tested positive for methamphetamine. She was provided with psycho-education about methamphetamine use and harm reduction practices. She agreed to a referral to a TRUST Clinic recovery counselor specialist for therapy. During the physical exam, a video camera was used so she could see inside her ears, and she agreed that she did not see any bugs. It was noted that one ear drum was ruptured and she was referred to an ear, nose and throat specialist. She agreed to monthly co-visits with her psychiatrist and PCP.

VI. FY 21/22 Additional Information: N/A

VII. FY 22/23 Projections of Clients to be Served: 1,800

VIII. FY 22/23 Programs or Service Changes: Modification of the Trust Clinic facility to increase the number of patients who can be seen; ACHCH and LifeLong are working with GSA to convert one of the clinic rooms into another medical exam room which will allow providers to see more patients; construction to be completed in September 2022. We want to increase in COVID-19 vaccination rates, with less need for vaccination-related visits for Trust patients and community members. We also hope to increase in SUD services.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 25

PROVIDER NAME: Alameda Health Consortium (AHC)

PROGRAM NAME: Pediatric Care Coordination Pilot

Program Description: In FY 21/22 ACBH began supporting an 18-month pilot to introduce care coordination activities for the pediatric systems within eight local Federally Qualified Health Centers (FQHCs) in Alameda County. Each FQHC will hire 1 care coordinator (8 care coordinators in total). The Pediatric Care Coordinator will be responsible for linking pediatric clients to medical, behavioral, and social services in a preventative and comprehensive manner. This position will act as the liaison between the client and the community, and will serve to dissolve the silos between the Medical and Behavioral Health departments within the FQHCs. This role will also work to support young clients with the basic health and social needs to minimize their risks for entering the criminal justice system as adults. The AHC will serve as the centralized hub for these care coordinators, providing technical assistance, peergroup formation, and problem-solving for the duration of this program. Furthermore, AHC will embed a process and outcome evaluation to assess impact, effectiveness, and long-term potential of the Pediatric Care Coordinator Program.

Target Population: Clients of the Federally Qualified Health Centers (FQHCs) that are 0-18 yrs of age.

How Much Did We Do?

I. FY 21/22:

a. **Number of Unique Clients Served:**
   - Number of unique young clients and families attempted to reach for establishing care and being enrolled in wrap-around preventive services: **5,502**
   - Number of young clients receive universal Behavioral Health, trauma, and/or pediatric screenings: **3,426**
   - Number of young clients who have experienced adverse childhood experiences (ACEs) referred to appropriate follow-up resources: **1,250**
   - **ACBH portion of program budget:** $100,000

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

a. **Reduce Mental Health Stigma:** Our team of Pediatric Care Coordinators (PCCs) are key in reducing mental health stigma for their pediatric clients and their families. The PCCs are situated between primary care settings and behavioral health settings, often managing the warm hand-offs between departments and facilitating conversations around clients' mental health needs. The PCCs have been trained in addressing sensitive mental health topics, providing appropriate behavioral health resources and support, and practicing cultural humility when supporting their clients' mental health. Alameda Health Consortium also connected the PCCs to the following mental health-related trainings:
   1. ACEs/PEARLS training with Dr. Dayna Long and Artanesha Jackson

2. Behavioral Health Landscape Overview with Sun Hyung Lee and Christine Mukai from Alameda County Behavioral Health
3. Training on having difficult conversations with Shoshana Rosenberg, LCSW at LifeLong Medical Care
4. Meeting and Greet with Dr. Madeline Lansky, Pediatric Psychiatry Consultant, PCPCP Team (Primary Care Psychiatry Consultation Program) with Alameda County Behavioral Health Care Services

b. **Create a Welcoming Environment:** Our team of PCCs have been dedicated to creating welcoming environments and building trusting relationships with their clients and families. In addition to learning how to navigate conversations around difficult topics, below are a few actions our PCCs have taken in creating welcoming environments for their clients:
   1. Modifying the office space and adding with children-friendly decorations
   2. Greeting pediatric clients and families at the clinic with goody bags, stickers, and books
   3. Clearly communicating plans with clients and families ahead of appointments, ensuring that they are prepared and comfortable
   4. Writing letters to clients that summarize care plans and next steps in their primary language
   5. Joining phone calls between clients and external organizations in order to advocate for the clients' needs, provide translation if needed, and support the clients through the conversation

III. Language Capacity for this Program: A majority of our PCCs speak multiple languages including Spanish, Cantonese, and Mandarin.

IV. FY 21/22 challenges: Data reporting was a challenge during FY21/22. Given that the PCCs were a new role at the clinics, the clinics experienced delays in implementing new referral and data collection workflows. By the end of FY22/22, almost all of the clinics had finalized their workflows and are now able to automatically collect data for quarterly reports. The COVID-19 pandemic also proved to be a challenge in FY21/22. Some health centers expressed challenges in hiring their PCC given that the recruitment phase occurred virtually. Some health centers also experienced staff shortages and/or limited staff capacity, causing greater delays in data reporting and recruitment. Alameda Health Consortium provided support during this time through check-ins with clinic supervisors, data teams, and the PCCs.

Is anyone better off?

V. FY 21/22 Client Impact: Our team has continued to hear about the positive impact the PCCs are making on their clients and families. Below are two brief examples of positive client interactions with two of the PCCs:

A 7-year-old patient with a Spanish monolingual family has had an extended unmet need for speech therapy. It has been very challenging for the mother to navigate and advocate for her son. With the PCC's support, the patient is now receiving regular speech therapy at school. The client's mother is very happy and found the PCC's support to be very helpful. The patient is now on his way to more functional communication skills.

A PCC worked with patient & four other family members in a 1-month span. This referral brought access to dental, medical, covid vaccines, as well as navigation support for speech delay & disability insurance for patient, parents, and two older siblings. The client's mother expressed appreciation for PCC's

assistance, guidance, and time. The mother stated that the PCC made her feel comfortable & supported throughout the process, which is why she thought of contacting PCC first if she any medical or community services questions

VI. FY 21/22 Additional Information: The Pediatric Care Coordinator Pilot was a success in FY21/22. All health centers retained their PCCs through the fiscal year. The providers themselves also shared that their PCCs have started to improve the ways in which they provide pediatric care at the clinics. One provider shared, “Our Pediatric Care Coordinator has been an angel sent to us. Their efforts have been noticed and appreciated by the other staff. I can't describe how much of a huge help they have been. They stepped up to the plate and started running.”

VII. FY 22/23 Projections of Clients to be Served: The PCCs are currently at capacity while taking on increasingly complex cases as they’ve become more established at the clinics. As a result, we expect caseloads to stay consistent with what we saw near the end of FY21/22. We hope to see increases in the number of referrals for clients that screen positively for ACEs given that more clinics have started to incorporate their PCCs into their ACEs screening workflows.

VIII. FY 22/23 Programs or Service Changes: In addition to adding three Pediatric Care Coordinators to the Pediatric Care Coordinator cohort, the Alameda Health Consortium team will be implementing new data reporting strategies and metrics to ensure that the pilot’s impact is clearly communicated in future quarterly reports. Each health center will be receiving the same template to fill out each quarter, which will ensure that data teams are reporting the same numbers in the same way. Additions to quarterly reports will also include the following:

- Total amount of time the Pediatric Care Coordinators spend with patients
- Patient success stories written by the Pediatric Care Coordinators
- Provider satisfaction surveys (collected every other quarter)

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 25

PROVIDER NAME: Multiple Federally Qualified Health Centers (FQHCs)- Asian Health Services (AHS)

PROGRAM NAME: Behavioral Health - Primary Care Integration Project: Care Coordination

Program Description: To serve AAPI community with mental health services within Asian Health Services and utilizing outside community resources. We strive to connect patients with their individual mental health needs.

Target Population: Our target population is all ages. However, our Adult Care Coordinator is focused on Adult ages 22 to older adults.

How Much Did We Do?

I. FY 21/22:

a. **Number of Unique Clients Served:** 689. ACBH portion of total program budget: $101,275

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

a. **Reduce Mental Health Stigma:** Our Adult care coordinator addresses patients with a non-judgmental approach, ask open ended questions, informs patients she is here to support them in connecting them to mental health resources and provides an open-door policy for any questions or concerns. Also, provides mental health education and explains the different type of therapeutic services such as a therapist or case manager. If needed, the care coordinator will refer patients to the Psych NP or to AHS Specialty Mental Health Dept.
b. **Create a Welcoming Environment:** When calling patients, our care coordinator begins with a welcoming introduction by introducing herself and the reasons for calling. In addition, the care coordinator provides background information on where and who wants to provide additional mental health resources. After the initial introduction, the care coordinator will provide the patient with a follow-up call and check in to make sure they are connected with resources or need any additional support.

III. Language Capacity for this Program: Our care coordinator is fluent in Cantonese, Mandarin and English. However, if the patient speaks another language, the care coordinator is able to access interpretation services.

IV. FY 21/22 challenges: Over the past year, there has been an increase in patient referrals and reduction in the no show rate. This has caused a challenge with providing appointments within 2 weeks and limited internal resources. Also, the external community resources for the AAPI population is very limited.

Is anyone better off?

V. FY 21/22 Client Impact: In response to the limited internal resources to provide mental health services, we have developed a triage system to address and prioritize the referrals based upon

Currently, our SMH dept has a long waiting list and the IBH dept is holding onto severe patient cases until the next opening. During the wait time, our IBH clinicians continue to see the patient with additional support by the Psych NP assessing for medication management. The care coordinate follows-up with SMH and advocates for the patient to be seen as soon as possible. In addition, the care coordinator works closely with the consulting psychiatrist, PCP and IBH clinician to ensure the patient is appropriate services during the wait time for SMH.

VI. FY 21/22 Additional Information: The care coordinator attends the monthly CHCN meetings to share resources with other care coordinators and attends trainings. Also, CHCN invites outside agencies to present other types of community-based programs and provides presentation by the different types of health care insurances.

VII. FY 22/23 Projections of Clients to be Served: Continue to serve the AAPI community with mental health services and triage patient referrals for timely access.

VIII. FY 22/23 Programs or Service Changes: Continue to hire on clinicians and/or PSYCH NP collaborate with SMH, and triage referrals to reduce wait times. In the past years, we have added group therapy and wish to continue with providing group therapy.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 25

PROVIDER NAME: Multiple Federally Qualified Health Centers (FQHCs)- Axis Community Health

PROGRAM NAME: Behavioral Health - Primary Care Integration Project: Care Coordination

Program Description: IBHCC provides warm hand offs, helps engage patients who have never received BH services before, and provides resources based on SDOH screening.

Target Population: Adults 18+

How Much Did We Do?

I. FY 21/22:

a. **Number of Unique Clients Served:** 867. ACBH portion of total program budget: $60,828

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

a. **Reduce Mental Health Stigma:** Having the position as part of an integrated care team helps to reduce stigma by providing ease of access via hand offs which gently introduces patients to the existence of BH services.
b. **Create a Welcoming Environment:** The IBHCC provides patient support through a nonjudgmental, peer-level advocate.

III. Language Capacity for this Program: English and Spanish.

IV. FY 21/22 challenges: System wide changes stemming from the pandemic, including telecommuting.

Is anyone better off?

V. FY 21/22 Client Impact: 50 year old woman and single mom of two was referred to IBHCC by a behavioral health clinician for housing, case management, and legal assistance following denial of disability. IBHCC helped patient obtain legal assistance and provided ongoing help with housing resources, including help with housing applications.

VI. FY 21/22 Additional Information: Care coordinators helped with the resource needs of patients by connecting with community programs, offered patients access to telehealth care by providing cell phones to patients in need which were provided by a grant, supported clinic fiscal goals by helping with clinician productivity by providing administrative support, and promoted pathways to care for all patients.

VII. FY 22/23 Projections of Clients to be Served: We expect to help increasing numbers of patients as individuals and families continue to be impacted by the socioeconomic aspects of the pandemic including job loss, changes in insurance, and the emotional impact of isolation due to quarantine and other factors.

VIII. FY 22/23 Programs or Service Changes: We have created a Lead Care Coordinator position to support care coordinators' access to promotion to support their career development.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 25

PROVIDER NAME: Axis Community Health

PROGRAM NAME: Behavioral Health - Primary Care Integration Project: Axis

Program Description: ACBH is supporting the startup of a Mental Health Urgent Care Service for East County/Tri-Valley residents through the use of MHSA one-time funds in Fiscal Year 2021/2022 with potential for additional funding in future fiscal years. The proposed Axis Community Health, Mental Health Urgent Care Center will be available to all members of the community, regardless of income or insurance status. Individuals and families with urgent mental health needs will be able to call for same-day appointments. During the COVID pandemic, mental health services will be provided via telehealth; long term plans will include a walk-in access point as well. The Axis MH Crisis Center will also serve as a central entry point for assessment, triage, treatment, and care coordination for individuals seeking mental health treatment, regardless of insurance type or status. Like a medical urgent care setting, the MH Urgent Care Center will provide assessment and timely connection to services in a setting that is less costly than an emergency department.

Target Population: Community members in need of urgent mental health care.

How Much Did We Do?

I. FY 21/22:

a. **Number of Unique Clients Served:** 563, ACBH portion of total program budget: $250,000

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

a. **Reduce Mental Health Stigma:** This program reduces stigma by providing urgent mental health to all community members regardless of their insurance or ability to pay. Anyone is able to call into the urgent care line for themselves or family members ages 5+. We are able to assist pts in obtaining services they might otherwise be hesitant to seek out and/or have had difficulty connecting with in the past.
b. **Create a Welcoming Environment:** Our care coordinator is available to answer the phone all day within program hours. It is the same person answering the phone during program hours and patients will meet with the same therapist over their time in Bridge. We make an effort to keep in frequent contact with the patient and follow up with them even if they don't show up for appointments. We offer both telehealth and in-person visits. An effort is made to express to each and every caller that we are here to assist with their mental health needs and provide immediate care. We have received numerous positive compliments from patients about how much they appreciate the service. Valley Care hospital can send us direct referral via EPIC which allows us to outreach to patients directly following their ER stay which removes the task of them needing to call us in the first place.

III. Language Capacity for this Program: English only at this time due to provider availability. Looking to expand to Spanish next year.

IV. FY 21/22 challenges: Staffing shortages were difficult this year, but luckily we were able to replace open positions failry quickly and leverage IBH providers to assist in providing coverage so there weren't any gaps in treatment provided.
Marketing has been somewhat difficult also given that most organizations are communicating remotely. Programs tend to send a lot of referrals all at once and then wean off over time.

Is anyone better off?

V. FY 21/22 Client Impact: All of the following patients received care coordiation that included referral for longer-term care, but also housing, financial, legal, food, insurance, etc referrals/resources. Patients also received individual therapy, some participated in family therapy and most met with the psychiatrist also.

- 39 y/o male experiencing auditory hallucinations seeking support to treat symptoms and re-engage with his family and community; was able to receive injectable anti-psychotic which helped to stabilize symptoms and increase participation in services.
- 27 y/o male referred to Axis by the ED after several visits for anxiety, and we linked to health insurance, mental health treatment other community resources;
- 53 y/o male struggling as a result of his mom's depression, as well as his own mental health struggles completed mental health sessions and received psychiatry services;
- 38 y/o female struggling with crippling anxiety;
- 69 y/o female, presenting with cognitive disorganization, depression and anxiety, resulting in a leave from work and exacerbating symptoms benefitted from counseling and psychiatry;
- 16 y/o female, marijuana abuse, school disciplinary issues, and high family conflict;
- 59 y/o female, history of severe substance use, high level of paranoia, danger to self, and delusional thought patterns benefitting from counseling and psychiatry.

VI. FY 21/22 Additional Information: N/A

VII. FY 22/23 Projections of Clients to be Served: 700

VIII. FY 22/23 Programs or Service Changes: Next year we plan to expand service into Castro Valley and increase marketing in the Tri-Valley. We also plan to expand the program staffing by almost double given incoming federal funds.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 25

PROVIDER NAME: Multiple Federally Qualified Health Centers (FQHCs)- Bay Area Community Health (BACH)

PROGRAM NAME: Behavioral Health - Primary Care Integration Project: Care Coordination

Program Description: Provide Behavioral Health Support and Care to All Bay Area Community Health (BACH) Behavioral Health Patients focused on increasing patient centered care coordination across multiple departments and programs.

Target Population: Mild to Moderate Outpatient Behavioral Health Treatment

How Much Did We Do?

I. FY 21/22:

a. **Number of Unique Clients Served:** 2,023. ACBH portion of total program budget: 124,407

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

a. **Reduce Mental Health Stigma:** We are focused on reducing barriers to treatment and welcome all referrals to BH and let our BH Providers determine if the person is a good fit for continued treatment. Also working with Eric Yuan regarding an innovative program to refer AAPI patients to BH through our Acupuncture Department.
b. **Create a Welcoming Environment:** BACH utilizes the GUEST model where we are focused on providing an empathetic, attentive, equity driven, and compassionate approach to the care of all of our patients at BACH.

III. Language Capacity for this Program: English, Mandarin, and Spanish speaking BH Providers. We also utilize Translation services to provide therapy in any other languages. We do not let language serve as a barrier to administering BH services.

IV. FY 21/22 challenges: We continue to have a waitlist and conitnue to focus greatly on hiring and retention as a method to reduce time on waitlist and to reduce time between scheduled follow up appointments.

Is anyone better off?

V. FY 21/22 Client Impact: We had more than 10,990 unique patient touches in the 2021 and 2022 year. We connected over 2,000 unique patients to our BH Services. We continue to expand and grow our BH services heading into the 2022/2023 year.

VI. FY 21/22 Additional Information: With the ongoing pandemic, and to meet our hiring goals, BACH has begun implementing more tele-therapy services in order to meet the needs of our patient population and to increase access to behavioral health services.

VII. FY 22/23 Projections of Clients to be Served: Our current goal is to reach 2,287 unique behavioral health patients in the 2022/2023 service year.

VIII. FY 22/23 Programs or Service Changes: We have hired two remote behavioral health providers Suelen Yancor, LCSW, and Perla De La Torre, LCSW. Both providers are Spanish speaking and are helping reach our Spanish speaking populations. We also lost one behavioral health provider, Senaida Rangel, LCSW, due to her receiving a promotion at her other job.

We are continuing to focus on reducing our waitlist by hiring more behavioral health providers. We see this as an access to care issue and are also putting a greater emphasis on a brief intervention model of 18 sessions, but still do offer longer length of treatment for those who need it.

We are also anticipating the start date for Darnell Nash, LCSW, who will be working primarily for our HIV and Transvision teams. Darnell is currently licensed in another state and he is working toward his CA licensure at this time and will start once that process is completed.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 25

PROVIDER NAME: Fremont-PATH/Bay Area Community Health

PROGRAM NAME: Behavioral Health - Primary Care Integration Project: Fremont

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

Target Population: PATH services are offered to all adults (18-59) and older adults (60+) assigned to the service team at the support center.

How Much Did We Do?

I. FY 21/22:

a. **Number of Unique Clients Served:** 147, ACBH portion of total program budget: $111,537

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

a. **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.

b. **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. FY 21/22 challenges: The COVID-19 pandemic. We continue to adjust 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 21/22 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 client's 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 21/22 Additional Information: N/A

VII. FY 22/23 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 10 patients scheduled per clinic.

VIII. FY 22/23 Programs or Service Changes: There have been no changes since July of 2021.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 25

PROVIDER NAME: Multiple Federally Qualified Health Centers (FQHCs)- La Clinica de la Raza

PROGRAM NAME: Behavioral Health - Primary Care Integration Project: Care Coordination

Program Description: Integrated Behavioral Health Care Coordination program connects the clients to appropriate resources who are not accessing services in an efficient manner. The program identifies and remove barriers to improve utilization of required primary care and referrals to specialists. The program facilitates care coordination so our clients can receive the services that includes screening, assessing and treating mild to moderate behavioral health conditions, and treating the chronic medical conditions of clients with moderate to severe behavioral illnesses. By keeping track of clients' medical records and clinic appointments, the Integrated Behavioral Health Care Coordination program improves accessibility for Behavioral health services for our clients who are experiencing difficulty in accessing and utilizing primary care and behavioral health care services. Alameda County Behavioral Health using Medi-Cal and Medicare funds currently funds the program. The program delivers care coordination services and connect behavioral health client to behavioral health providers to improve the life outcomes for the population served.

Target Population: Alameda County residents who have an annual income below 200 percent of Federal Poverty Level and have Medicare, Medi-Cal, or HealthPAC.

How Much Did We Do?

I. FY 21/22:

a. **Number of Unique Clients Served:** 724. ACBH portion of total program budget: 121,656

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

a. **Reduce Mental Health Stigma:** La Clinica reduces stigma by sharing with patients that mental health is a part of their physical health as well, and it is as important as physical health. La Clinica provides explanation about mental health, psychotherapy, psychiatry, cultural practices, and brief counseling to our clients that may already incorporated in their day-to-day routine. Providers also reassure patients that taking care of their mental health does not make them "odd". Our clients also receive the information about how insurance plans work for mental health services. At La Clinica, mental health services are part of primary care and we provide a compassionate and open space to our patients to ask questions, we listen to their challenges, asses their barriers and work with them to find solutions that is within their reach. La Clinica also assists clients with advocacy whenever possible.
b. **Create a Welcoming Environment:** La Clinica has created a welcoming environment for clients in several ways. Our staff members communicate with patients in Spanish and practice using translation services whenever needed to create smooth communication as possible. La Clinica provides cultural relevant examples of healing practices related to Latinx community. Our staff members approach patients with the upmost respect and provide support to them without judging their perspectives. La Clinica also make follow up phone calls with patients when

possible. Our providers, schedulers, and staff members are easily accessible to clients for communication as necessary.

III. Language Capacity for this Program: English and Spanish.

IV. FY 21/22 challenges: La Clínica's case managers continue facing challenges linking patients to mental health resources. There is a need for more coordination between providers and patients, which the Case Managers attempt to do, but it is challenging with the volume of clients they work with. Many providers also do not have availability, are not affordable to La Clínica's patient population, do not speak Spanish, or do not accept patients' insurance. In addition, many providers are only doing telehealth visits, but more families are requesting in-person care. Case Managers also have to differentiate between the types of services that are covered by insurance – for example, family therapy might not be covered even if it would be beneficial, though some providers may allow patients to have their families present. Nonetheless, La Clínica's Case Managers continue to look for resources and alternatives to meet the patients' needs and demand for these services.

Is anyone better off?

V. FY 21/22 Client Impact: La Clinica has shown patients that there are health resources available and ensured that patients know ways to get assistance. Patients have been linked to therapy services and other resources to help alleviate stress or social challenges. La Clinica helped patients acknowledging their power and ability to be safe and encourage them to take steps towards safety and wellbeing. Our services were also beneficial for our clients in Improving family relationships. Our clients expressed that they felt heard, respected and supported from La Clinica's providers and staff members. Furthermore, La Clinica made it possible for patients to access and receive mental health services that they had not been able to get on their own.

VI. FY 21/22 Additional Information: N/A

VII. FY 22/23 Projections of Clients to be Served: Deliver at least 100 care coordination services, per quarter, per IBHCC FTE, to eligible clients.

VIII. FY 22/23 Programs or Service Changes: Some of the case managers will be supporting the intern program by being mentors to BA interns this fall.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 25

PROVIDER NAME: The Alliance for Community Wellness dba La Familia Counseling Center/Early Childhood Integrated Program

PROGRAM NAME: Behavioral Health - Primary Care Integration Project: Silva Clinic

Program Description: Provide mental health services (i.e., screening, assessment, collateral, individual and group therapy, family engagement, individual and group rehabilitation, and plan development), crisis intervention, and case management/brokerage. Treatment includes additional Family Partner services. Providing specialized early childhood mental health services within the context of children's families/caretakers in the Central and South Alameda County area. Services range from very brief assessment to short-term treatment lasting typically from nine to 12 months in duration. The Integrated Health Program works in close collaboration with the client's pediatrician and medical support staff and shall provide primarily on-site, home-based or telehealth short-term services. In addition, clients may, when approved as clinically appropriate, continue to be seen within the program or by the Early Childhood Mental Health (ECMH) Program for longer-term services.

Target Population: Children, eight years of age or younger, with their families and or caregivers.

How Much Did We Do?

I. FY 21/22:

a. **Number of Unique Clients Served: Unduplicated:** 6, **Total clients served** 16. The issues with having reduced staff and the Pandemic affected our program this year. ACBH portion of total program budget: $88,708

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

a. **Reduce Mental Health Stigma:** Many clients/families are immigrants dealing with multiple traumas and seek help with managing their parenting with children that may have been traumatized as well. Therapists provide education on the impacts on children from these experiences and support the caregivers to understand and normalize both their own and the child's emotional reactions and behaviors. By holding a safe environment in which to explore their experiences the therapists and the Family Partner provide support and meaning to the family's lived experiences, which reduces concerns around mental health stigma.
b. **Create a Welcoming Environment:** The ECMH integrated – Silva Clinic program clinicians and Family Partner all speak Spanish and strive to connect with clients/families both through speaking their primary language and through having a relevant cultural perspective. As well, clinicians and the family partner work to meet the family in locations that work for the family, whether at their home, the office or out in the community.

III. Language Capacity for this Program: All of our clinicians and our Family Partner speak Spanish and English. Most of our clients are Spanish speaking and some families are Bilingual Spanish and English speaking. During this fiscal year we had 10 monolingual Spanish speaking families, and 6 Bilingual Spanish and English-speaking families.

IV. FY 21/22 challenges: The Pandemic continued throughout the year having an impact especially with in-person sessions and some challenges with collaboration with the pediatricians at the Silva Clinic. La Familia followed county guidelines around wearing masks and working offsite, and often met with families over on-line telehealth programs. The Silva Pediatric clinic also limited in person appointments and the clinicians were not meeting with clients/families at that location. Due to less in-person encounters, the warm hand-off's for introducing clients and families from the medical staff to the therapists did not happen. We still received referrals from the medical clinic, however the amount of referrals dropped off presumable due to the lack of in-person medical appointments with the pediatricians at the medical clinic.

Another challenge was engagement with families due to the manner of meeting young children on screen. Telehealth can work well for old children and families, however less so for younger children. Therapists continued to seek new ways of engaging a child on a screen for play therapy. And at times caregivers found it difficult to be available for sessions with the child due to burn-out from on-line school when the child no longer wanted to be present in front of a screen.

Illness was another barrier to services when many occurrences of clients, caregiver's and therapists being out due to illnesses that caused disruption in services.

Is anyone better off?

V. FY 21/22 Client Impact: Integrated Health Program: Contractor's Family Partners shall work within Contractor's programs to assist families in accessing needed services, promoting independence and building advocacy skills. Contractor's Family Partners shall collaborate with the primary mental health clinician to:

- Directly provide outpatient services;
- Promote access and linkages to services;
- Advocate with and on behalf of families;
- Assist families in increasing their support network;
- Provide mental health education and consultation to help families understand their role as their child's advocate and role model;
- Advocate for and champion family-driven practice;
- Act as a role model and mentor for parents whose children are receiving treatment services.

Our Family Partner submitted an example of her work with one of our clients and the family.

Example of Family Partner work: A mother of a 5-year-old client who was very anxious that her child learn and keep up with preschool on zoom during the Pandemic. This mother's expectations for her young child was to sit with full attention to learn her ABC's in front of a computer screen for the on-line preschool. Our Family Partner built rapport and supported the mother with her own anxiety around her child's education. The Family Partner shared about child development and what was typical for the child's age. The Family Partner helped the mother with resources. Our Family Partner wrote:

"When I started working with Mom she had many questions about child development since the client was an only child and Mom did not have a lot of experience. Mom shared the problems with her child in her school during the pandemic. I helped Mom with understanding the school system and the different options that exist such as a bilingual system and schools with a year-round calendar because Mom grew

up in a small town where there was only one school. In order to support the Mom, I referred her to the Hand-in-Hand website and the Hively trainings and to programs that had afternoon readings of children's books to help client become interested in stories and reading. Mom had begun looking for schools for the client for the next school year and she was thinking of enrolling her in a bilingual school. After providing this support, Mom informed me that the client was doing better and Mom was preparing the client to start in-person school. As a Family Partner, I shared my work with the therapist regarding the family progress."

Sharing a clinician's experience with one client/family where the intervention of our services brought a positive change:

"I am a Licensed Clinical Social Worker. I have served several culturally diverse families in the community and provided culturally informed services. One of these families was an ECMH Integrated- Silva Clinic client. This client was a bilingual 5-year-old girl of Mexican descent. The client was initially referred for services due to separation anxiety, excessive crying during preschool drop offs, frequent tantrums around limit setting, changes in routine, and transitions. The child experienced irritability and restlessness in the home and with her daycare provider. My work with this client and her mother involved tailoring my services to better serve them in their own language and have used my similar cultural background to connect with this family, while learning about differences between our backgrounds. Interventions were implemented in therapy to help strengthen the parent-child relationship including evidence-based practices, such as Brief Strategic Family Therapy techniques and Solution Focused Therapy techniques. The child made significant improvements in her time in treatment, such as being more flexible with changes that occurred in her daily life, managing her frustration, and decreasing her separation anxiety. The client's case was closed due to positive improvements in her behavior and due to mother's ability to feel prepared in managing her daughter's behaviors in the moment. "

VI. FY 21/22 Additional Information: Our program has recently hired a new clinician and is now fully staffed to serve the clients and families referred from Silva Clinic. The Long-term plans for the ECMH integrated – Silva Clinic program include the building of a new medical center where services by the medical providers at TVHC and the mental health providers from La Familia Counseling will be housed under one roof. The plans for this collaboration continue to be viable although there has been a delay in the building of this project. It is hoped that this structure will proceed sometime this year or the next.

VII. FY 22/23 Projections of Clients to be Served: For the coming year we hope to serve more families now that our program is recently fully staffed. Our new therapist has a background of working both in child therapy as well as working in medical fields. She is familiar with many impacts on clients from medical diagnoses, so she will be collaborating with the pediatricians on a more consistent basis, and will be able to therefore serve more clients and families referred through the Silva Clinic.

VIII. FY 22/23 Programs or Service Changes: The pandemic has been a challenge to providing consistent services to families with young children. We hope that during this new fiscal year families will be more available for in-person services and that the isolation needed to prevent the spread of the COVID is less of a concern, and that families and staff are healthier over the year.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 25

PROVIDER NAME: Multiple Federally Qualified Health Centers (FQHCs)- LifeLong Medical Care

PROGRAM NAME: Behavioral Health - Primary Care Integration Project: Care Coordination

Program Description: Integrated Behavioral Health Care Coordinators (IBHCCs) connect patients with behavioral health (BH) services both within our organization (LifeLong Medical Care) and in the community. They make appointments for patients, call other organizations together with patients, and follow up on appointments and referrals. They are the "glue" of our behavioral health teams and help bridge medical and behavioral health care.

Target Population: All patients referred to behavioral health services from primary care providers. These referrals are for patients of all ages, genders, and races.

How Much Did We Do?

I. FY 21/22:

a. **Number of Unique Clients Served:** LifeLong's IBHCCs provided services to 1,404 patients. ACBH portion of total budget: $130,006

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

a. **Reduce Mental Health Stigma:** Our IBHCC coordinators actively participate in trainings and workshop discussions that address stigma in mental health. These trainings and discussions have allowed our IBHCCs, and entire behavioral health (BH) team to talk openly with patients, BH team members, and other clinic staff about mental health. They have also helped us and deepen our understanding of ways to diminish stigma.
b. **Create a Welcoming Environment:** Integrated Behavioral Health services at LifeLong have allowed our IBHCCs to provide warm handoffs for our patients seeking behavioral health services. WHOs have helped create a friendly environment that makes patients feel more at ease which helps improve their healthcare experience. They also help normalize mental health as part of a patient's overall healthcare, which is both welcoming and helps reduce stigma.

III. Language Capacity for this Program: Our IBHCCs are bilingual and fluent in English and Spanish. We also have numerous bilingual therapists who conduct sessions in both English and Spanish, and two therapists in other clinics at the organization who see patients in other languages.

Language can be an obstacle for connecting our patient to BH services, but our IBHCCs use an interpreter line and assist patients who need a different language in getting connected to a BH provider who speaks that patient's language. We also offer BH appointments using the interpreter line or if the patient's insurance allows it, we can request an in-person interpreter.

IV. FY 21/22 challenges: Staffing changes at the organization has been one of greatest challenges in this past year. Onboarding and training new BH staff, including both new IBHCCs and new BH providers, has impacted the number of referrals our IBHCCs were able to process.

A sustained high rate of referrals to BH has been another challenge. Since the beginning of the pandemic, there has been an increased and high number of BH referrals. This has impacted many levels – for our IBHCCs, it has impacted being able to outreach patients in a timely manner, getting patients into BH care within the clinic, and getting our patients connected to BH services outside of our organization. Many outside organizations that we refer to have similarly been impacted, and so have not taken our referral. This has made it challenging to refer patients who need it to a higher level of BH care, to long-term therapy, and to agencies that conduct ADHD assessments and provide medication management for ADHD.

Is anyone better off?

V. FY 21/22 Client Impact: IBHCCs have connected hundreds of patients with therapy, psychiatry, substance use, medical, transportation, and other services.

Additionally, we've conducted focus groups and patient feedback surveys to better understand patients' experiences receiving mental health services at LifeLong. The goals of these were to find out if mental health services have been helpful, whether the mental health services patients have received have been aligned with patients' identities and cultural backgrounds, and what can be done to improve patients' experiences. Patients who participated in the focus groups gave us positive feedback that services have helped them make positive changes in their lives. Patients also shared what ideas and areas of improvement.

VI. FY 21/22 Additional Information: Our IBHCCs have worked hard to build relationships with patients, BH team members, medical providers, other staff members, and community agencies. They are constantly on the phone or meeting with patients, connecting patients with all of these other people and resources. They also work with similar positions across the agency, and across Alameda County, to share resources and learn together.

VII. FY 22/23 Projections of Clients to be Served: We estimate around the same number of clients will be served in FY 22/23.

VIII. FY 22/23 Programs or Service Changes: We anticipate additional staffing changes and growth of the BH team in FY 22/23. We will be working to implement some of the recommendations we have learned from patient focus groups and feedback surveys, such as mindfully asking patients about their preferences for a BH provider in terms of identity, race, and culture.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 25

PROVIDER NAME: Federally Qualified Health Centers (FQHCs)- Native American Health Center

PROGRAM NAME: Behavioral Health - Primary Care Integration Project: Care Coordination

Program Description: Care Coordinators at Native American Health Center assist members in navigating the medical, behavioral health, and social services systems by helping connect to specialists and community resources. They also help coordinate care amongst different specialties and primary care as needed.

Target Population: Members who are receiving primary care at Native American Health Center who are ages 22 and over.

How Much Did We Do?

I. FY 21/22:

a. **Number of Unique Clients Served:** 221. ACBH portion of total program budget: $60,828

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

a. **Reduce Mental Health Stigma:** Our care coordinator provides warm handoffs during medical visits for members who may have a mental health diagnosis to discuss service options and provide supports. The care coordinator also provides education around mental health services and helps to address member concerns regarding engagement in mental health care. An example of this is a member that originally was working with our care coordinator regarding housing, but who also had a long history of depression treated via medications only with continued symptoms. The care coordinator offered to connect member to therapy services and provided further information about the ways that therapy may support them. Member was hesitant and the care coordinator let member know that it was always an option in the future and would continue to suggest engagement in therapy from time to time as appropriate. Eventually, member agreed to connect to therapy and continues to attend sessions.
b. **Create a Welcoming Environment:** Our care coordinator greats members when walking around the clinic, introduces themselves and obtains consent when doing warm handoffs and beginning care coordination services, they utilize members' preferred names and help members connect to appropriate administrators when they feel their needs are not being met within the health care system.

III. Language Capacity for this Program: English, Spanish, Utilization of Proprio and/or Language Line Solutions for translation services in other languages.

IV. FY 21/22 challenges: The biggest challenge generally has come when working with specialists who do not always have registration packets in languages other than English or that cannot or will not offer translation services during appointments. Our care coordinator when regularly attend (via telephone and with member consent) specialist appointments with the member to help support with translation.

The second challenge CC faced in quarter 1 was getting members connected to their specialty appointments at Highland Hospital. CC was faced with the challenge of no appointments being available for patients. At times, appointments will be available 1 month out. As a result, care coordinator encouraged patients to not miss their specialty appointments.

The biggest challenge that Neftaley faced in quarter 2 was getting patients connected to NorCal Imaging in Oakland for CT scans and ultrasounds. Over the last three months, it has been difficult to get anyone to pick up the phone at NorCal Imaging. At times, care coordinator was on hold for 3 hours and would not get a response/ anything resolved. Patients reported the same problem with scheduling their own CT scans and ultrasounds. As a result, care coordinator and referrals team started sending patient's to alternative locations.

The biggest challenge that Neftaley faced for quarter 3 was getting transportation for member's specialty appointments. Motive Care has become very unreliable over the last few months and often times they forget to pick up members for their appointments or they show up one to two hours late. This has been a problem given that some of these members cannot afford the late cancel fees or missed appointment fees that specialist charge members. Members are now having to pay $25 - $100 in fees, which they cannot afford, due to the lack of consistency from Motive Care. Care coordinator has started scheduling member's pick-up time one-hour prior in order for members to be picked up on time and make it to their appointments.

One of the biggest challenges that Neftaley faced this quarter was getting patients connected to physical therapy. When trying to connect members to Montclair Physical Therapy, care coordinator was unable to receive a response from PT location. After multiple calls and member's trying to go in-person, care coordinator had a lot of difficulty getting connected to someone at that facility. Care coordinator updated PCPs at NAHC so that they can send their patients elsewhere who are in need of physical therapy.

Is anyone better off?

V. FY 21/22 Client Impact: CN is a Spanish speaking member Neftaley worked closely with this quarter that was referred to her via warm handoff. CN's primary care physician was concerned with member's health and wanted care coordinator to assist member and her family with making specialty appointments. Care coordinator was able to establish a connection with member and her family as she was able to communicate with them in Spanish and understand their cultural background. Member's authorized representative/daughter let CC know that her mother needed to see an eye specialist because her vision was getting blurrier. CC was able to schedule ophthalmologist appointment for member and she was able to get checked by a specialist right away. Additionally, Neftaley helped the family fill out IHSS application so that member could get additional support in the home. Care coordinator has been working closely with member's primary care physician and family to ensure that member has all the support she needs to get back to health. If member attends all her specialty appointments she should be able to get her surgery she needs on.

JVF is a Spanish Speaking patient Neftaley worked closely with this quarter referred to her via warm handoff. Care coordinator worked on getting member connected with BH services at NAHC. JVF's therapist and primary care physician were concerned member was not attending his specialty appointments and asked for care coordinator's support. Member let care coordinator know that his biggest obstacle with making it to his appointments was transportation. Member has HealthPac, which

unfortunately, does not cover transportation. Care coordinator asked member if he knew how to navigate the bus and BART system in Oakland. Member let care coordinator know that he knew how to get around on public transportation with directions. Care coordinator printed member directions for all three of his specialty appointments and sent them to him via mail. Additionally, care coordinator sent member appointment reminders. With all the additional support, member made it to his optometry and ENT appointments. Next month, member has a surgery coming up and care coordinator is working towards making sure member completes all his pre-surgery requirements.

JD is a care coordination member Neftaley worked closely with this quarter referred to her via care coordination referral. Care Coordinator has worked closely with member and her primary care physician to get her health back on track. The priority in the members care plan is figuring out what is causing member to have short term memory loss. Member's primary care physician wanted her to get connected to neurology to have a specialist weigh in on the matter. Care coordinator worked diligently to make sure that member was connected to a neurologist. Care coordinator assisted member with new patient paperwork and even taught member how to use Zoom for her telemedicine visit with the neurologist. In order to ensure member remembered to tell the neurologist all of her concerns, Neftaley virtually attended appointment with member via Zoom. Additionally, care coordinator reported back the recommendations and next steps given by the neurologist for patient and primary care physician. Care coordinator continues working with member on making sure she makes it to her specialty appointments and keep her primary care physician up to date with all of her appointments.

CR is a patient that Neftaley has been working closely with for a few months who was referred for care coordination services via PCP. Care coordinator has worked closely with member and her primary care physician on getting her connected to specialists,
like neurology, and working on getting her more accessible transportation due to her limited mobility. The priority for this member was making sure that she was established with Home Health at home so that they could provide her with both Occupational
Therapy and Physical Therapy. In addition, care coordinator has worked alongside PCP to get her the proper DME she needs at home like shower chair, toilet support, and medical bed, in order to help her move around her home when her IHSS worker is not
available to help her. The biggest challenge that has risen in this member's case is transportation. Due to member's limited mobility and lack of reliability with Motive Care, it has been difficult for member to get to her specialty appointments. With the support of fellow care coordinator and PCP, care coordinator was able to get member connected to gurney transports, which will be able to help member with getting to her appointments safely. Care coordinator is happy she was able to find a solution for member prior to her departure.

VI. FY 21/22 Additional Information: The care coordination program at Native American Health Center consists of several components. We have an Integrative Behavioral Health Care Coordinator whose program is described in the above narratives. We also have three Community Health Workers who are part of the Care Neighborhood program through CHCN. The Care Neighborhood program is part of CalAIM and focuses on adult members who fit into one of three categories: homeless or at imminent risk of homelessness, are high utilizers of the emergency department or in-patient hospitalizations, or have severe mental illness or substance abuse concerns. We also have the Pediatric Care Coordinator who works with youth and families, his focus is on ages 0-21. Finally, we recently hired a Native American/Alaskan Native Care Coordinator who will assist our Native population connect to resources and will emphasize engagement in the Native community and cultural practices.

VII. FY 22/23 Projections of Clients to be Served: Members to be served by the IBHCC – at least 200. Projected members to be serviced by all of the care coordination programs at NAHC – around 650.

VIII. FY 22/23 Programs or Service Changes: We are increasing screenings of Social Determinants of Health for all of our members at Native American Health Center which will allow us to more quickly identify members that could benefit from being connected to needed social service resources in the community. We are also increasing utilization of care plans developed by the care coordinator and member to monitor and track care coordination goals.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 25

PROVIDER NAME: Federally Qualified Health Centers (FQHCs)- Tiburcio Vasquez Health Center

PROGRAM NAME: Behavioral Health - Primary Care Integration Project: Care Coordination

Program Description: Provides integrated behavioral health care coordination (care coordination) in order to improve access and linkages to multiple social support services through referrals, warm hand-offs, and follow up services. Also works with behavioral health clients who are not accessing health services in an efficient manner to identify and remove barriers that can improve utilization of needed primary care and referrals to specialty, increase the capacity and effectiveness of primary care clinics to screen, assess and treat mild to moderate behavioral health conditions, improve the capacity of primary care clinics to effectively treat the chronic medical conditions of individuals with moderate to severe behavioral illnesses, enable timely monitoring of medical records and clinic appointment schedules to identify clients who face continuous barriers accessing and utilizing primary care and/or behavioral health services reflected by their high no shows rates as well as poor utilization of referral resources, enhance services through better tracking and improved accessibility to primary and behavioral health care services, and improve the monitoring and achievement of health and life outcomes among individuals served.

Target Population: Low-income individuals who are in need of multiple social support services in areas such as behavioral health, physical health and housing to address chronic and co-occurring physical and behavioral health conditions

How Much Did We Do?

I. FY 21/22:

a. **Number of Unique Clients Served:** 4,113 (Q1: 1,064, Q2: 1,070, Q3: 945, Q4: 1,034) ACBH portion of total program budget: $101,275

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

a. **Reduce Mental Health Stigma:** The Care Coordinators speak to many pts (esp. in the in the Latinx community) who have stigma against mental health and feel that behavioral health services are only for "crazy" people. Care coordinators engage with patients by using reflective listening, holding space, providing psychoeducation and meeting patients where they are at
b. **Create a Welcoming Environment:** Care coordinators provide a nonjudgmental space for patients. Care Coordinators are present, empathetic, engage in active listening and reflection, and provide culturally congruent services

III. Language Capacity for this Program: Our care coordinators are bilingual in English and Spanish. For all other languages, we use the language line to help facilitate communication with patients in their native language.

IV. FY 21/22 challenges: Some challenges included continued increased need in the community and limited resource. More specifically, there was difficulty connecting Medicare patients to services, limited services for Spanish speaking patients, lack of available specialty services for pediatric patients, lack of

housing resources, lack of transportation resources, difficulty with regional center and adults with undiagnosed delays. Also difficulty following up with some patients

Is anyone better off?

V. FY 21/22 Client Impact: Care Coordinators were able to offer information and assistance with direct linkage to community resources including, but not limited to, housing, food assistance, SUD services, psychiatry, specialty services, transportation, and primary care. Care coordinators were also able to help educate patients on how to best navigate and advocate for these resources. Care Coordinators continuously empower patients and offer tools and assistance for patients to become more self efficient.

VI. FY 21/22 Additional Information: N/A

VII. FY 22/23 Projections of Clients to be Served: 3,500

VIII. FY 22/23 Programs or Service Changes: Things that could be helpful: Ability to add more care coordinators and clinicians to the team, continued ability to use the telehealth/hybrid model, working on improved tracked through EHR, Continued expansion of services/program, Continued improvement with respect to communication and partnerships with specialty programs and resources, Increased training for staff, increased funding for more services.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 25

PROVIDER NAME: Multiple Federally Qualified Health Centers (FQHCs)- West Oakland Health Center

PROGRAM NAME: Behavioral Health - Primary Care Integration Project: Care Coordination

Program Description: The Integrated Behavioral Health Program is a short-term (10-12 sessions), goal-oriented mental health treatment program that serves adults presenting with mild-moderate mental health symptoms. The intention of the program is for the medical team and the behavioral health team to work together and actively collaborate to provide whole-person care to the people we serve.

Target Population: Clients who receive their primary care at West Oakland Health and experience mild to moderate mental health symptoms.

How Much Did We Do?

I. FY 21/22:

a. **Number of Unique Clients Served:** 227 ACBH portion of total program budget: $60,828

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

a. **Reduce Mental Health Stigma:** Our IBH program strives to reduce the stigma by providing non-judgmental, unconditional care as well as staying connected and integrated with the client's care team.
b. **Create a Welcoming Environment:** We have welcoming staff who screen all patients at the door. Our BH hallway also has a display case with affirmations and information to support the growth and well-being of our clients**.** We also provide our clients with the option of providing telehealth.

III. Language Capacity for this Program: English and Spanish.

IV. FY 21/22 challenges: "No shows" for appointments. Although we offer telehealth appointments and that has reduced our overall no-show rate, we still have difficulty with this.

We are also limited by language. I am grateful we have at least one Spanish-speaking clinician, but I would love to have another one.

Is anyone better off?

V. FY 21/22 Client Impact: Many of our clients successfully complete our short-term therapy program with a lower PHQ-9 and GAD-7 score than when they started. They report feeling satisfied with their course of treatment and feel safe and comfortable reconnecting with their therapist if necessary. They can also depend on our team to connect them to a higher level of care if their symptoms are more severe and to support them in getting medications from their PCPs when needed.

VI. FY 21/22 Additional Information: Our care coordinator works hand in hand with our clinical and medical staff to get them connected to resources within the community. We will have an intern this academic year who will also be able to provide services and help reduce our waitlist.

VII. FY 22/23 Projections of Clients to be Served: 275

VIII. FY 22/23 Programs or Service Changes: We have been approved to hire another therapist, which will allow us to serve more people.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 26A

PROVIDER NAME: Training and Technical Assistance on Accurate Diagnosis and Appropriate Medication Treatment and Healing Practices for African Americans

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

Program Description: Hiawatha Harris, M.D., Inc./Pathways to Wellness Medication Clinic designs and delivers culturally responsive services and technical assistance support to help psychiatric prescribers who provide medication assessment and support to African American adults (18-59) living with mental health issues. The culturally responsive curriculum was developed to address the topics of: 1. Stigma around mental health problems in the African American community that can lead to delays in or termination of treatment; 2. Medication issues such as over/under prescribing, incorrect dosage and side effects; 3. Historical trauma of African Americans; 4. Health disparities impacting African American communities; 5. Bias and racial stereotypes; 6. Understanding barriers to accessing mental health services; 7. Knowledge of community holistic interventions such as spiritual, family, and community support; and 8. Strategies for provision of more culturally responsive and congruent services.

Target Population: Alameda County psychiatric prescribers who are identified by ACBH who provide services to adults who identify as African American, ages 18-59 who have moderate to severe mental illness impairments resulting in at least one significant impairment in an important area of life functioning.

How Much Did We Do?

I. FY 21/22:

a. **Number of Unique Clients Served:** We completed a total of seven full trainings and three technical assistance training and one listening session for a total of 735 participants from July 2021 to June 2022. **Program budget:** $334,581

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

a. **Reduce Mental Health Stigma:** Throughout this year's training program, a number of the speakers focused on issues that particularly create stigma in specific African American communities. The trainers presented clear information which outlined the intersectionality of diversity and trauma and how those two issues are linked to create stigma in African American communities. In order to highlight the issues of stigma speakers focused on the importance of grassroots-based initiatives for holistic healing and health within the African American community.

   There was also specific training related to creating a safe space for African American LGBTQ Youth who often are excluded and disenfranchised both in the community and in their school settings. This training offered specific ways that safer spaces can be created in both schools and the community for this very vulnerable youth group.

Implicit Bias is now incorporated into all of our training curriculum. All continuing education course content must now contain a curriculum that also includes specified instruction in the understanding of implicit bias in treatment. This requirement is based on California assembly bill 241. Understanding implicit bias helps providers to develop more insight when serving more diverse populations.

b. **Create a Welcoming Environment:** The trainers definitely understood the importance of creating a welcoming environment for African Americans who receive services in the behavioral health system. One of the trainings pacifically targeted the issue of women's mental health and creating a welcoming and safe environment for African American women by talking with them and not assuming as a provider that you know their issues. The trainer stressed the importance of listening to clients with understanding and compassion. Another speaker dealt with the utilization of culturally sensitive diagnostic assessment and treatment approaches when working with the African-American community and utilizing these approaches to create a more welcoming environment. We offer the best board certified, licensed and seasoned trainers. They know how to engage their audience and provide up to date information for practitioners.

   In fiscal year FY 21/22, we offered trainings that were specifically requested by participants who attended our trainings in FY20/21. So, we used the feedback and training topic requests that participants listed on their Survey Monkey questionnaires to come up with this fiscal years' curriculum. This made this years' trainings an even more valuable experience.

   We also added made our last two trainings of FY21/22 "hybrid" for those who learn better in-person. COVID tests were administered and proof of vaccine and/or boosters were also required. In addition, we secured additional space to comply social distancing rules to make it welcoming and to promote safety.

III. Language Capacity for this Program: N/A

IV. FY 21/22 challenges: The primary challenges we encountered in the 21/22 fiscal year was our moving from virtual to live presentations. We utilized a hybrid program for two of our trainings, which allowed for participants to join the training virtually or in person. We offered these two trainings near the end of the fiscal year. We found that there was still some reluctance on the part of people to attend and participate in live trainings. We will continue to review this issue in order to gain a better understanding of what has created this reluctance in terms of people returning to live presentations.

As we move into year-four of our TA contract, we continue to diligently work to adequately respond to the growing needs within our community during the pandemic. Ongoing individualized technical assistance and training around this subject matter critical for the CBOs and FQHCs who are requesting our services. This has become particularly important with the number of changes that have occurred in Alameda County related to the changes with Cal AIM and the grand jury investigation that has targeted a number of Alameda County behavioral health programs. As shared in FY20/21, our AATA program believes that it is not only fiscally responsible to allocate additional funding for innovation of our contract but it also allows our program the ability to connect and train even more providers in Alameda County. This increase will allow Pathways AATA Program to have a positive impact on community understanding and needs for African American mental health services.

Is anyone better off?

V. FY 21/22 Client Impact: While the program does not specifically see clients there is an impact from some of the training programs that we believe will improve the use of psychiatric medication in the African American population and in the behavioral health system. The training titled Cultural Psychiatry: Psychiatric Medication Use in the African American Population offered specific tools and information regarding medication use with African American clients.

VI. FY 21/22 Additional Information: We would like to expand our trainings by offering training podcasts and as well as more community listening sessions for a larger population in the community. We have noted there are a number of mental health issues that are impacting CBOs, federally qualified health centers, schools, hospitals and correctional facilities. There is an increasing need for the Technical Assistance Podcast and Community Listening Sessions given some of the issues currently existing in the Alameda County community. The issue of homelessness and youth suicides are only two of the issues that we would like to have an opportunity to make an impact on through our Technical Assistance Training program. In order to begin training and implementing programs in these other systems, we have now developed the "No Wrong Door Policy," in which we will require additional funding in order to offer the Training and Technical Assistance program to these additional systems.

VII. FY 22/23 Projections of Clients to be Served: We are projecting a minimum of 200 to 300 unduplicated participants for the year with an average of 35 to 45 in attendance at any given training. Participant attendance next year will depend on topics that we offer and what the community needs are during each contract year. Meanwhile, we plan to offer a minimum of quarterly individualized Technical Assistance Trainings.

VIII. FY 22/23 Programs or Service Changes: This new fiscal year we intend to begin to increase our number of webinars, utilization of social media specifically with podcasts, community listening sessions, and the utilization of LinkedIn to connect us to additional providers and the broader Alameda County community. Alameda County providers, CBOs and FQHCs will continue to be a core focus for the AATA team.

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 21/22:

a. **Number of Unique Clients Served:** 58. **Cost per client:** $6,663

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

a. **Reduce Mental Health Stigma:** AfiyaCare clinicians and Navigators identify as African American and are trained in culturally competent and trauma informed approaches. This contributes to a program that is culturally responsive, congruent, and has a positive impact on its members as a whole.

   Furthermore, program staff strive to reduce mental health stigma by normalizing the process of seeking mental health resources through education. This includes educating members on how their holistic wellness is interconnected between health, mind, body, and spirit. This approach is particularly helpful for members coming from a cultural perspective that views mental health and seeking out mental health treatment as something that is done when you are 'crazy,' or when something is 'wrong' with you. As members understand the symptoms they are experiencing can be decreased, managed, or eradicated, there is increased openness to receiving support.

b. **Create a Welcoming Environment:** During a member's initial session, AfiyaCare clinicians take a learning role and allow each member to educate them on the experiences that brought them to therapy. Staff practice non-judgmental, non-verbal communication; making sure each member feels heard. We acknowledge that each member is the expert of their own life. People make decisions based on the information they have available to them at the time–this pedagogy is welcoming and lays the groundwork for a joint exploration of new actions that can achieve wellness. We recognize that each client will share their story if they feel accepted, heard, and in an environment where they are free from judgment.

III. Language Capacity for this Program: All participants and staff spoke English. If a member who spoke a different language was referred to the program, we informed the referral source and connected them with a program that had the appropriate language capacity. If our staff encountered a member who spoke a language other than English, they would have utilized the Language Line Solution services offered through Alameda County Behavioral Health.

IV. FY 21/22 Challenges: During FY 21/22, the AfiyaCare program experienced staffing changes–we lost one clinician and as a result, the remaining clinician worked to balance additional members in her schedule as well as re-author treatment plans for transferred members. AfiyaCare clinicians are already challenged with the intensity of treating moderate to severe diagnoses and symptoms of our AfiyaCare members, therefore, having only one clinician was difficult. This also contributed to strain surrounding the timely completion of documentation. Furthermore, while management made extensive efforts to hire additional clinical staff throughout the year, the number of applicants was limited. Barriers to hiring continue to include a low number of applicants who apply, lack of appropriate qualifications, and candidates requesting entirely remote schedules as Roots remains hybrid.

While the development of new documentation and billing workflows have been successful, adapting to new protocols in Roots' electronic health record system, AdvancedMD, required training and adjustment. In addition, extensive staff time went towards late billing entries.

Lastly, maintaining contact with AfiyaCare members often poses a challenge as many individuals no longer respond to communication attempts or lack additional contact information. This contributes to a significant number of members who become inactive in the program, as it is difficult to keep members engaged for a consistent amount of time.

Is Anyone Better Off?

V. FY 21/22 Client Impact: Our AfiyaCare Clinician and Health Navigators have worked to provide resources including but not limited to; housing, food assistance, primary care, behavioral health care, clothes for interviews, benefits (CalFresh, Medi-Cal, & General Assistance), hotel vouchers, transportation, employment assistance, ID vouchers, hygiene kits, and diapers. Staff members have continued to work with members in-person and via telehealth. Both clinicians and Health Navigators remain on site every day to aid in connecting walk-in clients to the AfiyaCare program.

In addition, our program exceeded the projected number of members served for FY 21/22. Of members who were part of the program, 74% were retained for at least two months or transitioned to a more appropriate program. Impact measures for AfiyaCare were either met or surpassed; as 89% of members had a reduction in admissions to jail and 100% of members had a reduction in admissions to John George Psychiatric Pavilion, Psychiatric Emergency Services/Crisis Stabilization Unit and inpatient.

AfiyaCare Clinician Monika Davis-Scott has provided the following Member Highlights:

Mr. N's Story: Mr. N joined the AfiyaCare program with PTSD symptoms ranging from moderate to severe. The client's sleep was impaired due to intrusive thoughts, his hypervigilance, and never feeling safe in his environment. Mr. N was unhoused when he came to us, residing in his car. He began working with his navigator Mr. Perrie Anderson, who assisted him with housing placement and addressing barriers to employment.

One of the most significant barriers for Mr. N was his inability to regulate his emotions. He had a long history of trauma, and when it looked like things were not going to work out for him, he could quickly become agitated and fall back on his fatalistic viewpoint about life.

The combined services of therapy and Health Navigation were instrumental in the successes Mr. N achieved. He learned tools to regulate his heightened emotional state in therapy. The most important work came in between sessions when Mr. N would meet with Perrie. The road to permanent housing can produce many frustrating moments; Perrie was able to model self-soothing exercises with Mr. N in order to reduce anxiety. In therapy sessions, Mr. N also responded well to visualization and manifestation exercises.

Mr. N is now housed in his own apartment. He has a strong work ethic and is currently working two jobs, both at Tesla and at a warehouse stocking merchandise. Mr. N expressed that he enjoys working two jobs because it makes him feel good not relying on one source of income. Mr. N's speech and presentation is more relaxed than when he first came to the Afiya Care program. He continues monthly therapy sessions by phone for a check-in.

Ms. G's Story: Ms. G came to the Afiya Care program in May 2021. She is originally from Memphis, Tennessee, and had moved to Oakland with her partner a few years back in search of better employment opportunities. Ms. G's relationship with her partner had become unhealthy and she made the decision to leave the relationship; resulting in her becoming unhoused and sleeping in her car. Ms. G was working at the time and still trying to maintain her employment. In addition, she was about to begin a new position at Tesla, which she was very excited about. In session, Ms. G stated that with her new position at Tesla, she would have the ability to move into an apartment and afford to pay rent.

Ms. G had a historical diagnosis for bipolar depression, but she also was dealing with the aftermath of the trauma she sustained with her ex-partner. Ms. G's symptoms included intrusive thoughts, impaired sleep, and anxious and depressive feelings. She described periods of time when she could function and manage on little sleep, while at other times, her depressive feelings made it difficult to get activated for the day. Ms. G responded well to the somatic tools of deep breathing and grounding exercises, as well as the Cognitive Behavioral interventions of examining thoughts, testing them for validity, and removing cognitive distortions.

Ms. G began working with Navigator Kim Stovall to develop a plan to address barriers related to regaining housing and maintaining stable employment. She was very open to the therapeutic process and worked collaboratively with Kim. In between sessions, Ms. Stovall provided active and supportive listening and offered resources such as personal care items, food cards, and interim hotel stays to get Ms. G through the waiting process. Kim was instrumental in working with Ms. G to construct an action plan based on her personal goals.

After Ms. G's close work with Kim, she was finally able to move into her apartment. While she graduated from the AfiyaCare program, she remains a member at Roots. Ms. G is now a member of our Complex Care program due to her chronic health conditions and will continue to receive behavioral health services with us.

VI. FY 21/22 Additional Information: N/A

VII. FY 22/23 Projections of Clients to be Served: We project and strive to serve a minimum of 40 unduplicated clients per year. In addition, we aim to maintain a panel of 25 unique clients at any point in time throughout the year.

VIII. FY 22/23 Programs or Service Changes: Both an additional Behavioral Health Clinician and a Program Specialist were hired during FY 21/22. Updated documentation protocols for clinicians and Health Navigators were also created and implemented. This documentation process included the development of an AfiyaCare-specific billing workflow. Improvements to the referral process and tracking system for both internal and external AfiyaCare referrals were also conducted throughout the year. These processes expanded referral data collection and our ability to maintain consistent contact with referrals, ensuring none fell through the cracks.

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.

How Much Did We Do?

I. FY 21/22:

a. **Number of Unique Clients Served:** 150. Cost per client: $3,829

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

a. **Reduce Mental Health Stigma:** The Abode Services IHOT team works to reduce the stigma of mental health with families and our participants. We do this by engaging with people on their terms. That means that we meet them where they are most comfortable and build rapport by focusing on what they identify as an important need. Our team avoids using stigmatizing language or mental health jargon that may turn off participants or families. As much as we can, we focus on participants' strengths and wellness and assist them to address barriers to mental health and other services. Our team also works intensively with families, providing education and support helping them to better understand their loved ones who are dealing with mental health issues. Finally, our team advocates for the best treatment options available for our participants and provide support to deal with barriers.

b. **Create a Welcoming Environment:** Our team engages with participants using a conversational style best suited to their individual needs. We offer support by providing food, clothing, transportation, and other items to assist with reducing barriers and to meet current needs. The

team honors and respects participants by following through on commitments and striving to be on time for appointments and meetings.

III. Language Capacity for this Program: We have just hired a staff person who speaks Farsi. We have found that most of our participants speak English. When we have needed to utilize a translation service, we use the ACBH Language Line.

IV. FY 21/22 challenges: Challenges this year have been related to the lack of availability of temporary housing (shelters serving participants with MH issues, waiting lists for CRT's). For participants who are homeless, it has been difficult at times to engage them on the streets as well as locating participants. In addition, our system of care focuses on those with long Mental Health and incarceration histories when referring to intensive MH services. This is sometimes a challenge because IHOT referrals include people who have never been in a hospital or incarcerated. However, they are suffering from some serious MH challenges and do not respond well to outpatient services without ongoing case management support. This has been challenging for our IHOT team to determine when to discharge our participants from the program.

Is anyone better off?

V. FY 21/22 Client Impact: We have been successful in connecting many participants to MH services and to other services including Social Security, medical and Social Services. We have provided much needed support and education to their families helping them to remain as intact families in many cases.

VI. FY 21/22 Additional Information: N/A

VII. FY 22/23 Projections of Clients to be Served: As referrals have continued at a steady pace, I believe we will serve 150+ participants this fiscal year.

VIII. FY 22/23 Programs or Service Changes: This year our goal is to incorporate the use of WRAP for participants who can benefit from developing a wellness plan.

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.

How Much Did We Do?

I. FY 21/22:

a. **Number of Unique Clients Served:** 110 unduplicated clients served, which is twice as much as the contracted 50 unduplicated client target. **Cost per client:** $5,222

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: All services were provided in English. If needed Language Line can be utilized.

IV. FY 21/22 challenges: Biggest challenge of the previous year was 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.
- Infection has impacted staffing

Is anyone better off?

V. FY 21/22 Client Impact: At least 50% of engaged clients were successfully linked to outpatient mental health services or rehabilitation and recovery services within the first 12 months of referral (Target =>50%). Workflow was significantly impacted by COVID 19 and primarily working remotely.

Client story: * For confidentiality purposes pseudo initials are used in story below. Pseudo initials are used to protect the individual's confidentiality.

BB was a recently assigned male aged 54 with Bi-Polar d/o, disengaged in services with a long history of forensic and psychiatric encounters along with several linkages to outpatient services dating back as far as 1983. Client's mental health continued to decline as a result BB struggled with hopelessness, medication adherence, and following through with mental and physical health care. Family relations became increasingly strained which led to BB being unhoused as result BB became amendable to services thereby reaching out and working with IHOT ultimately getting linked to a full service partnership. BB's quality of life has improved, receiving on-going case management. BB is currently housed and actively engaged in services allowing BB to focus on self-care and reconnecting with family.

VI. FY 21/22 Additional Information: Fill vacant 1.0 FTE Peer Support position.

VII. FY 22/23 Projections of Clients to be Served: We expect to meet the following 2022/2023 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 22/23 Programs or Service Changes: Added full-time peer support specialist.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 27

PROVIDER NAME: La Familia Counseling Center

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.

How Much Did We Do?

I. FY 21/22:

a. **Number of Unique Consumers Served:** 117. **Cost per client:** $4,909

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

a. **Reduce Mental Health Stigma:** IHOT has helped reduced mental health stigma in the lives of consumers and family members of consumers by Peer Support Specialists and a Family Coach providing IHOT services, IHOT providing culturally-informed psychoeducation to family members, and by La Familia hosting a Support Group for Family Members and Caregivers of IHOT consumers. Peer Support Specialists and a Family Coach who possess similar lived experiences as consumers and their families. The Family Coach and Peer Support Specialists coach consumers and their family members in a way that imparts their lived experiences as way to encourage consumers and family members to maintain hope that change is possible. IHOT also helps to reduce mental health stigma by educating families on the causes of mental illness and how mental illness is not the fault of the parents and family. IHOT teaches family members that mental illness is rooted in various factors, such as genetics and adverse life events, that are not necessarily in the control of the families. This helps families feel that the mental illness of their loved one is not a fault of their own. IHOT also normalizes for families the various feelings they experience in relationship to their

loved one suffering from mental illness, such as helplessness, hopelessness, anger and sadness and how such feelings are commonly experienced by family members in similar circumstances. IHOT has also helped to reduce mental health stigma by providing a Support Group for Families and Caregivers of Consumers. The purpose of the IHOT Family and Caregiver Support Group is to provide a space where family members and caregivers of La Familia IHOT consumers can reduce a sense of isolation through sharing their personal experiences. Families and caregivers also receive education about mental illness and how to navigate a complicated mental health care system.

b. **Create a Welcoming Environment:** La Familia IHOT creates a welcoming environment for consumers and their family members by informing the consumer and family members that IHOT is committed to listening to all sides of the story in regards to the family, not just one family member or the consumer. La Familia IHOT also provides IHOT services in Spanish through Spanish-language IHOT staff as well as IHOT staff utilizing the Alameda County Language line for other languages besides English. The IHOT team prides itself in building rapport and connection with clients who are commonly perceived as "difficult" by other individuals in the community. We meet with clients on a regular basis even if they present as ambivalent about IHOT services and listen to their stories of frustration of the manner they have been treated unfairly in the past. IHOT allows them to fully express themselves in a way they have not experienced for a long time. We often defer to whatever goals consumers stipulate are of immediate priority as differentiated between the goals family members or other community members may perceived as the goals of consumers. In this way, we meet clients where they are at and recognize a basic level of their humanity. IHOT also meets with consumers on a consistent basis at whatever location they would prefer, such as in community parks, alleys, homeless encampments, their home, homeless shelters, etcetera. IHOT also has the ability to support clients in purchasing basic items such as a meal, a sleeping bag, coffee, and a change of clothes. It is through these methods IHOT seemingly creates a parallel experience of family and new social support system which may have been absent in their lives for a significant period of time which includes a mixture of socio-emotional support and support with basic necessities.

III. Language Capacity for this Program: La Familia IHOT possessed two (2) fluent Spanish-speaking staff, Lead Case Manager and Peer Support Specialist, who provided IHOT services. IHOT also possessed a one (1) staff, a Peer Support Specialist, who was proficient, but not fluent in providing IHOT services. These three staff have transitioned out of their role in IHOT. The Program Supervisor understands and speaks basic rudimentary Spanish to provide IHOT services to Spanish-speaking consumer population and their families. However, the Program Supervisor is utilizing the Alameda County Language Line to provide Spanish-English translation for IHOT services when necessary. IHOT has also utilized this past fiscal year the Alameda Language Line to provide IHOT services to some families of Asian descent who do not speak English. The utilization of the Alameda County Language Line to provide IHOT services to families of diverse languages has been effective in contributing to the success of the IHOT consumers achieving their goals of well-being and mental health.

IV. FY 21/22 challenges: Five (5) IHOT Positions Vacant: The La Familia Counseling Services IHOT Program has been without a IHOT Clinician for two (2) years. La Familia IHOT has not been successful in hiring an IHOT Clinician as Clinicians are not applying to the open position. La Familia is currently in transition amongst our IHOT staff composition. Our personnel formerly occupying the positions of Lead Case Manager and two (2) Peer Support Specialist have transitioned out of their positions during the months of June and July respectively. IHOT is currently accepting applications for the four (4) positions of Lead Case Manager, two (2) Peer Support Specialists, and Clinician/Staff Therapist.

Consumers who passed away: One consumer passed away during the time IHOT was providing services. The consumer passed away due to suspected medical complicates related to late-stage cirrhosis of the liver. An Unusual Occurrence & Death Reporting Form was completed for their consumer.

Elderlly & Medically-Complex Consumers: IHOT worked with two consumers in particular who were elderly and experienced complex medical needs. Unfortunatley, these consumers did not qualify for Operation Saferground as they did not live in the qualifying area. These consumers continued to remain homeless during the duration IHOT services. One consumer in particular has been continually refused residene in boarding care homes due to difficulty with activities of daily living. The other consumer in particular was one of the consumers who passed away due to complex medical complications stated above. Although shelter is a resource that is very difficult to access for any person, IHOT experience extended difficulty working these these elderly consumers who continued to remain homeless during IHOT services. One of the consumers qualified for a Level 1 Service Team while the other consumer did not meet the criteria for any specialty mental health services.

Is anyone better off?

V. FY 21/22 Consumer Impact: IHOT and Family Caregiver Support Groups: La Familia IHOT launched a Family & Caregiver Support Group via Zoom on March 17, 2022 and continued to conduct thier virtual support group on the third (3rd) Thursday of each month, including on April 21st and May 19th. A total of seven (7) unduplicated individuals have attended the support group who comprised individuals from five (5) different unduplicated families. Two individuals representing two families came to the group for more than one support group session. On April 21st, La Familia hosted a guest speaker, Lead Family Advocate from Family Education & Resource Center, to speak to families about the services offered by FERC . On May 19th, La Familia hosted a guest speaker from Patients' Rights Advocates to speak about the patients rights and grievance process.

Increase of Referrals from Homeless Shelters: La Familia IHOT experienced a steady increase and maintenence of referrals from a particular homeless shelter in Castro Valley, First Presbyterian Church of Alameda County. These referrals requested assistance with residents at the shelter who shelter staff experienced difficulty engaging and who need more assistance than could be provided by shelter staff. IHOT supported shelter staff to assist consumers with document readiness and provide additional emotional support.

IHOT Referral Linkage: La Familia IHOT has successfully connected many IHOT consumers 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 consumers to Assisted Outpatient Treatment (AOT). Many of these consumers would not be aware of how to access these mental health services without the support of IHOT. IHOT also supported consumers to successfully apply for General Assistance and CalFresh/food stamps.

IHOT Incentives: IHOT provided two-hundred and twenty-two (222) gift cards to total number of forty-seven (47) consumers. Some consumers were provided gift cards more than once. Consumers who received more than one gift card on more than on occasion were very low-income earners and who more often than not did not have steady income.

VI. FY 21/22 Additional Information: N/A

VII. FY 22/23 Projections of Consumers to be Served: Seventy-five (75) consumers projected to be served in FY 22/23

VIII. FY 22/23 Programs or Service Changes: Five (5) IHOT Positions Vacant: The La Familia Counseling Services IHOT Program has been without an IHOT Clinician for two (2) years. La Familia IHOT has not been successful in hiring an IHOT Clinician as Clinicians are not applying to the open position. La Familia is currently in transition amongst our IHOT staff composition. Our personnel formerly occupying the positions of Lead Case Manager and two (2) Peer Support Specialist have transitioned out of their positions. IHOT is currently accepting applications for the four (4) positions of Lead Case Manager, two (2) Peer Support Specialists, and Clinician/Staff Therapist.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 27

PROVIDER NAME: STARS Behavioral Health Group

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 21/22:

a. **Number of Unique Clients Served:** 54. Cost per client: $9,215

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

a. **Reduce Mental Health Stigma:** The program works to meet clients where they are with the support of transition facilitators and family advocates who have personal lived experience with mental health, substance use, and / or previous homelessness. The individuals on the team have support and receive extra peer training to meet clients where they are and assist them in envisioning and attaining any identified future goals they may have. The peers and lead clinician hold the view that the struggles that a client may be managing do not define the individual but are simply a part of their overall life experience.
b. **Create a Welcoming Environment:** The team works hard to locate individuals first and then slowly create a relational connection with those individuals. They meet with the individuals they are working with in a caring and non-clinical manner in order to assist in gaining trust and to promote a relational connection. The team utilizes a variety of methods to engage individuals

that they are trying to connect with. These methods include games, art, food, and activities such as going to libraries or small walks. The team always seeks to connect with the individuals they are working with in a respectful manner and use the goals that the individual is interested in to help them see the benefit of connecting and linking with other treatment providers. The team expresses interest in the topics and goals that the individual has stated are important to them. The team will also work with other people that the individual has identified as important supports, once permission is given to include them and create specific supports for family who may be overwhelmed.

III. Language Capacity for this Program: Currently IHOT has language capacity for Spanish and Punjabi. Forty clients were served primarily in English. Fourteen clients received services in Spanish.

IV. FY 21/22 challenges: The biggest challenge impacting the program at this time is the global pandemic we continue to face. It makes connecting with clients in hospitals extremely difficult and it is harder for the team to utilize the resources that they have previously utilized to find and connect with clients. Client anxieties and occasional mental health related paranoia impact the client's desire to connect or increase their individual stress overall which causes more irritability, difficulty managing symptoms and isolation. We have attempted to utilize more collateral supports to connect and link clients. However, not all individuals have a trusted family support system that can be of help.

Another challenge in the past year has been coordinating with referring parties. Over the past year, number of referrals made by parents has increased. When IHOT is unable to connect directly with the client, IHOT relies on the support of the referring party to support with coordination. Over the past year, there has been an increase in referring party not supporting the coordination of care with client, causing a delay in services.

Is anyone better off?

V. FY 21/22 Client Impact: 15 clients who were not linked anywhere; 33 clients linked back to previous provider or IHOT bridged to a new provider; 6 are still in the process of engaging with IHOT and are not linked to a program yet.

The IHOT program offers a once monthly family support group using tele-health modalities. This group is co-facilitated by a clinician and a family advocate. At the initial IHOT assessment of a youth, family resources are also assessed and if appropriate families are invited to participate in a monthly family support group. Through participation in this group, a community of supportive families has developed. Family members can rely on each other and the shared lived experiences for support as their youth is being offered services. Participating family members also receive psycho-education from facilitators and other participants normalizing and supporting them in their experiences. This not only supports the family but also allows for the youth to be better served by the IHOT team.

Over the past year, every parent who has participated in family group is or was a foster parent who moved forward with adoption. This has allowed our group participants to build rapport on having a similar story of becoming a parent. Our group participants have been able to support each other while navigating adult children who are curious of their biological parents. They have been able to share their lived experiences to support each other when navigating new situations. Facilitators were able to bring

in resources and supports catered to the groups needs over the past year and hold a space parents could connect in.

VI. FY 21/22 Additional Information: Of the clients who could not be linked:

- 1 went to jail long term and could not be linked in jail
- 1 went to Villa Fairmont long term
- 3 moved out of county, state, or country

VII. FY 22/23 Projections of Clients to be Served: Approx. 60

VIII. FY 22/23 Programs or Service Changes: N/A

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 27

PROVIDER NAME: Telecare Corporation

PROGRAM NAME: Adult Recovery, Outreach and Connection (AdROC) Program

Program Description: Telecare AdROC is a short-term (90 days) outreach-evaluation-triage program serving adults who are not already connected to the ACBH System of Care. AdROC members include individuals who are homeless or at risk of homelessness, have co-occurring substance use and/or physical health disorders, frequently use hospitals and other emergency services, are at risk of institutionalization, and/or have limited English proficiency. AdROC conducts in-reach and engagement at inpatient facilities, CSUs, and CRPs, and conducts outreach and engagement to community locations and providers. AdROC staff provide linkages, supports, and resources to help clients stay in the least-restrictive , most selfsufficient, and recovery-oriented settings; reduce the need for inpatient and emergency room care; and improve mental health outcomes. Services are delivered by a team of case managers, peer support specialists, a team lead, and a clinical director. Services provided by the AdROC team including individual and group rehabilitation, crisis intervention, plan development, individual and group therapy, and targeted case management. The latter service links the consumer to needed resources and supports in the community such as housing, benefits, therapy, medication, and medical/dental services. 80% of the AdROC services are delivered in the community. AdROC is located in the Eastmont Town Center in Oakland, CA.

Target Population: AdROC serves adult Alameda County residents, 18 years of age and older, who appear to be experiencing a mental health crisis; and/or are affiliated with one of the AdROC referral sources; and who are not already connected to the ACBH System of Care.

How Much Did We Do?

I. FY 21/22:

a. **Number of Unique Clients Served:** 81 **Cost per client:** $5,346

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

a. **Reduce Mental Health Stigma:** At Telecare, we talk openly about mental health and respond to misperceptions or negative comments by sharing facts and experiences. We address internalized stigma by treating clients as individuals, getting to know them as humans through direct conversations and whole person assessments, learning their psychosocial histories, understanding the reasons behind their challenges, learning their strengths and creating individualized treatment goals that come from client's hopes and dreams. We provide clients with education about their mental health and substance use symptoms that can increase understanding and a sense of control over their lives. We educate about ways that stigma from society may impact their own self perceptions.

b. We are with clients side-by-side in the community which allows us to advocate for fair treatment, as well as model for community members, how to interact with people who are experiencing symptoms of mental health diagnoses in real time

c. We work with family members and other loved ones to provide psychoeducation and skill building about how to interact with clients in ways that minimize stigmatization.

d. We provide ongoing training and support to help staff recognize own internalized biases and minimize potential microaggressions towards clients

b. **Create a Welcoming Environment:**

a. Almost all of our services are provided in the community, where are clients are located. We have a receptionist who answers calls with respect and ensures that clients' stated needs are forwarded to their team. We have a 24/7 Crisis Line answered by a live staff member, which allows clients to receive support when they feel the need. We have staff on-site all day, every day (M-F) to address the needs of clients who come to the office looking for support.

b. We host client-focused events that honor and welcome our clients, to help them feel like integral members of society.

c. III. Language Capacity for this Program: English & Spanish

IV. FY 21/22 challenges: FY21/22 was a time of great uncertainty due to the stressors of the global pandemic, housing insecurity, increased risk of substance use, increase of hate crimes directed towards vulnerable populations, increased cost of livng, especially for housing and food. While all these factors impacted our clients, the most challenging of the past year were the shortage of safe, affordable housing, increased cost of living due to inflation.

Is anyone better off?

V. FY 21/22 Client Impact: An AdROC Member who was recovering from abuse in childhood, dealing with transgender identity and coming out, and having severe depression, frequent suicidal ideation and hospital visits, while losing their job and their housing. AdROC Peer Support Specialist was able to support the member and help them achieve a stable shelter bed, return to therapy and medication management services, and then to find work again. The Member was able to work and earn enough to move into a studio apartment again, no longer needing shelter or hospitalization.

VI. FY 21/22 Additional Information: This is our first year running the AdROC program and have had success serving the community and having at least one staff person at John George in-patient and PES Monday-Friday.

VII. FY 22/23 Projections of Clients to be Served: 90

VIII. FY 22/23 Programs or Service Changes: In November 2022, the AdROC Clinical Director will transition out of her role. Additionally, the program will welcome a new Administrator. The AdROC Program expects to be fully staffed by January 2023. There will be ongoing evaluation and changes in practices to follow the federal, state and local guidelines about Covid as they develop. If able, we plan to reinstate all in-person partner events.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 27

PROVIDER NAME: Telecare Corporation

PROGRAM NAME: Transition Age Youth Recovery, Outreach and Connection (TAY ROC)

Program Description: Telecare TAY ROC is a short-term (90 days) outreach-evaluation-triage program serving TAY youth who are not already connected to the ACBH System of Care. TAY ROC members include transition age youth who are homeless or at risk of homelessness, have co-occurring substance use and/or physical health disorders, frequently use hospitals and other emergency services, are at risk of institutionalization, and/or have limited English proficiency. TAY ROC conduct in-reach and engagement at local inpatient facilities, CSUs, and CRPs. The team also provides outreach and engagement to other locations and organizations where TAY experiencing mental health crises are likely to be found. TAY ROC staff provide linkages, supports, and resources to help clients stay in the least-restrictive , most selfsufficient, and recovery-oriented settings; reduce the need for inpatient and emergency room care; and improve mental health outcomes. Services are delivered by a team of case managers, peer support specialists, a team lead, and a clinical director. Services provided by the TAY ROC team include individual and group rehabilitation, crisis intervention, individual and group therapy, plan development and targeted case management. The latter service links the consumer to needed resources and supports in the community such as housing, benefits, medication, therapy, and medical/dental services. 80% of the TAY ROC services are delivered in the community. TAY ROC is located in the Eastmont Town Center in Oakland, CA.

Target Population: TAY ROC serves TAY youths 16 to 24 years of age who are Alameda County residents, who appear to be experiencing a mental health crisis; and/or are affiliated with one of the TAY ROC referral sources; and who are not already connected to the ACBH System of Care.

How Much Did We Do?

I. FY 21/22:

a. **Number of Unique Clients Served:** 73 **Cost per client:** $3,280

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

a. **Reduce Mental Health Stigma:** At Telecare, we talk openly about mental health and respond to misperceptions or negative comments by sharing facts and experiences. We address internalized stigma by treating clients as individuals, getting to know them as humans through direct conversations and whole person assessments, learning their psychosocial histories, understanding the reasons behind their challenges, learning their

strengths and creating individualized treatment goals that come from client's hopes and dreams. We provide clients with education about their mental health and substance use symptoms that can increase understanding and a sense of control over their lives. We educate about ways that stigma from society may impact their own self perceptions.

b. We are with clients side-by-side in the community which allows us to advocate for fair treatment, as well as model for community members, how to interact with people who are experiencing symptoms of mental health diagnoses in real time

c. We work with family members and other loved ones to provide psychoeducation and skill building about how to interact with clients in ways that minimize stigmatization.

d. We provide ongoing training and support to help staff recognize own internalized biases and minimize potential microaggressions towards clients

b. **Create a Welcoming Environment:**
   a. Almost all of our services are provided in the community, where are clients are located. We have a receptionist who answers calls with respect and ensures that clients' stated needs are forwarded to their team. We have a 24/7 Crisis Line answered by a live staff member, which allows clients to receive support when they feel the need. We have staff on-site all day, every day (M-F) to address the needs of clients who come to the office looking for support.

   b. We host client-focused events that honor and welcome our clients, to help them feel like integral members of society.

III. Language Capacity for this Program: English and Spanish

IV. FY 21/22 challenges: FY21/22 was a time of great uncertainty due to the stressors of the global pandemic, housing insecurity, increased risk of substance use, increase of hate crimes directed towards vulnerable populations, increased cost of livng, especially for housing and food. While all these factors impacted our clients, the most challenging of the past year were the shortage of safe, affordable housing, increased cost of living due to inflation.

Is anyone better off?

V. FY 21/22 Client Impact: A twenty something year old member needed extensive outreach and was at risk for suicide, and we attempted to engage over a number of weeks. She was severely depressed, had visited PES with a suicidal plan, and was dealing with complex trauma and bereavement. Her parent figure who was her grandmother had died, and her other family was less supportive, she had frequent conflict with them. She had dropped out of college, and was in debt, unemployed and isolative. After persistent outreach from us, she returned to active meetings with TAY ROC clinician and Peer Support.

She re-engaged in care and began to tell her story more, and within 2 more months, she accepted medication services and therapy weekly with Sausal Creek. She became employed again and was able to live with her boyfriend and pay rent.

VI. FY 21/22 Additional Information: This is our first year running the TayROC program and have had success serving the community and having at least one staff person at John George in-patient and PES Monday-Friday.

VII. FY 22/23 Projections of Clients to be Served: 120

VIII. FY 22/23 Programs or Service Changes: In November 2022, the TAYROC Clinical Director will transition out of her role. Additionally, the program will welcome a new Administrator. The TAYROC Program expects to be fully staffed by January 2023. There will be ongoing evaluation and changes in practices to follow the federal, state and local guidelines about Covid as they develop. If able, we plan to reinstate all in-person partner events.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 28

PROVIDER NAME: Bay Area Community Services (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 21/22:

a. **Number of Unique Clients Served:** 170 **Cost per client:** $12,354

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

a. **Reduce Mental Health Stigma:** When working with our partner's we like to use the ideology of empowering them rather than pathologizing their mental health. Empowerment of the partners is intended to help them adopt self-determination and autonomy, and gain self-sufficiency. Empowerment process means overcoming a state of powerlessness and gaining control of one's life. We start by exploring defined basic needs (whether that be housing, connecting to medical services, mental health services) and develop goals that focuses on achieving those goals. We understand that everyone has a story and we are here to hear their story, the challenges of their past and present, and pointing out their resiliency to increase their empowerment and their ability to improve their lives with the support of BACS Sage team. We see every partner has a voice and choice and they are the decision makers of their lives and by allowing a person to make their own decisions increases empowerment of their lives. In order to make the best decision for themselves, we work on providing them with a sufficient amount of information and resources for them to make the best decision for themselves and be a support provider with their best interest.

b. **Create a Welcoming Environment:** In order to provide a welcoming environment, we approach each individual with non-judgement and see every individual has strengths and has a voice and choice in their treatment. We understand that everyone has different needs and goals so we approach the situation in an individual bases and meet them where they are at in their lives.

III. Language Capacity for this Program: We have staff that speak English and Spanish. We have access to language line to accommodate all language needs for our partners.

IV. FY 21/22 challenges: We continue recovery from the fluxuating challenges of Covid pandemic; however, we still are community based and we continuet to engage with the partners in the community. Staff Retiton: There has been a large turnover in staff which can hinder the communication and engagement with the partner to a new provider. Partners have expressed that meeting someone new can impact their mental health by having to develop trust with a new provider and experiencing the loss of a relationship of the previous provider. The Sage team is also working on increasing their capacity of 400 census and has been working with HAC/BALA to obtain referrals and outreaching to referrals in a timely manner.

Is anyone better off?

V. FY 21/22 Client Impact: We are an agency that does "Whatever it takes" and we continue to provide services and meet partner's where they are at and strive to provide them with a whole person care which means that we support every individual with their unique needs. We continue to have a lot of successes with our partners whether it be they obtain their SSI benefits and we graduate them from our program, get permanent housing, or even reconnect them to natural supports which impacts their mental health and connectedness to family/friends. One success story comes to mind is a partner who has been in the program since 7/2020, she experiences a signficant history of Bipolar and PTSD. She has been homeless since starting the program, was on Behavioral Health Court and had no engagement with her children and grandchildren. Throughout the time she was working with BACS, she has been able to connect to medical and therapy resources, graduated from Behavioral health Court, is currently at a safe haven transitional housing and working with BACS to look at apartments since obtaining a permanent housing voucher as of this month and she has been engaging with her children/grandchildren and they have come to visit her at the safe haven placement. She recently told provider that she can't wait for her to have an apartment where her grandchildren can come over and play in her living room. These are the stories and so many other stories that show how the partners and BACS work together to improve and empower their lives by doing "whatever it takes".

VI. FY 21/22 Additional Information: N/A

VII. FY 22/23 Projections of Clients to be Served: 400

VIII. FY 22/23 Programs or Service Changes: N/A

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 29

PROVIDER NAME: Bay Area Community Services (BACS)

PROGRAM NAME: Service Team Program

Program Description: The Service Team supports clients by building and teaching coping skills, living skills, creating easy access to psychiatric care, and providing housing resources. These services assist adults with SMI to decrease or even diminish mental health symptoms in order to integrate into a community, successfully. Another important purpose of the Service Team program is to avoid and eliminate repeated patterns of psychiatric hospitalizations for our client adults. The service design includes anywhere from weekly to monthly contacts of direct service. Alameda County Behavioral Health using Medi-Cal and Medicare funds currently funds the program. Hospitalizations and incarcerations are a meaningful problem in our area, which occur annually at an increased rate. Supporting our adult clients to understand their mental health symptoms, identify triggers, and manage those symptoms is an essential process of our program. Poor mental health negatively affects an individual's whole-person health, life expectancy, and their ability to envision as well as create their best lives through the Social Determinants of Health.

Target Population: Service Team Program assignment - typically due to their diagnosis and high utilization of emergency/urgent behavioral health systems. Adults 18-59, must have Medi-Cal, Medicare, or be uninsured. Private insurance is not accepted.

How Much Did We Do?

I. FY 21/22:

a. **Number of Unique Clients Served:** 155 **Cost per client:** $7,679

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

a. **Reduce Mental Health Stigma:** Care Coordinators in the BACS Intensive Case Management Service Team (ICM) Program have profound influence on care and attitudes towards care throughout the entire mental health ecosystem in Alameda County, where stigma still exists even within providers and community partners who serve our mutual population. Our staff are trained to hold a “whatever it takes” stance while brokering care with all providers to overcome not only stigma from mental health diagnoses, but also negative history from our participants’ “rap sheet” where many are well-known around the county and often refused services or housing due to their troubled past. We have found that the best way to overcome stigma and “blackballing” towards our participants is to approach providers and partners will a carefully thought out plan of action and rich discussion of the human aspects of the participant’s current situation in a way that paints a picture of how significant change and growth is still, and always possible for our partners.
b. **Create a Welcoming Environment:**
    1. We treat our partners as human beings, not as a case # or diagnosis
    2. The plan is centered around the partner and what is most important to them

3. We do not treat our partners as though their future will repeat the past, we hold unconditional positive regard, hope and optimism.

III. Language Capacity for this Program: English, Spanish, Nigerian Pidgin, African English.

IV. FY 21/22 challenges: Over the past year, ICM has been challenged by a decline in labor force in the mental health field, as well as a reduction in basic resources for emergency and permanent housing, food, clothing and substance use treatment. Staff turnover in FY 21-22 was at least 75%, with moderate signs of this problem continuing to be a challenge for FY 22-23. Important emergency housing resources such as Keep Oakland House and Prop 41 funding were exhausted in FY 21-22 and have not yet been replenished for FY 22-23 with no anticipated timeframe. Demand for substance use treatment programs has increased significantly, with longer wait-times for program entry. The same can be said for emergency and transitional housing, which leads to increased frequency of decompensation and hospitalization for many participants. Enrollment to higher level programs such as FSP is also impacted due to low labor force, so low-level programs like ICM are holding on to acute cases longer. ICM participants would benefit from at least $50,000 (per 150 census) in flexible program funding to help compensate for loss or resources and longer wait-times for resources to come available, and would help prevent participants from having to escalate to a higher level of care.

Is anyone better off?

V. FY 21/22 Client Impact: In the past year, an estimated 30 participants graduated successfully from the program by meeting treatment goals w/ improved functioning that necessitated a lower level of care. Countless episodes of crisis response and prevention mitigated client escalation to a higher level of care such as FSP or long-term impatient care. Clients are routinely reconnected with long-lost family, natural supports, employers and educators that help establish growth and stability ensuring that participants are far less likely to decompensate and require a higher level of care. ICM has a core of low-turnover participants who have formed supportive, reliable and consistent relationships with our staff and have stabilized as a result.

VI. FY 21/22 Additional Information: This year, ICM enjoyed philanthropic support by recieving significant grant funding from a generous donor who believes in and shares our mission. This money has been used to support creative solutions and opportunities for our partners.

VII. FY 22/23 Projections of Clients to be Served: ICM is seeking to open approximately 50-60 new participants in the next fiscal year.

VIII. FY 22/23 Programs or Service Changes: ICM has seen approx. 50% staff turnover in the past year, with a new manager starting in June 2022. The program is currently fully staffed and has a strong outlook for stability w/ low turnover in the new fiscal year. The program aims to resume a traditional structure for division of labor with clinical staff taking lead on case planning and ensuring clinical services are available to all participants while coordinating with adjunct staff to provide a critical rehabilitation role to support daily functioning.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 29

PROVIDER NAME: Felton Institute

PROGRAM NAME: Older Adult Service Team

Program Description: The Older Adult Service Team supports client recovery through a holistic and strength-based approach 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 21/22:

a. **Number of Unique Clients Served:** 78 Cost per client: $14,082

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

a. **Reduce Mental Health Stigma:** Reducing the stigma around mental health issues is an ongoing challenge that OAST, and Felton as an organization, take very seriously. We make an effort to talk openly about this subject in an effort to normalize this and frequently talk to clients about how a psychiatric diagnosis is no different than another medical diagnosis (e.g. you take medication to control your diabetes, taking medication to control your Bipolar I Disorder is similar). We are cognizant of the language we use with clients, family members, and other community members and try to educate people whenever possible about why it is important to talk about mental health and use non-judgmental language.
b. **Create a Welcoming Environment:** Although clients have come into the office much less during the pandemic, Felton has worked hard to make our Alameda office a welcoming place. Front desk staff strive to be helpful and friendly to clients coming in, and all Felton staff present a welcoming attitude. The office is visually welcoming, with open areas with seating, plants, artwork, and signage that clearly welcomes people from various demographics, as well as “all gender” restrooms.

III. Language Capacity for this Program: For the first half of the fiscal year, OAST had a Psychiatric Nurse Practitioner with Arabic language capacity. OAST recently hired an Administrative Manager with Cantonese, Mandarin, and Vietnamese language fluency. Our Peer Specialist has limited Spanish

language capacity. Recruiting and hiring staff, particularly clinicians, with additional language capacity is a priority.

IV. FY 21/22 challenges: The main challenge for the team during FY 21/22 was the pandemic and its myriad related obstacles. When Covid surged, we had to adjust accordingly, and since the population OAST serves is at increased risk, we had to be very careful in this regard. Ongoing outbreaks in residential facilities made it difficult to see clients face-to-face as often as we would have liked, and in many cases caused delays to supporting clients with their case management needs. The fact that this population is less fluent with technology (no client on the caseload has a computer, most do not have cell phones, it is difficult to have a private appointment on a landline in a congregate living facility, etc.) meant that telehealth was often not an option for our clients.

The pandemic's impact on the team in terms of staff being out due to their or a family member's illness was also a challenge. The difficulty of doing this work was certainly compounded by the pandemic, which led to staff attrition and increased difficulty with recruiting new staff.

Is anyone better off?

V. FY 21/22 Client Impact: The contract requires that OAST clients receive a face-to-face meeting within 7 days of discharge from a psychiatric hospitalization or crisis residential facility at least 65% of the time. Even in light of the aforementioned challenges, we were able to surpass this goal, seeing clients in this situation 72% of the time. This likely contributed to the continued stability of clients post-release, as well as strengthening the therapeutic rapport.

Connection to a primary care medical provider is particularly important for older adults, given the increased medical needs and the complex interactions between psychiatric, cognitive, and medical issues. The contract requires that OAST support at least 75% of our clients to see their PCP at least once during the fiscal year. In FY21/22, 78% of OAST clients saw their PCP and most had multiple appointments with their PCP. Many clients who had not seen a PCP in a long time were connected to primary care.

Additionally, several clients who had been precariously housed were supported to move into safer, more supportive, and more stable environments. A number of clients who had previously resisted taking psychiatric medication have successfully started medication regimens and reported symptom reduction. Several clients who had been disengaged from services were re-engaged in treatment during FY 21/22. There are many individual stories of success among the OAST clients, one of which is described below.

Case Study (Pseudonym used below and identifying information altered)

Sheldon Humphreys is a 76 y.o. Black male who came to the Older Adult Services Team (OAST) on January of 2019 due to a long history of mental health issues. Originally from the south, he moved to Oakland at the age of 5. His parents died when he was a teenager and his symptoms began shortly thereafter, leading to a lengthy hospitalizations. Mr. Humphreys also has a long history of homelessness and had difficulty adjusting to living indoors. He has had multiple hospitalizations and crisis contacts within this system of care. Mr. Humphreys has many strengths, including his resilience, optimism, and resourcefulness. He has a strong Baptist faith and maintains a close relationship with his sister, Betty.

Mr. Humphreys has a primary diagnosis of Bipolar I Disorder, Severe, Most Recent Episode Depressed, w/ Psychotic Features, as well as a history of Cocaine Use Disorder and Alcohol Use Disorder. His symptoms include depressed mood, agitation, fatigue, feelings of worthlessness, internal preoccupation, auditory hallucinations, and isolative behavior. These symptoms were not well-controlled, due to his

substance use and difficulty adhering to his medication regimen. His alcohol use contributed to violent behavior that led to multiple arrests. He also struggled to attend to ADLs, including personal hygiene, a healthy diet, money management, and keeping scheduled medical appointments. In mid-2021, Mr. Humphreys was drinking daily and returning to his residence (an independent living home) intoxicated, where he disturbed other residents and caused significant property damage. This behavior ultimately led to his eviction and a return to homelessness.

OAST team members have worked with Mr. Humphreys over the past 3 years to provide case management, individual rehabilitation, and medication management. He was connected to primary care through LifeLong Medical and to Alameda County Subpayee for money management services, and was supported to move into a very nice Licensed Board & Care home. Mr. Humphreys has maintained this placement for nearly a year and says that he is very happy living there. He has now been sober for 10 months. He has been able to attend to ADLS with limited support, including following through with medical appointments and maintaining medication compliance. He reports a significant reduction in his mental health symptoms, and the property manager describes him as a “role model” for other residents.

VI. FY 21/22 Additional Information: N/A

VII. FY 22/23 Projections of Clients to be Served: 90-100

VIII. FY 22/23 Programs or Service Changes: In collaboration with ACBH, OAST has restructured for the coming fiscal year in order to better suit the needs of the individuals we serve. The program has hired a new Administrative Manager and a new Clinical Case Manager, both expected to begin in the coming weeks. At that point, OAST will be fully staffed and with a dedicated full-time manager for the first time in well over a year. OAST has adjusted well to the county’s adoption of the CalAIM standards, which will allow clinicians and staff to spend less time on documentation and more time providing services to our clients. As a largely field-based program, we continue to try to find creative solutions to transportation challenges. One change implemented in the second half of the fiscal year was to set up a Lyft concierge account for use with our clients, which has been helpful.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 29

PROVIDER NAME: La Clinica de la Raza

PROGRAM NAME: Service Team Program

Program Description: The Service Team supports clients by building and teaching coping skills, living skills, creating easy access to psychiatric care, and providing housing resources. These services assist adults with SMI to decrease or even diminish mental health symptoms in order to integrate into a community, successfully. Another important purpose of the Service Team program is to avoid and eliminate repeated patterns of psychiatric hospitalizations for our client adults. The service design includes anywhere from weekly to monthly contacts of direct service. Alameda County Behavioral Health using Medi-Cal and Medicare funds currently funds the program. Hospitalizations and incarcerations are a meaningful problem in our area, which occur annually at an increased rate. Supporting our adult clients to understand their mental health symptoms, identify triggers, and manage those symptoms is an essential process of our program. Poor mental health negatively affects an individual's whole-person health, life expectancy, and their ability to envision as well as create their best lives through the Social Determinants of Health.

Target Population: Service Team Program assignment - typically due to their diagnosis and high utilization of emergency/urgent behavioral health systems. Adults 18-59, must have Medi-Cal, Medicare, or be uninsured. Private insurance is not accepted.

How Much Did We Do?

I. FY 21/22:

a. **Number of Unique Clients Served:** 63 **Cost per client:** $23,368

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

a. **Reduce Mental Health Stigma:** La Clinica reduces stigma by use non-stigmatizing language and interchanging the terminology of mental health with emotional well-being, allowing for a more receptive message to be communicated. For example, sadness (tristesa) is a topic used to engage community members, rather than approaching discussions with mental health language terms such as “depression”. La Clinica emphasizes the improvement in well-being, recognizing disequilibrium, and providing tools and resources for establishing emotional well-being, physical health, and supportive, healthy relationships in one’s life. La Clinica also normalizes the mental health symptoms and promotes recovery through treatment. La Clinica supports individuals and families in becoming active participants in their own healing process by drawing upon their own talents, skills, knowledge, interests, dreams, passions, culture and connections.
b. **Create a Welcoming Environment:** La Clinica has created a welcoming environment for clients in many ways. The art that is posted in waiting rooms, hallways and treatment rooms is soothing and culturally relevant to Latinx families. In addition, La Clinica utilizes a strength-based, family focused cultural approach that identifies, supports and reinforces each Latino individual and family’s critical strengths and protective characteristics to help build resiliency and reduce risk.

La Clinica also uses culturally based methods including “dichos” (proverbs) and “Pláticas” or individual/family sessions to engage participants and employ culturally familiar stories and discussions. One example is the dicho “*No hay mal porbien no venga*” (there is nothing so bad from which something good cannot come), which may be used with participants struggling with depression or loss and helps them to identify that amidst their struggle, someone may have reached out to them and shown care or offered assistance (for example) that can be noted and appreciated to help them feel better.

III. Language Capacity for this Program: English and Spanish.

IV. FY 21/22 challenges: Two clinicians who had some of their FTE dedicated to Service Team clients resigned this fiscal year. In addition, La Clinica has been deeply impacted by the workforce shortages for both clinicians and MHRS positions. La Clinica has recieved less applicants than previous years and the applicants are more likely to drop out of the process.

Is anyone better off?

V. FY 21/22 Client Impact: La Clinica provided 2,342 hours of services to 63 clients. Furthermore, La Clinica provided 534 hours of medication hours to service team clients.

VI. FY 21/22 Additional Information: N/A

VII. FY 22/23 Projections of Clients to be Served: Average monthly caseload 142.

VIII. FY 22/23 Programs or Service Changes: N/A

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 29

PROVIDER NAME: La Familia Counseling Center

PROGRAM NAME: Service Team Program

Program Description: The Service Team supports clients by building and teaching coping skills, living skills, creating easy access to psychiatric care, and providing housing resources. These services assist adults with SMI to decrease or even diminish mental health symptoms in order to integrate into a community, successfully. Another important purpose of the Service Team program is to avoid and eliminate repeated patterns of psychiatric hospitalizations for our client adults. The service design includes anywhere from weekly to monthly contacts of direct service. Alameda County Behavioral Health using Medi-Cal and Medicare funds currently funds the program. Hospitalizations and incarcerations are a meaningful problem in our area, which occur annually at an increased rate. Supporting our adult clients to understand their mental health symptoms, identify triggers, and manage those symptoms is an essential process of our program. Poor mental health negatively affects an individual's whole-person health, life expectancy, and their ability to envision as well as create their best lives through the Social Determinants of Health.

Target Population: Service Team Program assignment - typically due to their diagnosis and high utilization of emergency/urgent behavioral health systems. Adults 18-59, must have Medi-Cal, Medicare, or be uninsured. Private insurance is not accepted.

How Much Did We Do?

I. FY 21/22:

a. **Number of Unique Clients Served:** 109 **Cost per client:** $10,396

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

a. **Reduce Mental Health Stigma:** 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.

The Program team strives to reduce mental health stigma for the clients. One way to achieve this is to help make services accessible for the clients, providing the client knowledge about their symptoms, and about resources they can use (internal) coping skills or external (community resources) to improve their mental health symptoms. Our case managers provide a majority of their service out in the field or homes to make services accessible. The Program staff strive to support client to link to the team psychiatrist to improve their mental health symptoms via the benefit of taking medications consistently. The Program staff provide psychoeducation about the client symptoms to the client and their families. Additionally, Clients receive coaching, to enhance their daily living activities, and learn coping skills. Also monitoring at risk behaviors is another important part of the work the Program staff and creating safety plans and efforts to reduce the risks.

b. **Create a Welcoming Environment:** La Familia's value of belonging speaks to creating the welcoming environment to our clients. This value along with the other ones noted above, are integrated into the organization to remind staff of the values, such as at All Agency Staff meetings. The Program staff provide unconditional positive regard, empathy, compassion and respect to the program clients to help the clients feel welcomed. Staff provide services to clients and their families in the Spanish language helping them receive support in their native language or their preferred language. All of the programs staff are bilingual Spanish and English and many are also bi-cultural. La Familia respects and values their staff and clients for their variety of cultural diversity and provide culturally sensitive services. As mentioned previously, making services accessible by staff serving client in the field or in their homes helps clients feel like the staff are going the extra mile to support them and this fosters a sense of being welcomed and a sense of belonging. The Program staff provide consistent services for our client also helps create a predictable, safe and welcoming space for our clients.

III. Language Capacity for this Program: All the program staff are bilingual Spanish and English speaking.

IV. FY 21/22 challenges: Sadly, La Familia Service Team Program has had 3 clients who have passed away this past year.

La Familia in the Service Team Program do have clients for multiple years and some are age 70 or older that are facing aging health issues and sometimes isolates, many are living in skilled nursing facilities or boarding care homes. There is one client who has the diagnosis of dementia and has interacted with the legal system whom we are currently working with Behavioral Health Court to support him and working towards finding him long term appropriate housing.

The program has several clients who are homeless (with challenges with engaging in services, challenges with med compliance, and refusal to use shelters) and for such clients their case manager worked hard to try to locate the client in the community and also some were referred to other services like IHOT or higher level of care like FSP. To find appropriate housing for the program aging clients is a challenge. Some of the program's clients struggle with substance use and display challenges with wanting to engage consistently with their service provider and often decline linkage to SUD treatment programs. Additionally, some of the program's clients may struggle with Benzodiazepine or other prescribed medications. The Program's Psychiatric Prescribers provide a plan to best support each patient with high tolerance to medications like those who are frequently seeking specific medications (like Benzodiazepine) outside the medications that the La Familia psychiatric prescriber has approved. Some

interventions Psychiatric Prescriber may utilize is to monitor polypharmacy usage by specific patients using web-based system accessible for psychiatric prescribers, come up with a specific medication plan, and coordinate care with other medical providers, review medication records and utilize lab testing. The program Team works together to support the programs client's around their medication compliance. For example, the program's Case Managers support clients with the following interventions: linking the client to the psychiatric provider, supporting the client to get medication refills, assisting with medications delivered, supporting the client with organizing medications in a pill organizer, assisting the client with getting their lab tests or following up with their primary care providers, following up with the client's family or caretaker about medication compliance, and problem solving issues that may arise and report back to the team on challenges.

Another challenge is that some program clients due to their severe mental illness impairments and for some paranoia may not be receptive to wanting to visit their primary care physicians. Staff work using motivational interviewing techniques, coaching about the importance of seeing a doctor, and often implement a reward system (gift card) to encourage clients to have an appointment with their primary care provider for clients that struggle in this area.

With an increase in TAY clients this year, especially towards the end of the fiscal year (May-June 2022) the program management is looking into supporting staff in receiving training in how to work with this special population in a manner that can foster their adult independence skills and desire to seek out employment opportunities. Staff utilize linking clients to the vocation program.

A final challenge to mention is that some clients may not qualify for public benefits like SSI/SSA, Boarding Care, or other housing opportunities, which creates barriers to access needed resources. The Staff work to support such clients in utilizing other community resources that can help fill the need as much as it can.

Providing Services during COVID Pandemic for In-Person Face-to-Face Mental Health Services: The Program continued the 2021 and 2022 year with providing services primarily in person. We did provide more remote services during shelter in place events that occurred especially in the timeframe of: January and February months of the 2021 year, because of the high number of COVID outbreaks. Otherwise, we have been able to resume services while using COVID safety protocols. We also continued to utilize the implemented technology and case managers assist clients with accessing their psychiatric providers via remote services/telehealth sessions. We also implemented video conference office rooms for clients to utilize and see their psychiatric provider, who is remote with their case manager present in the room with them.

Barriers to Medi-Cal & Private Insurance: Our clients come to us with Medi-Cal, or Medi-Cal or Medi-Care and or Health Pack insurance. Some challenges we have faced this past fiscal year was that clients whose Medi-Cal expire for a variety of reasons. Clients may show registered in another county for example.

Is anyone better off?

V. FY 21/22 Client Impact: Over this past fiscal year, we have continued to have services in person. Many of our case managers provide services in clients' homes, boarding cares, visit clients at hospitals, or provide them support out in the community or "field" such as by taking them to doctor appointments etc… Our Case Managers also help search for clients in the community for those that are homeless or

those that have gone AWOL. Our clients benefit most from in person services and the program staff have successfully been able to meet the need of clients with continuing to provide services in person. Many of the program clients have severe mental illness such as Schizophrenia and may have problems with organizing and keeping remote appointments without assistance. For clients that also face the challenge of being homeless, having a case manager that is willing to look for them, has resulted in increased the chances of client engagement with the services. The program supports the clients to link to the vocational program for those interested in employment. The program supports clients to maintain their psychiatric appointments. The program also supports clients who need help with money management via the sub payee program. The program works to reduce homelessness or risk of homelessness by helping them maintain their housing, support those with finding housing such as use of temporary housing and applying to board and care homes. Staff work to improve client's health, mental health and well-being by helping to overcoming barriers to access to social determinants of health by linking client to community resources.

La Familia has installed monitors and webcams for clients to utilize in the conference rooms to speak to their psychiatric providers who are remote with the assistance of the case manager present. This provides the opportunity for the client to use a large screen monitor to interact with their psychiatric provider while having the safety of the case manager present. The opportunity also provides the case manager the information about clients' medications to help encourage client medication compliance.

VI. FY 21/22 Additional Information: The program faced some staff turn-over this past fiscal year; however, we were able to get 2 new Case Managers this summer of 2022 to replace our staff that left in Spring of 2022 and the program Staff Therapist position became vacant this Summer of 2022.

VII. FY 22/23 Projections of Clients to be Served: 110-120.

VIII. FY 22/23 Programs or Service Changes: The program plans to hire a Staff Therapist. The program is implementing the Cal Aim changes to documentation. The program is looking to continue to increase clients seeing their primary care doctor a minimum of 1 x a year. The program is looking to learn how to provide appropriate interventions that can instill gaining adult living skills, and independence and linkage to employment to support the increase of TAY clients referred to the program.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 29

PROVIDER NAME: Asian Health Services

PROGRAM NAME: Service Team Program

Program Description: The Service Team supports clients by building and teaching coping skills, living skills, creating easy access to psychiatric care, and providing housing resources. These services assist adults with SMI to decrease or even diminish mental health symptoms in order to integrate into a community, successfully. Another important purpose of the Service Team program is to avoid and eliminate repeated patterns of psychiatric hospitalizations for our client adults. The service design includes anywhere from weekly to monthly contacts of direct service. Alameda County Behavioral Health using Medi-Cal and Medicare funds currently funds the program. Hospitalizations and incarcerations are a meaningful problem in our area, which occur annually at an increased rate. Supporting our adult clients to understand their mental health symptoms, identify triggers, and manage those symptoms is an essential process of our program. Poor mental health negatively affects an individual's whole-person health, life expectancy, and their ability to envision as well as create their best lives through the Social Determinants of Health.

Target Population: Service Team Program assignment - typically due to their diagnosis and high utilization of emergency/urgent behavioral health systems. Adults 18-59, must have Medi-Cal, Medicare, or be uninsured. Private insurance is not accepted.

How Much Did We Do?

I. FY 21/22:

a. **Number of Unique Clients Served**: 274 **Cost per client:** $9,192

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

a. **Reduce Mental Health Stigma:** Our clinicians are bilingual and bicultural staff with social and cultural experiences from immigration families. The staff have been equipped to effectively access clients' social/cultural needs and deliver services in clients' various AAPI spoken languages. Flyers, brochures, and psychoeducation are available in certain AAPI languages to meet the corresponding cultural and language needs in AAPI populations.
b. **Create a Welcoming Environment:** All of our staff are trained in trauma informed care from administration thru clinician level. Through community outreach and wellness sharing, community members are supported to address the challenges of immigration loss, culture shock, self-care, inter-generational communication, and mental health. We also linked community members and clients to other programs at AHS to meet some of their current needs including health, dental, community engagement programs (parenting group, youth group, etc.).

III. Language Capacity for this Program: Services are available in API languages including, but not limited to: Cantonese, Japanese, Khmer, Korean, Mandarin, Mien, Lao, Thai, Vietnamese, and English. Other API languages require use of language line or external interpreters.

IV. FY 21/22 challenges: The workforce crisis that has made hiring culturally sensitive staff with language capaicty a huge challenge. Additionally, the pandemic and community violence is making some of our clients feel unsafe to attend medical and counseling appointments in person regularly.

Is anyone better off?

V. FY 21/22 Client Impact: We were able to provide effective services to clients despite shortage and transitions. We met all contact quality measures during the FY inclduing client engagment and engaging our cleints to recieve care from PCP.

VI. FY 21/22 Additional Information: We have additional added bilingual and culturally responsive staff as of August 2022. This will help to increase capacity for care for the upcoming FY.

VII. FY 22/23 Projections of Clients to be Served: 272

VIII. FY 22/23 Programs or Service Changes: Change in service location from 310 8th Street, Suite 210 to Suite 201. Effective August 26th, 2022.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 29

PROVIDER NAME: West Oakland Health Council

PROGRAM NAME: Service Team Program

Program Description: The Service Team supports clients by building and teaching coping skills, living skills, creating easy access to psychiatric care, and providing housing resources. These services assist adults with SMI to decrease or even diminish mental health symptoms in order to integrate into a community, successfully. Another important purpose of the Service Team program is to avoid and eliminate repeated patterns of psychiatric hospitalizations for our client adults. The service design includes anywhere from weekly to monthly contacts of direct service. Alameda County Behavioral Health using Medi-Cal and Medicare funds currently funds the program. Hospitalizations and incarcerations are a meaningful problem in our area, which occur annually at an increased rate. Supporting our adult clients to understand their mental health symptoms, identify triggers, and manage those symptoms is an essential process of our program. Poor mental health negatively affects an individual's whole-person health, life expectancy, and their ability to envision as well as create their best lives through the Social Determinants of Health.

Target Population: Service Team Program assignment - typically due to their diagnosis and high utilization of emergency/urgent behavioral health systems. Adults 18-59, must have Medi-Cal, Medicare, or be uninsured. Private insurance is not accepted.

How Much Did We Do?

I. FY 21/22:

a. **Number of Unique Clients Served:** 192 **Cost per client:** $7,122

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

a. **Reduce Mental Health Stigma:** We provide psychoeducation to our surrounding community through community events and interacting with our community partners. We also provide ongoing psychoeducation and training to our staff to help ensure that all our clients are treated fairly and respectfully, even if they display challenging behavior.
b. **Create a Welcoming Environment:** We have welcoming staff who screen all patients at the door. Our BH hallway also has a display case with affirmations and information to support the growth and well-being of our clients.

III. Language Capacity for this Program: English

IV. FY 21/22 challenges: Staffing. We had one staff member on our adult team retire at the beginning of FY 21 and have just now replaced her. We also had another staff on the adult team retire at the end of FY 22. We have no staff for our Children's Outpatient program or for our school-base program.

Is anyone better off?

V. FY 21/22 Client Impact: We have had several clients graduate from our program and shift down to a lower level of care. We began working with Vocational Rehab and have successfully place several of our clients into employment.

VI. FY 21/22 Additional Information: We hired an Associate Director at the beginning of FY 21 and she has been a wonderful addition to our team. My staff continues to be dedicated to our clients in spite of there not being enough staff. We have not been getting any new referrals as the county has been understanding that we are understaffed.

VII. FY 22/23 Projections of Clients to be Served: 160

VIII. FY 22/23 Programs or Service Changes: N/A

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 30

PROVIDER NAME: La Familia Counseling Center

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- Peers Organizing Community Change (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, are able to manage medical needs independently and who voluntarily agree to engage in services.

How Much Did We Do?

I. FY 21/22:

a. **Number of Unique Clients Served:** Sally's Place has provided Peer support Services to 86 unduplicated new guests and re-admitted 121 guests that had returned who required more support either with referrals or respite services. **Cost per client:** $5,103

How Well Did We Do?

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 our 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: We strive to keep our staff as diverse as possible and 30% of staff is bilingual (Spanish/English). When guest arrive to Sally's Place and there is a language barrier we

IV. FY 21/22 challenges: Even though we have a current process on reaching the interested, pending and return guests that are on the waiting list still face challenges with matching the bed availability to the immediate need for respite services. Sometimes when the bed becomes available here at Sally's Place we have difficulty making contact with the next guest which sometimes results in a waitlist.

Sally's Place has continuously received referrals that exceeds the established bed capacity. That is, we have far more people who are interested – and qualify for – services at Sally's Place than we do available beds. This is good because it means that word is getting out about our services and that guests and providers are sharing their positive experiences, but the challenge for staff is holding the knowledge that many of these individuals will go unserved.

It is also challenging when we receive a referral from a case manager, they will give a qualifying address for the guest, but once the guest arrives to Sally's Place, the guest will state that they are effectively homeless. Our current resolution is to forward the information to our Peer Advocate who works on housing during the 14 day stay. We have been successful in finding a housing option for these guests upon exit from Sally's Place. In order to resolve this, we do our best to be as clear as possible about the criteria and explain the rationale to referring providers. We have also worked to identify alternatives to Sally's Place for individuals who do not meet our criteria.

Another challenge that some of the staff at Sally's Place is with staff sharing their personal story in ways that can be triggering to guests; the staff have been coached on how to do more listening and how to thoughtfully gauge how much self-disclosure is useful and helpful for the guests.

Is anyone better off?

V. FY 21/22 Client Impact: Sally's Place impacted 58 African Americans, 23 Caucasian, 24 Mexican/Mexican Americans, 94 Non-Hispanic or Non –Latino, 0 Vietnamese, 2 Asian, 0 American Indian or Alaska Native, 5 Another Race not listed , 4 Unknown, 1 Native Hawaiian or Other Pacific Islander, 0 Other Non –Caucasian community members.

Having only 35 guest's return for services at Sally's Place may mean that they were feeling better also connected to helpful supportive services.

Data shows that Sally's Place have served and supported 40 Females, 52 males and one unknown/unclassified.

According to our guest exiting survey most of the guests were pleased with the Peer support service given and felt hopeful even connected, after working with the Peer Advocate on the 4 phases during their duration of stay at Sally's Place. During Phase #1 the 1-2 days the guest and the Peer Advocate work on the Welcoming and Program overview. During phase #2 –Day 2-6 is spent working on Connections with family and outside social services that the guest would qualify for in Alameda County. Phase #3-day 6-8 is when the Peer Advocate works with the guest on Reflection, checks on how the referrals are going and if any of the referrals were helpful; during this phase the guest would be supported on creating a list of supporters or local sponsors. This is intended to let guest know they're

not alone. The Sally's Place team collaborates on alternatives needed for challenging situations and on Phase #4 day 10-14 is the Preparation phase by where the staff and the Peer Advocate will continue to encourage the guest with tools of hope and motivating words. Also reminds the guest that Sally's place staff are here to support her/him/them with information and resources even after exiting Sally's Place. By creating the four Phases chart we will be able to ensure that we give complete care and support to each guest that Sally's Place comes in contact with, and that it's well documented.

VI. FY 21/22 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, encouraging, 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), CATT TEAM, Mobile Evaluation Team - Fremont Police Department, La Familia, Fred Finch, Cherry hill Sobering station, Cherry hill Detox station, John George Psychiatric Hospital, Jay Mahler, Berkeley Drop In Center, Alameda County Mental Health Network, Sausal Creek, Homeless Action Center –Oakland, Berkeley Mental Health, BACS, Social workers- Stanford Valley care Hospital, Alameda County Family services, Families and Friends.

VII. FY 22/23 Projections of Clients to be Served: 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.

VIII. FY 22/23 Programs or Service Changes: Sally's Place Peer Respite is still fairly a new program. We are the first Peer run Respite in Alameda County. We make constant changes but over all our service delivery model remains the same.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 31

PROVIDER NAME: Felton Institute

PROGRAM NAME: (RE)Mind and BEAM - Early Psychosis Programs (formerly PREP Alameda)

Program Description: The Felton Early Psychosis Programs - (re)MIND® and BEAM - formerly known as PREP Alameda, provide evidence-based treatment and support for transition age youth (TAY) who are experiencing an initial episode of psychosis or severe mood disorder. The programs provide outreach and engagement, early intervention, and outpatient mental health services that include the following categories: mental health services, case management/brokerage, medication support, crisis intervention. In addition, (re)MIND® and BEAM Alameda also provide Individual Placement and Support (IPS) supported employment and education services. The program goals of (re)MIND® and BEAM Alameda are designed to delay or prevent the onset of chronic and disabling psychosis and mood disorders; reduce individuals' hospitalizations and utilization of emergency services for mental health issues; improve the ability of program participants to achieve and maintain an optimal level of functioning and recovery as measured by functional assessment tools; connect participants with ongoing primary healthcare services and coordinate healthcare services with individuals' primary care providers; increase participants' educational and/or employment success; increase meaningful activity as defined by the individual; decrease social isolation; and assist participants with advocating for adjustment of medications to the minimum amount necessary for effective symptom control.

Target Population: Transition Age Youth (TAY) ages 15-24, who are experiencing the onset of first episode psychosis associated with serious mental illness (SMI) and severe mood disorder.

How Much Did We Do?

I. FY 21/22:

a. **Number of Unique Clients Served:** 76 clients. 48 in (re)MIND®, and 28 individuals in BEAM.
   Cost per client: $17,631

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

a. **Reduce Mental Health Stigma:** Felton staff continues to educate program participants and families to normalize the experience of mental health challenges. In May of 2022, the Felton (re)MIND and BEAM programs held an Open House to reduce stigma around mental health. The theme was "Mental Health IS Health". Felton staff hosted around 30 people coming into the program's offices to learn more about the program; it was attended by several families and clients, staff from sister agencies, and other stakeholders. Felton staff and several Felton clients provided psychoeducation around psychosis and bipolar disorders, medication use, employment and education resources and community resources that promote mental health. The Open House was a great success and enjoyed by all.

The Felton (re)MIND® program has developed and maintained several groups to reduce mental health stigma. The first is the Youth Group; this group is focused on providing psychoeducation around psychotic and bipolar symptoms, building coping skills, developing a social network between the program youth and normalizing mental health experiences. It is regularly attended by 3 to 7 transition age youth. Felton also restarted the virtual Family Group in 2022, in which Felton staff provides psychoeducation to families of the youth.

In addition, Felton has an ongoing outreach program; Felton staff has presented our program and provided psychoeducation about mental health issues to a variety of community programs, including NAMI family groups, a local synagogue, inpatient programs, and case management programs. Felton staff provided mental health resources to participants and strongly encouraged de-stigmatization at all the program's community presentations. In addition, Felton staff uses various strategies that are non-stigmatizing and non-discriminatory with the youth and families served.

b. Create a Welcoming Environment: In the office, the Felton staff have created a space that is TAY friendly by incorporating youth-friendly art in the office space. Felton staff have also developed resource centers, providing a variety of materials to the youth and their families about psychoeducation around mental health symptoms and interventions, substance use treatment resources and vocational and educational resources. Felton staff have also created a youth-oriented lending library; the program is encouraging engagement through reading. Felton staff have created an environment that reflects ethnic and cultural diversity which is also reflected in the program materials.

Felton staff is responsive to the cultural needs of our youth and their families, encourage cultural expressions, and use client-centered and non-discriminatory language. Felton staff consistently attend 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, Felton staff have continued to implement changes to the office space to promote health and safety during the pandemic, such as a sanitation station, staff and visitor sign-in log and furniture spaced 6 feet apart. Although these changes made the environment slightly less welcoming (temporarily discontinued snacks, games, and rearranged furniture in common areas), Felton staff have approached them from a community-safety perspective and use every opportunity to educate 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, Felton's staffing language capacity includes English and Spanish. Overall, the programs served 70 participants in English and 6 participants in Spanish. In addition, Felton staff have prompt access to interpreter services as needed for other threshold languages.

IV. FY 21/22 challenges: Felton staff faced two primary challenges that impacted service delivery: COVID-19 and its impact on service delivery and lengthy staff vacancies (including a clinical care manager and a peer support staff). To address the challenges due to COVID-19, Felton staff have continued to utilize a hybrid model of service delivery. Felton staff continued to provide face-to-face services to the TAY youth in the community as well as in the programs' offices, using all COVID-19 safety precautions. Felton staff 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. Felton staff also created accessibility for staff to be able to provide telehealth through Zoom for Healthcare and for faxes to be sent and received electronically. Felton staff strive to provide as many sessions as clinically appropriate via Zoom and phone calls; however, many of the youth and their families prefer and require face-to-face contact. To help prevent the spread of COVID-19, Felton is providing KN95 masks to all staff for in-person visits. In addition, Felton have obtained at-home rapid COVID-19 tests to test staff and clients if there is a potential exposure. This has helped keep many of the youth and their families engaged with services. In addition, Felton staff continued to deliver group support; the programs are currently providing both a Youth group and a Family Support group via Zoom once per week. This required a great deal of adaptability on the part of Felton staff, the youth and their families.

In order to reduce staff vacancies, Felton Institute has developed better recruitment strategies; Felton have invested in a recruiting service called ICIMS. This service aggressively seeks new recruits across a variety of job recruitment websites. In addition, Felton have also reached out to local colleges, reentry programs and BestNOW. Over the past 12 months, the Felton (re)MIND® and BEAM programs have hired a Peer Support Specialist (a BestNOW Graduate) and an additional SEES/IPS staff from a local college. The programs also hired a bilingual clinical care manager as well as a clinical care manager. Our only remaining vacancies are for a bilingual master's level care manager/therapist and a peer support specialist. With COVID-19 restrictions lessening, Felton staff remain hopeful to be able to continue to provide the full scope of case management, psychiatric and employment/education services.

Is anyone better off?

V. FY 21/22 Client Impact: Impact Objective was to have an 80% decrease in CS, PHF, and psychiatric hospital admissions for the youth served for 12 months or more. During this reporting period, there were 30 youth who had received services for 12 months or more. Of these 30 youth, 25 individuals had at least one admission to CS, PHF, or psychiatric hospital in the previous 12 months before enrollment. Sixteen out of these 25 youth (64.0%) showed reduction in the total number of crisis stabilization or inpatient services episodes. While the programs were unable to reach the Impact Objective of having 80% of the participants have a reduction in the inpatient admissions, many of the youth experienced increased anxiety and paranoia as a result of the impact of COVID and its social isolation, increasing their need for hospitalization.

- A notable outcome related to reduction in inpatient services is that 14 of the 25 (56.0%) youth who had prior inpatient stays did not have any CS, PHF, or psychiatric hospital stays after entering the program. The Felton (re)MIND® and BEAM programs were successful in helping 56.0% of these youth re-integrate into the community and return home to their families. Thus, these youth were able to avoid the debilitating effects of any further hospitalizations.
- It should also be noted that Felton was successful in assisting several clients from entering the inpatient system. Five participants, because they had no history of inpatient care, were excluded from group of clients receiving 12 months or more of services; these five participants continued to not have any inpatient stays. If these participants were included in the outcome for reduced or zero hospitalizations, the outcome measure would be 76.7% of all youth did not have an increase in hospitalizations. The Felton (re)MIND® program was successful in helping these youth undergoing early psychosis symptoms from ever entering the inpatient system.

Personal Client/Success Story: For FY 2021-22, the Felton programs had a number of success stories. One such story involved a youth who was struggling with severe depression with psychotic features while they attended college at Howard University. As a result of their symptoms, they were hospitalized

several times and withdrew from Howard University. After returning to the Bay Area to live with family, they were referred to the program almost 2 years ago. While in the program, they continued to struggle with depression and substance use. With supportive therapy, medication services and family support, they were able to better manage their symptoms; they have been clean and sober for many months and they have not been back to the hospital in 1.5 years. In fact, they have applied to and been reaccepted into Howard University; they plan to restart Howard this Fall. At the time of writing this report, the client and their father are researching apartments in the DC area that are close to Howard University; they are both excited about their return to college. The youth attributes their success to the support they received from their Felton staff.

Another success story is about a young person who has struggled with psychotic symptoms for several years. Prior to the onset of their symptoms, they were working as a manager at a local sandwich shop; they were also on track to attend college. However, their symptoms disrupted their life; they lost their job and had to move back home with their family. Initially, they were difficult to engage; after having multiple bad experiences with hospitalizations, they were reluctant to accept services and declined to take psychotropic medications. Felton staff took a supportive, engaging and recovery-focused approach to providing care; with a great deal of encouragement, the client accepted Felton services and learned coping skills to better manage their symptoms. With a great deal of coaching and support from our IPS staff, the client was able to apply to and be accepted at Civicorps; they have been working there for several months now. The client states that they love their job; they also report that their quality of life is much better, thanks to the support they received through the Felton (re)MIND program.

VI. FY 21/22 Additional Information: A notable outcome related to reduction in inpatient services is that 14 of the 25 (56.0%) youth who had prior inpatient stays did not have any CS, PHF, or psychiatric hospital stays after entering the program. Our programs were successful in helping 56.0% of these youth re-integrate into the community and return home to their families. Thus, these youth were able to avoid the debilitating effects of any further hospitalizations.

It should also be noted that Felton was successful in assisting several clients from entering the inpatient system. Five participants, because they had no history of inpatient care, were excluded from group of clients receiving 12 months or more of services; these five participants continued to not have any inpatient stays. If these participants were included in the outcome for reduced or zero hospitalizations, the outcome measure would be 76.7% of all youth did not have an increase in hospitalizations. The Felton (re)MIND® program was successful in helping these youth undergoing early psychosis symptoms from ever entering the inpatient system.

VII. FY 22/23 Projections of Clients to be Served: Our programs are expecting to serve 100 unduplicated individuals in FY2022-23.

VIII. FY 22/23 Programs or Service Changes: Our programs plan to continue to adapt the services due to the COVID-19 pandemic. To address the challenges due to COVID-19, Felton staff have developed a hybrid model of service delivery. Felton staff continued to provide face-to-face services to the TAY youth in the community as well as in the programs' offices, using all COVID-19 safety precautions. Felton staff 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. Felton staff also created accessibility for staff to be able to provide telehealth through Zoom for Healthcare and for faxes to be sent and received electronically. Felton staff strive to provide as many sessions as clinically appropriate via Zoom and phone calls; however, many of the youth and their families prefer and require face-to-face contact. This has helped keep many of the youth and their families engaged with services.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 32

PROVIDER NAME: Crisis Support Services

PROGRAM NAME: Suicide Prevention Crisis Line

Program Description: The Suicide Prevention Crisis Line is a 24-Hour Crisis line provided by Alameda County Crisis Support Services to provide: Crisis counseling in order to reduce the incidence of suicidal acts; lessen the number of psychiatric hospitalizations needed by individuals with suicidal thoughts; resolve crises; decrease self-destructive behavior; and increase awareness of suicide risk factors.

Target Population: The Suicide Prevention Crisis line provides a 24-Hour phone line for assistance to people of all ages and backgrounds during times of crisis, or their families, to work to prevent the suicide. Translation is available in more than 140 languages. We also offer teletype (TDD) services for deaf and hearing-impaired individuals.

How Much Did We Do?

I. FY 21/22:

a. **Number of Unique Clients Served:** 10,510 Clients ACBH portion of total program budget:$275,165

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

a. **Reduce Mental Health Stigma:** One major component of mental health stigma is the stigma around asking for help. Having 988 be an easy to remember number to access the crisis line service normalizes the act of reaching out for mental health care. For example, one caller stated they were struggling with suicidal experiences and have thought about reaching out for a while. Seeing advertisements about 988 motivated them to call for the first time. Our 988 Alameda County Collaborative invites community members who may not have considered themselves as part of the crisis continuum to join. This empowers the community leaders to talk about mental health services with their constituents, further normalizing help seeking behavior. We share information about our team mates on social media and 988AlamedaCounty.org website. The teammates share their own lived experiences with mental health challenges. This demystifies the crisis line services and hopefully increases the caller's confidence in reaching out for help. Lastly, we've spoken to the media including the SF Chronicle and El Tecolote. We hope that stories and pictures of the crisis line program and our agency and team mates encourage people to utilize the services.
b. **Create a Welcoming Environment:** Our recruitment efforts prioritize equity. We are actively recruiting for a workforce (with paid positions) that reflects the diverse ethnic and cultural communities of Alameda County, and demonstrates knowledge and/or understanding of the cultural beliefs, practices, and language needs of the populations considered un-served, underserved, or inappropriately served. We want folks who belong to groups and communities that have been historically marginalized and harmed by systemic racism and other forms of oppression and folks who have linguistic capacity to provide services in one of the Alameda County threshold languages. This value is systematically woven into our recruitment and hiring

practices including updated job descriptions, flyers and posters, interview questions, and hiring process.

III. Language Capacity for this Program: English mostly. Crisis Line Counselors have access to 24/7 interpreter services in more than 140 languages via Language Lines Solutions. We understand that native speakers are more effective than interpretation services because of their cultural understanding when providing mental health services. We currently have 1-5 native Spanish speakers, as well as 1 Korean speaker on the team. We continue to recruit bilingual staff and incentive their position at CSS with annual stipends.

IV. FY 21/22 challenges: Staff shortage with paid staff and volunteers continues to be a challenge. With the state of the pandemic and the economy, fewer people are able to volunteer their time, especially for the crisis line role that requires a high level of knowledge, skill, and time commitment. It also takes longer to acquire the knowledge and skills for volunteers who typically work 4 hours/week. We created a new paid phone counselor where their primary duty is to answer the crisis lines and county after-hours line. They typically work 10-40 hours/week. We've been successful in recruiting the staff and now are in the process of training them.

Is anyone better off?

V. FY 21/22 Client Impact:

IMPACT MEASURES	IMPACT OBJECTIVES	ACTUAL IMPACT	Objective Met?
The percent of crisis line consumers with a risk level of 3 or higher who self-report a reduction in suicide intent from the initiation of the call to the end of the call among those who report suicide intent at the start and end of the call.	At least 20%	59.1%	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	899 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%	83.8%	Yes

QUALITY MEASURES	QUALITY GOALS	ACTUAL SCORE	Objective Met?
Percentage of qualifying participants who answer the survey	10%	5.15%	No
Percentage of survey participants who rated they are likely, more than likely, or extremely likely to call again if they needed help.	75%	82.87%	Yes

Percentage of survey participants who rated they felt connected, very connected or extremely connected to the counselor they spoke with.	75%	82.55%	Yes

With our phone system, we set up an automated satisfaction survey. Only a single question can be set up at a time so we alternated the questions below each month between July-February. During the survey period we had 23,134 calls. Of those the survey was completed 1192 times by callers for a conversion rate of 5.15% of qualifying calls. To reach our goal of surveying 10% of calls we will likely need to adjust our practices, perhaps scripting in a reminder message from the counselor at the end of calls.

Here are some positive sentiments shared on the survey:

- The counselor I spoke to today was really awesome. He listened, validated, and encouraged me, and I definitely felt a little bit better with the grief I was dealing with after talking to him. Thank you for all you do on this line.
- I just want to say thank you for answering the phone, because that is an amazing thing. I just needed someone to hear me and to get these feelings out of my head. I will definitely share this number with my family and friends.
- This counselor was really good. I have some serious stuff going on. Scary and sad stuff. And she was so helpful. She was making me feel it was normal to feel what I was feeling and that there was hope for the future. She listened to me and she gave me a lot of good information and I am just so appreciative of this service.

VI. FY 21/22 Additional Information: N/A

VII. FY 22/23 Projections of Clients to be Served: 10,000 clients

VIII. FY 22/23 Programs or Service Changes: 988 is the new easy to remember number to reach the National Suicide Prevention Lifeline (the Lifeline) which has been around since 2005, providing access to crisis lines through more than 200 local crisis centers across the country. Calls from 510, 341, and some 925 area codes ring to our crisis line program.
In partnership with Stephanie Lewis and Alameda County Behavioral Health, CSS created the Alameda County 988 Collaborative - A collaboration of first responders, crisis services providers, mobile crisis teams, peer responders, family advocates, and anyone who provides care along the crisis continuum. We have a shared vision of an Alameda County where everyone - in all our diversity - has ease of access to life saving services. We hope to facilitate communication and collaboration with each other - as well as state and federal stakeholders as we move towards a more robust and connected crisis system. Working together, we will continue to educate the community and general public about accessing crisis services and realistic expectations of what our system can offer. We are so inspired by everyone's dedication and hard work meeting the crisis needs of Alameda County.

The key objectives of the 988 Alameda County Collaborative include:

1. Facilitating communication between all county, community-based organizations, first responders, crisis stabilization, crisis residential, peer respite and anyone who provide services along the crisis continuum.
2. Establish protocols with every 911 call center to transfer non-violent, non-emergency, mental health and substance use related calls to the crisis line program.
3. Communicate to the public information about services along the crisis continuum

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 32

PROVIDER NAME: Crisis Support Services

PROGRAM NAME: Zero Suicide Program

Program Description: The Zero Suicide program includes 4 components: Hospital follow-up, Survivors of Suicide Attempt groups, Educational presentations at Santa Rita Jail, and outreach and education to health providers.

Target Population: Each of the four components listed above has a specific population that it works to reach in an effort to address those working with high risk populations or to support individuals directly who are at high risk for dying by suicide due to recent hospitalization or history of an attempt.

How Much Did We Do?

I. FY 21/22:

a. **Number of Unique Clients Served:** 698 ACBH portion of total program budget: $275,165
   - Hospital follow-up: 100
   - Survivors of Suicide Attempt (SOSA) groups: 19
   - Educational presentations at Santa Rita Jail: 277
   - Outreach and education to health providers: 302

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

a. **Reduce Mental Health Stigma:** Both the educational components of the program specifically address stigma regarding suicide at a systemic level as part of the curriculum. SOSA groups and Hospital Follow-up contacts are able to address stigma around help seeking on an individual group through providing positive help seeking experiences and being a bridge to appropriate level of care.
b. **Create a Welcoming Environment:** The two educational components address this at a systemic level by helping other systems be more welcoming to those experiencing mental health challenges and suicidality specifically. The SOSA groups and Hospital Follow-up are explicitly our opportunity to provide caring connections, meet clients where they are at, and use those with lived experiences as a way to be welcoming.

III. Language Capacity for this Program: Hospital Follow up supervisor is bilingual in Spanish. All other services are provided in English only.

IV. FY 21/22 challenges: Outreach and education to health providers: Before the onset of the COVID-19 pandemic, outreaching to primary care clinics and other healthcare settings in Alameda County was challenging partly due to the inherent nature of community health clinics being very busy and finding time for a training. Many of our trainings frequently occurred during a time when a clinic was closed for lunch. In these 2 years of the pandemic, we hosted virtual presentations for health care providers nearly every month and on different days and times in order to attempt to reach our target population who

were among the most important frontline workers against COVID-19. A 15 of 25 significant challenge was that while registration would be high at times for these workshops, attendance was about 50% or less. Other times, registration would be low, and would need to cancel.

Survivors of Suicide Attempt (SOSA) groups: Our SOSA group had fewer referrals and less attendees, with the highest number of attendees in one group being four. The mean number of attendees was two throughout the first cycle, and ended with one consistent participant. A decision was made to put the group on pause in order to do more outreach. Clinical program staff developed a plan to offer the group at a community setting over the summer as a part of our outreach attempts. The BACS Hedco Wellness Drop-in Center agreed to host the SOSA group, and the first group was June 23rd. Modifications were made to the curriculum to allow for a drop-in model while keeping the intent of the curriculum intact. As of 6/30, fifteen individuals agreed to attend two groups, all of whom were coping with housing insecurity and mental health challenges. This is an increase of more than four times our highest attended SOSA group. The program plans to explore ways to increase accessibility and develop connections with agencies providing adjacent services to increase engagement.

Is anyone better off?

V. FY 21/22 Client Impact: Below are some direct feedback from our hospital follow up program. Considering the elevated risk for suicide for those who have recently been hospitalized, the ability to build individual connections and provide positive help seeking experiences is at the core of this service.

- Your calls help me feel so calm inside. I always look forward to them. - Female 54
- This means so much to me. When a psychologist tells me something I just get upset because I never feel like they really understand…but this feels different. I feel like you really understand my struggle. Thank you. - Male 38
- Sorry to text you so late but I couldn't wait for our next session. I just wanted to share that it's been 45 days that I've been self-harm free and I'm so proud of myself! - Female 18
- Thanks for calling my wife…these calls mean a lot to her. - Husband of Female client 65

VI. FY 21/22 Additional Information: N/A

VII. FY 22/23 Projections of Clients to be Served: 750

VIII. FY 22/23 Programs or Service Changes: SOSA groups will collaborate with other providers to offer the groups at sites that are more established in the community as a way to build on existing rapport and address some barriers to accessing services.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 33

PROVIDER NAME: Felton Institute

PROGRAM NAME: Deaf Community Counseling Services (DCCS)

Program Description: DCCS provides outpatient mental health services, including assessments, individual psychotherapy, family therapy, collateral and indirect services to provide information and referrals to community members.

Target Population: DCCS provides services for residents of Alameda county who have medi-cal, medi-medi or who are medi-cal eligible who are Deaf, DeafBlind, deaf with additional disabilities, late Deafened (those who were born hearing and became Deaf or lost their hearing in adulthood), hard of hearing (those who do not use sign language but use spoken language), from age 5 years to older adults. We also work with parents and family members of Deaf children or adult Deaf children. For the rest of this report, the word: "Deaf" will be used to include all clients with any kind of hearing impairment or loss or preferred communication mode.

How Much Did We Do?

I. FY 21/22:

a. **Number of Unique Clients Served:** 26 **Cost per client:** $11,452

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

a. **Reduce Mental Health Stigma:** by educating the community and providers about Deaf culture, norms, beliefs, and values and that the Deaf community feels proud about their Deaf identity and helping Deaf individuals to reclaim their identity. DCCS also educates the community about demonstrating social model of deafness rather than deficit model, which is a perspective that a Deaf person needs to be "fixed" or believe to have little to no decision-making capabilities, which lead to internalized stigma among the Deaf community.
b. **Create a Welcoming Environment:** DCCS uses promotional materials stating that this is a safe space for Deaf-friendly LBTQIA+ community and all DCCS staff are fluent in American Sign Language. Staff also attends students' IEP meetings and other multidisciplinary meetings as requested by providers, schools, parents/caregivers, and clients.

III. Language Capacity for this Program: English and American Sign Language (ASL). ASL Therapists and Case Managers are fluent in American Sign Language and ProTactile Sign Language. Some of the staff are oral English speakers who can work with Hard of Hearing clients who rely on oral English communication and lipreading only.

IV. FY 21/22 challenges: The referrals have increased dramatically after the program director restragized referral system and outreach efforts and program is understaffed. There is a statewide/nationwide shortage of clinical staffing who are fluent in ASL and works primarily with the Deaf and Hard of Hearing

community. With the increasing referrals, the interpreting expenses have exceeded in order to accommmdate interpreter requests.

Is anyone better off?

V. FY 21/22 Client Impact: A youth was referred to DCCS for services to address self harm and suicidal behavior, which prevented this youth from living in a dormority due to risk of safety to self. After three months of providing services, the client no longer demonstrates self harm and suidicial behavior and was able to return to school domoriity, thus reducing caregiver's long drive from home to the school doromority and relationship with caregiver has improved.

VI. FY 21/22 Additional Information: The program director focused on workforce development by establishing a DCCS internship program and have recruited 3 interns from various universities. One of the interns' specialties is art therapy and the program director assisted the intern and developed art therapy program for the Deaf clients to participate in. The program director strategized and increased hiring and outreach efforts by attending conferences in another state, providing presentations, training, and consultation to service providers, and collaborating with Felton Institute's communication team. As a result, DCCS received more than 100 referrals in the past 12 months. By the end of this fiscal year, DCCS hired 1 Administrative Manager/Interpreter and 1 full-time case manager. DCCS recently added more positions and have been interviewing candidates. Most of them learned about DCCS through word of mouth in the Deaf community after program director increased networking with other states as well as attending out of state conference.

VII. FY 22/23 Projections of Clients to be Served: The DCCS program hopes to serve 40 adults and 10 for children in the next 12 months. DCCS's goal is to increase staffing to accommodate the increasing referrals.

VIII. FY 22/23 Programs or Service Changes: N/A

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 34

PROVIDER NAME: Alameda Family Services

PROGRAM NAME: School-Based Behavioral Health

Program Description: The Outreach for School-Based Health Centers program is designed to bring awareness and information about how to identify early signs of mental illness in youth and connect those in need with the mental health services offered through the School-Based Health Centers. Efforts are targeted to reach potential responders and youth.

Target Population: Adult potential responders and high school age youth living in Alameda County.

How Much Did We Do?

I. FY 21/22:

a. **Number of Unique Clients Served:** 1,452 **Cost per client:** $87

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

a. **Reduce Mental Health Stigma:** AFS has helped reduce mental health stigma at 3 different high schools in Alameda this year. Our School-Based Health Center (SBHC) staff, in coordination with our Youth Advisory Board Members organize and facilitate classroom presentations and tabling events focused on suicide awareness and prevention, healthy relationships (creating awareness around the cycle of violence, warning signs), and how to identify as well as manage stress and anxiety (around finals).

   All of the outreach efforts are focused on reducing stigma by both openly talking about mental health concerns and normalizing them within the school community. Students who attend a presentation or participate at one of the lunchtime fairs will obtain information about a mental health topic, how to identify when something is a concern, and how to reach out for support both on campus and in the community. Students become aware of the SBHC and its services throughout the year and even self-refer for mental health services.

b. **Create a Welcoming Environment:** Students engaging with our events is key to our success, therefore we place a great deal of emphasis on creating a welcoming environment at all of our lunchtime tabling fairs. One of the first ways that we do this is by having the tables hosted in partnership with our Youth Advisory Board members. We aim to eliminate the barrier of a student being intimidated to come to a table hosted solely by adults. Once a student is at a table, they are greeted by an array of colorful and informative flyers, handouts, and an activity designed to promote education on the topic or practice a self-care/coping skill. Students are then encouraged to participate in the other activities as we have no less than 4 distinct tables at each of our events.
   Our SBHC team knows the vulnerability a student has when they come to the SBHC for the first time to ask questions and/or seek mental health support. Our staff make every effort to create a warm, welcoming environment. Teachers and school faculty are at the classroom presentations

and also stop by our tabling events. We also make sure to support and appreciate those responders who identify and then refer youth to our services.

III. Language Capacity for this Program: We currently offer services in English.

IV. FY 21/22 challenges: A challenge this year was deciding if we were going to host in-person events and if we were, how would we prioritize the health and safety of our staff, the Youth Advisory Board, and the student community. We spent time evaluating options and brainstorming solutions. Once school started and we saw the energy that students had returning on campus we quickly made the decision that all of our events will be in-person. To mitigate risks, we held all of our events outside and had all of our staff and Youth Advisory Board members wear masks. We set up hand sanitizer stations at each of the tables. We created QR codes so that students could take surveys on their own devices rather than sharing a tablet.

Is anyone better off?

V. FY 21/22 Client Impact: Outreach efforts are focused on increasing students' awareness about mental health, as well as where and how to seek support if in need. Students who attend our events, classroom presentations, or interact with our social media receive information about a variety of mental health topics. We provide students with local and accessible resources both on campus and in the community. Additionally, we ask students to fill out a survey as they leave our events to provide us information on what they learned, their knowledge about where to access support if needed, and suggestions for future topics.

Of the students who participated in the surveys, 95% reported learning something new about the topic of the event. And 94% of the students reported knowing/learning that they could access mental health services at the SBHC if needed. Approximately half of the students that we serve at the SBHCs are self-referral, highlighting that students are going to the SBHC on their own with the knowledge they can obtain mental health support.

The impact of this program is also extremely influential on the Youth Advisory Board members. The students who volunteer to be a part of the Youth Advisory Boards have a passion for the health and wellbeing of their peers and community. These youth dedicate time to learn about mental health topics in an effort to spread awareness and reduce stigma. A number of the youth who participate in the Youth Advisory Board actually access mental health services for the first time after having joined. They also provide feedback to our staff and clinicians about how to better support the needs of the school community.

VI. FY 21/22 Additional Information: N/A

VII. FY 22/23 Projections of Clients to be Served: Plan to provide outreach to a similar number of youth in the following year.

VIII. FY 22/23 Programs or Service Changes: There are no plans to make any changes to our programming or services the following year.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 34

PROVIDER NAME: East Bay Agency for Children (EBAC)

PROGRAM NAME: School-Based Behavioral Health: Castlemont Middle School, Castlemont High School and Roosevelt Middle School

Program Description: MHSA Braided funding for Expansion of School-Based Behavioral Health in the Oakland Unified School District (OUSD). MHSA funding is being braided with Educationally Related Mental Health Services (ERMHS) and Early Periodic Screening Diagnosis and Treatment (EPSDT) funds to provide enhanced (non Medi-Cal billable) mental health services and supports to children in Counseling-Enriched Special Day Classes (CESDC) and two of its School Based Behavioral Health (SBBH) programs in OUSD in order to assist these children and their families in becoming successful in school and at home.

Target Population: Youth attending Counseling-Enriched Special Day Classes (CESDC) and/or two of its School Based Behavioral Health (SBBH) programs in OUSD.

How Much Did We Do?

I. FY 21/22:

a. **Number of Unique Clients Served:** EBAC provided a total of 3,596 unduplicated services to 22 clients (students enrolled) throughout the 21-22 school year. The total unduplicated services are within the following categories: Family and Caregiver Supports, School Culture and Climate, and Direct client related services and supports. ACBH portion of total program budget: $138,250

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

a. **Reduce Mental Health Stigma:** EBAC continues to collaborate with partnership staff to ensure community agreements are developed so that all students are inclusive to the school climate and culture. We want to continue building authentic relationships and activities, create safe-enough spaces, support self-regulation along with co-regulation, and having time and space for consultation and relationship building amongst team members as well.
b. **Create a Welcoming Environment:** EBAC continues to develop and implement trauma-informed therapeutic spaces for staff, youth and families. We want to ensure staff are supported with engaging clinical tools to aid in building recovery and resilience with youth/families, create an intentional system that is accessible to staff and can be utilized and improved together over time, and hope that this will create lasting change and help staff feel they have access to the tools to do their work, and do it well.

III. Language Capacity for this Program: While the data we collected informed us that the primary language needs at Castlemont and Roosevelt are unknown for the 3,596 services, our services were predominantly provided in English. Staff spoke with students, caregivers, and site staff in English when conducting services.

IV. FY 21/22 challenges: 21-22 continued to be a challenging year as we continue to navigate the pandemic and its unknowns. While almost all learning and engagement occurred in-person and onsite, there continued to be inconsistency in attendance, causing inconsistency in services provided by EBAC. Additionally, parent/ family contact on a consistent basis was a challenge. Due to the ongoing pandemic challenges, several families shared feeling stressed and/or overwhelmed while juggling home life and work.

Is anyone better off?

V. FY 21/22 Client Impact: Over the course of the year, students were impacted at various times of the year. Despite the staffing challenges at Roosevelt, having a smaller caseload/number of students allowed for increased 1:1 support and student growth. Multiple students were more engaged both academically and with mental health services and were motivated to meet their individual goals. At Castlemont, the freshman displayed some difficulty adjusting to a new school environment but multiple students actively participated in services, obtained support in their mainstream classes, and seniors were on-track to graduate.

VI. FY 21/22 Additional Information: One of our on-going challenges has been related to data systems. Our team is working to ensure data is entered in a timely manner and the county is receiving the information correctly. There are a lot of "unknowns" in the data. The staff are only collecting what is in the Alameda County Survey Monkey so we do not have any data on Veteran Status, Sex at Birth, Disability, etc.

VII. FY 22/23 Projections of Clients to be Served: EBAC is anticipating changes to the number of clients being served as the classroom size for the 22-23 school year will be increasing on both of our sites (from 4-6 students to 8-12 students). We will continue to partner with all available caregivers and collateral supports for each student.

VIII. FY 22/23 Programs or Service Changes: EBAC is happy to collaborate with new OUSD staff at Roosevelt Middle School. During this time, we are actively learning about the roles and responsibilities between EBAC and new OUSD staff but will continue collaborating on how to best support the clients and their families.

EBAC continues to be flexible in providing services and working through any COVID guidelines and restrictions with in-person services. As we continue to be in-person, there are more opportunities to work collaboratively with school staff to support client needs and connect with caregivers.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 34

PROVIDER NAME: Fred Finch Youth and Family Services

PROGRAM NAME: School-Based Behavioral Health: Westlake Middle & High School, Montera Middle School, Oakland High School and Skyline High School

Program Description: MHSA Braided funding for Expansion of School-Based Behavioral Health in the Oakland Unified School District (OUSD). MHSA funding is being braided with Educationally Related Mental Health Services (ERMHS) and Early Periodic Screening Diagnosis and Treatment (EPSDT) funds to provide enhanced (non Medi-Cal billable) mental health services and supports to children in Counseling-Enriched Special Day Classes (CESDC) and two of its School Based Behavioral Health (SBBH) programs in OUSD in order to assist these children and their families in becoming successful in school and at home.

Target Population: Youth attending Counseling-Enriched Special Day Classes (CESDC) and/or two of its School Based Behavioral Health (SBBH) programs in OUSD.

How Much Did We Do?

I. FY 21/22:

a. **Number of Unique Clients Served:** 33 youth and their families. ACBH portion of total program budget: $273,000

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 feel successful in 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 the use of conversational Spanish when needed. Our Family partner staff supported 4 of our Spanish speaking parents with navigating systems. All threshold languages are available via Alameda County Behavioral Health Language Phone Line when needed. Printed materials are available in English and Spanish.

IV. FY 21/22 challenges: Challenges during this fiscal year have been the difficulty of hiring Clinicians for school sites of Life Academy and Skyline High school, we also lost a clinician towards the end of the

school year at Montera. Not being fully staff greatly impacted the ability to provide services in key areas such as teacher training, life skills, and college/ career exploration. We experienced challenges with teacher consult on trauma informed interventions and implementing positive behavior systems, related to OUSD teachers often not engaging in active teaching of lesson plans.

Is anyone better off?

V. FY 21/22 Client Impact: Though our MHSA funding we continue to make an impact on the climate and culture within the school and our ability to support the I-CESDC students engage in schoolwide events. During this school year school site Life Academy and Fred Finch staff collaborated and planned for ways to ensure the I-CESDC students had every chance available to engage in a month long of post session activities. Historically I-CESDC students are often not engaged in large school activities or looked over due to the needs that they present with. Having MHSA funding has allowed us to make an impact at the school for our clients. We planned ways to ensure clients participation which often was our staff also participating in field trips or seminars. Fred Finch staff provided tools to teachers on ways to engage and supportive interventions to use to encourage client's participation in activities. One particular client benefited from this support. This client has social anxiety that prohibits them often from engaging in school activities, speaking with peers and adults, and a fear of being in the community. With the support of our staff this student was able to attend field trips, rode on BART and a bus for the first time, and was exposed to new experiences.

VI. FY 21/22 Additional Information: With the support of MHSA funding (which allows us to have a family partner) we continue to see an increase in family engagement with services and engagement from caregivers in their youth's education. Our monthly caregiver group for ICESDC caregivers continues to be a space for caregivers to support each other on their sucesses and struggles in raising youth in Special Education.

VII. FY 22/23 Projections of Clients to be Served: 36 clients and their families.

VIII. FY 22/23 Programs or Service Changes: N/A

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 34

PROVIDER NAME: Lincoln Child Center

PROGRAM NAME: School-based Behavioral Health: MLK, McClymonds, Skyline and Oakland Academy of Knowledge (OAK)

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 21/22:

a. **Number of Unique Clients Served:** MLK: 8, McClymonds: 7, Skyline: 9, and Oakland Academy of Knowledge (OAK): 9 ACBH portion of total program budget: $302,430

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

a. **Reduce Mental Health Stigma:**

MLK: Although it was challenging to collaborate with components of our school team due to staffing challenges and an unwillingness to partner, our team attempted to support students push into the general education classes and develop positive peer relationships on the playground. We hosted several classroom activities that included general education peers and provided leadership opportunities where they modeled appropriate skill sets to younger students.

McClymonds: At McClymonds, the stigma of being in an SDC program is quite present. The classroom being located on the first floor across from the administration office also reinforces the negative mental health stigma associated with being in an SDC class. The classroom team has created an outdoor space and indoor space for students to take breaks and regulate themselves rather than walk the halls. There are program talks of changing the structure of the program so students transition between different SDC classes in the Fall of 2022 so students do not feel they are excluded and kept in the mental health classroom.

Skyline: The program at Skyline focuses on inclusion and pushing students into their general education classes with their peers. In addition, the students in both Counseling Enriched programs transition between teachers for different periods. As a result, students with mental health needs and supports and not placed in one classroom all day that is often labeled the "SDC classroom." The structure allows for students to feel comfortable and confident being in their classroom rather than being labeled or judged by the peers.

OAK: The OAK team was committed to inclusion to support to reduce the mental health stigma that comes with being in a counseling enriched program. Students were supported by staff in general education classes to support their academic progress and goals as well as to expose them the peers in a general education setting. In addition to daily inclusion opportunities both in the classroom and at recess, they joined fieldtrips with the school and with the lower elementary classrooms.

b. **Create a Welcoming Environment:**

MLK: It was challenging to create welcoming environments when the students transitioned between multiple teachers due to teacher assignments and staffing barriers throughout the school year. In the K-2 classroom the substitute teachers were open to collaborating so we were able to create safe and nurturing environments; however, the staffing rotated which is the foundation for creating a safe and welcoming environment for our students. We greeted students from the bus area with positivity and celebrated with field trips at the end of the school year.

McClymonds: The McClymonds team has worked endlessly to create a welcoming environment with a "doors open" policy. They transformed their back patio area into a break space and look forward to making it a classroom garden in the fall. The staff have also create a break space in the classroom and have snacks and water available for their students. During passing periods and lunch, the staff have tried different activities such as playing music, making smoothies, and having games available to foster a comfortable space for students.

Skyline: The Skyline team has created a fun and welcoming environment with a "doors open" policy. Students enjoy spending passing periods and lunch in the classroom as there is often music playing and students from all grades and programs walking through.

OAK: The OAK team did a great job creating a welcoming environment for their students and their families. Although families were still not permitted on campus due to COVID protocols, when families attended meetings, IEPs, or end of the year events, the team made them feel welcomed. On a daily basis, the OAK team greeted their students at the bus drop off and welcomed them to school. They created fun activities that involved art and cooking to supplement their academic assignments which made learning fun and motivating to engage in.

III. Language Capacity for this Program: All students and families at **MLK** spoke English as a primary language and did not require translation assistance. For Spanish speaking referrals, we had a Spanish speaking behavior staff that could provide translation support and translate all clinical documents. The translation hotline was also a resource for staff.

All caregivers for clients at **McClymonds** High School spoke English as their primary language. For Spanish speaking referrals, we had a Spanish speaking behavior staff that could provide translation support and translate all clinical documents. The translation hotline was also a resource for staff.

All caregivers for clients at **Skyline** High School spoke English as their primary language. One student who was enrolled in the program spoke Spanish as did his primary caregiver. The student was 18 and declined services. Our Spanish speaking staff supported the team in communicating with caregiver. For Spanish speaking referrals, we had a Spanish speaking behavior staff that could provide translation support and translate all clinical documents. The translation hotline was also a resource for staff.

All caregivers for clients at **OAK** spoke English as their primary language. For Spanish speaking referrals, we had a Spanish speaking behavior staff that could provide translation support and translate all clinical documents. The translation hotline was also a resource for staff.

IV. FY 21/22 challenges: MLK: In our 3-5 class, any attempt to collaborate with the teacher continued to result in conflict. Both the students and their families continued to feel the tension in the classroom and as a result of the teacher communicating inaccurate information to the families regarding staffing, behavioral incidents, or interventions, our relationships with our families has been impacted. With safety as a priority, we have been able to engage with our client's families, but have continued to experience limitations connecting as a community as parents/caregivers are still not permitted in the PODs.

McClymonds: The main challenges during the 21/22 school year focused on providing all the necessary information and supplies to staff so they felt safe on their school site during the return to classroom and during the numerous shifts in protocols and policies around COVID-19. When the mask mandate was in place, students often did not wear masks or wore them incorrectly (hanging at the chin). Staff struggled to find a balance between redirection and prompting and not initiating a power struggle or causing students to disengage. As a team we embedded wearing masks correctly as part of the level system, but students were not motivated. As a result to the inconsistent attendance and engagement throughout the year, staff displayed compassion fatigue towards the end of the school year. As a team we did an end of the school reset to create a positive and engaging environment for the last month of school.

Skyline: The main challenges during the 21/22 school year focused on providing all the necessary information and supplies to staff so they felt safe on their school site during the return to classroom and during the numerous shifts in protocols and policies around COVID-19. When the mask mandate was in place, students often did not wear masks or wore them incorrectly (hanging at the chin). Staff struggled to find a balance between redirection and prompting and not initiating a power struggle or causing students to disengage. As a team we embedded wearing masks correctly as part of the level system.

OAK: The main challenges during the 21/22 school year focused on providing all the necessary information and supplies to staff so they felt safe on their school site during the return to classroom and during the numerous shifts in protocols and policies around COVID-19. There were some challenging behaviors throughout the school year that were more challenging to intervene due to mask compliance and minimizing reinforcement of avoidant/escape behaviors (e.g. spitting, mask removal).

Is anyone better off?

V. FY 21/22 Client Impact: MLK: One student in the K-2 classroom who transition to MLK in January responded to classroom interventions and therapy as evident in a significant decrease in unsafe behaviors and aggressive tantrums. By the end of the school year he consistently used coping skills and remained safe. He did not require his OUSD para to intervene and was more responsive to classroom supports. He was able to participate in the end of the year field trip to the Oakland Zoo.

In the SDC 3-5 classroom, both graduating fifth graders reported that they were most proud of their improved reading scores and math skills. Both graduates were able to communicate how excited they were to be going to middle school as well as their fears such as being the "new kid" and being "smaller than all the big kids." Both students were not as articulate at communicating their feelings as well as reflecting about their experiences.

McClymonds: One student engaged in services and the academic curriculum throughout the school year. As a team we were able to create "wrap around" like support system for her and her mother to

facilitate positive changes both at school and home. She received TBS services, psychiatric support, as well as the services from being in a school based mental health program.

Skyline: Overall, there were numerous success stories for the school year. Students were taking part in more inclusion opportunities, students went to college tours and museums as part of the level system. Our one graduating senior applied to college and was accepted into his top two college choices. To honor his successes and his family's engagement, Lincoln recognized this student at our annual ROOTs fundraiser where he was given a scholarship for his college studies.

OAK: Overall, there were numerous success stories for the school year. Students were taking part in more inclusion opportunities. The school team joined with a student's family and collaborated with special education to determine a more appropriate placement to meet the student's needs related to his new diagnosis of Autism. After returning from winter break, the student students started participating in a skills group biweekly, facilitated by a Lincoln behavior staff, that taught basic skills around kitchen safety, cleanliness, and basic cooking skills. The students learned to prepare and cut fruit and vegetables and learned how to make smoothies, lasagna, nachos, and even sushi.

VI. FY 21/22 Additional Information: N/A

VII. FY 22/23 Projections of Clients to be Served: MLK: All clients will continue to be served in OUSDs SDC/CE programs.
McClymonds: We are projected to start the year with 9 students, 6 returning and 3 new students.
Skyline: We are projected to start the year with 11 students, 8 returning and 3 new students.
OAK: All 8 students who ended the year at OAK, will either transition to the 3-5 Seneca run SDC program, transition to a different SDC/CE program at a different school site, or a different special education program to better meet the client's needs. We are projected to start the year with one student.

VIII. FY 22/23 Programs or Service Changes: MLK: Due to the program closing, all students in the K-2 SDC/CE program will transition to the SDC/CE program at Sequoia Elementary School. Two students in the 3-5 SDC/CE program will do a lateral transition to their prospective Middle School programs at Edna Brewer and Roosevelt. One student will transition to the SDC/CE program at Sequoia Elementary school and one student will transition to either the Intensive SDC/CE program at Oakland School of Knowledge (OAK) or Maya Angelo NPS program.
McClymonds: The clinician assigned to McClymonds plans to return in the fall and the case manager gave notice that she was resigning at the end of July. The case manager position is posted and the interview process has started to fill the position so the candidate can start New Hire Orientation in September.
Skyline: The clinician assigned to Skyline plans to return in the fall and the case manager gave notice that she was resigning at the end of July. The case manager position is posted and the interview process has started to fill the position so the candidate can start New Hire Orientation in September.
OAK: There are no planned staffing changes to members of the behavior team. The clinician transitioned out of Lincoln after closing all of her clients at the end of July. A new clinician was hired in July and will start 8/15/22.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 34

PROVIDER NAME: Seneca Family of Agencies

PROGRAM NAME: School-Based Behavioral Health: ASCEND, Oakland Academy of Knowledge, Sequoia and Think College Now

Program Description: MHSA Braided funding for Expansion of School-Based Behavioral Health in the Oakland Unified School District (OUSD). MHSA funding is being braided with Educationally Related Mental Health Services (ERMHS) and Early Periodic Screening Diagnosis and Treatment (EPSDT) funds to provide enhanced (non Medi-Cal billable) mental health services and supports to children in Counseling-Enriched Special Day Classes (CESDC) and two of its School Based Behavioral Health (SBBH) programs in OUSD in order to assist these children and their families in becoming successful in school and at home.

Target Population: Youth attending Counseling-Enriched Special Day Classes (CESDC) and/or two of its School Based Behavioral Health (SBBH) programs in OUSD.

How Much Did We Do?

I. FY 21/22:

a. **Number of Unique Clients Served:** 1,670 ACBH portion of total program budget: $425,975
    a. **SBBH at ASCEND:** 463
    b. **Oakland Academy of Knowledge:** 510
    c. **Sequoia Elementary:** 344
    d. **Think College Now:** 353

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

a. **Reduce Mental Health Stigma:** Through Seneca's Unconditional Education Model (UE), Seneca UE coaches and clinicians work with school staff, administrators, families, and students to support a whole system approach to providing mental health services in schools. UE coaches and clinicians not only collaborate with teachers around the individual needs of students but also to develop a social emotional learning curriculum that can support all students' varying needs. UE coaches and clinicians work to support school wide training and implementation of Positive Behavioral Interventions and Support (PBIS) to provide a common understanding of the drivers of student's social emotional challenges as well as trauma-informed and healing centered responses to address them. This work promotes consistent, early, and effective interventions to increase student's ability to thrive in their school environment. UE's whole school approach infuses trauma-informed and healing-centered practices into the day-to-day experiences of students, normalizing the need to address the social emotional development and well-being of everyone in the school community, and reducing stigma around mental health.
b. **Create a Welcoming Environment:** UE coaches and clinicians work with school administration and teachers to assess the culture and climate needs of their schools and provide training, coaching and consultation opportunities. Additionally UE coaches and clinicians partner with their schools' teams to plan and support staff to implement a social-emotional learning

curriculum, providing intake and outreach support for families and family engagement/involvement activities throughout the school year. Coaches additionally work with the entire school team to identify and implement activities and initiatives that support staff wellness, camaraderie, and positivity.

III. Language Capacity for this Program: UE Coaches at CESDC/ICESDC utilize contracted agencies to provide in person/phone interpretation or translation as needed. Specific languages used and number of people served in each was not able to be tracked for FY 21/22.

UE Clinicians at SBBH/ASCEND were bilingual in English and Spanish and able to provide services in both languages as needed. UE Clinicians additionally utilize contracted agencies to provide in person/phone interpretation or translation as needed. Specific languages used and number of people served in each was not able to be tracked for FY 21/22.

IV. FY 21/22 challenges: Primary challenges in FY 21/21 continued to center around returning to full time in person learning while also building new systems and supports for safely navigating health and safety guidelines regarding the COVID-19 global pandemic. The beginning of the year brought stress and needs for support in helping teaching staff rebuild routines and relationships. This was also made difficult due to significant staffing shortages at leadership transitions at multiple sites. As things began to normalize through the fall, these challenges again arose mid-year following the winter break when the Omicron variant surged and both staffing and student absence through February caused barriers to successful implementation of planned structures and supports. After the surges faded, teams began hitting their strides again and were able to refocus on goals for the year however due to the ongoing impact of changing schedules, timelines and staffing, most sites had to prioritize their focus on deliverables for the end of year, supporting primarily student and staff social emotional and wellness initiatives and less school wide systems supports.

Is anyone better off?

V. FY 21/22 Client Impact: ASCEND Deliverable: Contractor shall provide school culture and climate work through social-emotional learning curriculum as an ongoing service.
Case Study: UE Clinicians have supported the design and implementation of “Crew”, a space in which students meet three times a week for the first half hour of the school day in groups of 10-12 students to build community with one another and receive social-emotional support through skill building and positive, joyful experiences. UE Clinicians contributed to the curriculum by providing activity plans for all Crew leaders on identity exploration, empathy building, mindfulness, and restorative community building practices. UE Clinicians also facilitate their own Crews, which has provided students with critical opportunities to reconnect with one another after a year of isolation and distance learning. At the beginning of the school year, one student in this clinician’s Crew who was new to ASCEND expressed that he did not feel very connected to the school and felt that other kids did not understand him. Due to the flexible structure of Crew, this clinician was able to provide brief individual support for this student throughout the week to help him become oriented to the school. Eventually, he also began to share about challenges his family has faced from moving many times, as well as his ongoing process of exploring his sexuality and gender identity. By creating a culture of safety and community within the Crew space, the clinician was able to support him in sharing some of his vulnerabilities with his peers through the practice of talking circles. He received support and affirmation from his peers, and many of them expressed that they related to him. This allowed for more open conversation around difficult themes impacting students’ mental health and wellbeing while deepening trust among Crew members.

The student has expressed gratitude for the support he received from the clinician and his peers through Crew, and other students have also shared that they appreciate having a space at school where they can support one another and talk about issues that are important to them.

Oakland Academy of Knowledge Deliverable: Contractor will participate in school Culture and Climate Committee meetings monthly, focused on creating a learning environment where all students, staff, and families feel welcomed and all adults feel capable of building genuine relationships with students, regardless of their level of need.
Case Study: The presence of an Unconditional Education (UE) Coach has contributed to the use of data to develop responsive initiatives and systems that address the most pressing needs. One example of this occurred as part of the Culture and Climate team's follow-up to the School Climate Assessment Instrument. After reviewing student data, the team wanted to dive further to better understand student responses to specific questions: "I feel like I can ask an adult for what I need" and "I feel comfortable asking for things (food, sleep, clothes) that I need". More than half of students respond with "I don't know/indifferent" or "No" to both sets of questions. With the support of the UE Coach, a child friendly survey was developed and administered to students. Once the data was collected, the team began meeting and synthesizing the data and what came out were intentional conversations about what kids need to feel safe to learn and to seek support. The UE Coach provided support and guidance in thinking about how the school addresses the issue of lack of resources amongst students without shaming them. For example, "take what you need" cards were discussed by the UE Coach as a strategy for kids to communicate when they are in need of resources. These take what you need cards are the first step of many to helping our students to better communicate when they are in need of resources that are difficult to access at home such as food, sleep, clothes, etc. It has been shared with the UE Coach that having cards where students can quietly ask to have needs met can be empowering for them and alleviate stigmas around asking for help. Oakland Academy of Knowledge serves an urban community of mostly Black and Brown Children and this helps prioritize that they are set up for success, starting with helping to meet their basic needs.

Sequoia Deliverable: Contractor shall provide positive behavior intervention and supports ongoing, supporting school staff in implementing the evidence-based PBIS program with fidelity to provide appropriate strengths-based responses to challenging student behaviors.
Case Study: A new student joined Sequoia in October who was previously expelled from his last two schools for high behavioral needs (i.e. destruction of property, elopement, hitting staff). After hearing about his educational and trauma history, our staff collaborated to brainstorm around support for this student so that we can create a positive experience at school for him to thrive. The Unconditional Education (UE) Coach met with his teacher and caregivers where we identified two goals for him to focus on. The UE Coach started a Tier 2 strategy of Check-In Check-Out (CICO) with the student so that he could build another trusting relationship with an adult on campus other than his teacher. The UE Coach then informed the office staff and school administration around strategies that are helpful when supporting this student with high anxiety and behavioral needs to provide consistent care and response. The UE Coach also provided consultations and coaching to his teacher around strategies and interventions (giving him a transitional object from home, using a visual timer, using "If" and "then" statements, communicating his schedule for the day so things are predictable, etc.) to support this student. With the daily CICO and the consistent response from staff, this student has made monumental growth in the last few weeks by staying in class and engaging in assignments. He now follows through with the classroom routines and transitions, can communicate his needs towards staff, and has been reaching his daily point sheet goals. His parents are grateful for the collaboration and strategies with

CICO and daily communication from the UE Coach so that they can process with him at home to provide the whole child support.

Think College Now Deliverable: Contractor shall support ongoing development and implementation of trauma-informed social-emotional learning curriculum into school-wide and classroom-based routines. **Case Study:** A second grade student was having frequent behavioral incidents, resulting in COST referrals, observations from the OUSD Network 2 Behavioral health department and several parent meetings to brainstorm additional strategies to support the student in having a successful experience at school. The COST Team was experiencing challenges finding effective interventions for this student and was seeking support from numerous sources. This Unconditional Education (UE) Coach offered to partner with the OUSD behavioral health specialist to create and restart a Tier 2 intervention plan that included Check-In, Check-Out, embedded sensory breaks and facilitated rapport building opportunities with other adults on campus outside of the student's classroom teacher. The goal was to provide consistent support and see if improvements could be made with a new support person. Additionally, this Unconditional Education (UE) Coach facilitated a social skills group with the student and his friend group as a target to explicitly teach behavioral expectations in various settings on campus (classroom, recess, cafeteria etc.), appropriate boundary setting and conflict resolution to not only support the student but also support capacity building for this intervention and the overall classroom culture. The UE Coach additionally worked with the teacher to strengthen and align the classroom's Tier 1 management and interventions practices with that of the school. After 1 month, the student showed tremendous progress based on a significant decrease in behavioral incidents and increased academic participation. The student's classroom teacher also reported that he has begun taking on a leadership role in the classroom and enjoys helping others. The principal also made a special phone call home to the student's parents to celebrate the great progress he has made in such a short amount of time. The parents were excited and relieved to hear that their child is now able to have mostly successful days at school. They added that since the change in plan, the student has mentioned he really enjoys going to school, resulting in them experiencing less challenges with getting him to attend school.

VI. FY 21/22 Additional Information: During our "End of Year Partner Survey," we asked for feedback about what impact of Seneca staff and partnerships have had on the school communities. Responses from staff at our partner programs indicate an appreciation for ongoing efforts to address staff and family wellness and to promote connection and community during this challenging year:

- "I feel like a collaborative relationship has been formed with the Seneca partnership. It feels like we are all working to serve the student and willingness for feedback on both sides of how to best support that student is welcomed and encouraged."
- "I appreciate how attentive and open Seneca providers are to providing support to students who are not in their caseload this year. This year has seen a rise in student need for social-emotional support and our clinicians have stepped up in a huge way. I recognize it is not an easy ask to be supporting such a big number of students, so I would like to really appreciate every one of our Ascend clinicians for everything they do to support our community."
- "Our Culture and Climate Team makes this school an enjoyable environment to work and learn in for staff and students. People feel appreciated, seen, and heard."
- "They have established PBIS expectations for the whole school, embraced our 5 values, and given students positive rewards/incentives for positive behavior."
- "It was a tough year, but the transition back would have been even tougher if not for the support given to our school by the Seneca team. The team assisted with our neediest students when we otherwise would not have had any support."

- "I see the students in the Seneca program positively interacting with the other students in the school that are not in the program. They also share their thoughts, through art about issues in our communities and globally that they are passionate about."
- "The UE Coach has had a positive impact on our school climate including positive impact on staff, students, and overall climate."
- "I can see how Seneca has made an incredible impact on the school culture. I have heard from coworkers who have been here over the years that from the first year to present, Seneca addressed issues and since has sustained a presence that's impacted positive behavior and procedures school wide."

VII. FY 22/23 Projections of Clients to be Served: We project the number of students, parents/caregivers and school staff served to decrease by approximately 200-300. This decrease reflects a reduction in partner schools, with one less school in 2022-23 than we had in FY 2021-22.

VIII. FY 22/23 Programs or Service Changes: We will no longer be providing MHSA funded support at one of the CESDC/ICESDC schools, Think College Now. We are currently in assessment with our other school partners to determine which contract deliverable will be the primary focus of partnerships for the 2022-2023 school year. While the overall goals will remain to build capacity of the whole school to provide trauma-informed, inclusive, and welcoming support for CESDC/I-CESDC students and the entire student body, the specific activities may change depending on the needs of the school and student population.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 34

PROVIDER NAME: STARS Behavioral Health Group

PROGRAM NAME: School-Based Behavioral Health: East Oakland Pride Elementary School

Program Description: MHSA Braided funding for Expansion of School-Based Behavioral Health in the Oakland Unified School District (OUSD). MHSA funding is being braided with Educationally Related Mental Health Services (ERMHS) and Early Periodic Screening Diagnosis and Treatment (EPSDT) funds to provide enhanced (non Medi-Cal billable) mental health services and supports to children in Counseling-Enriched Special Day Classes (CESDC) and two of its School Based Behavioral Health (SBBH) programs in OUSD in order to assist these children and their families in becoming successful in school and at home.

Target Population: Youth attending Counseling-Enriched Special Day Classes (CESDC) and/or two of its School Based Behavioral Health (SBBH) programs in OUSD.

How Much Did We Do?

I. FY 21/22:

a. **Number of Unique Clients Served:** 290 ACBH portion of total program budget: $96,474

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

a. **Reduce Mental Health Stigma:** Our clinicians work to integrate themselves fully into the school community and to create multiple pathways to addressing social emotional needs. We partner closely with school staff members and provide psychoeducation to demystify mental health issues. Through the partnership and working relationships built with school staff, we have identified larger social emotional needs of the school community and have been able to provide classroom wide support throughout the school year for students at EOP. Our integration into the school community serves to normalize the need for mental health support and allows youth to feel comfortable accessing our services when in need.
b. **Create a Welcoming Environment:** As mentioned above, we have worked to integrate ourselves into the school community, which often involves participating in school events and joining with families during such events. In addition, our staff have engaged the youth in creating the therapeutic space where many of our services are offered. We have done this by placing artwork created by EOP students (with their permission) on the walls of the therapy room. We have solicited feedback from students about setting up the office space in ways that would make them feel most comfortable. For instance, students helped with the creation of a quiet corner in the therapy room, including creating a fort to be used in the space. Clinicians also, set up stations throughout the therapy space for different types of activities (e.g. an art station, a group circle, a space to read). We also ensure that the tools, books, and toys used in therapeutic work are representative of the students' cultures.

III. Language Capacity for this Program: Our team at East Oakland Pride consists of 2 full time staff members and one part time staff member. Amongst the team, we have one bilingual (Spanish speaking)

clinician. Of the youth served, a large portion are bilingual (English/Spanish speaking) and 46 youth and/or parents served were primarily Spanish speaking.

IV. FY 21/22 challenges: The primary challenges this school year have been COVID related as there were several instances of potential COVID exposure resulting in the need for clients and/or staff to quarantine at varying points throughout the year.

Is anyone better off?

V. FY 21/22 Client Impact: Over the course of the school year, we have been able to provide individual and group support as well as crisis management for youth at East Oakland Pride. We provided Tier 1 and Tier 2 support to the school community to improve social emotional outcomes (Direct client services and support), by offering ongoing 1:1 support to youth, providing intensive support to one of the kindergarten classes to aid in acclimating to the school environment, and connecting families to needed resources. Additionally, we have conducted several ongoing therapeutic groups including social skills group, a "friendship group", groups to assist with conflict resolution, debriefing support after a crisis, and a psychoeducation group around risk for students who had witnessed the suicidal behavior of a classmate. Our clinicians also offer additional support for students during unstructured time (e.g. recess and lunch) to help with the development of social skills and managing transitions. We provided support to teachers/school staff through regular staff consultations and participation in COST meetings. One of our clinicians also joined the "culture committee" to support efforts in fostering a positive school climate.

VI. FY 21/22 Additional Information: While we are able to provide support for our Spanish speaking families with the assistance of our full-time bilingual clinician, we still lack resources to support the fairly large Mam speaking population at the school. Any resources the county is aware of to provide translation support for these families would be most helpful.

VII. FY 22/23 Projections of Clients to be Served: Over the course of the 2021-2022 school year, we have been able to offer support schoolwide to students. We expect the same level of service provision for the 2022-2023 school year. We also hope to increase outreach to families and ideally increase engagement in a parenting support group.

VIII. FY 22/23 Programs or Service Changes: We intend to continue to provide the support outlined in our contract and hope to increase our offerings of teacher trainings and opportunities for parent engagement. We have started partnering with the school administration to develop programming/workshops around suicide prevention to be rolled out in the fall during suicide prevention month.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 35

PROVIDER NAME: East Bay Agency for Children (EBAC)

PROGRAM NAME: Community-based Outreach & Consultation

Program Description: EBAC's Fremont Healthy Start Program engages, encourages, and trains potential community responders, primarily family members of youth and children but also school staff and community members, about ways to recognize and respond to early signs of mental illness.

Target Population: Adults (18+) who are potential community responders, primarily family members of youth and children but also school staff and community members.

How Much Did We Do?

I. FY 21/22:

a. **Number of Unique Clients Served:** 1,629 Cost per client: $49

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

a. **Reduce Mental Health Stigma:** Staff at East Bay Agency for Children's Fremont Healthy Start (FHS) program help to break the stigma around seeking mental health support by normalizing conversations about mental health and assisting clients to increase their capacity to help themselves and others. In our interactions with clients, staff:

- Engage in difficult conversations about mental health topics and the importance of clients having these same conversations with their families and children. Staff normalize talking about painful experiences and emphasize that all experiences are valid, regardless of the level of intensity of those experiences.
- Explain the benefits of mental health services in a way that clients can understand why the services are being advised and how helpful they can be.
- Raise awareness among less privileged community members that they can have access to mental health services.
- Raise awareness of signs, symptoms and types of mental illnesses and coping strategies.
- Ensure that clients are aware of the importance of being a support system for someone in their family who is experiencing mental health struggles, and where they can go to seek resources and help.

b. **Create a Welcoming Environment:** EBAC's FHS program offers a safe, warm and welcoming environment for clients. The office has a child and family friendly waiting area and private areas for clients and staff to meet confidentially. Although located on a school campus, the office is located at a separate portable so that the community does not have to enter the school to access services. Clients are greeted and assisted by staff who represent the diverse cultures, languages, and immigration/refugee experiences of the clients served. Family Resource Specialists are paraprofessional staff who live in the community; many have utilized supports for their own families in the past.

III. Language Capacity for this Program: Staff are able to assist families in 10 languages: Cantonese, Farsi, Hindi, Korean, Mandarin, Pashto, Punjabi, Spanish, Urdu, and English.

IV. FY 21/22 challenges: Despite COVID restrictions being lifted, many clients were hesitant to meet in-person. Our staff accommodated this by interacting with these clients over the phone. For services that could not be delivered virtually (for example, Parent Cafes due to technological difficulties), staff provided services at a location outside of the office (e.g. parking lot).

The lack of Dari speaking therapists and long wait lists presented a tremendous challenge for Afghan refugees who have an urgent need for counseling support. Our Afghan FRS are providing counseling to these clients while they await professional services.

The long closure of in-person appointments at the Alameda County Social Services Administration office from the start of the pandemic to April 2022 was a major challenge for clients and a deterrent for accessing services.

We did not have enough staff or staff hours to manage the influx of Afghan refugees seeking support and their needs.

Contrasting opinions and choices regarding COVID vaccination within families created a great deal of friction and damaged familial relationships.

Clients often rejected counseling services, saying they “will get over it”.

Is anyone better off?

V. FY 21/22 Client Impact: Our Afghan Family Resource Specialists (FRS) used their nearly 40 years of combined experience and long-standing community partnerships to assist the influx of Afghan refugees seeking support. The FRS connected families with external as well as internal resources that offered assistance with housing, health insurance, health care, CalFresh, food, clothing, grief and loss support, and connection to immigration, legal and other services. In all, our staff had 889 encounters with Afghan refugees during the 2021-2022 program year. Through emergency cash assistance funding, 50 Afghan refugees were given gift cards and checks ranging from $50-$800 to help alleviate some of their financial burden. Our program also joined as a member of a city-wide Afghan Refugee committee, formed to support the urgent need for basic needs among Afghan refugees in Fremont. Our participation in this collaborative provided excellent opportunities to connect with other community-based organizations to strategize on how to best support the needs of Afghan refugees and seamlessly connect them to services.

FHS offered a Parent Cafe workshop series focused on the five protective factors. Workshop participants reported feeling comfortable with the open discussions about parenting and grief. Parents learned the importance of making social connections during difficult times and how this is key to mental health. The workshops also stressed the importance of managing stress as children can be negatively impacted by parent/caregiver anxiety. The workshops further shared information about external and internal resources available to families, such as EBAC’s grief and loss support services for adults and children/youth.

Staff participated in monthly Motivational Interviewing (MI) workshops to strengthen and deepen their MI skills. They focused on OARS (Open ended questions, Affirmations, Reflection, Summary) and Righting Reflex training modules. This training promotes active listening skills and interviewing styles that empower clients to be self-reflective of their behavior. Using this process leads to sustained changes in their lives that will be very powerful and beneficial.

VI. FY 21/22 Additional Information: Below is a summary of lessons learned throughout the year:

- Cultural beliefs and customs greatly influence a client's decision to access mental health services. Although we inform them of the benefits of counseling, strong cultural beliefs against counseling usually prevail. Despite this, having these conversations opens the door to this taboo topic and encourages at minimum a consideration about using mental health resources.
- Explaining benefits of counseling in a way that clients can understand is extremely important. We found that using terms such as "getting it off your chest", "sharing your burden," and "venting with a trained specialist" are more effective when suggesting counseling than saying "I would like for you to look for counseling". Our experience has shown that being too directive with clients creates a fear reaction and lacks an explanation as to why counseling is being advised.
- Modeling healthy boundaries is a must when working with vulnerable populations. This is important because participants who understand and identify their own priorities and boundaries are better able to advocate for themselves. We have found that when staff are clear on realistic expectations and limits, the process of working with families is smoother.
- Maintaining active collaboration with our partners is even more paramount now in order to best serve the newcomer refugee population. Our staff participate in many meetings to stay abreast of service implementation and/or changes.
- The time and effort that must be given to the refugee population is extremely intensive and challenging. It is extremely important to be aware of all of the community resources available to best serve this population.

VII. FY 22/23 Projections of Clients to be Served: 1,000

VIII. FY 22/23 Programs or Service Changes: There are no planned program or service changes for the 2022-2023 fiscal year.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 35

PROVIDER NAME: Mental Health Association of Alameda County (Family Education and Resource Center [FERC])

PROGRAM NAME: Community-based Outreach & Consultation

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

Target Population: Family members and caregivers of loved ones with a severe mental illness (SMI) or a severe emotional disturbance (SED) living in Alameda County

How Much Did We Do?

I. FY 21/22:

a. **Number of Unique Clients Served:** 2,120 Cost per client: $866

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

a. **Reduce Mental Health Stigma:** Reducing mental health stigma is foundational to all aspects of FERC's program design:
   - FERC employs staff with lived experience as caregivers of loved ones living with mental health illness and conditions. Throughout the fiscal year the program adhered to this precept: FERC staff are caregivers and all program volunteers were caregivers and sometimes consumers.
   - Family Advocates are trained and supported to speak openly about their lived experience. FERC finds that the model of staff openly sharing their stories about mental health caregiving creates a stigma-free, safe space in which Family Members can share openly about their experiences, identify needs, receive resources, learn about mental health and self-care for the caregiver.
   - This safe space is also provided through 9 discrete monthly peer-based support groups (90 groups in total) in which Family Members can learn to speak openly about the challenges they face and receive validation from their peers who share similar experiences. FERC support groups build community and strengthen support networks and allow families to develop leadership skills as they become resources for one another.
   - FERC provides culturally syntonic supports for Spanish speaking families; the Oakland and Fremont sites are safe places where bi-lingual/bi-cultural advocates provide support that is sensitive to the stigma that caregivers encounter within and without the family. FERC provided 16 Café Para Padres (Parent Cafes) for Spanish speaking families throughout the year and built this community support through leadership development of Family Member volunteers who provide the cafes in collaboration with FERC. Families report finding a safe-haven free of stigma in which they can openly share their experiences and support one another.

- FERC's Bingo Fridays is a fun weekly social gathering 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 experience in group settings due to mental health stigma.
- The program provided CIT training for 205 police officers throughout the year: this training is pivotal to reducing the mental health stigma existent within police departments. The powerful stories presented by family members and mental health consumers provided the officers with expanded perspectives and understanding. The goal is to shift officer responses from stigma-based assumptions to compassionate understanding for those living with serious mental health illness and their families.
- In FY 2020-21, in response to the death of George Floyd and the ongoing institutionalized racism dominating our society, FERC Outreach developed an Annual REACH event called: Recognize, Express, Acknowledge through Community Healing. In FY 2021-22 the Annual REACH event focused on the Afghan Community in Alameda County. Afghan Presenters spoke about trauma, mental health stigma, shared insight into rich cultural history and customs and presented updates on current challenges the Alameda County Afghan Community is facing.

b. Create a Welcoming Environment: To experience a welcoming environment, FERC strives to provide Family Members with the opportunity to see themselves reflected in the FERC environment. In FY 21/22, our FERC team represented the African American community, the Latinx community, the Asian community, the Middle Eastern community and the LGBTQIA+ community. Our staff had age diversity ranging from TAY youth to Older Adults and we had gender diversity. The team also had diversity in abilities and in Family Member and Consumer lived experience. Since programming was provided virtually throughout most of the year due to COVID-19, we focused on providing welcoming virtual environments for clients and the community. Our Zoom environments were culturally syntonic virtual spaces where caregivers could come for support, resources, learning and social connection. Some of the FY 21-22 strategies FERC adopted in our virtual programming were:

- Client support groups and client meetings begin with a brief relaxation practice and Family Members are invited to set their intentions for their time together.
- Virtual meetings and programming often close with a mindfulness grounding exercise.
- FERC facilitators include a self-care component in the service design for each virtual gathering.
- Using humor and compassion when technological glitches and challenges are navigated In zoom, real-time.
- In partnership with OFE, FERC increased online programming for Spanish-only speaking families and found that our virtual programming resulted in families saying they felt more connected, less isolated and that these environments, in which only Spanish was spoken, were freeing, facilitated learning and resource sharing and met our clients' needs for feeling connected to community in COVID.
- We provided snacks and beverages (that we would normally have for clients attending in person programming) with $5 e-gift cards to Starbucks. Although these "snacks" were provided in arrears (to attendees), we felt that this incentive recognized the cross-cultural value of food as an important social connector.
- We created colorful activity flyers for events and created zoom backdrops with flyer graphics to create a positive virtual environment.

- We used ice breakers sometimes with break out rooms and more often as a large group to relax and connect participants with one another.
- We used an online raffle game for event raffle prizes.
- We used our Weekly Bingo Friday event as a conduit for clients to meet our staff: the task of hosting this activity rotated across our Family Advocates, Outreach Coordinator, and management staff. Families relaxed together having fun playing old fashioned, cage rolling, personalized re-usable-bingo-card Bingo games.

III. Language Capacity for this Program: Throughout the year our staff was 37% bilingual bicultural Spanish/English and held the following positions: Administrative Assistant/Reception; Warmline Coordinator; three Family Advocates.

IV. FY 21/22 challenges: FERC's primary FY 21/22 challenge was in staffing. Although there was no change in leadership staff across the year, the program struggled with the attrition and replacement of Family Advocates. FERC started the fiscal year at 67% staffed which lasted through quarter 2. In quarter 3, the program finally became 100% staffed, however, we ended quarter 4 staffed at 89%. Family advocates left the program for a variety of reasons including: family caregiving needs, starting a higher education program, parenting needs, decision to work directly with mental health consumers. Throughout the year, the agency and program continually assessed hiring practices. The Executive Director created a bi weekly hiring team meeting for all hiring managers and hiring support staff across the agency. This meeting was helpful and resulted in an ongoing practice of hiring funnel review and responsive brainstorming and adjusting which has improved our applicant to onboarding timeline. It is anticipated that in the new fiscal year, our hiring processes will continue to streamline.

The second challenge that the program experienced throughout the year was the lengthly Family Advocate training period from first day on the job to first day in direct client service. We attributed some extension of training time to the nature of remote work, however, by the end of the fiscal year, it became evident that the 4 – 5 month training period was also a result of curriculum design. The FERC Family Advocate training curriculum will be redesigned in Q1 of FY 22/23 and it is anticipated that trainees will complete their training in 2 months, begin modified direct client service in the second month aned will begin direct client service in the third month of employment.

Is anyone better off?

V. FY 21/22 Client Impact: The Program provided 14,760 hours of programming and achieved 564 outreach contacts in the fiscal year.

The program met the contract deliverable to make at least 400 follow-up contacts to these sources, which resulted in 6 collaborative projects: 10/28/21 Fremont FRC Day Away Event Planning Committee and event hosting; 11/16/21 FERC Annual Virtual Resource Fair with 5 Community Partners: PEERS; UCFC; Seneca; IHOT/AOT; Roots: PIWI; 12/4/2021 Warriors Community Mental Health Outreach Event; 5/7/22 CSS Healing Hearts Suicide Prevention Outreach Event; 5/14/22 FERC & First Presbyterian Berkeley Mental Health Symposium; 6/17/22 FERC Annual R.E.A.C.H. Event with the Afghan Coalition.

The program hosted 6 virtual outreach and engagement activities: 9/23/21 FERC Game Day event; 10/26/21 FERC Lunchtime Learning event: **"**Laws We Need to Know"; 2/15/22 Lunchtime Learning event: "Understanding the Medical System"; 12/2 – 12/16/21 Three Vitality in the Black Community Café Events.

Our contact requires the program to establish five resource displays for family members in the five Alameda County threshold languages. This deliverable was met in FY 21 – 22 with the FERC website that translates all content into a selection of languages including all county threshold languages.

The program provided 54 virtual peer and social support groups throughout the year: 30 Bingo Friday group events; 16 Café Para Padres Parent Café groups.

FERC responded to 1,014 new Warmline contacts this year, exceeding our requirement of 900 new contacts. The Warmline was operated M – F 10:00 AM – 6:00 PM. The FERC Warmline Coordinator is bilingual English/Spanish.

The program provided Family Coaching and Leadership Development to 8 volunteers in the year. 4 Spanish Speaking volunteers were developed by FERC staff, in partnership with OFE. The subject area specific to these volunteers was: Mental Health and the Five Protective Factors for Family Resilience. These volunteers hosted the 16 Café Para Padres events in the year. The program recruited 3 TAY volunteers to provide outreach support throughout the year. These volunteers supported preparing for the program outreach events and supported the Warmline Coordinator by completing a resource Updating project to assure that all resource information listed in the MHAAC Resource Library is current. The program continued to coach the peer volunteer for the FERC Friday Bingo group to support her in developing her skills for the work environment.

FERC Family Advocates and the Outreach Coordinator provided 983 AB 1424 consultations/educations in the fiscal year. All new clients were provided with this consultation and consultations were provided by FERC during 5 AAFOP workshop presentations throughout the year.

The program held 9 virtual monthly support groups throughout the year (covering all four regions of the county) for a total of 90 support groups. Two of these monthly support groups were in Spanish. The program also provided two Family to Family Sessions (8 mental health education classes for Family Member per series) for the community.

Throughout the fiscal year the program provided 8 provider education trainings to community partners including: ACBH Children and Young Adult System of Care; San Lorenzo Unified School District (2 presentations); Youth and Family Services; Ohlone & Peralta Community Colleges; Fremont MET; ACBH IHOT and ACBH EPSDT. Due to the need for providing these trainings on zoom, the FERC leadership team felt that a day long training was not a feasible format for this comprehensive training. The program adjusted and provided 2 – 4 hour trainings in these topic areas for community partners. These trainings did not offer Continuing Education Units (CEUs).

In FY 21-22 FERC provided training for the Crisis Intervention Trainings (CIT) with the Oakland Police Department that resulted in an average of 90% of officers reporting “strongly agree” or “agree” on the CIT training evaluation to the statements: “I expect to use some of the information learned today” and “This information will improve my effectiveness in interacting with consumers and family members”. An average of 97% of officers reported “High Satisfaction or Satisfaction” with the FERC CIT training. Officers did not prefer the zoom training format however, they were attentive and participated in group exercises and training activities.

VI. FY 21/22 Additional Information: The FERC Oakland site moved to 7677 Oakport Street, Suite 100 Oakland, CA 94621 on 2/28/22. The goal of the move was need based: 1. To find a location that was easy to access with public transportation and had ample parking for Family Member clients and Resource Center visitors, 2. To find a location that was more centrally located in the city of Oakland and 3. To find a location that was large enough to house the program in a unified suite with no accessibility issues such stairs and elevator malfunction (prior site for this office was on 2 floors).

The new location meets each of the program needs listed above. The site is across HWY 880 toward the bay parallel to the Coliseum and is near Hegenberger Road. Families do not have to struggle to find parking, do not have to pay for parking and are able to reach the center by public transportation, both bus and BART. The suite is currently having some final construction work completed in the large training room and staff is present in the office 9am – 5pm Monday – Friday. FERC staff are working a hybrid schedule with 16 hours of their week in the office and 24 hours of their week working in their home office. Both the Office Manager and Administrative Assistant are in the office M – F 9am – 5pm. When it becomes COVID safe to host a large gathering, the program will have an Open House for the community.

VII. FY 22/23 Projections of Clients to be Served: 2,500

VIII. FY 22/23 Programs or Service Changes: FERC Warm Line hours: M – Th 9:00 AM – 5:00 PM and Friday 9:00AM – 1:00PM, FERC changed this time in FY 21/22 to: M – F 10:00 AM – 6:00 PM in response to client needs. The program would like to continue to maintain this Warm Line schedule in FY 22/23.

In FY 22/23, FERC plans to work with ACBH to develop a group of Family Member and Consumer presenters with a focus on diversity representation in the CIT Program with Oakland PD. FERC would like to train a group of 3 – 5 volunteers to present their 5150 stories at CIT on a rotating basis throughout the year. FERC also plans to assess, update, and redesign our CIT curriculum.

In ongoing community building for Family Members in the Spanish speaking community, FERC Family Coaching and Leadership (FCL) is developing Spanish speaking Family Leaders who provide the Café Para Padres (Parent Café) programming for Family Members. Current FCL Family Leaders would like to expand their work with FERC in FY 22/23 to include a Family Member/Caregiver Wellness and Support group based in the Five Protective Factors, wellness and recovery precepts, wellness and safety for Loved Ones, resource provision and community building. The proposed group will be called: Construyendo Mi Cuidado Personal Efectivamente (CCPE) (Building My Personal Care Effectively). It will be an open group and will be created and delivered in Spanish only. This Leadership group will develop an evaluation survey with the guidance of the FERC Director and will collect evaluations at the end of each group. This tracking will continue throughout the year and results will be reported in the Annual FY 22/23 report.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 36

PROVIDER NAME: CalMHSA

PROGRAM NAME: CALMHSA Presumptive Transfer Project

Program Description: Assembly Bill 1299 (Ridley-Thomas, Chapter 603, Statutes of 2016) established presumptive transfer. Presumptive transfer means a prompt transfer of the responsibility for providing or arranging and paying for specialty mental health services (SMHS) from the county of original jurisdiction to the county in which the foster child or youth resides.

Presumptive transfer is intended to provide foster children and youth who are placed outside of their counties of original jurisdiction with *timely access* to Specialty Mental Health Services (SMHS) consistent with their individual strengths and needs, and Medicaid Early and Periodic Screening, Diagnostic and Treatment (EPSDT) requirements.

Target Population: Foster youth receiving mental health services outside of Alameda County. This is a current mandate for all California Counties.

How Much Did We Do?

I. FY 21/22:
Number of Unique Clients Served: Alameda County has received 150 youth from other counties through the Presumptive Transfer process. ACBH budget for this program: $762,973

Alameda County has placed 226 youth in out of County placements through the Presumptive Transfer process

II. FY 22/23 Programs or Service Changes: No Service Changes expected.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 37

PROVIDER NAME: Bay Area Community Services (BACS)

PROGRAM NAME: Oakland Project Connect (OPC)

Program Description: The OPC team is a multidisciplinary treatment and case management program that serves adults who are literally homeless in Oakland. The program pairs clinical staff with peer case managers with lived experience in systems impacted by homelessness to meet the broad range of client needs. The program uses a 12-24m "critical time intervention"-based framework, providing intensive services and wraparound resources during the initial stabilization phase and then transitions the client to community care and supports.

Target Population: Adults, 18+ years old, who are literally homeless in Oakland and have a severe mental illness (SMI).

How Much Did We Do?

I. FY 21/22:

a. **Number of Unique Clients Served:** 85

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

a. **Reduce Mental Health Stigma:** OPC works collaboratively with our clients, their natural supports and other service providers and supports from a person-centered approach to support partners with increased wellness and to strive for their goals. OPC makes an effort to meet clients where they are at and normalizes and validates their experiences; additionally, OPC works to provide clients with opportunities to connect with other clients at social and other events to decrease the stigma and isolation common with people struggling with their mental health.

b. **Create a Welcoming Environment:** OPC works to support clients and those involved in their care wherever they are, whether that be in the community, at a hospital or other medical or mental health facility, in jail, at the office, at an outdoor location, by phone, or anywhere else. OPC additionally seeks to be collaborative and flexible in all interactions and to embody the principle of cultural humility for both clients and each other. Finally, OPC encourages clients to come to the Towne House wellness center to connect with a larger community and a safe space to receive support, and has also been diligent in following health guidelines regarding COVID-19 to ensure the safety of our clients.

III. Language Capacity for this Program: The OPC team has staffing that is fluent in English. In addition, BACS has invested in a language line service, in the event any partner is referred and needing services translated in a language that our current staffing cannot provide. The OPC team had no barriers to providing services to partners with the language of choice.

IV. FY 21/22 challenges: As the program continues to provide services through the pandemic there were challenges around engagement, increasing census and connecting partners to community resources. Many of our partnerships closed their doors during the pandemic, which limited the program's ability to

connect to supports such as: social services, social security, day programs, feeding programs and recovery support groups. In addition, housing resources continued to be scarce during this fiscal year, with COVID restrictions, and as a result, affected program outcomes to permanent housing.

Is anyone better off?

V. FY 21/22 Client Impact: During this fiscal year, we saw a decrease in hospitalizations and incarcerations. On average, less than 1 hospitalization or incarcerations occurred per month. In addition, this year the OPC team connected a handful of individuals were connected to permanent supportive housing this fiscal year, and many others connected to alternative housing opportunities in the community (e.g. transitional housing, shared living, etc.).

VI. FY 21/22 Additional Information: Staffing was also challenging to navigate, with COVID heavily influencing potential hires desire to not work within the communities.

VII. FY 22/23 Projections of Clients to be Served: We project to serve between 100-120 partners this FY year, As the programs ramp up from adjustments during COVID, we project to see an increase in staffing and census.

VIII. FY 22/23 Programs or Service Changes: We will continue to build staffing for the program, and increase community engagements this fiscal year. We are prioritizing strategy to increase our ability to reach more clients in need of services within the community.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 37

PROVIDER NAME: Bay Area Community Services (BACS)

PROGRAM NAME: Re-entry Treatment Teams (RTT)

Program Description: The Re-entry Treatment Teams (RTT) are a multidisciplinary treatment and case management program that serves adults who were previously incarcerated or involved in the criminal justice system. The program pairs clinical staff with peer case managers with lived experience in systems impact from the criminal justice system to meet the broad range of client needs. The program uses an eighteen month "critical time intervention"-based framework, providing intensive services and wraparound resources during the initial stabilization phase and then transitions the client to community care and supports.

Target Population: Adults, 18-59 years old, who were involved in the criminal justice system and have a severe mental illness (SMI).

How Much Did We Do?

I. FY 21/22:

a. **Number of Unique Clients Served:** 194 **Cost per client:** $1,159
   1. **RTT1**-105
   2. **RTT2**-89

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

a. **Reduce Mental Health Stigma:** RTT works collaboratively with our clients, their natural supports and other service providers and supports from a person-centered approach to support clients with increased wellness and to strive for their goals. RTT makes an effort to meet clients where they are at and normalizes and validates their experiences; additionally, RTT works to provide clients with opportunities to connect with other clients at social and other events to decrease the stigma and isolation common with people struggling with their mental health.
b. **Create a Welcoming Environment:** RTT works to support clients and those involved in their care wherever they are, whether that be in the community, at a hospital or other medical or mental health facility, in jail, at the office, at an outdoor location, by phone, or anywhere else. RTT additionally seeks to be collaborative and flexible in all interactions and to embody the principle of cultural humility for both clients and each other. Finally, RTT encourages clients to come to the Towne House wellness center to connect with a larger community and a safe space to receive support, and has also been diligent in following health guidelines regarding COVID-19 to ensure the safety of our clients.

III. Language Capacity for this Program: the RTT treatment teams have staffing fluent in both English and Spanish, and had no barriers to providing services to partners with their language of choice. In addition, Bacs has invested in a language line service, in the event any partner is referred and needing services translated in a language that our current staffing cannot provide, and staff use this language line as appropriate.

IV. FY 21/22 challenges: As the programs continued to provide services through the pandemic there were challenges around increasing census, client engagement, staffing and connecting partners to community resources. Many of our partnerships closed their doors during the pandemic, which limited the programs' ability to increase influx of referrals to the program, as well as connect existing clients to supports such as: social services, social security, day programs, feeding programs vocational opportunities and support/recovery groups. In addition, housing resources continued to be scarce, as many landlords stopped new tenants from leasing or reduce bed availability to try and combat with the spread of COVID, as a result, affected program outcomes to permanent housing. With all of that said, half way through the fiscal year we saw a shift in the community. With the community slowly re-opening we saw an increase in available resources for clients, as well as an increase in motivation/desire to pursue opportunities.

Is anyone better off?

V. FY 21/22 Client Impact: During this fiscal year, we saw a decrease in hospitalizations and incarcerations. On average, less than 1 hospitalization or incarceration occurred per month.

VI. FY 21/22 Additional Information: Due to COVID related matters, staffing was also challenging to navigate this fiscal year, however by end of FY RTT1 was at 90% staffing capacity.

VII. FY 22/23 Projections of Clients to be Served: We project to serve between 100-130 partners collectively between both cohorts during this next FY. With a recent reduction in contract size for RTT1, unfortunately we expect to serve less clients this FY.

VIII. FY 22/23 Programs or Service Changes: We will continue to build staffing for the program, maintain minimum census and increase community engagements this fiscal year. We are prioritizing strategy to increase psychiatry services within the programs in hopes to reduce partners need to access services from multiple providers and make their ability remain connected easier to manage.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 37

PROVIDER NAME: La Familia Counseling Center

PROGRAM NAME: Re-entry Treatment Teams (RTT)

Program Description: The Re-entry Treatment Team (RTT) is a multidisciplinary treatment and case management program that serves adults who were previously incarcerated or involved in the criminal justice system. The program pairs clinical staff with peer case managers with lived experience in systems impact from the criminal justice system to meet the broad range of client needs. The program uses an eighteen month "critical time intervention"-based framework, providing intensive services and wraparound resources during the initial stabilization phase and then transitions the client to community care and supports.

Target Population: Adults, 18 years of age or older, who were involved in the criminal justice system and have a severe mental illness (SMI).

How Much Did We Do?

I. FY21/22:

a. **Number of Unique Clients Served:** 47 clients served. Cost per client: $4,787

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

a. **Reduce Mental Health Stigma:** RTT staff are expected to use trauma-informed care practices with all clients – i.e., the approach to working with clients is not "*what's wrong with you?"* but rather *"what happened to you?"* – as well as motivational interviewing interventions – i.e., work collaboratively with individuals to achieve their goals by creating an atmosphere of acceptance and compassion.
b. **Create a Welcoming Environment:** RTT staff are encouraged and expected to demonstrate an awareness of and sensitivity to clients, including cultural and ethical beliefs. Additionally, staff are to implement care in a thorough, skillful, consistent, and continuous manner. La Familia's values are discussed when staff are hired, and touched upon continuously throughout the work, e.g., in team meetings, in one-on-one meetings, etc. Values discussed include belonging (helping 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) and social justice (amplifying 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).

III. Language Capacity for this Program: RTT served 47 clients in English.

IV. FY21/22 challenges: RTT funding for FY21-22 was cut significantly ($86,000) from the previous fiscal year/FY20-21. This decrease limited RTT staff ability to help clients with their basic needs, housing, etc. Additionally, with a more limited support services budget, we have not been able to offer as many

milestone incentives to keep clients engaged in the treatment program (due to prioritizing the funds we do have for client's basic needs).

The most prominent and ongoing challenge RTT faced during FY21-22 was related to staffing. RTT operated throughout the entirety of the fiscal year with only one part-time peer counselor (we are contracted for two full-time peer counselors). RTT leadership worked with La Familia HR to recruit, hire, and retain new staff, but faced ongoing challenges. During FY21-22, RTT made offers/commenced employment to/with five different individuals to fill the peer counselor role – two individuals lasted almost a month, one individual lasted one day, and two individuals never made it to onboarding. There was a variety of reasons as to why these hirings did not pan out – each specific to that particular individual/hire. Being short-staffed over the course of the year meant that we were limited in the number of clients we could open at any one time, and in the number of overall service hours we could provide. The one peer counselor for RTT worked incredibly hard and was able to meet the needs of the clients on the RTT caseload (and she nearly always exceeded her monthly productivity targets). However, we were not able to serve as many people as we could have if we were fully staffed.

It is common for RTT clients to present with dual diagnosis/SUD challenges. RTT staff support these clients in their efforts to enroll in SUD treatment – often after significant time is spent processing and motivating the client to consider SUD treatment. However, there appears to be an ongoing lack of beds/open spaces for residential SUD treatment (for those who do qualify). A typical experience for RTT staff is as follows: staff work with a client for some time, they utilize Motivational Interviewing techniques around the client's use and overall functioning, and finally get the client agree to engage in SUD treatment. However, when RTT staff and the client call the Substance Use Access and Referral Helpline, they are told that there are no openings for SUD treatment in the county and that the client needs to call back. When clients are not put on a waitlist (and are expected to keep calling back regarding treatment), they often lose the motivation, continue using, and it becomes much harder to treat their MH symptoms and improve their overall functioning.

Unfortunately, RTT clients do occasionally recidivate and end up incarcerated after they have commenced treatment. When this happens, clients may be incarcerated for a few days to a few weeks (and RTT will hold their spot for them, so long as it is not a prolonged incarceration – i.e., 90 days or less). During this challenging time, clients appear to rely on the supportive relationships that they have built with RTT staff. Clients will ask RTT staff to meet via video/phone, or to be present for their court dates. RTT staff are not permitted to bill time for clients who are in a locked setting. Therefore, staff do not get credit towards their productivity goals when they interact with and support incarcerated clients (example: RTT clinician drove to Oakland and spent several hours in court supporting an incarcerated client during his court date and was not able to attribute any of that time spent with the client to her monthly total). Of note, at the end of the fiscal year, ACBH began permitting RTT staff to get reimbursed for payments towards video visits while clients were in Santa Rita. This was helpful and greatly appreciated by RTT leadership and staff.

The COVID-19 pandemic safety measures continued to pose some challenges to program implementation (though much less so as compared to the previous fiscal year). All RTT staff were vaccinated throughout the FY21-22. Vaccination helped, but client illness continued to create limitations surrounding in-person interactions. The decrease of in-person interactions led to some challenges in rapport building and sustaining client engagement.

Is anyone better off?

V. FY21/22 Client Impact: RTT is a voluntary program, and while individuals referred to the treatment program may be prompted to do so at the recommendation of Probation or the Court, getting clients to engage is often the first challenge that staff will encounter. In the past fiscal year, once clients showed up for their initial intake, RTT staff were successful in engaging clients initially in treatment – in fact, over 90% of new RTT clients had two or more treatment sessions within the first 30 days.

The great majority of RTT clients come into treatment with significant challenges related to housing and/or employment. For RTT staff, addressing housing needs is often the starting point. Employment challenges are also important to address in treatment, as employment is often required before the clients can obtain housing. In FY21-22, 83% of RTT clients were successfully linked to community-based support services to address their housing and/or employment needs.

- Case study – a 20 year old Mexican and Cuban American male was referred to RTT by the Alameda County Public Defender's office. The client reported experiencing feelings of anxiety and depression that had become much more pronounced due to his pending criminal case. He reported that his low mood, anxiety, lack of motivation, and feelings of hopelessness impaired his ability focus on applying for work and school. He was unemployed, not in school, and reported strained relationships with family members. The client disclosed feelings of deep shame related to his charge (sexual contact with an animal). The client expressed fear that he would be judged by RTT staff – and others – due to the nature of his charge. As treatment progressed, the client began to open up and he reported a history of childhood sexual abuse to his RTT clinician, the first time he had spoken about the abuse. As the client began to be more open during therapy, he also became more engaged during case management sessions. The client asked RTT staff to be present at his court dates for support – RTT staff attended and reported that the client was subject to judgment and mistreatment during at least one court date (due to the nature of his charge), but the client continued to express appreciation for RTT staff supporting him and continuing to show up for him. The client began to work more diligently with his RTT Peer Counselor to complete an application and FAFSA for Lake Merritt College. The client ultimately enrolled in general education classes and is now working on picking an area of concentration. RTT staff also supported the client with resume building, job leads, and interview preparation and follow up. The client was able to obtain-and-retain a warehouse job. The client also entered into a healthy relationship with a girlfriend and reported improved relationships with his mother and sisters. The client recently successfully graduated from Diversion Court and asked RTT staff to be present for the court date, as well as a celebratory lunch.

VI. FY21/22 Additional Information: Housing continues to be the primary and most urgent case management need for clients. RTT staff continue to work hard to link clients to any-and-all resources, but if we were able to help financially as well (e.g., with a deposit and first months' rent to get clients going, etc.), that would be significant. The times when we have been able to get clients connected to housing quickly are when we see faster and more sustained success – such as when were able to connect clients to Prop 47 housing funds. Our current support services budget allows us to support clients with approximately $100 (for all basic needs), and does not afford us the capability to help more directly with housing. Also, about half way through the fiscal year, we got word that the program that helped link our clients to Prop 47 housing funds had hit the limit and could no longer take on new referrals. This further limited our ability to support clients with their most urgent need.

Most of our clients appear to do well at the RTT level of care (i.e., weekly and as needed individual therapy and weekly and as needed case management –> approximately two services per week for 12-18 months). However, there are a number of clients who end up requiring more support when compared to a more typical RTT client. These clients may have periods of stability, but these periods tend to be the exception rather than the rule. Over the course of the 18 months, these clients frequently present in crisis and may require three or four services per week (or even daily check-ins with RTT staff) in order to avoid hospitalization. RTT staff have reported efforts to connect these individuals to a higher level of care, such as FSP or intensive case management (Level 1), but are often met with challenges in doing so. When staff try to refer these clients to a more appropriate level of care, they are told that since the clients do not have a history of hospitalizations, they are not eligible for a higher level of care. At that point, it would be inappropriate to refer the client elsewhere, so they stay in our program. While staying in our program is ultimately the thing that (hopefully) helps them to maintain some stability and avoid DTS/DTO, it is much harder for our staff to manage their caseloads, as the program is not designed for that level of contact given the number of clients our clinician is supporting at any one time. Additionally, it ultimately becomes a problem once the client reaches the maximum of 18 months as they would still be deemed ineligible for a FSP or Level 1, and would very likely decompensate if referred to OP treatment services.

Related to the point above, RTT clients can present as very high need; we have one FTE clinician who often ends up being stretched thin to meet the significant demands of clients. If we were able to have two FTE clinicians - to go with our two FTE peer counselors - we would be better equipped to serve our clients while avoiding staff burn out and turnover.

VII. FY 22/23 Projections of Clients to be Served: As of July 2022, we are finally fully staffed – for the coming fiscal year, we hope to remain fully staffed and to subsequently be able to increase our caseload to maintain an average of 40 clients.

VIII. FY 22/23 Programs or Service Changes: We have recently modified our policy around no-shows for intakes. Due to the high demand for services for our target population, RTT has been experiencing a larger than usual influx of referrals and subsequent longer than usual callback list. We want to ensure that we are moving through the list as quickly as possible. It is vital that we connect with and engage individuals soon after the referral, before the window of possibility for treatment closes. Therefore, if an individual does not show up (or call) for an intake appointment, they will be automatically moved to the bottom of the callback list (rather than rescheduling and prolonging the outreach/enrollment process). It is a challenging balance, because we do want to give each individual an opportunity to engage in services but we also do not want to lose time waiting for someone who may never engage.

We are hoping to come up with a plan to better meet the needs of individuals released from Santa Rita Jail without a phone/contact information. We are considering options such as exploring ways to better connect with referrals while they are still incarcerated (i.e., we've made a request to get info from ACBH and the SRJ discharge team regarding how staff can connect with referrals via phone). We've also better prepared our front desk staff (with a document that has directions on how to get a free phone from the Social Services office) for any clients that come to La Familia RTT from Santa Rita and don't have a phone/phone number.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 38

PROVIDER NAME: Bay Area Legal Aid (BayLegal)

PROGRAM NAME: Alameda County Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) Program Advocacy Services Project

Program Description: BayLegal Provides SSI/SSDI advocacy to increase the number of Alameda County residents facing moderate to severe mental health issues who are approved for SSI/SSDI benefits. (Formerly known as program number FSP 7)

Target Population: Individuals with moderate to severe mental and individuals released from or about to be released from Santa Rita Jail, Glenn Dyer Detention Facility, or the State prison system.

How Much Did We Do?

I. FY 21/22:

a. **Number of Unique Clients Served:** 294 **Cost per client:** $1,439

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

a. **Reduce Mental Health Stigma:** BayLegal engages in staff and community education to reduce mental health stigma. Staff are trained in Harm Reduction and Trauma-Informed Lawyering and provide client-centered services to help normalize treatment and reduce mental health stigma for clients. Staff provides trainings regarding mental health and other disability issues to the National Organization of Social Security Claimants' Representatives, Practicing Law Institute, BHCS and primary care providers, and Covenant House.
b. **Create a Welcoming Environment:** BayLegal strives to create a welcoming and inclusive environment for all clients. BayLegal attorneys are trained to provide clients with respectful, culturally and linguistically competent services that help clients identify their goals and the steps needed to achieve those goals. Written materials are reviewed regularly for readability and attorneys provide reasonable accommodations for clients with disabilities. Clients in this program meet with attorneys one-on-one and are offered water, a snack, and toiletries if needed. Staff eliminates barriers to service by conducting meetings in clients' primary language, meeting with clients in their preferred location or by phone, and following-up with clients who miss meetings.

III. Language Capacity for this Program: BayLegal served clients in English (264), Spanish (11), Cantonese (4), Vietnamese (3), Farsi (1), Arabic (1), Tagalog (1), Burmese (1), Dari (1), French (1), Gujarathi (1), Hindi (1), Khmer/Mon-khmer (3), and Punjabi (1).

IV. FY 21/22 challenges: The ongoing COVID-19 pandemic continued to present challenges to service delivery in FY 21/22, particularly in ways the pandemic affected communication with clients. USPS delays in processing mail particularly affected homeless clients who use General Delivery and made obtaining necessary signatures more difficult. Clients sometimes do not have a stable address, move in

and out of Santa Rita Jail or medical facilities, and experience periods of homelessness. All of these issues slowed services and delayed communications between staff and clients.

The SSA field offices continued to be understaffed and were generally closed to the public except for limited appointments, and hearings were held virtually. Additionally, Social Security experienced technical problems with their phone lines, making it more difficult to conduct business with SSA by phone. BayLegal worked with clients to ensure they could attend virtual hearings and brought clients into the Oakland office as needed to attend hearings in special conference rooms retrofitted to comply with all safety protocols.

Is anyone better off?

V. FY 21/22 Client Impact: BayLegal served 294 clients with 319 cases in FY 21/22. BayLegal closed 133 cases: 10 cases assisted clients with advice and counsel, 37 cases assisted clients with brief services, and 86 cases assisted clients with extended services. Of extended service cases, 58 cases assisted clients with Administrative Agency Decisions, 3 cases assisted clients with court decisions, 21 cases assisted clients with extensive services not resulting in settlement or court or administrative action, and 4 cases assisted clients with other extended representation. Monetary benefits for clients from back awards and lump-sum settlements, reductions or eliminations of claimed amounts, cost savings, and benefits totaled $773,544.

BayLegal's ACBH contract, Section IV Contract Deliverables and Requirements sets the following Impact Objective: Contractor shall achieve a SSI/SSDI allowance rate at least equal to that of the national average approval rate. In the *SSI Annual Statistical Report, 2020,* the national 2019 allowance rate was 46.6%.[1] BayLegal's FY 21/22 allowance rate for closed cases was 79%. BayLegal successfully accomplished this goal.

The client story below illustrates the work funded by this grant:
Kemi B.* was incorrectly denied SSDI benefits in 2014 and came to BayLegal for help. Kemi's BayLegal attorney helped her reapply for benefits. When the reapplication was denied, BayLegal represented Kemi at the reconsideration and administrative hearings, and then at the Appeals Council and federal court. Kemi won a favorable court decision to remand for a new hearing, where BayLegal again represented her. Kemi then won a favorable decision at the new hearing that backdated her award to the original alleged disability onset date amounting to nearly $150,000 and ongoing payments. Kemi is now more stable and financially secure with SSDI benefits.
*Client name changed to protect confidentiality.

VI. FY 21/22 Additional Information: Cases with the Social Security Administration (SSA) and the California Disability Determination Services (DDS) are generally moving more slowly due to the ongoing pandemic. SSA and DDS are both understaffed and SSA field offices are generally closed to the public. Technical problems with SSA phone lines made conducting business by phone more difficult. Cases with DDS are sometimes stalled awaiting a consultative examination that DDS staff has been unable to schedule due to the lack of in-person appointments, or client or clinician objections to an in-person appointment.

[1] This is the latest national allowance rate published directly by the Social Security Administration. https://www.ssa.gov/policy/docs/statcomps/ssi_asr/2020/ssi_asr20.pdf.

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

VII. FY 22/23 Projections of Clients to be Served: BayLegal estimates the number of clients to be served in FY 22-23 to be approximately 300. Clients will be represented at all stages of SSI/SSDI applications, and staff will advocate for clients with SSA and DDS.

VIII. FY 22/23 Programs or Service Changes: Due to the ongoing pandemic, staff provided remote services whenever possible. The Oakland office was open during the reporting period on a limited basis for walk-in clients. The SSI/SSDI advocacy project is supported by a remote attorney of the week who calls back clients looking for assistance. The attorney of the week screens for eligibility and merit, provides advice or brief service as needed, and adds clients to the referral list for representation. As the Oakland office opens to the public, BayLegal will resume an attorney of the day model to serve clients who walk into the office seeking assistance with SSI/SSDI benefits.

OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 38

PROVIDER NAME: Alameda County Homeless Action Center (HAC)

PROGRAM NAME: Alameda County Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) Program Advocacy Services Project

Program Description: HAC Provides SSI/SSDI advocacy to increase the number of Alameda County residents facing moderate to severe mental health issues who are approved for SSI/SSDI benefits. (Formerly known as program number FSP 7)

Target Population: Individuals with moderate to severe mental and individuals released from or about to be released from Santa Rita Jail, Glenn Dyer Detention Facility, or the State prison system.

How Much Did We Do?

I. FY 21/22:

a. **Number of Unique Clients Served:** 355 **Cost per client:** $2,384

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

a. **Reduce Mental Health Stigma:** Our clients overwhelmingly have some history of mental health diagnosis and/or treatment, and it is our job to encourage them to work with us to document the extent to which those concerns have impacted their lives. That task, usually over the course of several years, is at the heart of representing people in Social Security disability claims. HAC's collective understanding of some of the common threads running through the lives of individuals who are poor and mentally ill in Alameda County makes it a place that the range of experiences, we hope, can be shared with significantly less fear of judgment or discomfort than people expect in other settings.

   In addition to what staff gain from direct experience with the work, they receive training from a variety of internal and external sources to help them effectively and respectfully work with clients with mental illness: From trauma-informed lawyering, harm reduction, de-escalation, to tolerance, acceptance, and forgiveness. HAC believes that mental health and mental illness exist on a continuum. Location on that continuum varies over time both within and across individuals and families and communities. You are welcome at HAC, even if you sometimes have days where your symptoms prevent the business at hand for you and your attorney. We'll meet you where you are, repeatedly.

b. **Create a Welcoming Environment:** HAC extends a welcoming hand beyond the walls of our office into the community where possible. Our Outreach Team may make initial - or repeated - contact with clients during encampment visits or at clinics where we offer help with public benefits, identification, and referrals, or donations of tents, socks, or snacks. Acknowledging our clients' needs for things beyond representation in their disability claim is part of our strategy of engagement. While some clients really only need help with SSI, the majority have a variety of other concerns related to health or income or housing or food at some point during their relationship with HAC. To keep clients engaged and in touch during what is frequently a multi-year

relationship while we wait for action from Social Security and appeal unfavorable decisions, we need to some extent to be a place people think of when they need some more immediate help. The pandemic reduced our ability to provide drop-in services within the walls of our office, but enhanced our efforts to provide these services in other ways. Notable beside our outreach team is our helpline, staffed by a rotating crew of our SSI attorneys and advocates who are trained and supported to provide remote help with the same sorts of benefits and housing concerns that people bring to our offices. If you do come to our office, if you are thirsty, hungry, or want to pet a dog or even a cat for a bit, or just need a mask or some hand sanitizer, you'll usually be in luck.

III. Language Capacity for this Program: On Staff: Arabic; Cambodian/Khmer; Farsi/Persian; French; Korean; Mandarin; Portuguese; Spanish; Vietnamese. Capacity is augmented by use of Language Line whenever necessary. It has over 240 languages available.

IV. FY 21/22 challenges: Social Security continued to be much harder to reach than in pre-pandemic years, extending the length of decisions at each stage of the application process by several months on average – a 20 – 25% inccrease in the time from filing to decisions and opening to closing of cases over prepandemic years. By the spring of 2022 we were tracking the number of our calls to SSA that simply wouldn't complete at all. Some weeks it was more than 50%, and wait times for the calls that did complete were much longer, stretching each attorney thin as they tried to carry a full caseload with routine transactions in each case taking more time than usual.

Is anyone better off?

V. FY 21/22 Client Impact: 59 cases were closed with an award of benefits during the FY.

VI. FY 21/22 Additional Information: N/A

VII. FY 22/23 Projections of Clients to be Served: SSA Processing times, while still worse than in pre-pandemic years, did see some improvement in 2022, and at this writing, Social Security has finally opened their doors for some in person services. If things continue to return to normal, we hope to be able to process cases faster – when cases turn over faster, we can serve more clients in a year. We hope to at least get back above 400 in the next FY, including the 233 cases that were still pending as of the end of this FY.

VIII. FY 22/23 Programs or Service Changes: N/A

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).
- Prevention and Early Intervention to promote wellness and to foster health, to provide treatment when needed, and to prevent the suffering that can result from untreated mental illness.

Mental Health Services Oversight & Accountability Commission (MHSOAC) established priorities for the use of County's 2020-2023 Prevention and Early Intervention funds[3]:

- **Childhood trauma prevention and early intervention**, as defined in Section 5840.6(d), to address the early origins of mental health needs.
- **Early psychosis and mood disorder detection and intervention**, as defined in Section 5840.6(e), and mood disorder and suicide prevention programming that occurs across the lifespan.
- **Youth outreach and engagement** strategies, as defined in Section 5840.6 (f), that target secondary school and transition age youth, with a priority on partnerships with college mental health systems.
- **Culturally competent and linguistically appropriate prevention and early intervention** as defined in Section 5840.6(g).
- Strategies targeting the mental health needs of **older adults** as defined in Section 5840.6(h).
- **Early identification programming of mental health symptoms and disorders**, including but not limited to anxiety, depression, and psychosis.

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

3 MHSOAC Memo, January 30, 2020

Prevention and Early Intervention Strategies and Priorities [1]

Build protective factors; reduce risk factors for developing a SMI. Improve mental health for people with a greater than average risk of SMI.	***PREVENTION***
CHILDHOOD TRAUMA	Prevention and early intervention to deal with the early origins of mental health needs.
MH treatment, including relapse prevention, to promote recovery for a mental illness early in emergence.	***EARLY INTERVENTION***
EARLY PSYCHOSIS & MOOD DISORDERS	Detection and intervention and mood disorder and suicide prevention programming that occurs across the lifespan.
Engage/train potential responders to recognize and to respond to early signs of a severe and disabling mental illness.	***OUTREACH***
YOUTH OUTREACH AND ENGAGEMENT	Strategies that target secondary school and transition age youth, with a priority on partnership with college mental health programs.
Activities that reduce negative feelings, attitudes, beliefs, perceptions and/or discrimination related to MH diagnosis or to seeking MH services.	***STIGMA & DISCRIMINATION REDUCTION***
CULTURE AND LANGUAGE	Culturally competent and linguistically appropriate prevention and intervention.
Activities to connect people with SMI to medically necessary early care and treatment.	***ACCESS & LINKAGE TO TREATMENT***
OLDER ADULTS	Strategies targeting the mental health needs of older adults.
Activities that the County undertakes to prevent MH-related suicide. May be part of Prevention or Early Intervention program.	***SUICIDE PREVENTION***
EARLY IDENTIFICATION	Prevention and early intervention to deal with the early origins of mental health needs.

[1] The figure above represents both the PEI strategies documented in the California Code of Regulations (CCR) and the priorities enshrined through SB 1004 *priorities enshrined through SB 1004 to which all counties must adhere.*

Prevention and Early Intervention
Strategies and Priorities (by PEI #/name)

	PREVENTION	*EARLY INTERVENTION*	*OUTREACH*	*STIGMA & DISCRIMINATION REDUCTION*	*ACCESS & LINKAGE TO TREATMENT*	*SUICIDE PREVENTION*
CHILDHOOD TRAUMA						
	1A-Blu Sky 6-AHS 6-ROYAA 7-Afghan 8-NAHC		1C-Early Child MH		1B-School Based MH	
EARLY PSYCHOSIS & MOOD DISORDERS						
	6-AHS 6-ROYAA	17B-REACH			1B-School Based MH	
YOUTH OUTREACH & ENGAGEMENT						
	6-AHS 6-ROYAA 6-Arise 6-Rams 7-Afghan 7-FAJ 7-HUME 8-NAHC 9-DHTI 1D La Fam 20A-BRL 20F-RJOY 20E Tri Cities 20E PEERS 28 HHREC	17A-Youth Up Rising 17B-REACH 24-Sobrante Park	22 Peer Mentor	4-Everyone Counts	1B-School Based MH	12 Text line 12 Comm Education
CULTURE AND LINGUISTIC						
	5-La Clinica 6-AHS 6-ROYAA 6-Arise 6-Rams 6-KCCEB 7-Afghan 7-FAJ 7-IRC 7-HUME 8-NAHC 10-PTR 9-DHTI 1D-La Fam 20A-BRL 20B-BMS 20C-MHAAC 20F-RJOY 20E Tri Cities 20E PEERS 26 HHREC 27 HHREC		1C-Early Child MH 20C-MHAAC 22 TA Prog 28	4-Everyone Counts		
OLDER ADULTS						
	6-Arise 6-Rams 7-Afghan 7-FAJ 7-HUME 8-NAHC 9-DHTI 20E Tri Cities 20E PEERS	3-GART	22 Older Out 22 Peer Mentor	4-Everyone Counts		
EARLY IDENTIFICATION						
	1A- Blu Sky 5-La Clinica 6-AHS 6-ROYAA 6-Arise 6-Rams 6-KCCEB 7-Afghan 7-FAJ 7-IRC 7-HUME 8-NAHC 10-PTR 9-DHTI 20F-RJOY	17A-Youth Up Rising 17B-REACH	1C-Early Child MH 1F-Fremont 22 Peer Mentor		1B-School Based MH	12 Text line 12 Comm Education 12 Clinical Program

% Of PEI programs with a focus in each priority area:
(Most programs have multiple priorities.)

CHILDHOOD TRAUMA	**20.51%**
EARLY PSYCHOSIS & MOOD DISORDERS	**10.25%**
YOUTH OUTREACH & ENGAGEMENT	**66.66%**
CULTURE AND LINGUISTIC	**61.53%**
OLDER ADULTS	**43.59%**
EARLY IDENTIFICATION	**66.66%**

Program Outcomes & Impact:

PEI Participant Satisfaction Survey

ACBH used an electronic survey in fiscal year 21/22 to assess participant satisfaction with the PEI program portfolio. It was the first time the entire PEI system implemented a similar survey tool across all programs simultaneously. The optional survey was open to all Underserved Ethnic and Language Program (UELP)[2] participants who had received four or more services (including preventive counseling, community events, workshops, support groups, and prevention visits) from January 1 to March 31, 2022, and to all PEI program participants who received services between February 15th and March 15th, 2022. The PEI Participant Satisfaction Survey was implemented primarily in electronic format for ease of access and completion. Participants received assistance, by request, in person and by phone to complete paper surveys. Some providers allowed time near the conclusion of various virtual programming and events to facilitate survey completion via a link shared in the chat function.

PEI contracted providers collaborated with ACBH to design the survey and the implementation process. The design team held inclusiveness as a core value for example, advising that the survey, formerly named "Client Satisfaction" be re-titled "Participant Satisfaction". Some program participants don't consider themselves clients and prefer not to be referred to by that designation. Further, the survey is brief with simple language. Finally, ACBH coordinated with providers to translate the survey into the various languages representing the diverse communities that receive PEI services: Chinese, Korean, Farsi, Dari, Pashto, Tigrinya, Amharic, French, Arabic, Cambodian, Mein, Vietnamese, Burmese, Spanish, Tagalog, Fijian, Tongan, Urdu, Hindi, and Punjabi. Providers collected **1,342** surveys during the assessment period from **752 PEI** program participants and from **590 UELP** program participants.

In the post-assessment review, providers requested edits to descriptions of some race/ethnicity categories. They also recommended extending the data collection period for up to six months to increase participation.

[2] UELP is a subgroup within the PEI portfolio with a specific evidence/community-based, community informed model and program requirements around fidelity. Due to UELP's programmatic and service delivery standardization and evaluation processes, these programs implemented a longer survey. The results are listed separately.

PEI Survey Results

As a result of the services and supports I've received in this program:								
	YES		**SOMEWHAT**		**NO**		**NA**	
	#	**%**	**#**	**%**	**#**	**%**	**#**	**%**
I am more prepared to seek support when I need it. *(n=727)*	**563**	77.44	**138**	18.98	**7**	.96	**19**	2.61
I have someone to turn to when I need to talk about my problems. *(n-=723)*	**517**	71.50	**165**	22.82	**20**	2.76	**21**	2.90
I have learned more ways to manage stress or emotional problems. *(n=727)*	**459**	63.13	**230**	31.63	**22**	3.02	**16**	2.88
I feel like I am part of a community. *(n=723)*	**523**	72.33	**158**	21.85	**29**	4.01	**13**	1.79
I feel better about myself. *(n=726)*	**501**	69.00	**187**	25.75	**20**	2.75	**18**	2.47
I am more aware of the resources in my community. *(n=722)*	**506**	70.08	**176**	24.37	**23**	3.18	**17**	2.35

UELP Survey Results

Which services are you receiving?			
Prevention Services (community events, support groups, workshops, a visit to get information on resources).		**Preventative Counseling** (one on one sessions with a counselor).	
#	**%**	**#**	**%**
384	**63.36**	**222**	**36.63**

As a result of the services and supports I've received in this program:								
	YES		**SOMEWHAT**		**NO**		**NA**	
	#	**%**	**#**	**%**	**#**	**%**	**#**	**%**
I feel like I am part of a community. *(n=561)*	**485**	86.45	**48**	8.55	**6**	1.06	**22**	3.92
I have more opportunities to connect with activities and traditions from my culture. *(n=557)*	**447**	80.25	**65**	11.66	**11**	1.97	**34**	6.10
I have people I can talk to and do enjoyable things with. *(n=556)*	**486**	87.41	**54**	9.71	**8**	1.43	**8**	1.43
I have more skill to deal with difficult daily situations and people. *(n=557)*	**443**	77.73	**105**	18.85	**9**	1.61	**10**	1.79
I am more prepared to seek out support when I need it. *(n=556)*	**463**	83.27	**71**	12.76	**10**	1.79	**12**	2.15
I have learned more ways to manage stress or emotional challenges. *(n=560)*	**461**	82.32	**77**	13.75	**7**	1.25	**15**	2.67
I have improved interactions/relationships with one or more people in my family. *(n=558)*	**430**	77.06	**85**	15.23	**16**	2.86	**27**	4.83
When people experience stress, worries, and lack of basic needs, their mental health or emotional wellness is affected. *(n=557)*	**469**	84.20	**48**	8.61	**14**	2.51	**26**	4.66
When people have access to programs like this they can grow, change, and improve their emotional wellness and mental health. *(n=557)*	**503**	90.30	**35**	6.28	**1**	.17	**18**	3.23

Which of the following areas of your life have improved as a direct result of your participation in these services (check all that apply)?		
	#	**%**
Access to legal resources (crime victim, immigration, intimate partner violence, probation, etc.)	**182**	30.84
Access to referrals and resources (food, school, jobs, housing, benefits, etc.)	**268**	45.42
Access to health insurance	**149**	25.25
Connection with my culture and/or community	**269**	45.59
Dealing with substance misuse (alcohol or other substances)	**41**	6.94
Relationships with family, parent, spouse, or child	**293**	49.66
Mental health/emotional wellness (reduction of any of the following: stress, anxiety, depression, self-harm, grief and loss, fear, etc.)	**382**	64.74
Wellness, self-care, physical health	**401**	67.96

How much do you agree with the following statements:	**YES**		**SOMEWHAT**		**NO**		**NA**	
	#	**%**	**#**	**%**	**#**	**%**	**#**	**%**
Services were available at times that were good for me. *(n=556)*	**505**	90.82	**34**	6.11	**2**	.35	**15**	2.69
Services were available at locations that were good for me. *(n=551)*	**475**	86.20	**35**	6.35	**4**	.72	**37**	6.71
Virtual services (for example, Zoom) were easy for me to access. *(n=543)*	**439**	80.84	**49**	9.02	**6**	1.10	**49**	9.02
Staff were sensitive to my cultural background (race, religion, language, etc.) *(n=554)*	**517**	93.32	**18**	3.24	**10**	1.80	**9**	1.62
Staff here treated me with dignity and respect. *(n=554)*	**532**	96.02	**13**	2.34	**2**	.36	**7**	1.26

Prevention & Early Intervention Program Summaries:
Prevention Programs

MHSA Program #: PEI 1A

PROVIDER NAME: Blue Skies Mental Wellness Team-Alameda County Public Health Department

PROGRAM NAME: School-Based Mental Health Consultation in Preschools

Program Outcomes & Impact: PEI Data Report FY 21/22

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):	Prevention	
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).

The Blue Skies Mental Wellness Program is a prevention and early intervention program that provides comprehensive behavioral health services for active participants in Alameda County's Public Health's Maternal, Paternal, Child, and Adolescent Health's home visiting programs. The program is designed to strengthen parent/infant's attachment and to support parents in adjusting to the emotional changes that can happen before and after childbirth.

Box B: Number of individuals served during this fiscal year through MHSA funding.	
Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	0
Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	79
Number of unduplicated individual family members served indirectly by your program:	38
Grand total of unduplicated individuals served:	**117**

Box C: Demographics of individuals served during this fiscal year through MHSA funding.

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	38
Transition Age Youth (16-25 yrs.)	14
Adult (26-59 yrs.)	69
Older Adult (60+ yrs.)	
Declined to answer	
Unknown	
TOTAL	**121**

VETERAN STATUS	
Yes	
No	
Declined to answer	
Unknown	79
TOTAL	**79**

SEXUAL ORIENTATION	
Gay/Lesbian	
Heterosexual/Straight	
Bisexual	
Questioning/Unsure	
Queer	
Declined to answer	
Unknown	
Another group not listed	
TOTAL	**79**
If another group is counted, please specify:	

CURRENT GENDER IDENTITY	
Female	
Male	
Transgender	
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	
Another identity not listed	
TOTAL	
If another identity is counted, please specify:	

PRIMARY LANGUAGE	
English	71
Spanish	1
Cantonese	
Chinese	
Vietnamese	
Farsi	
Arabic	
Tagalog	
Declined to answer	
Unknown	7
Another language not listed	
TOTAL	**79**
If another language is counted, please specify:	

SEX ASSIGNED AT BIRTH	
Male	96
Female	21
Declined to answer	
Unknown	
TOTAL	**117**

DISABILITY*** STATUS	
Communication Domain	
Vision	
Hearing/Speech	
Another type not listed	
Communication Domain Subtotal	
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	1
Physical/mobility	
Chronic health condition	
Disability Subtotal	**1**
None	120
Declined to answer	
Unknown	
Another disability not listed	
TOTAL	**121**
If another disability is counted, please specify:	

RACE	
American Indian or Alaska Native	
Asian	4
Black or African American	59
Native Hawaiian or other Pacific Islander	
White	
Other Race	
Declined to answer	16
Unknown	
TOTAL	**79**
If another race is counted, please specify:	

Ethnicity/Cultural Heritage (Please choose only one per individual)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	2
Mexican/Mexican American/Chicano	7
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	5
Total Hispanic or Latino	**14**

If Non-Hispanic or Non-Latino, please specify:	
African	
African American	59
Asian Indian/South Asian	
Cambodian	
Chinese	1
Eastern European	
European	
Filipino	3
Japanese	
Korean	
Middle Eastern	3
Vietnamese	
Other Non-Hispanic or Non-Latino ethnicity not listed	
Total Non-Hispanic or Non-Latino	**64**
More than one ethnicity	
Unknown Ethnicity	1
Declined to answer	
EHTNICITY TOTAL	**79**

Box D: Program successes/accomplishments of the past year with one example or case study that the agency is particularly proud of. Note: 1,000-character limit.

During this reporting period Blue Skies launched a Mom-to-Mom depression group. The goal of the group is to support mothers in exploring ways to build resiliency, decrease stress and isolation by building connections with other mothers to promote health and well-being. This 10-week postpartum support group served 16 mothers. All 16 participants attended 80% or more of the group sessions.
During the final group session, through qualitative analysis, group participants reported decreased feelings of isolation and sadness due to developing relationships with other members of the group. All participants reported they enjoyed the group so much and they didn't want it to end. Group participants reported they had several gatherings on their own with their babies and the mom-to-mom participants.

Box E: Program challenges of the past year and how the agency mitigated challenges? Note: 1,000-character limit.

During this reporting period, we received limited number of referrals for substance use (6 in total). The BSMWT may not have generated a larger pool of referrals due to the lack of Starting Out Strong clients in need of substance use services. Some clients shared they did not have the bandwidth to focus on substance use issues due to competing priorities as such adjusting to parenthood coupled with the Covid-19 pandemic. Due to the limited number of referrals, we did not conduct an 8-week substance use/ harm reduction group for current MPCAH participants. To mitigate this challenge, substance use harm reduction sessions were merged into existing groups for pregnant and parenting clients. Our Registered Addiction Specialist provided substance use psychoeducation sessions to pregnant and parenting people who were enrolled in the Embrace Her-Beloved Birth Black Centering Pregnancy Groups.

Box F: Program lessons learned of the past year? Note: 1,000-character limit.

As noted previously, through qualitative analysis we received a positive response from group participants regarding the effectiveness of our mom-to-mom group. However, we did not administer a comprehensive pre and post survey to evaluate the effectiveness of our work from a quantitative standpoint. Although are utilizing an evidence-based curriculum called the Northwestern Mother's and Babies Course, we are not able to measure the impact of our work from a data analysis perspective. We are currently working with the Northwestern Mothers and Babies course to ensure we have a thorough and accurate pre and post survey to capture the necessary data.

Box G: For programs that refer individuals with severe mental illness, information about those that were referred.	
G.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e., mental health treatment services):	4 clients referred to supports within the ACBH System The Hume Center - 1 Brighter Beginnings - 1 Open Path Collective - 1 Pathway to Wellness - 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):	1 client referred to San Joaquin MCAH/Mental Health Services

G.3: Types of treatment individuals were referred to (list types) (250 characters):	Post-partum depression, family stressors, and couples therapy
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:	Unknown - data not collected
G.6: Average number of days between referral and first participation in referred treatment program:	Approximately 14 days

Box H: For programs that work to improve timely access to mental health services for underserved populations, information about those programs is provided below.	
H.1: Who is/are the underserved target population(s) your program is serving (e.g., TAY, Southeast Asian) (250 Characters):	Medi-Cal receiving Black or African American pregnant and parenting mothers, with children between 0-3 years old, living in following zips 94601, 94605, 94621, 94544, and 94603.
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:	121 mothers and children
H.4: Average number of days between referral and first participation in referred PEI program:	Approximately 7 days
H.5: Describe how your program encouraged access to services and follow through on above referrals (250 Characters):	The Blue Skies program expanded our outreach efforts to community-based organizations through-out Alameda County who serve the perinatal population. We developed a 2-sided Blue Skies brochure to share with CBO's along with our internal programs in hopes to expand our reach.

Box I: For Outreach, Suicide Prevention, and Stigma Reduction programs, information for unduplicated potential responders (i.e., those who are able 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.)

TOTAL 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 Program Summaries:
Prevention-Underserved Ethnic Language Population (UELP) Programs

Each UELP program is built on a framework of three core strategies: *1) Outreach & Engagement, 2) Mental Health Consultation, and 3) Early Intervention service*s. These strategies are implemented through a variety of services, including one-on-one outreach events; psycho-educational workshops/classes; mental health consultation sessions with a variety of stakeholders (e.g., families, teachers, faith community, and community leaders); support groups; traditional healing workshops; radio/television/blogging activities; and short-term, low-intensity early intervention counseling sessions for individuals and families who are experiencing early signs and symptoms of a mental health concern.

Alameda County is an incredibly diverse population of over 1.5 million people. To address its diversity, Alameda County Behavioral Health Care Services (ACBH) has contracted thirteen programs to provide culturally responsive Mental Health PEI services to state-identified underserved populations. This evaluation report was provided in coordination and partnership with Alameda County Behavioral Health and the Unserved/Underserved Ethnic Language Population (UELP) programs and their community partners:

- Afghan Coalition
- Asian Health Services
- Bay Area Community Health
- Center for Empowering Immigrants & Refugees
- Diversity in Health Training Institute
- Filipino Advocates for Justice
- International Rescue Committee
- Korean Community Center of the East Bay
- La Clinica de la Raza
- Native American Health Center
- Partnerships for Trauma Recovery
- Portia Bell Hume Center
- Richmond Area Multi-Service, Inc.

In 2014, Alameda County Behavioral Health (ACBH) worked with seven Unserved/Underserved Ethnic Language Population (UELP) programs to develop and administer an outcome-based survey. The survey was administered again in 2015. The outcome-based survey was revised in 2016 and separated into two different data tools – the UELP Community Health Assessment and the UELP Community Wellness Client Satisfaction Survey. Each of the UELP providers vetted and implemented the new tools in 2017.

The current UELP system has now expanded to a total of 13 providers, serving additional ethnic and language groups.

This section references the 2020/2021 evaluation.

Information regarding the 21/22 Participant Satisfaction Survey is in the Program Outcomes & Impact Section. The health assessment and satisfaction surveys were disseminated to the UELP community in 23 different languages including English, Spanish, Vietnamese, Chinese, Dari, Hindi, Khmer, Nepali, Korean, Thai, and Burmese and covered the following outcomes:

- Forming and strengthening identity;
- Changing knowledge and perception of mental health;
- Building community and wellness;
- Connecting individual and family with their culture;
- Improving access to services and resources;
- Transforming mental health services.

All UELP providers offer services in two main categories: 1) *Prevention* services, for clients who are at higher than average risk of developing a significant mental illness and 2) *Preventive Counseling (PC)* services, designed for clients who are showing early signs and symptoms of a mental health concern. Responses to the client satisfaction survey were analyzed separately for *Prevention* and *PC* services to measure any differences between the two types of services. The health assessment is only given to *PC* clients. The evaluation used mixed methods. To better understand the meaning of survey responses, ACBH also conducted focus groups with the UELP program participants.

KEY FINDINGS

The client satisfaction survey and focus groups were used to assess the program outcomes. The critical findings of the analysis are summarized below. During fiscal year 2020-2021, a total of 668 respondents from all 13 of the UELP programs completed the survey.

In FY 20/21, the data shows that UELP providers in total produced:

- 9,135 *Prevention* events, which is a 22% increase from last year and a 15% increase over pre-pandemic FY 18/19.
- 70,239 people were served at these *Prevention* events (duplicated count); and
- 1,174 unique clients were served through *PC* services, which is an 8% increase in the number of clients served in FY 19/20.

In FY 20/21, both assessment tools assessed the impact of the three core strategies (Outreach and Engagement; Mental Health Consultation; and Early Intervention services) across the following outcomes:

- Forming and Strengthening Identity
  Prevention services enhance self-efficacy. Ninety-two percent of *Prevention* and eighty-four percent of *PC* respondents reported feeling better about themselves.

- Changing Individual Knowledge and Perception of Mental Health Services
  Providers are working towards changing the perception and narrative around mental health. Ninety-three percent of *Prevention* respondents and eighty-nine percent of *PC* respondents reported having a stronger belief that most people with mental health experiences can grow, change, and recover. Having these discussions more frequently and openly works towards normalizing mental health and reducing the ***stigma*** associated with it.

- Building Community and Its Wellness
  UELP providers are working towards a healthier community for their clients. Respondents reported ***establishing relationships*** because of their participation in services. UELP programs help clients build and reduce the risk of social isolation. Ninety-four percent of *Prevention* respondents and eighty-six percent of *PC* respondents reported that they have people with whom they can do enjoyable things.

- Connecting Individual and Family with Their Culture
  UELP programs provide clients with opportunities to connect with their culture. Focus group/interview respondents reported that they had improved their ***parenting skills*** and learned how to parent in America. Ninety-four percent of *Prevention* respondents and eighty-five percent of *PC* respondents reported feeling more connected to their culture and community. Due to the COVID-19 pandemic activities have moved to online spaces, Focus Group participants said that this makes it easier for them to participate in the programs. However, there was a decrease in the mention of participants connecting to their culture during the Focus Groups this year.

- Improving Access to Services and Resources
  UELP programs strive to improve access to services and resources for their client populations. Respondents reported several examples in which their program has connected them to ***resources*** such as employment, housing, food, and financial services. Ninety percent of *Prevention* respondents and eighty-two percent of *PC* respondents reported becoming more effective in getting the resources that they or their family need.

- Transforming Mental Health Services
  UELP programs are transforming the way mental health services are delivered in Alameda County. One example is by providing ***linguistically and culturally competent*** programs. Ninety-seven percent of *Prevention* respondents and 95% of *PC* respondents said that staff were sensitive to their cultural backgrounds and understood what they are going through. Ninety-nine percent of *Prevention* and PC respondents reported that program staff treated them with dignity and respect. Additionally, ***staff*** were said to be among the most beneficial parts of the program in the open-ended responses.

  This is reflected in the high percentage of *Prevention* (97%) and *PC* (96%) respondents agreeing that they would recommend this program to a friend or family member. Despite largely providing online services since March of 2020, the UELP agencies are still able to provide a welcoming and inviting atmosphere that is safe for clients.

ADDITIONAL FINDINGS

Overall, respondents reported improved ***quality of life*** because of their participation in their programs, but still reported a need for continued support. *PC* respondents are also benefitting from more intensive services from their UELP providers. More than half (72%) of *PC* respondents reported fewer crises, which is a large increase compared to last year (57%).

Focus group respondents suggested that participation might be more sustainable if the groups ***continued online***. They find it more convenient because they do not have to find transportation or take more time out of their day. When asked what they would like to see more of on the client satisfaction survey respondents wanted more help with ***mental health*** and focus group respondents mentioned that they wanted ***youth programming*** to help them with their mental health.

EVALUATION LIMITATIONS

Although this annual evaluation data continues to show positive results, it has several limitations in our assessment methods, including the small sample size, the lack of comparison group, and the subjective nature of qualitative assessment and analysis. ACBH will continue to work with the program evaluator to better capture the results of PEI programs and the longer-term impact on clients.

MHSA Program #: PEI 1D

PROVIDER NAME: La Familia Counseling Services

PROGRAM NAME: Outreach, Education & Consultation for Unaccompanied Immigrant Youth (UIY)

Program Outcomes & Impact: UELP Prevention Data Report FY 21/22

Program Name:	**Unaccompanied Immigrant Youth Outreach (UIY)**	
Organization:	La Familia Counseling Services	
PEI Program # and Name:	PEI 1D Unaccompanied Immigrant Youth Outreach (UIY)	
Type of Report (Choose one):	Annual	
PEI Category (choose one):	Outreach	
Priority Area (place and X next to all that apply):	x	Childhood Trauma
		Early Psychosis
	x	Youth/TAY Outreach and Engagement
	x	Cultural and Linguistic
		Older Adults
	x	Early Identification of Mental Health Illness

Box A: Please provide a brief program description (character limit 1,000).

Unaccompanied immigrant youth (UIY) are minors who make dangerous journeys across borders to flee extreme violence, traumatic experiences, and economic deprivation in their home countries. The UIY team provides linguistically and culturally responsive trauma informed services, outreach and preventive counseling, stabilization, identification of early signs of mental illness, and linkages to various resources/supports to a population sensitive to acculturation and challenges navigating new systems.

Box B: Number of individuals served this fiscal year through MHSA funding.

Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	126
Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	15

Number of unduplicated individual family members served indirectly by your program:	112
Grand total of unduplicated individuals served:	**253**

Box C: Demographics of individuals served this fiscal year through MHSA funding.

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	204
Transition Age Youth (16-25 yrs.)	1818
Adult (26-59 yrs.)	4216
Older Adult (60+ yrs.)	480
Declined to answer	
Unknown	8
TOTAL	**6294**

SEXUAL ORIENTATION	
Gay/Lesbian	28
Heterosexual/Straight	6215
Bisexual	1
Questioning/Unsure	
Queer	2
Declined to answer	
Unknown	45
Another group not listed	3
TOTAL	**6294**
If another group is counted, please specify:	

VETERAN STATUS	
Yes	3
No	6226
Declined to answer	
Unknown	65
TOTAL	**6294**

CURRENT GENDER IDENTITY	
Female	4254
Male	1719
Transgender	
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	320
Another identity not listed	1
TOTAL	**6294**
If another identity is counted, please specify:	

PRIMARY LANGUAGE	
English	3512
Spanish	2753
Cantonese	
Chinese	
Vietnamese	
Farsi	
Arabic	
Tagalog	
Declined to answer	
Unknown	
Another language not listed	29
TOTAL	**6294**

SEX ASSIGNED AT BIRTH	
Male	1719
Female	4254
Declined to answer	
Unknown	321
TOTAL	**6294**

DISABILITY*** STATUS	
Communication Domain	
Vision	
Hearing/Speech	
Another type not listed	
Communication Domain Subtotal	
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	
Physical/mobility	
Chronic health condition	
Disability Subtotal	
None	6273
Declined to answer	
Unknown	21
Another disability not listed	
TOTAL	**6294**
If another disability is counted, please specify:	

RACE	
American Indian or Alaska Native	
Asian	
Black or African American	354
Native Hawaiian or another Pacific Islander	
White	668
Other Race	194
Declined to answer	
Unknown	736
TOTAL	**6294**
If another race is counted, please specify:	

Ethnicity/Cultural Heritage (Please choose only one per individual)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	
Mexican/Mexican American/Chicano	905
Puerto Rican	3
South American	
Another Hispanic/Latino ethnicity not listed	3434
Total Hispanic or Latino	**4342**
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	1952
Total Non-Hispanic or Non-Latino	**1952**
More than one ethnicity	
Unknown Ethnicity	
Declined to answer	
EHTNICITY TOTAL	**6294**
If another ethnicity is counted, please specify:	

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of. Note: 1,000-character limit.
Our team supported a 13-year-old student from Guatemala. She immigrated to the U.S with her biological mother in search of better opportunities. We supported the student for six months due to her history of severe depression, anxiety, low self-esteem, and active suicidal Ideation. For six years she had been dealing with these conditions in silence due to the stigma around mental health within her family. Student is learning to cope with the disappearance of her Father, who immigrated to the U.S 6 years ago and whom she has not heard from ever since. Her Mother's health condition is another stressor in her life. The student has learned to identify her protective factors to reduce risk. The Mother has received psychoeducation on mental health, ways to support her daughter. Client has been successfully connected to long-term treatment to continue receiving the support she needs to continue building her self-esteem, developing relationships, improving life skills, and managing her symptoms.

Box E: Program challenges of the past year and how did the agency mitigate challenges? Note: 1,000-character limit.
Staff turnover across most agencies and districts (including Alameda County) has resulted in a barrier to link participants to long-term services, once the need has been identified and some level of care has been provided through the UIY program, the team has been able to support those in need by creating community within their own community. We have collaborated with community partners and school health centers to provide wrap around support and services. In partnership, we are providing workshop and support groups where students and families are learning to navigate resources and build trust within their own community.

Box F: Program lessons learned of the past year? Note: 1,000-character limit.
We learned that access to care and preventative mental health services with vulnerable communities of color is significantly more successful in person. We also learned that healing in community is needed and well received by the communities UIY program serves. Furthermore, we received feedback that having a program name with the word "immigrant" can discourage participations due to negative experiences this community has had in the past.

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):	11

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)	EBAC, La Familia EPSDT/SBBH, Alameda County-ACCESS, Alameda County -Tri Cities and ACBH-MH
G.4: Unduplicated number of individuals who participated in referred program at least one time:	4
G.5: Average duration of untreated mental illness in weeks:	15.6 weeks
G.6: Average number of days between referral and first participation in referred treatment program:	32.25 days

Box H: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
H.1: Who is/are the underserved target population(s) your program is serving (e.g. TAY, Southeast Asian) (500 Characters):	Unaccompanied Immigrant Youth and Children of Migrant Families - these are immigrant youth and children who are predominately Spanish speaking and are, by definition, newcomers to the United States.
H.2: Number of paper referrals to an ACBH PEI-funded program:	126
H.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	126
H.4: Average number of days between referral and first participation in referred PEI program:	2
H.5: Describe how your program encouraged access to services and follow through on above referrals (500 Characters):	UIY obtains referrals, and advocates for the continuum of care through regular COST (Coordination of service team) meetings.

Box I: For Outreach, Suicide Prevention, and Stigma Reduction programs, please provide information for unduplicated potential responders (i.e., those who are able 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:	**3,000**
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 based organizations, staff, Faith based partners, church members and leaders.*

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 21/22

Program Name:	**Cultura Y Bienestar**	
Organization:	La Clinica de La Raza, Inc.	
PEI Program # and Name:	PEI 5, Outreach, Education & Consultation (Latino)	
Type of Report (Choose one):	Annual	
PEI Category (choose one):	Prevention	
Priority Area (place and X next to all that apply):		Childhood Trauma
		Early Psychosis
		Youth/TAY Outreach and Engagement
	X	Cultural and Linguistic
		Older Adults
	X	Early Identification of Mental Health Illness

Box A: Please provide a brief program description (character limit 1,000).
Cultura y Bienestar (CYB) is a prevention and early intervention mental health program that offers individual and group interventions to Latinx and Indigenous families in Alameda County. Our program is a partnership between three large Latinx health service providers and has 4 sites throughout central, south, and eastern Alameda County. We center our work in the use of traditional healing and community-based practices to bring about balance, wellness, and healing in our communities.

Box B: Number of individuals served this fiscal year through MHSA funding.	
Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	unavailable
Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	unavailable
Number of unduplicated individual family members served indirectly by your program:	unavailable
Unique prevention clients served:	330

Box C: Demographics of individuals served this fiscal year through MHSA funding.

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	2189
Transition Age Youth (16-25 yrs.)	1262
Adult (26-59 yrs.)	5375
Older Adult (60+ yrs.)	1769
Declined to answer	
Unknown	2346
TOTAL	**12941**

VETERAN STATUS	
Yes	30
No	4023
Declined to answer	
Unknown	8888
TOTAL	**12941**

CURRENT GENDER IDENTITY	
Female	8015
Male	3091
Transgender	6
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	1827
Another identity not listed	2
TOTAL	**12941**
If another identity is counted, please specify:	

SEXUAL ORIENTATION	
Gay/Lesbian	7
Heterosexual/Straight	4165
Bisexual	3
Questioning/Unsure	
Queer	8
Declined to answer	
Unknown	8754
Another group not listed	4
TOTAL	**12941**
If another group is counted, please specify	

PRIMARY LANGUAGE	
English	2988
Spanish	9669
Cantonese	
Chinese	
Vietnamese	
Farsi	
Arabic	
Tagalog	
Declined to answer	
Unknown	
Another language not listed	284
TOTAL	**12941**

SEX ASSIGNED AT BIRTH	
Male	3091
Female	8015
Declined to answer	
Unknown	1835
TOTAL	**12941**

DISABILITY*** STATUS	
Communication Domain	
Vision	6
Hearing/Speech	15
Another type not listed	
Communication Domain Subtotal	**21**
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	
Physical/mobility	6
Chronic health condition	430
Disability Subtotal	**436**
None	
Declined to answer	
Unknown	
Another disability not listed	2
TOTAL	**459**
If another disability is counted, please specify:	

RACE	
American Indian or Alaska Native	
Asian	0
Black or African American	179
Native Hawaiian or another Pacific Islander	
White	456
Other Race	11,188
Declined to answer	
Unknown	1118
TOTAL	**1294**
If another race is counted, please specify: Latino (9,545)	

Ethnicity/Cultural Heritage (Please choose only one per individual)	
If Hispanic or Latino, please specify:	
Caribbean	3
Central American	788
Mexican/Mexican American/Chicano	3737
Puerto Rican	23
South American	118
Another Hispanic/Latino ethnicity not listed	4876
Total Hispanic or Latino	**9545**
If Non-Hispanic or Non-Latino, please specify:	
African	
African American	179
Asian Indian/South Asian	
Cambodian	
Chinese	
Eastern European	
European	
Filipino	
Japanese	
Korean	
Middle Eastern	
Vietnamese	
Other Non-Hispanic or Non-Latino ethnicity not listed	1643
Total Non-Hispanic or Non-Latino	**1822**
More than one ethnicity	
Unknown Ethnicity	1118
Declined to answer	
ETHNICITY TOTAL	**12485**
If another ethnicity is counted, please specify:	

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of. Note: 1,000-character limit.

Our program surpassed all its service objectives for this fiscal year, including individual and group interventions, outreach and supporting other service providers. We increased the number of successful referrals to mental health and other social services, as well as to traditional healing resources and improved our client's experience with a reduction in waiting time for first-time appointments to less than a week in most cases. An overall satisfaction with our services was demonstrated in the yearly client satisfaction survey and we also received positive feedback from attendees to our traditional healing and community events. An evaluation conducted by the CDPH-OHE, demonstrated that our program is effective in reducing symptoms of anxiety and depression as well as increasing resiliency through cultural affirmation and community-based and traditional healing interventions.

Box E: Program challenges of the past year and how the agency mitigated challenges? Note: 1,000-character limit.

Pandemic restrictions in in-person meetings continue to be a challenge as we were forced to go back to virtual sessions and meetings during the surges which greatly impacted attendance. We had to cancel some activities, due to staff shortages and/or unsafe conditions due to a rapid increase in COVID cases in our communities. A significant increase in demand was met with 2 staff departures, a temporary leave and a very difficult time recruiting bilingual/bicultural providers, which resulted in delays in programming and staff working beyond their capacity to meet the needs of our clients. The increase in demand also brought to light the limited resources available for communities of color, as in many cases we were unable to find appropriate mental health resources that had available space for our clients. Finally, a combination of COVID restrictions and increase in demand have made our physical spaces insufficient to meet client's needs and ensure staff and participant's safety.

Box F: Program lessons learned of the past year? Note: 1,000-character limit.

Staff self-care and development is very important, especially during the pandemic when demand increased not only in numbers but also in its intensity. In the upcoming year we will be creating more opportunities for training and for emotional and otherwise support for our own staff and other providers and healers in our community. Along the same lines, we have learned that community empowerment and participation is crucial in prevention in mental health and so we will be creating more opportunities for consumers and community leaders to become trained, involved and engaged in our program. In addition, ongoing coordination and communication among partners and outside agencies has proven to be effective in helping us connect community members to resources and/or to engage them and brake cycles of isolation or build effective networks of support and available space for our clients. Finally, a combination of COVID restrictions and increase in demand have made our physical spaces insufficient to meet client's needs and ensure staff and participant's safety.

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):	42
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):	Child Protective Services, Domestic Violence counseling/support group, PTSD treatment, legal resources, access to health insurance, substance abuse treatment, food and housing resources, traditional healers, rehab centers, medical clinics
G.4: Unduplicated number of individuals who participated in referred program at least one time:	40
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:	7

Box H: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
H.1: Who is/are the underserved target population(s) your program is serving (e.g. TAY, Southeast Asian) (500 Characters):	Latinx, immigrants and mono-lingual Spanish speaking families. Indigenous Maya-Mam speaking immigrant families. TAY and school age children as well as older adults specifically.
H.2: Number of paper referrals to an ACBH PEI-funded program:	500
H.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	272
H.4: Average number of days between referral and first participation in referred PEI program:	5

H.5: Describe how your program encouraged access to services and follow through on above referrals (500 Characters):	During individual sessions, program staff ensures participants have linked to services and support with initiating phone calls and providing navigation and/or translation when and if needed.

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 6

PROVIDER NAME: Asian Health Services

PROGRAM NAME: Outreach, Education & Consultation for the Asian Community

Program Outcomes & Impact: UELP Prevention Data Report FY 21/22

Program Name:	**SMH Prevention**	
Organization:	Asian Health Services	
PEI Program # and Name:	PEI 6, Outreach, Education & Consultation (Asian)	
Type of Report (Choose one):	Annual	
PEI Category (choose one):	Prevention	
Priority Area (place and X next to all that apply):	X	Childhood Trauma
	X	Early Psychosis
	X	Youth/TAY Outreach and Engagement
	X	Cultural and Linguistic
	X	Older Adults
	X	Early Identification of Mental Health Illness

Box A: Please provide a brief program description (character limit 1,000).
The AHS SMH Prevention Program advocates emotional wellness in underserved AAPI communities in Alameda County. Our goals are to improve culturally competent preventative early intervention services; popularize the awareness of emotional wellness; and strengthen communities' knowledge of wellness practices and resources. Our services include community outreach, educational workshops, consultation, preventative counseling, case management, and support group. Services are free.

Box B: Number of individuals served this fiscal year through MHSA funding.	
Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	unavailable
Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	unavailable
Number of unduplicated individual family members served indirectly by your program:	unavailable
Unique prevention clients served:	57

Box C: Demographics of individuals served this fiscal year through MHSA funding.

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	141
Transition Age Youth (16-25 yrs.)	85
Adult (26-59 yrs.)	667
Older Adult (60+ yrs.)	478
Declined to answer	
Unknown	504
TOTAL	**1875**

SEXUAL ORIENTATION	
Gay/Lesbian	5
Heterosexual/Straight	481
Bisexual	
Questioning/Unsure	
Queer	1
Declined to answer	
Unknown	1388
Another group not listed	
TOTAL	**1875**
If another group is counted, please specify:	

VETERAN STATUS	
Yes	9
No	437
Declined to answer	
Unknown	1429
TOTAL	**1875**

CURRENT GENDER IDENTITY	
Female	1092
Male	284
Transgender	4
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	494
Another identity not listed	1
TOTAL	**1875**
If another identity is counted, please specify:	

PRIMARY LANGUAGE	
English	332
Spanish	
Cantonese	1075
Chinese	319
Vietnamese	32
Farsi	
Arabic	
Tagalog	14
Declined to answer	
Unknown	
Another language not listed	103
TOTAL	**1875**

SEX ASSIGNED AT BIRTH	
Male	284
Female	1092
Declined to answer	
Unknown	499
TOTAL	**1875**

DISABILITY*** STATUS	
Communication Domain	
Vision	
Hearing/Speech	
Another type not listed	
Communication Domain Subtotal	
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	
Physical/mobility	10
Chronic health condition	1
Disability Subtotal	**11**
None	
Declined to answer	
Unknown	
Another disability not listed	
TOTAL	**11**
If another disability is counted, please specify:	

RACE	
American Indian or Alaska Native	
Asian	1461
Black or African American	6
Native Hawaiian or another Pacific Islander	
White	2
Other Race	39
Declined to answer	
Unknown	367
TOTAL	**1875**
If another race is counted, please specify:	

Ethnicity/Cultural Heritage (Please choose only one per individual)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	
Mexican/Mexican American/Chicano	
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	
Total Hispanic or Latino	
If Non-Hispanic or Non-Latino, please specify:	
African	
African American	6
Asian Indian/South Asian	3
Cambodian	8
Chinese	1406
Eastern European	
European	
Filipino	
Japanese	
Korean	8
Middle Eastern	
Vietnamese	36
Other Non-Hispanic or Non-Latino ethnicity not listed	41
Total Non-Hispanic or Non-Latino	**1508**
More than one ethnicity	
Unknown Ethnicity	367
Declined to answer	
EHTNICITY TOTAL	**1875**
If another ethnicity is counted, please specify: White (2)	

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of. Note: 1,000-character limit.

We developed and trained new culturally and linguistically experienced staff members with various talents and a strong passion to serve. We were able to build a cohesive and collective team who listened to community needs and provided a variety of responsive services. A portion of our work focused on empowering Asian immigrant parents who shared increased concerns over the community trauma and their impacts on mental health. We responded by cultivating parenting support groups and workshops in languages that helped to increase their knowledges on emotional wellness, anti-racism, community trauma, self-harm, self-care, and managing boundaries. A success involved an individual who was triggered by current events that led to reexperiencing traumatic incidents. The individual had become isolated and withdrawn, leading to prolonged emotional distress. After months of care, the individual reported the ability to manage emotional distress, engage with peers, and return to normal routines.

Box E: Program challenges of the past year and how the agency mitigated challenges? Note: 1,000-character limit.

Our program faced challenges with staffing shortage, especially with the counseling level staff. Demand for care increased during parts of the year as well due to continued stress from the pandemic and community issues; fortunately, we were able to meet demand with help from our master level interns/trainees. We built new collaborations with local academic institutions that provided East Asian language interns and trainees who were able to provide care – they quickly learned how to best serve our community members as well. We are fortunate to be able to bring on a former trainee as an employee to fulfil our staffing needs for the upcoming year. We updated a variety of outreach methods to engage a broader audience. We established a collaborative network with 1000 community partners using emails, AHS social media platform, YouTube channel, and webpage. These engagements helped us to further spread the preventative works to community members through multiple channels.

Box F: Program lessons learned of the past year? Note: 1,000-character limit.

Developing an internship/training program is a key part in helping to support client care services as well as supporting a pipeline of future mental health professionals. We saw this first-hand how impactful the work our interns/trainees provided to our community members and how this can encourage a new wave of professionals to serve our community. A combination of virtual and in person activities will continue again this year. We have observed that the distress from the pandemic and community violence have impacted our community members' interest in seeking in person events and care. It is important to further invest in virtual and in person outreach support with tools such as recording options, language captions, and safe environments for community members to gather in person.

Box G: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
G.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e., mental health treatment services):	1
G.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e., mental health treatment services):	0
G.3: Types of treatment individuals were referred to (list types) (500-character limit):	Outpatient treatment program
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:	NA
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 Asia):	Monolingual immigrant children and family living in Oakland Chinatown, San Leandro, and Alameda areas. Monolingual seniors who are isolated due to pandemic and community violence, mainly living in 12 senior housings.
H.2: Number of paper referrals to an ACBH PEI-funded program:	51
H.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	35
H.4: Average number of days between referral and first participation in referred PEI program:	2-4 weeks
H.5: Describe how your program encouraged access to services and follow through on above referrals:	We are all culturally and linguistically experienced in working with our community members. From the first contact, we match the community member to a staff who speaks their language and supports the case until assigned to a language speaking provider.

Box I: For Outreach, Suicide Prevention, and Stigma Reduction programs, please provide information for unduplicated potential responders (i.e., those who are able 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:	**8966**
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):
Interactive Virtual Community Circle	*242 responders of community leaders and volunteers, medical providers, school administrative*
Interactive Virtual Parent Connection Club	*164 parents*
Interactive Virtual Clinic	*153 patients' leadership*
Interactive Virtual School Meeting	*16 school administrative, counselors and personnel*
Interactive In person Clinic	*42 patients and families*
Interactive In person Chinatown Community	*101 community members of seniors, children and families, and adults*
Interactive Senior Center on Virtual	*55 seniors and seniors center staff*
Non-interactive social medial platform	*7132 virtual viewers*
Infographic by email list	*1061 recipients from schools, NGO, community partners*

MHSA Program #: PEI 6

PROVIDER NAME: Center for Empowering Refugees and Immigrants (CERI)

PROGRAM NAME: ROYA

Program Outcomes & Impact: UELP Prevention Data Report FY 21/22

Program Name:	**ROYA**	
Organization:	Center for Empowering Refugees and Immigrants (CERI)	
PEI Program # and Name:	PEI 6, Outreach, Education & Consultation (Asian)	
Type of Report (Choose one):	Annual	
PEI Category (choose one):	Prevention	
Priority Area (place and X next to all that apply):	X	Childhood Trauma
	X	Early Psychosis
	X	Youth/TAY Outreach and Engagement
	X	Cultural and Linguistic
	X	Older Adults
	X	Early Identification of Mental Health Illness

Box A: Please provide a brief program description (character limit 1,000).

CERI provides culturally relevant mental health/social services to SEA communities, reaching over 1000 clients. We offer preventive counseling, community events, workshops, and support groups for elders, adults, children, and TAY. We link clients to resources and information related to basic needs and human rights, such as housing, voting, food security, medical care, legal support, and culturally tailored interventions such as gardening, meditation, art, and drama therapy, knitting, movement.

Box B: Number of individuals served this fiscal year through MHSA funding.

Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	unavailable
Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	unavailable
Number of unduplicated individual family members served indirectly by your program:	unavailable
Unique prevention clients served:	143

Box C: Demographics of individuals served this fiscal year through MHSA funding.

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	355
Transition Age Youth (16-25 yrs.)	642
Adult (26-59 yrs.)	3455
Older Adult (60+ yrs.)	2188
Declined to answer	
Unknown	341
TOTAL	**6981**

SEXUAL ORIENTATION	
Gay/Lesbian	70
Heterosexual/Straight	4709
Bisexual	3
Questioning/Unsure	
Queer	211
Declined to answer	
Unknown	1950
Another group not listed	38
TOTAL	**6981**
If another group is counted, please specify:	

VETERAN STATUS	
Yes	28
No	5068
Declined to answer	
Unknown	1885
TOTAL	**6981**

CURRENT GENDER IDENTITY	
Female	4677
Male	1933
Transgender	12
Genderqueer	
Questioning/unsure of gender identity	21
Declined to answer	
Unknown	114
Another identity not listed	224
TOTAL	**6981**
If another identity is counted, please specify:	

PRIMARY LANGUAGE	
English	1278
Spanish	3
Cantonese	
Chinese	
Vietnamese	284
Farsi	11
Arabic	
Tagalog	
Declined to answer	
Unknown	
Another language not listed	5405
TOTAL	**6981**

SEX ASSIGNED AT BIRTH	
Male	1933
Female	4677
Declined to answer	
Unknown	371
TOTAL	**6981**

DISABILITY*** STATUS	
Communication Domain	
Vision	1
Hearing/Speech	4
Another type not listed	46
Communication Domain Subtotal	**51**
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	3135
Physical/mobility	39
Chronic health condition	14
Disability Subtotal	**3188**
None	
Declined to answer	
Unknown	
Another disability not listed	68
TOTAL	**3307**
If another disability is counted, please specify:	

RACE	
American Indian or Alaska Native	2
Asian	6771
Black or African American	6
Native Hawaiian or another Pacific Islander	7
White	41
Other Race	144
Declined to answer	
Unknown	10
TOTAL	**6981**
If another race is counted, please specify: Latino (99), Multiracial (32)	

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	99
Total Hispanic or Latino	**99**
If Non-Hispanic or Non-Latino, please specify:	
African	
African American	6
Asian Indian/South Asian	29
Cambodian	5160
Chinese	49
Eastern European	
European	
Filipino	83
Japanese	14
Korean	38
Middle Eastern	12
Vietnamese	438
Other Non-Hispanic or Non-Latino ethnicity not listed	949
Total Non-Hispanic or Non-Latino	**6788**
More than one ethnicity	
Unknown Ethnicity	
Declined to answer	
EHTNICITY TOTAL	**6877**
If another ethnicity is counted, please specify: Afghan (8), Bhutanese (15), Burman (295), Chin (66), Indonesian (21), Kachin (6), Karen (165), Karenni (8), Malaysian (2), Mien (8), Mon (11), Mongolian (5), Nepalese (25), Rakhaing (277), Shan (12), Thai (5), Other South East Asian (11)	

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of. Note: 1,000-character limit.

We expanded youth programs, engaging children, teens, and TAY with art, nature, social justice, and academic support. We had monthly field trips to reduce isolation from COVID and anti-Asian hate, with 60 adult/older adult clients at each visit. We trained direct practice staff in EMDR, IFS, and the flash technique to prevent acute PTSD with evidence-based practices. We began a support group for adult children of genocide survivors struggling with mental illness. Our UELP program made us competitive for awards from private foundations, CA Dept of Social Services, CA Dept of Health Care Services, CA Natural Resources Agency, and MHSOAC. Soch joined CERI this year, struggling with physical health issues and isolation that triggered PTSD symptoms and suicidality. CERI connected Soch to public benefits, psychiatric medication, and trauma therapy. Her kids joined youth programs and preventive counseling. Now Soch attends support groups and field trips, and the whole family feels more ease.

Box E: Program challenges of the past year and how the agency mitigated challenges? Note: 1,000-character limit.

This year we had a rapid expansion of services and staff. While our numbers for preventive counseling remain the same, we've had a 20% increase in referrals for support groups, care management, and prevention visits. We serve youths who range in age from 6 to 24 as well as adults who struggle with mental illness and substance abuse, populations that have distinct needs and require us to figure out how to skillfully navigate sharing our small office space to offer groups and services. We are addressing this through improving communication across programs and developing staff training to address diverse client concerns and presentations around mental health. Managing staff overwhelm and preventing burnout through supportive supervision, staff retreat, and encouraging time off and self-care have been critical this year as the demand for services increased in the context of COVID, anti-Asian hate, climate crisis, global conflicts and war, and a polarizing political landscape.

Box F: Program lessons learned of the past year? Note: 1,000-character limit.

This year we reaffirmed the critical need for groups, not only for our older adults, but also for our youths and adults struggling with chronic mental illness. We experienced an increased demand for care management and referrals for COVID relief services, public benefits and resources including housing, food, medical care and insurance, legal services, and more. We recognized that we need to improve our on-boarding training for staff, so that as an organization we are well equipped to address diverse client concerns and presentations/acuities around mental health, which is why we plan to integrate a Mental Health First Aid training for our direct practice staff. Finally, we saw the importance of in-person activities to reduce isolation and found opportunities to do so safely in the evolving COVID context.

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):	John George, Herrick Hospital, AHS Level 1 services
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:	4 weeks
G.6: Average number of days between referral and first participation in referred treatment program:	1

Box H: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
H.1: Who is/are the underserved target population(s) your program is serving (e.g., TAY, Southeast Asian) (500 Characters):	TAY, Southeast Asian, elderly, immigrants, and refugees
H.2: Number of paper referrals to an ACBH PEI-funded program:	16
H.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	16
H.4: Average number of days between referral and first participation in referred PEI program:	5 days
H.5: Describe how your program encouraged access to services and follow through on above referrals (500 Characters):	Made calls together, called provider together, we refer some of our clients to long term therapy funded by other programs, so we have internal processes that ensures quality of care and 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 can 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:	**45**
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):
Zoom Mental Health Forum	*30 therapists, Outreach workers, Mental Health Professionals*
Asian Law Caucus	*3 Lawyers, 6 advocates*
Interfaith Community	*6 Interfaith leaders*

MHSA Program #: PEI 6

PROVIDER NAME: **Bay Area Community Health**

PROGRAM NAME: Outreach, Education & Consultation for East Asian Community

Program Outcomes & Impact: UELP Prevention Data Report FY 21/22

Program Name:	**Arise: Asian Wellness Project**	
Organization:	Bay Area Community Health	
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):		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).
Arise: Asian Wellness Project is a Mental Health Prevention and Early Intervention program that aims to promote emotional and mental well-being through education and consultation. We provide FREE workshops, individual preventative counseling, support groups, and community events for youth, adults, and families of the East Asian Community in South Alameda County. We also assist with connecting participants to care and resources.

Box B: Number of individuals served this fiscal year through MHSA funding.	
Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	unavailable
Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	unavailable
Number of unduplicated individual family members served indirectly by your program:	unavailable
Unique prevention clients served:	20

Box C: Demographics of individuals served this fiscal year through MHSA funding.

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	
Transition Age Youth (16-25 yrs.)	329
Adult (26-59 yrs.)	75
Older Adult (60+ yrs.)	129
Declined to answer	
Unknown	
TOTAL	**533**

SEXUAL ORIENTATION	
Gay/Lesbian	
Heterosexual/Straight	172
Bisexual	
Questioning/Unsure	
Queer	
Declined to answer	
Unknown	361
Another group not listed	
TOTAL	**533**
If another group is counted, please specify:	

VETERAN STATUS	
Yes	0
No	94
Declined to answer	
Unknown	439
TOTAL	**533**

CURRENT GENDER IDENTITY	
Female	355
Male	178
Transgender	
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	
Another identity not listed	
TOTAL	**533**
If another identity is counted, please specify:	

PRIMARY LANGUAGE	
English	424
Spanish	
Cantonese	
Chinese	109
Vietnamese	
Farsi	
Arabic	
Tagalog	
Declined to answer	
Unknown	
Another language not listed	
TOTAL	**533**

SEX ASSIGNED AT BIRTH	
Male	178
Female	355
Declined to answer	
Unknown	
TOTAL	**533**

DISABILITY*** STATUS	
Communication Domain	
Vision	
Hearing/Speech	
Another type not listed	
Communication Domain Subtotal	
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	3
Physical/mobility	2
Chronic health condition	
Disability Subtotal	**5**
None	
Declined to answer	
Unknown	
Another disability not listed	1
TOTAL	**6**
If another disability is counted, please specify:	

RACE	
American Indian or Alaska Native	
Asian	485
Black or African American	
Native Hawaiian or another Pacific Islander	2
White	6
Other Race	
Declined to answer	
Unknown	40
TOTAL	**533**
If another race is counted, please specify:	

Ethnicity/Cultural Heritage (Please choose only one per individual)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	
Mexican/Mexican American/Chicano	
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	
Total Hispanic or Latino	
If Non-Hispanic or Non-Latino, please specify:	
African	
African American	
Asian Indian/South Asian	56
Cambodian	
Chinese	292
Eastern European	
European	
Filipino	12
Japanese	
Korean	
Middle Eastern	
Vietnamese	60
Other Non-Hispanic or Non-Latino ethnicity not listed	73
Total Non-Hispanic or Non-Latino	
More than one ethnicity	
Unknown Ethnicity	40
Declined to answer	
EHTNICITY TOTAL	**533**
If another ethnicity is counted, please specify: South East Asian (7), Pakistani (2) Pacific Islander (2), Taiwanese (1), East Asian (55), White (6)	

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of. Note: 1,000-character limit.

Our Arise team had very successful collaborations with a local high school for coordinating community events this year. We were able to provide guidance and support for students and their parents to engage the adolescent population, which made attendance at the events higher than past adolescent targeted events we've held. Another accomplishment was transitioning back to in-person activities/groups/events for older adults and senior clients. Having in-person meetings again helped improve the mood for seniors and gave them a sense of community as opposed to feelings of isolation during the previous year due to Covid19 Public Health Emergency. We had one case of a Korean elderly client who had recently lost her son and was grieving. Having prevention visits, providing emotional support with our Korean speaking Outreach Worker helped her process her grief and improved her mood and reduced her loneliness. She was very appreciative of the Prevention Visits.

Box E: Program challenges of the past year and how the agency mitigated challenges? Note: 1,000-character limit.

During this contract year, our biggest challenge was staffing. Our Mental Health Specialist, Hongmei Qu, left in July 2021 and we haven't been able to hire her replacement yet. We had a promising candidate who later withdrew her application due to finding another position with a higher salary. Many candidates were also in search of remote work, not in-person work. Without an MHS, we were unable to provide prevention counseling services. The Program Manager, Loc Tran, also left Arise at the end of Mar 2022. As the new Program Manager is coming onboard in April, I noticed deliverables that were behind schedule on: community events and psychoeducation workshops. One of our Outreach Workers also started her graduate program and needed to reduce her hours from 1.0 to 0.2 FTE starting in Jan 2022. I believe with a full staff and team, Arise would have easily completed all deliverables as it had in the previous contract year.

Box F: Program lessons learned of the past year? Note: 1,000-character limit.

We learned to utilize Outreach Workers to provide workshops in the absence of a Mental Health Specialist. This also gave Outreach Workers more opportunities to expand and add to their skillset, something that was a welcome challenge for them. For engaging and incentivizing more participation and attendance at events, we learned to collaborate with student leaders for their ideas and their connections. We also learned to incorporate day before reminders for workshops/presentations to help increase attendance at workshops.

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
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):	East Asians (Chinese, Korean, Japanese) in South Alameda County; all ages (we have clients range from 14 - 85)
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:	10
H.5: Describe how your program encouraged access to services and follow through on above referrals (500 Characters):	Informed them of the benefits of receiving services and told them the staff spoke their native language (Mandarin) for easier communication

Box I: For Outreach, Suicide Prevention, and Stigma Reduction programs, please provide information for unduplicated potential responders (i.e., those who are able 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:	**911**
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):
Mid-Autumn Festival: local high school	*Approx. 400 high school students, teachers at school, parents*
Local senior center	*20 Senior Community member*
Lunar New Year: local high school	*Approx. 400 high school students, teachers at school, parents*
Local Boba shop	*60 Community members*
Fremont Library	*1 librarian*
Online Zoom forum	*Approx. 30 Community Health Centers' staff*

MHSA Program #: PEI 6

PROVIDER NAME: Richmond Area Multi-Services, Inc. (RAMS)

PROGRAM NAME: Outreach, Education & Consultation for Pacific Islander Community

Program Outcomes & Impact: UELP Prevention Data Report FY 21/22

Program Name:	**Pacific Islander Wellness Initiative**	
Organization:	Richmond Area Multi-Services, Inc.	
PEI Program # and Name:	PEI 6, Outreach, Education & Consultation (Pacific Islander)	
Type of Report (Choose one):	Annual	
PEI Category (choose one):	Prevention	
Priority Area (place and X next to all that apply):		Childhood Trauma
		Early Psychosis
	X	Youth/TAY Outreach and Engagement
	X	Cultural and Linguistic
	X	Older Adults
	X	Early Identification of Mental Health Illness

Box A: Please provide a brief program description (character limit 1,000).
Pacific Islander Wellness Initiative (PIWI) is a prevention and early intervention mental health program of RAMS in collaboration with long-standing and trusted Pacific Islander community-based organizations. PIWI provides culturally responsive and in-language preventive counseling, psychoeducation, mental health consultation, and outreach and engagement services, including navigation, translation, and interpretation assistance to Pacific Islander residents of Alameda County.

Box B: Number of individuals served this fiscal year through MHSA funding.	
Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	unavailable
Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	unavailable
Number of unduplicated individual family members served indirectly by your program:	unavailable
Unique prevention clients served:	60

Box C: Demographics of individuals served this fiscal year through MHSA funding.

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	313
Transition Age Youth (16-25 yrs.)	2861
Adult (26-59 yrs.)	11525
Older Adult (60+ yrs.)	2818
Declined to answer	
Unknown	236
TOTAL	**17753**

VETERAN STATUS	
Yes	943
No	15210
Declined to answer	
Unknown	1600
TOTAL	**17753**

CURRENT GENDER IDENTITY	
Female	8304
Male	9179
Transgender	2
Genderqueer	
Questioning/unsure of gender identity	20
Declined to answer	
Unknown	247
Another identity not listed	1
TOTAL	**17753**
If another identity is counted, please specify:	

SEXUAL ORIENTATION	
Gay/Lesbian	238
Heterosexual/Straight	15154
Bisexual	91
Questioning/Unsure	180
Queer	36
Declined to answer	
Unknown	1784
Another group not listed	270
TOTAL	**17753**
If another group is counted, please specify:	

PRIMARY LANGUAGE	
English	7036
Spanish	485
Cantonese	86
Chinese	347
Vietnamese	
Farsi	20
Arabic	
Tagalog	350
Declined to answer	
Unknown	
Another language not listed	9429
TOTAL	**17753**

SEX ASSIGNED AT BIRTH	
Male	9179
Female	8304
Declined to answer	
Unknown	270
TOTAL	**17753**

DISABILITY*** STATUS	
Communication Domain	
Vision	180
Hearing/Speech	90
Another type not listed	
Communication Domain Subtotal	**270**
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	90
Physical/mobility	900
Chronic health condition	3600
Disability Subtotal	**4590**
None	
Declined to answer	
Unknown	
Another disability not listed	38
TOTAL	**4898**
If another disability is counted, please specify:	

RACE	
American Indian or Alaska Native	1
Asian	821
Black or African American	423
Native Hawaiian or another Pacific Islander	15113
White	532
Other Race	779
Declined to answer	
Unknown	84
TOTAL	**17753**
If another race is counted, please specify: Latino (328), Multiracial (312)	

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	328
Total Hispanic or Latino	**328**
If Non-Hispanic or Non-Latino, please specify:	
African	
African American	
Asian Indian/South Asian	15
Cambodian	360
Chinese	127
Eastern European	
European	
Filipino	300
Japanese	
Korean	
Middle Eastern	
Vietnamese	
Other Non-Hispanic or Non-Latino ethnicity not listed	15243
Total Non-Hispanic or Non-Latino	**16045**
More than one ethnicity	
Unknown Ethnicity	
Declined to answer	
EHTNICITY TOTAL	**16373**
If another ethnicity is counted, please specify: **Hawaiian/ Pacific Islander = 15,113**	

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of. Note: 1,000-character limit.
2,142 in-person home visits 87 prevention visits, 80% were virtual/telephone 80 community events reaching 16,736 people 50 clients screened and assessed (RAMS internal objective) 40 unduplicated clients received preventive counseling 28 promotional materials created and shared widely reaching 21,176 people 18 mental health consultations reaching 71 people 12 psycho-education workshops reaching 112 people 12 Talanoa4Wellness (support groups) reaching 118 people 8 referrals and successful linkages 3 cultural-based educational workshops reaching 94 people Case study: Female Tongan native came in for individual therapy, after a few sessions in the therapist recognized that the client needed family therapy with her older sister. Both learned how to listen and communicate with each other better about their personal trauma. Both successfully completed Family therapy and were referred to individual long-term therapy.

Box E: Program challenges of the past year and how the agency mitigated challenges? Note: 1,000-character limit.
Challenges faced were following-up with discharged clients to ensure they've engaged in services referred/linked to, engaging clients after initial contact to start preventive counseling, planning for in-person community events with pandemic still active, and adapting and pivoting back to in-person services. Our program mitigated some of the challenges by revising follow-up protocols, refining clinical process to improve internal services, navigating clients across the PIWI Pathway (non-clinical to clinical services), and participating in in-person community events.

Box F: Program lessons learned of the past year? Note: 1,000-character limit.
Screening + Assessment completed by the staff mental health specialist helped reduce wait time by 50% (from 10 days in FY20-21 to 5 days in FY21-22). In-person services were more beneficial than tele therapy. Clients "got more out of the sessions, they were more focused". MHS is better able to assess a client's overall presentation with in-person services. Creating mobile outreach kits in anticipation of more in-person community events and having adequate planning time for community events. Assuring staff that asking for time off when they need it for themselves, and their families is completely ok,

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):	4
G.3: Types of treatment individuals were referred to (list types) (500-character limit):	SMH services; long term counseling services; higher level case management
G.4: Unduplicated number of individuals who participated in referred program at least one time:	8
G.5: Average duration of untreated mental illness in weeks:	0 days
G.6: Average number of days between referral and first participation in referred treatment program:	5 days

Box H: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
H.1: Who is/are the underserved target population(s) your program is serving (e.g., TAY, Southeast Asian) (500 Characters):	Pacific Islanders (Samoans, Tongans, Hawaiians, Youth, TAY, parents, adults, students, athletes
H.2: Number of paper referrals to an ACBH PEI-funded program:	50
H.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	40
H.4: Average number of days between referral and first participation in referred PEI program:	5

H.5: Describe how your program encouraged access to services and follow through on above referrals (500 Characters):	PIWI staff engages in deep networking, harnessing relational connections and cultivating communal linkages with PI community members to raise awareness about PIWI services. PIWI staff hold dual roles as working professionals and as community members who care deeply about responding and supporting the mental health of their community.

Box I: For <u>Outreach, Suicide Prevention, and Stigma Reduction</u> programs, please provide information for unduplicated potential responders (i.e., those who are able 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:	**27**
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	*Coaches: 1; COST specialist: 3; Parents: 1; Counselors: 2; Teacher: 1*
Churches	*Parents: 2; Church members: 8; Caseworker: 1*
Cultural affinity groups	*Kumu instructor: 1; Parent: 2*
Colleges	*Advisor: 2; Peers: 2*
Community events	*Event planner: 1*

MHSA Program #: PEI 6

PROVIDER NAME: Korean Community Center of the East Bay (KCCEB)

PROGRAM NAME: Outreach, Education & Consultation for East Asian Community

Program Outcomes & Impact: UELP Prevention Data Report FY 21/22

Program Name:	**Asian Community Wellness Program**	
Organization:	Korean Community Center of the East Bay (KCCEB)	
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):		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).

Asian Community Wellness Program (ACWP) is a prevention and early intervention (PEI) program funded by Alameda County Behavioral Health Care Services (BHCS) addressing mental health and wellness needs in the underserved East Asian communities. Our goal is to improve access to culturally responsive mental health services, reduce stigma, and strengthen Asian communities' knowledge and experience in wellness practices and community resources. ACWP provide the following services: 1) Outreach and Education, 2) Preventive Counseling, 3) Mental Health Consultation and Training.

Box B: Number of individuals served this fiscal year through MHSA funding.

Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	unavailable
Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	unavailable
Number of unduplicated individual family members served indirectly by your program:	unavailable
Unique prevention clients served:	63

Box C: Demographics of individuals served this fiscal year through MHSA funding.

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	355
Transition Age Youth (16-25 yrs.)	278
Adult (26-59 yrs.)	697
Older Adult (60+ yrs.)	637
Declined to answer	
Unknown	69
TOTAL	**2036**

SEXUAL ORIENTATION	
Gay/Lesbian	
Heterosexual/Straight	129
Bisexual	5
Questioning/Unsure	1
Queer	4
Declined to answer	
Unknown	1895
Another group not listed	2
TOTAL	**2036**
If another group is counted, please specify:	

VETERAN STATUS	
Yes	0
No	348
Declined to answer	
Unknown	1688
TOTAL	**2036**

CURRENT GENDER IDENTITY	
Female	1115
Male	731
Transgender	1
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	189
Another identity not listed	
TOTAL	**2036**
If another identity is counted, please specify:	

PRIMARY LANGUAGE	
English	589
Spanish	25
Cantonese	552
Chinese	355
Vietnamese	28
Farsi	
Arabic	
Tagalog	17
Declined to answer	
Unknown	
Another language not listed	470
TOTAL	**2036**

SEX ASSIGNED AT BIRTH	
Male	731
Female	1115
Declined to answer	
Unknown	190
TOTAL	**2036**

DISABILITY*** STATUS	
Communication Domain	
Vision	6
Hearing/Speech	
Another type not listed	3
Communication Domain Subtotal	**9**
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	
Physical/mobility	2
Chronic health condition	3
Disability Subtotal	**5**
None	
Declined to answer	
Unknown	
Another disability not listed	
TOTAL	**14**
If another disability is counted, please specify:	

RACE	
American Indian or Alaska Native	
Asian	1594
Black or African American	15
Native Hawaiian or another Pacific Islander	31
White	99
Other Race	266
Declined to answer	
Unknown	31
TOTAL	**2036**
If another race is counted, please specify: Latino (91), Multiracial (17)	

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	91
Total Hispanic or Latino	**91**
If Non-Hispanic or Non-Latino, please specify:	
African	
African American	15
Asian Indian/South Asian	55
Cambodian	56
Chinese	1004
Eastern European	
European	
Filipino	32
Japanese	14
Korean	296
Middle Eastern	
Vietnamese	45
Other Non-Hispanic or Non-Latino ethnicity not listed	92
Total Non-Hispanic or Non-Latino	**1739**
More than one ethnicity	17
Unknown Ethnicity	189
Declined to answer	
EHTNICITY TOTAL	**206**
If another ethnicity is counted, please specify: Other Southeast Asian (12), Nepalese (32), Taiwanese (36), East Asia (10)	

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of. Note: 1,000-character limit.

1) KCCEB successfully provided preventive counseling to East Asians, specifically Chinese and Korean speaking children, youth, and adults in Alameda County. We have surpassed our preventive counseling deliverables due to high needs community members seeking mental health services. We have seen a dramatic increase in self- referral from the Korean community from previous year. Due to our intense outreach and mental health education/awareness to reduce stigma in the Korean community, we have noticed an increase in the Korean community seeking and accessing preventive counseling services.

Box E: Program challenges of the past year and how the agency mitigated challenges? Note: 1,000-character limit.

1) Due to the pandemic, KCCEB is seeing more moderate to severe clients who need more intensive counseling services. Our staff and interns have been providing more crisis intervention services (i.e., S/I crisis and self-harm behaviors) and family interventions and resource navigation to support API youth and family to address their mental crisis who are experiencing panic attacks, severe anxiety, depression, and complex traumas. KCCEB has been proactive in responding to those needs by supporting our staff in providing more clinical supervision support to help monitor clients' crisis needs, increase clinical training to support to reduce vicarious trauma, burnouts, and countertransference. In addition, we increase support to build more resources for family support for the clients.

Box F: Program lessons learned of the past year? Note: 1,000-character limit.

Continue to be flexible and adaptable to community needs and issues and to changing circumstances. Our strength to be flexible and adaptable continues to ensure that our clients and community members can access our KCCEB services via virtual, phone, office, home, and other community centers. 2) Supporting KCCEB staff to maintain work sustainability to reduce compassion fatigue or burnouts and promote healthy work-life balance and self-care to continue to effectively provide high quality of care and services to our clients during these demanding and challenging times. KCCEB has learned the importance of supporting staff in ensuring they have a healthy work environment by providing more resources to balance their workload, created self-care day or mental health days, and helping set healthy work-life boundary to promote their own self-care. KCCCEB believes that to create a healthy and thriving community, we must have a create a healthy and supportive work environment for our staff to thrive to care for our community.

Box G: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
G.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e., mental health treatment services):	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):	2
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, panic attacks, etc.), family stressors, intergenerational conflicts, and traumas, eating disorders, and suicide ideations/self-harm. Individuals are being seen by LCSW, MFT, and MSW/MFT graduate trainees. 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:	4
G.5: Average duration of untreated mental illness in weeks:	1 week to 1+ year
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: (Southeast Asian, mix-Asians, Middle Eastern, African, non-Asian). Youth, TAY, and adults.
H.2: Number of paper referrals to an ACBH PEI-funded program:	52
H.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	47
H.4: Average number of days between referral and first participation in referred PEI program:	5-10 days

H.5: Describe how your program encouraged access to services and follow through on above referrals (500 Characters):	1) Community/Cultural event and outreach, 2) Wellness checks outreach via phone calls, 3) Collaborative partnerships with CBOs, faith based and school-based programs to promote wellness program and 1-1 outreach and prevention visits, 3) newsletter, social media, and radio, 4) Individual engagement with community member to ensure they register and enrolled, including eliciting support from teachers, family members, school staff, and CBO's staff, and faith leaders.

Box I: For Outreach, Suicide Prevention, and Stigma Reduction programs, please provide information for unduplicated potential responders (i.e., those who are able 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 (8): 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 (12): Understand MH (depression, anxiety, S/I, trauma), screening and detecting MH symptoms	*community members and leaders, youth, TAY and adults and older adults*
MH Trainings (5): accessing culturally responsive resources, cultural healing, MH & COVID	*community based professionals (school-based staff, community-based worker staff)*
Mental Health Consultation (15): 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): Selfcare, COVID, cultural/sexual ID & pride, SUD prevention, healthy boundary	*general community members and CBO's professionals*
Tabling/Distributing materials (5): school fairs, community fairs, and cultural events	*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 elder community members, API community elders*

MHSA Program #: PEI 7

PROVIDER NAME: Afghan Coalition

PROGRAM NAME: Outreach, Education & Consultation for South Asian/Afghan Community

Program Outcomes & Impact: UELP Prevention Data Report FY 21/22

Program Name:	**Afghan Wellness Project**	
Organization:	Afghan Coalition	
PEI Program # and Name:	PEI 7 Outreach, Education & Consultation (Afghan) Afghan Coalition	
Type of Report (Choose one):	Annual	
PEI Category (choose one):	Prevention	
Priority Area (place and X next to all that apply):	X	Childhood Trauma
		Early Psychosis
	X	Youth/TAY Outreach and Engagement
	X	Cultural and Linguistic
	X	Older Adults
	X	Early Identification of Mental Health Illness

Box A: Please provide a brief program description (character limit 1,000).
AWP serves individuals and families at risk for serious mental health issues, decreases stigma through education/awareness, and prevents mental illness form becoming disabling. AWP bridges the language/cultural gaps between community members and mental health. AWP works with individuals that are isolated, trauma exposed, immigrants, families under stress, at risk youth and many individuals at risk of serious mental health issues by providing PEI services in Dari, Pashto, and English.

Box B: Number of individuals served this fiscal year through MHSA funding.	
Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	unavailable
Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	unavailable
Number of unduplicated individual family members served indirectly by your program:	unavailable
Unique prevention clients served:	100

Box C: Demographics of individuals served this fiscal year through MHSA funding.

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	640
Transition Age Youth (16-25 yrs.)	303
Adult (26-59 yrs.)	3094
Older Adult (60+ yrs.)	400
Declined to answer	
Unknown	840
TOTAL	**5277**

SEXUAL ORIENTATION	
Gay/Lesbian	
Heterosexual/Straight	3811
Bisexual	6
Questioning/Unsure	
Queer	
Declined to answer	
Unknown	1460
Another group not listed	
TOTAL	**5277**
If another group is counted, please specify:	

VETERAN STATUS	
Yes	4
No	1261
Declined to answer	
Unknown	4012
TOTAL	**5277**

CURRENT GENDER IDENTITY	
Female	3785
Male	1460
Transgender	
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	32
Another identity not listed	
TOTAL	**5277**
If another identity is counted, please specify:	

PRIMARY LANGUAGE	
English	560
Spanish	
Cantonese	
Chinese	
Vietnamese	
Farsi	452
Arabic	
Tagalog	
Declined to answer	
Unknown	
Another language not listed	4265
TOTAL	**5277**

SEX ASSIGNED AT BIRTH	
Male	1460
Female	3785
Declined to answer	
Unknown	32
TOTAL	**5277**

DISABILITY*** STATUS	
Communication Domain	
Vision	28
Hearing/Speech	3
Another type not listed	
Communication Domain Subtotal	**31**
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	3
Physical/mobility	26
Chronic health condition	25
Disability Subtotal	**54**
None	
Declined to answer	
Unknown	
Another disability not listed	47
TOTAL	**132**
If another disability is counted, please specify:	

RACE	
American Indian or Alaska Native	
Asian	4753
Black or African American	18
Native Hawaiian or another Pacific Islander	
White	118
Other Race	128
Declined to answer	
Unknown	260
TOTAL	**5277**
If another race is counted, please specify: Latino (1), Multiracial (65),	

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	18
Asian Indian/South Asian	
Cambodian	
Chinese	
Eastern European	
European	
Filipino	
Japanese	
Korean	
Middle Eastern	
Vietnamese	
Other Non-Hispanic or Non-Latino ethnicity not listed	4998
Total Non-Hispanic or Non-Latino	**5016**
More than one ethnicity	
Unknown Ethnicity	260
Declined to answer	
EHTNICITY TOTAL	**5277**
If another ethnicity is counted, please specify: Other East Asian (42), Afghan (4711)	

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of. Note: 1,000-character limit.

Female with history of severe physical abuse and was divorcing husband. The client reported she had never been without her husband and was very fearful of being a single parent to her 2-year-old son. Our client stated she could not imagine herself surviving without her husband and had a very "scary" view about the future. Client was able to be educated on healthy coping and parenting skills while in counseling. Our client reported that counseling was “so incredibly important, useful and effective" and it enabled her to make rational decisions regarding her divorce and moving forward. Client was able to work on her anxiety/stress, as well as being educated on healthy coping and parenting skills, healthy relationships, and being empowered. After several counseling sessions client said she was “no longer in a dark place" in her life and that she had been looking for a job and considering attending college. At the end of her counseling, client reported that she had found a "very satisfying" job.

Box E: Program challenges of the past year and how the agency mitigated challenges? Note: 1,000-character limit.

The agency experienced a large influx of new arrivals needing services due to the crisis in Afghanistan. Afghan Coalition was at or over capacity daily in our efforts to assist the new arrivals who either were sent to our area or left military bases on their own accord. To mitigate this increase in clients with complex needs, the program hired new staff and held several workshops and events that would reach many clients at once with information, resources, and enrollment to our Wellness program. Consortium Meetings, Workshops and Support group topics predominately addressed the issues and needs or new arrivals. Significant stigma reduction needs to be provided to newly arrived Afghans who historically have a negative outlook on receiving mental health services although many suffer from PTSD, depression, and anxiety. Community Workers helped to mitigate this by increasing the rate of acceptance of mental service by encouraging clients to participate in the Wellness program.

Box F: Program lessons learned of the past year? Note: 1,000-character limit.

Many of the refugees that we assisted were experiencing “Survivor Mode" and were not initially interested in the Wellness Program since their concern was more for addressing their basic needs such as food, housing, and employment. Although some clients expressed a need for mental health services many were reluctant to start individual counseling until they had met other needs such as access to social services, a place to live, jobs and transportation. Efforts were made by our staff and with resettlement agencies to ensure that clients’ basic needs were being met and access to mental health was provided for those interested clients. Continued efforts are made through outreach, home visits, invites to support groups, workshops, and cultural events to ensure clients have access to the mental health services they may need. In addition, helping clients have realistic expectations of getting settled in the US was another issue that we faced working with new Afghan arrivals.

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):	1
G.3: Types of treatment individuals were referred to (list types) (500-character limit):	These clients were referred to other care providers to receive a higher level of care such as medication management, and higher levels of individual and/or family therapy.
G.4: Unduplicated number of individuals who participated in referred program at least one time:	4
G.5: Average duration of untreated mental illness in weeks:	20 weeks -most of these clients stated the prevention counseling had been sufficient for them to manage their symptoms
G.6: Average number of days between referral and first participation in referred treatment program:	Average of 15 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):	Mostly and generally the Afghan refugee and immigrant population, and particularly the newly arrived Afghans.
H.2: Number of paper referrals to an ACBH PEI-funded program:	24
H.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	19
H.4: Average number of days between referral and first participation in referred PEI program:	7 days

H.5: Describe how your program encouraged access to services and follow through on above referrals (500 Characters):	Significant time and attention was paid by the staff to provide information in regards to mental health issues and to raise clients' awareness in order to destigmatize MH issues in a culturally appropriate manner. Clients are encouraged to participate in MH services.

Box I: For Outreach, Suicide Prevention, and Stigma Reduction programs, please provide information for unduplicated potential responders (i.e., those who can 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:	**5906**
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):
Fremont Community Center with FUSD	*3 Outreach workers, Partner organizations, 4 school administrators, City Mayor*
Eid Event -Central Park Fremont	*4 Outreach workers, 5 volunteers, 180 parents and 70 youth*
New Arrival Orientation -Afghan Restaurant	*6 Outreach Workers, 3 volunteers, 71 participants*
Hayward Wellness Center Facility - 2 Events for New Arrivals	*5 Outreach Workers, 2 volunteers, 24 Afghan families, 7 medical professionals*
UELP Training Series Virtual - Afghan Cultural Competency Training	*4 Outreach Workers, 72 Service Providers*
Outreach Presentation at Hayward Unified School District	*1 Outreach Worker, 7 school employees, 38 families*
Bahrat Celebration Community Event - FRC Building	*4 Outreach Workers, 1 Mental Health Specialist*
Consortium Meeting - Structural Competency Skills for Responding to Marginalized Communities	*5 Outreach Workers, 61 participants/service providers, 11 community members*
Consortium Meeting - Legal Challenges for Afghan New Arrivals and Afghan remaining in Afghanistan	*5 Outreach Workers, 59 participants/service providers*
Consortium Meeting - US "Safe Haven" Military Bases - Understanding Afghan Arrivals	*4 Outreach Workers, 155 participants service providers*
Consortium Meeting- Refugee Resettlement-Welcome Afghan Arrivals	*5 Outreach Workers, 126 participant/service providers*
Youth Group Program/ Tutoring	*1 Outreach Worker, 2 volunteers, 28 youth*
Social Media Posts	*4597 reached through social media posts specific to the Wellness Program*

MHSA Program #: PEI 7

PROVIDER NAME: Filipino Advocates for Justice

PROGRAM NAME: Outreach, Education & Consultation for Filipino Community

Program Outcomes & Impact: UELP Prevention Data Report FY 21/22

Program Name:	**Filipino Community Wellness Program**	
Organization:	Filipino Advocates for Justice (FAJ)	
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
	X	Early Identification of Mental Health Illness

Box A: Please provide a brief program description (character limit 1,000).
FAJ's Filipino Community Wellness Program aims to engage young people, immigrants and low-wage workers in healthy, positive, culturally relevant, and inclusive activities that prevent isolation, disconnection, anxiety, fear, and hopelessness, and reduces the stigmas associated with use of mental health services.

Box B: Number of individuals served this fiscal year through MHSA funding.	
Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	unavailable
Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	unavailable
Number of unduplicated individual family members served indirectly by your program:	unavailable
Unique prevention clients served:	40

Box C: Demographics of individuals served this fiscal year through MHSA funding.

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	0
Transition Age Youth (16-25 yrs.)	428
Adult (26-59 yrs.)	270
Older Adult (60+ yrs.)	104
Declined to answer	
Unknown	69
TOTAL	**871**

SEXUAL ORIENTATION	
Gay/Lesbian	2
Heterosexual/Straight	242
Bisexual	10
Questioning/Unsure	1
Queer	138
Declined to answer	
Unknown	478
Another group not listed	
TOTAL	**871**
If another group is counted, please specify:	

VETERAN STATUS	
Yes	0
No	0
Declined to answer	
Unknown	871
TOTAL	**871**

CURRENT GENDER IDENTITY	
Female	553
Male	217
Transgender	4
Genderqueer	
Questioning/unsure of gender identity	8
Declined to answer	
Unknown	73
Another identity not listed	16
TOTAL	**871**
If another identity is counted, please specify:	

PRIMARY LANGUAGE	
English	693
Spanish	
Cantonese	
Chinese	
Vietnamese	
Farsi	
Arabic	
Tagalog	177
Declined to answer	
Unknown	
Another language not listed	1
TOTAL	**871**

SEX ASSIGNED AT BIRTH	
Male	217
Female	553
Declined to answer	
Unknown	101
TOTAL	**871**

DISABILITY*** STATUS	
Communication Domain	
Vision	
Hearing/Speech	2
Another type not listed	
Communication Domain Subtotal	**2**
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	
Physical/mobility	
Chronic health condition	
Disability Subtotal	**2**
None	
Declined to answer	
Unknown	
Another disability not listed	
TOTAL	**2**
If another disability is counted, please specify:	

RACE	
American Indian or Alaska Native	
Asian	711
Black or African American	5
Native Hawaiian or another Pacific Islander	
White	13
Other Race	41
Declined to answer	
Unknown	101
TOTAL	**871**
If another race is counted, please specify: Latino (37), Multiracial (4)	

Ethnicity/Cultural Heritage (Please choose only one per individual)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	
Mexican/Mexican American/Chicano	3
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	34
Total Hispanic or Latino	**37**
If Non-Hispanic or Non-Latino, please specify:	
African	
African American	5
Asian Indian/South Asian	28
Cambodian	
Chinese	24
Eastern European	
European	
Filipino	640
Japanese	
Korean	
Middle Eastern	
Vietnamese	18
Other Non-Hispanic or Non-Latino ethnicity not listed	18
Total Non-Hispanic or Non-Latino	**733**
More than one ethnicity	
Unknown Ethnicity	101
Declined to answer	
EHTNICITY TOTAL	**871**
If another ethnicity is counted, please specify: Other East Asian (1) White (13)	

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of. Note: 1,000-character limit.

- Youth attend community hearings to advocate for mental health resource reforms.
- Multiple LGBTQIA+ youth expressing gratitude and joy for having a space that was Filipinx/AAPI and queer. Mixed race/ethnicity youth felt validated after struggling with feeling "not enough" "not real" Filipinxs/Asians".
- Graduating HS senior struggling with over stretched capacity and external expectations was able to reflect and prioritize what she most values, thus was able to be more whole for herself and in spaces she chose for herself. Said student went on to win multiple scholarships and a full ride to Stanford.
- New partnerships with Chabot and Ohlone Colleges resulted in expansion of services for LGBTQIA+ TAY.
- Older adults showed consistent attendance at virtual offerings despite age and lack of technology knowledge
- Several workshop attendees who have never experienced mental health services received preventative counseling.

Box E: Program challenges of the past year and how the agency mitigated challenges? Note: 1,000-character limit.

- Transitioning from online to in person was more difficult than imagined. Went from weekly meeting to bi-monthly general meetings and revised curriculum to adapt to what youth found most engaging.
- Having program housed in our Oakland office, while the most central location, provided challenges with youth coming from other North County cities versus being housed online and at Encinal High School (Alameda) previously. Staff and youth trained for more face-to-face outreach supplemented with social media efforts.
- Navigating engagement points for TAY due to the nature of this target population—TAY tends to be among the busiest target populations due to school, work, extracurricular activities, etc. Shifts were made to topics most salient: Financial Literacy, Navigating burnout, discussions on Representation, or Trans Visibility.
- Elder adult participants were still hesitant to attend in person workshops and meetings because of COVID so interactive virtual workshops were offered.

Box F: Program lessons learned of the past year? Note: 1,000-character limit.

- Community building activities and space to discuss feelings are even more important in ensuring youth are engaged and feel welcome than a year prior. Pausing from planning meetings to have talking circles was needed to resolve issues.
- COVID-19 and deciding on engagement via Zoom, hybrid or in-person meetings: Zoom tended to have higher turnout due to greater accessibility
- Having workshops on-site where TAY bases are the most – turnout and engagement tended to be higher at a community college resource center than FAJ's satellite office due to accessibility of location.
- We learned the importance of building and maintaining good working partnerships with school staff and administration to better serve our communities within the schools.

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):	Filipino and other AAPI youth, TAY, and adult, including immigrants and LGBTQ
H.2: Number of paper referrals to an ACBH PEI-funded program:	
H.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	35
H.4: Average number of days between referral and first participation in referred PEI program:	1-14 days (depending on availability of client/clinician schedule)

H.5: Describe how your program encouraged access to services and follow through on above referrals (500 Characters):	Received referrals from school COST teams and direct/word-of-mouth referrals from students and greater FAJ/Filipino-American community.

Box I: For <u>Outreach, Suicide Prevention, and Stigma Reduction</u> programs, please provide information for unduplicated potential responders (i.e., those who can 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:	**267**
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):
Virtual/Telehealth	*3 Outreach workers, Partner organizations, 4 school administrators, City Mayor*
Social media	*4 Outreach workers, 5 volunteers, 180 parents and 70 youth*

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 Prevention Data Report FY 21/22

Program Name:	**Afghan Path Towards Wellness (APTW)**	
Organization:	International Rescue Committee (IRC)	
PEI Program # and Name:	PEI 7 Outreach, Education & Consultation (Afghan)	
Type of Report (Choose one):	Annual	
PEI Category (choose one):	Prevention	
Priority Area (place and X next to all that apply):		Childhood Trauma
		Early Psychosis
		Youth/TAY Outreach and Engagement
	X	Cultural and Linguistic
		Older Adults
	X	Early Identification of Mental Health Illness

Box A: Please provide a brief program description (character limit 1,000).
Afghan Path Towards Wellness (APTW): Providing wellness and psychosocial support services to the Afghan community of North Alameda County. Primary services include preventative counseling, psychoeducational and educational workshops, community events, socials support groups, wellness assessments, and community provider and leader trainings.

Box B: Number of individuals served this fiscal year through MHSA funding.	
Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	unavailable
Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	unavailable
Number of unduplicated individual family members served indirectly by your program:	unavailable
Unique prevention clients served:	68

Box C: Demographics of individuals served this fiscal year through MHSA funding.

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	0
Transition Age Youth (16-25 yrs.)	128
Adult (26-59 yrs.)	602
Older Adult (60+ yrs.)	2
Declined to answer	
Unknown	479
TOTAL	**1211**

SEXUAL ORIENTATION	
Gay/Lesbian	
Heterosexual/Straight	383
Bisexual	
Questioning/Unsure	
Queer	
Declined to answer	
Unknown	828
Another group not listed	
TOTAL	**1211**
If another group is counted, please specify:	

VETERAN STATUS	
Yes	0
No	872
Declined to answer	
Unknown	339
TOTAL	**1211**

CURRENT GENDER IDENTITY	
Female	676
Male	58
Transgender	
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	477
Another identity not listed	
TOTAL	**1211**
If another identity is counted, please specify:	

PRIMARY LANGUAGE	
English	250
Spanish	
Cantonese	
Chinese	
Vietnamese	
Farsi	75
Arabic	
Tagalog	
Declined to answer	
Unknown	
Another language not listed	886
TOTAL	**1211**

SEX ASSIGNED AT BIRTH	
Male	58
Female	676
Declined to answer	
Unknown	477
TOTAL	**1211**

DISABILITY*** STATUS	
Communication Domain	
Vision	
Hearing/Speech	
Another type not listed	
Communication Domain Subtotal	
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	
Physical/mobility	
Chronic health condition	
Disability Subtotal	
None	
Declined to answer	
Unknown	
Another disability not listed	
TOTAL	**0**
If another disability is counted, please specify:	

RACE	
American Indian or Alaska Native	
Asian	963
Black or African American	
Native Hawaiian or another Pacific Islander	
White	
Other Race	5
Declined to answer	
Unknown	243
TOTAL	**1211**
If another race is counted, please specify:	

Ethnicity/Cultural Heritage (Please choose only one per individual)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	
Mexican/Mexican American/Chicano	
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	
Total Hispanic or Latino	
If Non-Hispanic or Non-Latino, please specify:	
African	
African American	
Asian Indian/South Asian	
Cambodian	
Chinese	
Eastern European	
European	
Filipino	
Japanese	
Korean	
Middle Eastern	
Vietnamese	
Other Non-Hispanic or Non-Latino ethnicity not listed	963
Total Non-Hispanic or Non-Latino	**963**
More than one ethnicity	
Unknown Ethnicity	248
Declined to answer	
EHTNICITY TOTAL	**1211**
If another ethnicity is counted, please specify: Afghan (963)	

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of. Note: 1,000-character limit.
One event that our team is particularly proud of was our first in-person community event since COVID-19 that took place in June. This event brought together Afghan new arrivals to Lake Merritt with a variety of events including art, soccer, and games. We also had the IRC Oakland Economic Empowerment Team and partner agencies including Multi-Lingual Counseling, Meditation Without Borders, ARTogether facilitating events and discussing their services with clients. One of the male clients that attended shared that he had been feeling very isolated and this was the first time he had left his hotel since arrival, was able to speak to others in his own language, meet other Afghans, and feel a sense of community.

Box E: Program challenges of the past year and how the agency mitigated challenges? Note: 1,000-character limit.
One challenge we faced was getting men to enroll and participate in our program. We made it a goal for this year to enroll men into our one-on-one counseling and group services. We partnered with our Economic Empowerment team to do men's workshops around finance and stress management to encourage attendance and both address a source of stress while providing tools to manage stress. We saw success with this model and were able to increase men attending our group workshops and our one-on-one counseling. As we started getting male participation, we also intentionally sought feedback about services both in material delivered and logistics including time and place to best meet the needs of our male clients and reduce barriers to accessing our services.

Box F: Program lessons learned of the past year? Note: 1,000-character limit.
A lesson learned from the past year was around connecting clients to mental health treatment. One barrier was lack of trust with individuals outside of the PEI Team. Clients were familiar with IRC and had heard from the community the work done by IRC and the PEI team but were not familiar with Mental Health Treatment organizations which led to clients declining referrals to longer term support. Thus, the team sought to reduce this barrier and brought in staff from Mental Health Treatment organizations such as Multilingual Counseling to speak about their services with clients. We found that this model, particularly when done in person, decreased hesitancy in clients to accept referrals as they had met someone that worked there and heard directly from them the type of support they provided. This model is one we will be incorporating into future services as well including workshops, events, and support groups.

Box G: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
G.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e., mental health treatment services):	10
G.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e., mental health treatment services):	8
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:	13
G.5: Average duration of untreated mental illness in weeks:	6
G.6: Average number of days between referral and first participation in referred treatment program:	30

Box H: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
H.1: Who is/are the underserved target population(s) your program is serving (e.g., TAY, Southeast Asian) (500 Characters):	Afghan
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:	14

H.5: Describe how your program encouraged access to services and follow through on above referrals (500 Characters):	Strategies revolve around 1:1 coaching on resources, and education re: myths about seeking mental health support. If/when a client is willing to be referred, support with transport, registration, logistics is offered. The team follows up to ensure a smooth transition.

Box I: For <u>Outreach, Suicide Prevention, and Stigma Reduction</u> programs, please provide information for unduplicated potential responders (i.e., those who can identify early signs of potentially severe mental illness provide support, and or refer individuals who need treatment) reached. ***(Note: For Prevention, Early Intervention, Access & Linkage programs, this section is optional.)***

Number of Responders:	**NA**
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):

MHSA Program #: PEI 7

PROVIDER NAME: The Hume Center

PROGRAM NAME: Outreach, Education & Consultation for South Asian/Afghan Community-South Asian Community Health Promotion Services Program

Program Outcomes & Impact: UELP Prevention Data Report FY 21/22

Program Name:	**South Asian Community Health Promotion Services**	
Organization:	The Hume Center	
PEI Program # and Name:	PEI 7 Outreach, Education & Consultation (So. Asian)	
Type of Report (Choose one):	Annual	
PEI Category (choose one):	Prevention	
Priority Area (place and X next to all that apply):		Childhood Trauma
		Early Psychosis
	X	Youth/TAY Outreach and Engagement
	X	Cultural and Linguistic
	X	Older Adults
	X	Early Identification of Mental Health Illness

Box A: Please provide a brief program description (character limit 1,000).
When life becomes too overwhelming, that result can bring changes in how an individual thinks, feels, and acts. The South Asian program offers prevention and early intervention services for individuals, couples, and families in distress. These sort-term culturally sensitive and language specific services offer support aimed at developing knowledge and skills to work through life.

Box B: Number of individuals served this fiscal year through MHSA funding.	
Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	unavailable
Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	unavailable
Number of unduplicated individual family members served indirectly by your program:	unavailable
Unique prevention clients served:	128

Box C: Demographics of individuals served this fiscal year through MHSA funding.

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	353
Transition Age Youth (16-25 yrs.)	432
Adult (26-59 yrs.)	4091
Older Adult (60+ yrs.)	346
Declined to answer	
Unknown	1
TOTAL	**5223**

SEXUAL ORIENTATION	
Gay/Lesbian	
Heterosexual/Straight	
Bisexual	
Questioning/Unsure	
Queer	
Declined to answer	
Unknown	
Another group not listed	
TOTAL	
If another group is counted, please specify:	

VETERAN STATUS	
Yes	9
No	3201
Declined to answer	
Unknown	2013
TOTAL	**5223**

CURRENT GENDER IDENTITY	
Female	3090
Male	2041
Transgender	16
Genderqueer	
Questioning/unsure of gender identity	3
Declined to answer	
Unknown	60
Another identity not listed	13
TOTAL	**5223**
If another identity is counted, please specify:	

PRIMARY LANGUAGE	
English	2401
Spanish	
Cantonese	
Chinese	
Vietnamese	
Farsi	351
Arabic	3
Tagalog	
Declined to answer	
Unknown	4
Another language not listed	2464
TOTAL	**5223**

SEX ASSIGNED AT BIRTH	
Male	2041
Female	3090
Declined to answer	
Unknown	92
TOTAL	**5223**

DISABILITY*** STATUS	
Communication Domain	
Vision	
Hearing/Speech	6
Another type not listed	3
Communication Domain Subtotal	**9**
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	7
Physical/mobility	2
Chronic health condition	12
Disability Subtotal	**21**
None	
Declined to answer	
Unknown	
Another disability not listed	6
TOTAL	**36**
If another disability is counted, please specify:	

RACE	
American Indian or Alaska Native	
Asian	3712
Black or African American	90
Native Hawaiian or another Pacific Islander	12
White	430
Other Race	478
Declined to answer	
Unknown	501
TOTAL	**5223**
If another race is counted, please specify: Latino (47),	

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	47
Total Hispanic or Latino	**47**
If Non-Hispanic or Non-Latino, please specify:	
African	
African American	90
Asian Indian/South Asian	887
Cambodian	
Chinese	49
Eastern European	
European	
Filipino	43
Japanese	
Korean	30
Middle Eastern	
Vietnamese	12
Other Non-Hispanic or Non-Latino ethnicity not listed	3564
Total Non-Hispanic or Non-Latino	**4675**
More than one ethnicity	
Unknown Ethnicity	501
Declined to answer	
EHTNICITY TOTAL	**5223**
If another ethnicity is counted, please specify: Afghan (236), Bangladeshi (9), Bhutanese (114), Mien (1), Nepalese (2,119), Pakistani (77), Tibetan (19) East Asian (68), South East Asian (48), White (430)	

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of. Note: 1,000-character limit.

We have seen many successes and accomplishments this past year as we are approaching our third year of using Telehealth platforms. We continued to help community members maintain anonymity and minimize barriers to treatment. We were able to offer 10 consistent support groups this year, 2 in Farsi, 5 in Nepali, 1 in English and 2 in Hindi. Through outreach we were able to increase referrals to our program and help make more referrals to higher levels of care through ACBH. With the roll out of vaccines and boosters we were able to go back on school campuses, participate in a lot more in-person outreach and education and offer in person PC sessions. We increased outreach to the LGBTQ community, collaborated with more organizations to increase access to resources/vaccinations/rental assistance/food/PPE, we continued to offer our coping strategies workshops bi-weekly, and we observed an increase in youth engagement.

Box E: Program challenges of the past year and how the agency mitigated challenges? Note: 1,000-character limit.

We experienced challenges around varying COVID protocols throughout the year, preventing us from working in the community. We tried to have telehealth options for back up. There were still some instances of low-tech literacy within the community, in which case we tried to provide more education and open the clinic for folks to use our tech devices to log into groups/workshops. We couldn't offer in person support groups at our clinic due to social distancing and other COVID protocols, we did Zoom groups and offered groups outdoors. Many were still struggling after the 1 year of PC and wanted to continue for a longer time, we advocated with the county to help provide extensions as needed, we supported participants in getting Medi-Cal and supported them in utilizing holistic healing. We adapted a new EHR while still having to interface with the county EHR so that added additional tasks for our team, we attempted to come up with streamlined process to lower the overwhelm.

Box F: Program lessons learned of the past year? Note: 1,000-character limit.

Some lessons learned: a) The need for telehealth services to continue even after pandemic accommodations are lifted b) The need for more outdoor in person events, as community members still have fears around COVID but are also feeling very disconnected c) The importance of talking about taboo topics such as gender, sexuality, and substance use within the South Asian community. d) The impact of case management and resource sharing. e) Our program is impacting a lot of change within the community, and we need to discuss with the county to have more opportunities to share the impacts so that funding can be increased. We need more advocacy to increase the total amount of prevention visits + Preventive Counseling for longer than 1 year.

Box G: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
G.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e., mental health treatment services):	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):	25
G.3: Types of treatment individuals were referred to (list types) (500-character limit):	Alameda & Contra Costa County Outpatient at the Hume Center, Tri- City Health, EAP programs, Private Health Insurance, College/University health programs, Kaiser, Palo Alto Med, Sutter Health, Out of County Medi-Cal services, and holistic healing.
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):	This program serves individuals from the unserved and underserved South Asian community, more specifically those from India, Pakistan, Bhutan, Nepal, Sri Lanka, Bangladesh, and Burma.
H.2: Number of paper referrals to an ACBH PEI-funded program:	10
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:	NA

H.5: Describe how your program encouraged access to services and follow through on above referrals (500 Characters):	

Box I: For <u>Outreach, Suicide Prevention, and Stigma Reduction</u> programs, please provide information for unduplicated potential responders (i.e., those who can 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):
K-12 schools	*counselors, social workers, principals, nurses, resource officers, district staff, family partner*
Colleges and universities	*professors, administration, counselors, staff, unlimited students & community members*
Senior centers	*Unlimited community members*
Local CBOs	*DV advocates, MH providers, Docs, nurses, social workers, peer/resource spec., first responders*
Community faith leaders	*100+ leaders in Nepalese, Bhutanese, Punjabi, Persian, Pakistani, Indian, Fijian community*
South Asian restaurants	*Unlimited community members*
South Asian grocery stores	*Unlimited community members*
Faith-based establishments	*Unlimited community members*
Libraries	*Libraries and Unlimited 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 Prevention Data Report FY 21/22

Program Name:	**Native American Prevention Center**	
Organization:	Native American Health Center, Inc	
PEI Program # and Name:	PEI 8 Outreach, Education & Consultation (Native American)	
Type of Report (Choose one):	Annual	
PEI Category (choose one):	Prevention	
Priority Area (place and X next to all that apply):	X	Childhood Trauma
		Early Psychosis
	X	Youth/TAY Outreach and Engagement
	X	Cultural and Linguistic
	X	Older Adults
	X	Early Identification of Mental Health Illness

Box A: Please provide a brief program description (character limit 1,000).
We provide an integrated approach that incorporates several evidence-based practices, culturally responsive programming, or training on mental health. To meet the PEI requirements as specified in our contract, we work to increase access to mental health services to underserved communities by implementing culturally and linguistically responsive services.

Box B: Number of individuals served this fiscal year through MHSA funding.	
Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	unavailable
Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	unavailable
Number of unduplicated individual family members served indirectly by your program:	unavailable
Unique prevention clients served:	unavailable

Box C: Demographics of individuals served this fiscal year through MHSA funding.

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	1372
Transition Age Youth (16-25 yrs.)	726
Adult (26-59 yrs.)	696
Older Adult (60+ yrs.)	1,040
Declined to answer	
Unknown	17
TOTAL	**3851**

SEXUAL ORIENTATION	
Gay/Lesbian	1
Heterosexual/Straight	962
Bisexual	
Questioning/Unsure	
Queer	
Declined to answer	
Unknown	2887
Another group not listed	1
TOTAL	**3851**
If another group is counted, please specify:	

VETERAN STATUS	
Yes	65
No	1896
Declined to answer	
Unknown	1890
TOTAL	**3851**

CURRENT GENDER IDENTITY	
Female	2380
Male	1420
Transgender	
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	51
Another identity not listed	
TOTAL	**3851**
If another identity is counted, please specify:	

PRIMARY LANGUAGE	
English	3755
Spanish	95
Cantonese	
Chinese	
Vietnamese	
Farsi	
Arabic	
Tagalog	
Declined to answer	
Unknown	
Another language not listed	1
TOTAL	**3851**

SEX ASSIGNED AT BIRTH	
Male	1420
Female	2380
Declined to answer	
Unknown	51
TOTAL	**3851**

DISABILITY*** STATUS	
Communication Domain	
Vision	2
Hearing/Speech	9
Another type not listed	
Communication Domain Subtotal	**11**
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	7
Physical/mobility	291
Chronic health condition	
Disability Subtotal	**298**
None	
Declined to answer	
Unknown	
Another disability not listed	1
TOTAL	**310**
If another disability is counted, please specify:	

RACE	
American Indian or Alaska Native	2452
Asian	
Black or African American	245
Native Hawaiian or another Pacific Islander	
White	25
Other Race	1110
Declined to answer	
Unknown	19
TOTAL	**3851**
If another race is counted, please specify: Latino (1054),	

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	1054
Total Hispanic or Latino	**1054**
If Non-Hispanic or Non-Latino, please specify:	
African	
African American	245
Asian Indian/South Asian	
Cambodian	
Chinese	
Eastern European	
European	
Filipino	
Japanese	
Korean	
Middle Eastern	
Vietnamese	
Other Non-Hispanic or Non-Latino ethnicity not listed	2533
Total Non-Hispanic or Non-Latino	**2778**
More than one ethnicity	
Unknown Ethnicity	19
Declined to answer	
EHTNICITY TOTAL	**3851**
If another ethnicity is counted, please specify:	

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of. Note: 1,000-character limit.
The success or accomplishment that really sticks out for this year has been the perseverance of the staff. So many obstacles have been put in our path. Be it COVD-19 protocols, lack of in-person programing, grief & loss, or just burn-out. Staff rose to the occasion & came up with plans to mitigate the challenges. Staff are closer, they lean on each other, & we have learned a lot. The team stepped up & made things happen for our community. Driving around & doing food deliveries to families. Staff always made sure the youth had activities in the bags. Our elders got special care packages. Staff went to visit with elders at their homes when making deliveries, spoke & shared a little time before the next delivery. Some of our elders stated we were their only visitors during this time. Staff did a fabulous job with whatever circumstance came their way; we made wonderful strides in our community& bonded with our Youth & Elders on a whole different level.

Box E: Program challenges of the past year and how the agency mitigated challenges? Note: 1,000-character limit.
1) Being able to hold events & groups with limited capacity. Once we were able to start holding very small groups and some small events that took place outside, we made it happen. We look forward to being able to bring in our community at the capacity prior to the pandemic, until then we will utilize the virtual world and be more creative. 2) Transportation has been an issue for some time, one staff was added to the drivers list. This opens so much opportunity for our program. When we had our youth in attendance they mostly walked or took public transportation. We can now do more pick- ups & drops offs with our youth as well as take them out on field trips that are further away.

Box F: Program lessons learned of the past year? Note: 1,000-character limit.
The lessons learned: 1) We realize now how important our gatherings & groups are to our community. We do not have a large number in neighborhoods, schools, or other environments, so we gather to create that space. We have missed each other so holding small events & groups is refreshing & healing. Our mental health is greatly improved when we get to be with each other. You do not realize the true value of something until you don't have it. 2) Virtual space has value & can work on many levels. The virtual platforms have taught us that it's ok to meet virtually, that sometimes it works out better for everyone to meet from their location instead of taking time to travel, it's a cost-effective alternative. For example: holding a parent meeting/orientation virtually so parents don't need to attend in person and can be in their own home taking care of their family.

Box G: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
G.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e., mental health treatment services):	1
G.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e., mental health treatment services):	0
G.3: Types of treatment individuals were referred to (list types) (500-character limit):	Individual therapy and case management
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:	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):	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:	16
H.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	77
H.4: Average number of days between referral and first participation in referred PEI program:	2

H.5: Describe how your program encouraged access to services and follow through on above referrals (500 Characters):	Our program encourages access to mental health services through the direct connection to a Behavioral Health clinician, and ensured engagement via follow-up call from the consulting provider and community health worker.

Box I: For <u>Outreach, Suicide Prevention, and Stigma Reduction</u> programs, please provide information for unduplicated potential responders (i.e., those who can identify early signs of potentially severe mental illness provide support, and or refer individuals who need treatment) reached. ***(Note: For Prevention, Early Intervention, Access & Linkage programs, this section is optional.)***	
Number of Responders:	**NA**
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):

MHSA Program #: PEI 10

PROVIDER NAME: Partnership for Trauma Recovery (PTR)

PROGRAM NAME: Outreach, Education & Consultation for African Community

Program Outcomes & Impact: UELP Prevention Data Report FY 21/22

Program Name:	**African Communities Program**	
Organization:	Partnership for Trauma Recovery (PTR)	
PEI Program # and Name:	PEI 10 Outreach, Education & Consultation (African)	
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).
Partnerships for Trauma Recovery (PTR) provides culturally reflective, trauma-informed, linguistically competent, and accessible UELP PEI services to the specific underserved population of forcibly displaced children, youth, adults, and families from African countries currently residing in North and South Alameda County. PTR specializes in providing holistic behavioral health care, psychosocial, and case management support for those who have fled violence and persecution in their home countries.

Box B: Number of individuals served this fiscal year through MHSA funding.	
Number of unduplicated individuals your program served who are at-risk of developing serious mental illness:	unavailable
Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	unavailable
Number of unduplicated individual family members served indirectly by your program:	unavailable
Unique prevention clients served:	39

Box C: Demographics of individuals served this fiscal year through MHSA funding.

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	12
Transition Age Youth (16-25 yrs.)	114
Adult (26-59 yrs.)	755
Older Adult (60+ yrs.)	91
Declined to answer	
Unknown	9
TOTAL	**981**

SEXUAL ORIENTATION	
Gay/Lesbian	33
Heterosexual/Straight	316
Bisexual	
Questioning/Unsure	
Queer	
Declined to answer	
Unknown	632
Another group not listed	
TOTAL	**981**
If another group is counted, please specify:	

VETERAN STATUS	
Yes	0
No	278
Declined to answer	
Unknown	703
TOTAL	**981**

CURRENT GENDER IDENTITY	
Female	429
Male	509
Transgender	
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	43
Another identity not listed	
TOTAL	**981**
If another identity is counted, please specify:	

PRIMARY LANGUAGE	
English	627
Spanish	
Cantonese	
Chinese	
Vietnamese	
Farsi	
Arabic	
Tagalog	
Declined to answer	
Unknown	
Another language not listed	354
TOTAL	**981**

SEX ASSIGNED AT BIRTH	
Male	509
Female	429
Declined to answer	
Unknown	43
TOTAL	**981**

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.)	3
Physical/mobility	2
Chronic health condition	
Disability Subtotal	**5**
None	
Declined to answer	
Unknown	1
Another disability not listed	
TOTAL	**6**
If another disability is counted, please specify:	

RACE	
American Indian or Alaska Native	
Asian	7
Black or African American	930
Native Hawaiian or another Pacific Islander	
White	11
Other Race	27
Declined to answer	
Unknown	6
TOTAL	**981**
If another race is counted, please specify: Latino (26)	

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	26
Total Hispanic or Latino	**26**
If Non-Hispanic or Non-Latino, please specify:	
African	
African American	930
Asian Indian/South Asian	
Cambodian	
Chinese	
Eastern European	
European	
Filipino	
Japanese	
Korean	
Middle Eastern	
Vietnamese	
Other Non-Hispanic or Non-Latino ethnicity not listed	19
Total Non-Hispanic or Non-Latino	**949**
More than one ethnicity	
Unknown Ethnicity	6
Declined to answer	
EHTNICITY TOTAL	**981**
If another ethnicity is counted, please specify: East Asian (7), White (11)	

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of. Note: 1,000-character limit.

PTR's African Communities Program reached a total of 2511 community members, provided counseling to 36 unique clients, and engaged in the following activities: 13 psychoeducational workshops; 3 educational workshops; 3 support groups; 6 community events; 16 MH consultations; 76 prevention visits for potential clients; and distributed program materials in 5 listservs. A major accomplishment was conducting a series of decolonizing mental health events and community-based healing workshops that were tailored to specific needs of the community without any stigma such as suicide prevention and response, mental health 101, intergenerational trauma, and generational gaps. Also, the community expressed feelings connected to and an ownership of the programming this year. PTR has also maximized reach to African communities in the Bay Area through diversifying outreach approaches and partnering with universities, associations, CBOs, and non-profit organizations.

Box E: Program challenges of the past year and how the agency mitigated challenges? Note: 1,000-character limit.

The main challenge continued to be entering personal client information in the InSyst system, and 3 clients did not consent to being registered in InSyst. Most of our clients are asylum seekers, many of whose immigration status is currently uncertain. Given their past histories of trauma and insecure legal status, sharing personal information causes clients stress and anxiety. To respond to this, PTR created a unique consent form, tip-sheet, and user-friendly referral form for UELP clients that indicate the information shared in InSyst, and the level of protection guaranteed by Alameda County. PTR provided prevention visits for 76 potential clients and conducted mental health consultations for 59 community members, which is an auspicious sign of PTR's ability to increase the number of PEI counseling clients. Since many community members seek immediate services due to the urgency of their needs, PTR is also improving its internal approach to respond more promptly to referrals.

Box F: Program lessons learned of the past year? Note: 1,000-character limit.

Having a series of community dialogues with community leaders and involving them in identifying the needs of the community and weaving their constructive feedback into the program helped to ensure community-led approach, community buy-in, and ownership to the program. African communities have diverse needs in addressing mental health issues, and using local language, tailored and context specific topics to respond to the different needs of the community increased community openness and destigmatized mental health care. Virtual engagement helped to reach out to the community wherever they are, and enhance access to services particularly for mothers, people who work multiple jobs or community members who have longer commuting time and expenses. The diverse perspectives, ethics, and experiences of PTR's African Communities Program staff, all of whom are immigrants--were relatable to the community we serve, and informed 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):	19
G.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e., mental health treatment services):	0
G.3: Types of treatment individuals were referred to (list types) (500-character limit):	PTR African Communities Program mental health specialist provided internal referrals for long-term individual and group psychotherapy with our staff clinicians and clinical interns, with the consent of clients/caregivers.
G.4: Unduplicated number of individuals who participated in referred program at least one time:	19
G.5: Average duration of untreated mental illness in weeks:	4 weeks
G.6: Average number of days between referral and first participation in referred treatment program:	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):	African refugees, asylum-seekers, and immigrants in general who reside in North and South Alameda County and beyond.
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:	36
H.4: Average number of days between referral and first participation in referred PEI program:	7 days

H.5: Describe how your program encouraged access to services and follow through on above referrals (500 Characters):	African Communities Wellbeing Coordinators conducted diverse outreach events, including prevention visits, case management, mental health consultations, outreach events, and psychoeducational workshops that encourage community health seeking behavior including access to MH services.

Box I: For <u>Outreach, Suicide Prevention, and Stigma Reduction</u> programs, please provide information for unduplicated potential responders (i.e., those who can 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:	**431**
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):
Remote Zoom session	*300 general community members and 42 community leaders through psychoeducational workshops*
Phone calls and in person meeting	*76 potential clients through prevention visits, 8 community leaders, 5 youth from school*
Social media (Facebook, Instagram)	*25 likes*
WhatsApp group	*African Student Association, Rwandan, Ethiopian, Eritrean, and Liberian Community Associations*
Senior centers	*30 Ethiopian and Eritrean senior and elderly communities*

MHSA Program #: PEI 19

PROVIDER NAME: Diversity in Health Training Institute (DHTI)

PROGRAM NAME: Outreach, Education & Consultation for Middle Eastern Community

Program Outcomes & Impact: UELP Prevention Data Report FY 21/22

Program Name:	**Sidra Community Wellness Program**	
Organization:	Diversity in Health Training Institute (DHTI)	
PEI Program # and Name:	PEI 19 Outreach, Education & Consultation (Middle Eastern)	
Type of Report (Choose one):	Annual	
PEI Category (choose one):	Prevention	
Priority Area (place and X next to all that apply):		Childhood Trauma
		Early Psychosis
	X	Youth/TAY Outreach and Engagement
	X	Cultural and Linguistic
	X	Older Adults
	X	Early Identification of Mental Health Illness

Box A: Please provide a brief program description (character limit 1,000).
Sidra Community Wellness Program (SIDRA) launched in July 2019. The purpose of SIDRA is to promote healing, wellness, and mental health among Middle Eastern and North African communities in Alameda County.

Box B: Number of individuals served this fiscal year through MHSA funding.	
Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	unavailable
Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	unavailable
Number of unduplicated individual family members served indirectly by your program:	unavailable
Unique prevention clients served:	38

Box C: Demographics of individuals served this fiscal year through MHSA funding.

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	43
Transition Age Youth (16-25 yrs.)	356
Adult (26-59 yrs.)	137
Older Adult (60+ yrs.)	1
Declined to answer	
Unknown	0
TOTAL	**537**

SEXUAL ORIENTATION	
Gay/Lesbian	2
Heterosexual/Straight	197
Bisexual	
Questioning/Unsure	
Queer	
Declined to answer	
Unknown	338
Another group not listed	
TOTAL	**537**
If another group is counted, please specify:	

VETERAN STATUS	
Yes	0
No	441
Declined to answer	
Unknown	96
TOTAL	**537**

CURRENT GENDER IDENTITY	
Female	417
Male	118
Transgender	
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	2
Another identity not listed	
TOTAL	**537**
If another identity is counted, please specify:	

PRIMARY LANGUAGE	
English	9
Spanish	29
Cantonese	
Chinese	19
Vietnamese	
Farsi	32
Arabic	
Tagalog	
Declined to answer	
Unknown	
Another language not listed	448
TOTAL	**537**

SEX ASSIGNED AT BIRTH	
Male	118
Female	417
Declined to answer	
Unknown	2
TOTAL	**537**

DISABILITY*** STATUS	
Communication Domain	
Vision	
Hearing/Speech	
Another type not listed	
Communication Domain Subtotal	
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	
Physical/mobility	
Chronic health condition	
Disability Subtotal	
None	
Declined to answer	
Unknown	
Another disability not listed	1
TOTAL	**1**
If another disability is counted, please specify:	

RACE	
American Indian or Alaska Native	
Asian	59
Black or African American	3
Native Hawaiian or another Pacific Islander	
White	444
Other Race	31
Declined to answer	
Unknown	
TOTAL	**537**
If another race is counted, please specify: Latino (29)	

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	29
Total Hispanic or Latino	**29**
If Non-Hispanic or Non-Latino, please specify:	
African	
African American	3
Asian Indian/South Asian	2
Cambodian	
Chinese	
Eastern European	
European	
Filipino	
Japanese	
Korean	
Middle Eastern	
Vietnamese	
Other Non-Hispanic or Non-Latino ethnicity not listed	495
Total Non-Hispanic or Non-Latino	**500**
More than one ethnicity	
Unknown Ethnicity	
Declined to answer	
EHTNICITY TOTAL	**529**
If another ethnicity is counted, please specify: Included in Total Non-Hispanic totals: Other Southeast Asian (38), Arab (209), Middle Eastern/North African (229) East Asian (19)	

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of. Note: 1,000-character limit.

Due to our outreach & engagement efforts Sidra connected with a MENA family that required a lot of support. Financial burdens and obligations brought a lot of anxiety to the family which resulted in major Health complications that effected the father. The Father suffered from diabetes and resulted in amputating part of his foot. Sidra's effort played a significant role in supporting the family through psychoeducation, 1on1 counseling, and connection to resources. Through our preventative visits, we connected the family with other resources (Rental assistance, Vaccine Clinics). Moreover, Sidra assisted the clients in explaining and translating various documents/paperwork. Sidra's goal was also to empower the mother and daughter. Mom enrolled in English courses to improve her language skills. Daughter joined one of Sidra's cultural group sessions. Sidra enrolled the family in In Home Supportive Services. Mom earned income as a provider by supporting her husband.

Box E: Program challenges of the past year and how the agency mitigated challenges? Note: 1,000-character limit.

Sidra faced some challenges during the past year. Covid19 remained a major challenge to us and our clients. We overcame this challenge by providing a hybrid model for group sessions & workshops. Sidra provided clients in the MENA community with PPE materials (masks, sanitizers, Covid test kits). Sidra had some personnel transitions this year, where our PM/Clinical specialist & Clinical Supervisor transitioned out of Sidra. This created some challenges for us. Despite these challenges and the lack of Arabic speaking M.H specialists, Sidra recruited a new Clinical Supervisor & a new M.H specialist (Farsi speaking) trainee. Sidra is still in the process of recruiting more culturally sensitive clinicians and outreach coordinators. Stigma regarding mental health remains a challenge. However, with Sidra's psychoeducational group sessions, workshops, 1on1 visits, and art sessions we can gradually destigmatize mental health in the MENA community.

Box F: Program lessons learned of the past year? Note: 1,000-character limit.

We learned that clients coming from the MENA community do not always share the same culture, traditions, and values. That's why we at DHTI-Sidra strive to hire culturally sensitive clinicians and outreach coordinators that can build rapport with clients coming from different cultures and sharing different backgrounds. We also learned that partnering with schools is essential. During the past year Sidra continued its partnership with Oakland International Highschool & West Oakland Middle school. Sidra partnered up with KIPP school to assist the MENA students and their families. After a year of marketing for additional Arabic-speaking M.H specialists, we learned that there is a lack of Arabic-speaking M.H specialists & outreach workers who can better serve and support the MENA communities. We hope to continue our recruitment effort and increase our efforts to shed a light on the need of culturally responsive M.H workers to serve the MENA 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):	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):	Clients were referred to culturally responsive clinicians that can speak the same language and can understand the client's culture to be treated for complicated grief.
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):	Middle Eastern and North African communities, Arabic and Persian/Farsi speaking communities, mothers and grandmothers, youth, transitional age youth, older adults, women, men.
H.2: Number of paper referrals to an ACBH PEI-funded program:	0
H.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	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):	Sidra encourages access to services through warm handoffs. The goal is to arrange a connection between the referred clients and the designated organization. The warm handoff is used to ass the services needed and the registration process. We continue to check in with the client after handing off.

Box I: For Outreach, Suicide Prevention, and Stigma Reduction programs, please provide information for unduplicated potential responders (i.e., those who can 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:	**531**
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):
Eid Adha Holiday	*32 parents / 32 Kids*
Back to School event (WOMS)	*24 Adults (Parents, teachers, community members)*
Summer TAY leadership (LAO) celebration	*12 Youth*
Community listening session - in collaboration with OUSD	*64 Parents*
Yalda event	*10 parents*
Cultural Affinity listening session	*7 Adults /12 youth*
De-stigmatization of mental health (FRN)	*295 + audience*
Coping with recent crisis in Afghanistan	*12 youth*
CBT conversational cards with OIHS students	*17 Youth*
Parenting skills: difference between kids with ADHD and those with mere hyperactivity/hyper	*14 Parents*

MHSA Program #: PEI 1B

PROVIDER NAME: Center for Healthy Schools and Communities (CHSC)

PROGRAM NAME: School-Based Mental Health Access and Linkage

Program Outcomes & Impact: PEI Data Report FY 21/22

Program Name:	**School-Based Mental Health Access and Linkage**	
Organization:	Center for Healthy Schools and Communities (CHSC)	
PEI Program # and Name:	PEI 1B School-Based Mental Health Access & Linkage in Elementary, Middle & HS	
Type of Report (Choose one):	Annual	
PEI Category (choose one):	Access and Linkage	
Priority Area (place and X next to all that apply):	X	Childhood Trauma
	X	Early Psychosis
	X	Youth/TAY Outreach and Engagement
		Cultural and Linguistic
		Older Adults
	X	Early Identification of Mental Health Illness

Box A: Please provide a brief program description (character limit 1,000).
Coordination of Services Team or COST is a strategy used to integrate behavioral health and other health care supports for students through a referral and triage process. Through COST, a universal referral system is used by teachers and staff to flag students identified as needing support. Referrals are reviewed by a team consisting of school staff and service providers that collaborate to determine the best intervention and/or support service for students. PEI funds currently aid in the implementation of the COST strategy in 268 schools across 14 school districts in Alameda County.

Box B: Number of individuals served this fiscal year through MHSA funding.	
Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	4399
Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	5349

Number of unduplicated individual family members served indirectly by your program:	0
Grand total of unduplicated individuals served:	9748

Box C: Demographics of individuals served this fiscal year through MHSA funding.

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	12579
Transition Age Youth (16-25 yrs.)	4916
Adult (26-59 yrs.)	0
Older Adult (60+ yrs.)	0
Declined to answer	0
Unknown	17495
TOTAL	**17495**

SEXUAL ORIENTATION	
Gay/Lesbian	5
Heterosexual/Straight	155
Bisexual	6
Questioning/Unsure	9
Queer	0
Declined to answer	482
Unknown	13353
Another group not listed	2
TOTAL	**14012**
If another group is counted, please specify:	

VETERAN STATUS	
Yes	
No	0
Declined to answer	
Unknown	
TOTAL	**0**

CURRENT GENDER IDENTITY	
Female	3926
Male	4436
Transgender	14
Genderqueer	6
Questioning/unsure of gender identity	11
Declined to answer	78
Unknown	5503
Another identity not listed	39
TOTAL	**14013**
If another identity is counted, please specify:	

PRIMARY LANGUAGE	
English	8426
Spanish	4636
Cantonese	152
Chinese	162
Vietnamese	103
Farsi	117
Arabic	124
Tagalog	80
Declined to answer	8
Unknown	2201
Another language not listed	721
TOTAL	**16730**

SEX ASSIGNED AT BIRTH	
Male	4941
Female	4494
Declined to answer	32
Unknown	6604
TOTAL	**16071**

DISABILITY*** STATUS	
Communication Domain	
Vision	21
Hearing/Speech	36
Another type not listed	1106
Communication Domain Subtotal	**1163**
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	261
Physical/mobility	5
Chronic health condition	13
Disability Subtotal	**279**
None	5105
Declined to answer	
Unknown	
Another disability not listed	1106
TOTAL	**7653**
If another disability is counted, please specify:	

RACE	
American Indian or Alaska Native	109
Asian	1534
Black or African American	1160
Native Hawaiian or other Pacific Islander	257
White	1704
Other Race	5801
Declined to answer	56
Unknown	5704
TOTAL	**16325**
If another race is counted, please specify: Hispanic or Latino- 5065; More than one race: 745	

	Ethnicity/Cultural Heritage (Please choose only one per individual)		
	If Hispanic or Latino, please specify:		
	Caribbean	4	
	Central American	63	
	Mexican/Mexican American/Chicano	419	
	Puerto Rican	3	
	South American	4	
	Another Hispanic/Latino ethnicity not listed	110	
	Total Hispanic or Latino		**603**
	If Non-Hispanic or Non-Latino, please specify:		
	African	49	
	African American	244	
	Asian Indian/South Asian	46	
	Cambodian	6	
	Chinese	80	
	Eastern European	3	
	European	96	
	Filipino	110	
	Japanese	4	
	Korean	5	
	Middle Eastern	33	
	Vietnamese	16	
	Other Non-Hispanic or Non-Latino ethnicity not listed	152	
	Total Non-Hispanic or Non-Latino		**844**
	More than one ethnicity		152
	Unknown Ethnicity		7955
	Declined to answer	795	
EHTNICITY TOTAL			**10349**
	If another ethnicity is counted, please specify:		

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of. Note: 1,000-character limit.

Through COST, 9700 students across 268 schools and 14 school districts in Alameda County were referred and linked to behavioral health services and supports—46% more than last year. As students returned to in-person learning, schools saw a drastic increase in behavioral health support for students. They built upon the multidisciplinary COST referral system by training staff, using virtual and in-person team meetings and referrals, increasing number of Wellness Centers and on-site providers, and strengthening partnerships with community providers. Many districts reported successfully reconnecting with students, who were struggling during shelter-in place, with needed behavioral health and academic support resulting in improvements. Schools referred more students with severe mental illness to treatment. One district connected a transgender student with suicidal ideation to community-based clinician specialized in LGBTQ students and on-going support through the school's Wellness Center.

Box E: Program challenges of the past year and how did the agency mitigate challenges? Note: 1,000-character limit.

COVID-19 pandemic and distance learning had a profound impact on behavioral and mental health of students and families. Schools were met by an increased need for mental health support and services, while faced with school and provider staff shortages and inconsistency, resulting in an inability to meet demand. This included an increased need to refer students with severe mental illness to higher levels of treatment but a limited number of providers and resources. School districts that mainly provided services in-house, developed partnerships with off-site providers to serve more students. While schools that had existing partnerships with off-sites agencies strengthened their communication and coordination. Finally, schools offered more prevention and early intervention drop-in and on-site positive youth development programming to support students.

Box F: Program lessons learned of the past year? Note: 1,000-character limit.

The return to in-person learning coupled with an increased need for behavioral health referrals led to strengthening existing referral systems. School districts streamlined their referral process, trained, and educated more staff on COST and Multi-Tiered Systems of Support (MTSS), and developed increased ability for student self-referrals. Schools saw the need to strengthen outreach and partnership with families to provide mental health and social service supports. Schools increased partnerships with community-based organizations (CBOs) that could provide culturally and linguistically proficient outreach and services to diverse families in the district. They found that providing school-based family programs and resources are crucial in strengthening families and connecting them to services. Finally, districts are voicing the need for more funding, staff and providers that can meet the need for higher levels of mental health services for students and families.

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):	2786
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):	Individuals were referred to school-based mental health treatment programs and non-school based services: individual or group counseling/therapy, crisis intervention, individualized behavior support, family counseling, and parent workshops.
G.4: Unduplicated number of individuals who participated in referred program at least one time:	2786
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:	15 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):	Transitional-aged and foster youth, LGBTQ-identifying youth, boys and young men of color, unaccompanied immigrant youth, food and shelter insecure youth and families, and English as a second language youth.
H.2: Number of paper referrals to an ACBH PEI-funded program:	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 program:	NA
H.5: Describe how your program encouraged access to services and follow through on above referrals (500 Characters):	Strategies that increase access & follow up: partnerships with family outreach workers, CBOs, information sharing through family workshop, and professional learning for staff, building relationships with students.

Box I: For <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 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 21/22

Program Name:	**Early Childhood Mental Health Outreach and Consultation**	
Organization:	Jewish Family and Community Services East Bay	
PEI Program # and Name:	Early Childhood Mental Health Outreach and Consultation	
Type of Report (Choose one):	Annual	
PEI Category (choose one):	Outreach	
Priority Area (place and X next to all that apply):	X	Childhood Trauma
		Early Psychosis
		Youth/TAY Outreach and Engagement
	X	Cultural and Linguistic
		Older Adults
	X	Early Identification of Mental Health Illness

Box A: Please provide a brief program description (character limit 1,000).
Early Childhood Mental Health Outreach and Consultation is a prevention and early intervention program that promotes the social, emotional, and behavioral health of children in early education programs. Consultants help build the capacity of staff, programs, systems, and families to increase the understanding of children's behaviors to prevent, identify, and reduce the impact of trauma, mental health and developmental challenges among young children. The aim is early identification of mental illness in children, parents/caregivers, and all ECE staff.

Box B: Number of individuals served this fiscal year through MHSA funding.	
Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	69

Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	

Number of unduplicated individuals in your program served who show early signs of forming a more severe mental illness:	64
Grand total of unduplicated individuals served:	**133**

Box C: Demographics of individuals this fiscal year through MHSA funding.

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	97
Transition Age Youth (16-25 yrs.)	1
Adult (26-59 yrs.)	26
Older Adult (60+ yrs.)	9
Declined to answer	
Unknown	
TOTAL	**133**

SEXUAL ORIENTATION	
Gay/Lesbian	
Heterosexual/Straight	4
Bisexual	
Questioning/Unsure	
Queer	
Declined to answer	
Unknown	129
Another group not listed	
TOTAL	**133**
If another group is counted, please specify:	

VETERAN STATUS	
Yes	
No	48
Declined to answer	
Unknown	
TOTAL	**48**

CURRENT GENDER IDENTITY	
Female	58
Male	31
Transgender	
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	44
Another identity not listed	
TOTAL	**133**
If another identity is counted, please specify:	

PRIMARY LANGUAGE	
English	39
Spanish	26
Cantonese	12
Chinese	7
Vietnamese	14
Farsi	
Arabic	4
Tagalog	2
Declined to answer	
Unknown	27
Another language not listed	2
TOTAL	**133**

SEX ASSIGNED AT BIRTH	
Male	54
Female	79
Declined to answer	
Unknown	
TOTAL	**133**

Communication Domain	
Vision	
Hearing/Speech	3
Another type not listed	
Communication Domain Subtotal	**3**
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	6
Physical/mobility	1
Chronic health condition	
Disability Subtotal	**7**
None	47
Declined to answer	
Unknown	
Another disability not listed	
TOTAL	**57**
If another disability is counted, please specify:	

RACE	
American Indian or Alaska Native	
Asian	43
Black or African American	52
Native Hawaiian or other Pacific Islander	
White	1
Other Race	8
Declined to answer	
Unknown	29
TOTAL	**133**
If another race is counted, please specify: Latino (6), Algerian (1), Ethiopian (1)	

Ethnicity/Cultural Heritage (Please choose only one per individual)	
If Hispanic or Latino, please specify:	
Caribbean	=
Central American	12
Mexican/Mexican American/Chicano	19
Puerto Rican	=
South American	
Another Hispanic/Latino ethnicity not listed	
Total Hispanic or Latino	**31**
If Non-Hispanic or Non-Latino, please specify:	
African	22
African American	30
Asian Indian/South Asian	2
Cambodian	
Chinese	19
Eastern European	1
European	
Filipino	2
Japanese	
Korean	
Middle Eastern	3
Vietnamese	23
Other Non-Hispanic or Non-Latino ethnicity not listed	
Total Non-Hispanic or Non-Latino	**99**
More than one ethnicity	2
Unknown Ethnicity	1
Declined to answer	
EHTNICITY TOTAL	**133**
If another ethnicity is counted, please specify:	

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of. Note: 1,000-character limit.

One program success that is still ongoing is blending in person and virtual services to support behavior challenges in one classroom. Consultant and teachers were able to hold a Zoom meeting with parents to better understand the student's needs, identify expectations for all involved, and identify interventions. The consultant was able to provide in person observations, build rapport with the student and family, and support the teachers in identifying potentially helpful strategies to meet the students' needs as well as other students in the classroom. This center has done a great job with communication and incorporating virtual services. In fact, starting in February 2022 consultant will be hosting/facilitating virtual parent cafes to support navigating parenting needs and social emotional development. The mental health consultant was able to meet regularly with the teachers and site supervisor to provide a reflective space to support the mental health needs of the children.

Box E: Program challenges of the past year and how did the agency mitigate challenges? Note: 1,000-character limit.

This past year our department has had a high turnover. Consultants have done their best to navigate these transitions by continuing to put our programs and clients first. Maintaining group and individual supervision has also served as an invaluable resource for consultants as we attempt to support similar challenges at our sites. (At our sites staffing has been a major issue. Many teachers have needed time off to care for family, recharge, or take care of personal needs making it difficult for coverage and causing creative approaches). COVID 19 continues to impact services causing consultants to be mindful of gauging the need for in person or virtual services.

Box F: Program lessons learned of the past year? Note: 1,000-character limit.

This year we are continuing to find ways to incorporate technology into our services as well as up to date health and safety protocol. As always, we are learning to be flexible, the importance of relationship building, and meeting individuals where they are at. This year we are learning the value of slowing down and honoring our strengths and differences and sitting with the unknown. An additional challenge presented this school year is the high rate of children and families getting covid-19 at the preschool, and the impact on the sense of safety in the staff and families. Our program supported the preschool reflecting on additional procedures to prevent spreading the virus and keep children enrolled in the program. Additionally, the mental health consultant provided support to the staff to help them be attuned to the children socio-emotional 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):	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 <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):
Early childhood centers	*1 school (2 classrooms), 6 teachers, 1 site principal*

MHSA Program #: PEI 3

PROVIDER NAME: Alameda County Behavioral Health

PROGRAM NAME: Geriatric Assessment and Response Team

Program Outcomes & Impact: PEI Data Report FY 21/22

Program Name:	**Geriatric Assessment and Response Team (GART)**	
Organization:	Alameda County Behavioral Health	
PEI Program # and Name:	PEI 3 - Geriatric Assessment Response Team	
Type of Report (Choose one):	Annual	
PEI Category (choose one):	Early Intervention	
Priority Area (place and X next to all that apply):		Childhood Trauma
		Early Psychosis
		Youth/TAY Outreach and Engagement
		Cultural and Linguistic
	X	Older Adults
		Early Identification of Mental Health Illness

Box A: Please provide a brief program description (character limit 1,000).

The Geriatric Assessment & Response Team/ACBH/GART is an Alameda County Behavioral Health field-based support team that provides brief, voluntary behavioral health treatment to older adults. The goal of the Geriatric Assessment & Response Team (GART) is to provide recovery strategies and alternatives to hospitalization and to enhance opportunities for independence, resiliency, wellness, and quality of life. Services may include assessment, treatment coordination, medication support, counseling, case management, and crisis support services.

Box B: Number of individuals served this fiscal year through MHSA funding.	
Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	0
Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	54
Number of unduplicated individual family members served indirectly by your program:	40
Grand total of unduplicated individuals served:	**94**

Box C: Demographics of individuals served this fiscal year through MHSA funding.

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	
Transition Age Youth (16-25 yrs.)	
Adult (26-59 yrs.)	20
Older Adult (60+ yrs.)	34
Declined to answer	
Unknown	
TOTAL	**54**

VETERAN STATUS	
Yes	1
No	
Declined to answer	
Unknown	53
TOTAL	**54**

SEXUAL ORIENTATION	
Gay/Lesbian	
Heterosexual/Straight	
Bisexual	
Questioning/Unsure	
Queer	
Declined to answer	
Unknown	54
Another group not listed	
TOTAL	**54**
If another group is counted, please specify:	

PREVENTION & EARLY INTERVENTION (PEI) PROGRAM SUMMARIES

Mentor on Discharge® - Post Crisis Peer Mentoring

CURRENT GENDER IDENTITY	
Female	34
Male	
Transgender	
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	
Another identity not listed	
TOTAL	**54**
If another identity is counted, please specify:	

PRIMARY LANGUAGE	
English	48
	1
Cantonese	2
Chinese	3
Vietnamese	
Farsi	
Arabic	
Tagalog	
Declined to answer	
Unknown	
Another language not listed	
TOTAL	**54**
If another language is spoken, please specify:	

SEX ASSIGNED AT BIRTH	
Male	33
Female	19
Declined to answer	
Unknown	2
TOTAL	**54**

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.)	2
Physical/mobility	3
Chronic health condition	
Disability Subtotal	**5**
None	28
Declined to answer	
Unknown	21
Another disability not listed	
TOTAL	**54**

RACE	
American Indian or Alaska Native	1
Asian	4
Black or African American	20
Native Hawaiian or other Pacific Islander	1
White	23
Other Race	3
Declined to answer	
Unknown	2
TOTAL	**54**
If another race is counted, please specify: Three individuals identified as Hispanic/Latino but the ethnicity/cultural heritage is unknown.	

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	3
Eastern European	
European	
Filipino	
Japanese	
Korean	
Middle Eastern	
Vietnamese	
Other Non-Hispanic or Non-Latino ethnicity not listed	3
Total Non-Hispanic or Non-Latino	**4**
More than one ethnicity	
Unknown Ethnicity	
Declined to answer	
EHTNICITY TOTAL	**4**
If another ethnicity is counted, please specify:	

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of. Note: 1,000-character limit.
The client is a 74-year-old, White female who is a published author with no social support. She resides independently and is not connected to mental health care. She was referred by Mobile Crisis for follow-up and linkage. GART clinician completed an assessment and found that the client's house is cluttered with cat feces everywhere, client at risk of losing housing, has rotten food in fridge, evidence of recent stovetop fire, client out of psychiatric medication, client struggles with anxiety, poor short-term memory, money management, and had a broken phone. Clinician assisted the client in obtaining new phone, connect to PCP, apply for Medi-Cal, transported the client to same day medication support, filled her prescription, and helped her sign up for free food delivery for elders.

Box E: Program of the past year and how did the agency mitigate challenges? Note: 1,000-character limit.
GART received many referrals for individuals between the ages of 55-59. Unfortunately, the program originally served individuals 60 and above. Many individuals were falling through the gap and were turned away due to the age requirement. Although GART was designed to be field based, due to the pandemic, GART had only provided telephone and telehealth. Many clients needed in-person services. To mitigate the challenges, GART lowered the age requirement for program participation to 55 and older with the understanding that individuals with SMI are frequently functioning as 20-25 years older than their natural age. As a result, GART is serving more clients.

Box F: Program lessons learned of the past year? Note: 1,000-character limit.
GART learned that while telephone and telehealth-based services can be convenient for some clients, many clients are without the proper equipment to access services. GART understands the importance of having a variety of methods to engage with clients. GART plans to give clients the option of meeting in the office at any of our office locations throughout Alameda County, in the community, at the clients' homes, via telephone or video, and at facilities. We learned that it's important to meet our clients where it is convenient for them to improve engagement outcomes. Further, while mental health linkage is our primary goal, we understand that the clients' basic needs are as important. We learned to prioritize the needs of our clients holistically. We learned the importance of training our clinicians about community resources, including housing and food.

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):	19

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):	35
G.3: Types of treatment individuals were referred to (list types) (500-character limit):	Outpatient/inpatient providers, day treatment and rehab centers, case management, peer support, friendly visitors, language specific providers, SUD, housing/homeless resources. Alzheimer's Association and Daybreak with dementia dx. PCP
G.4: Unduplicated number of individuals who participated in referred program at least one time:	14
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 48 business 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, 55 years and older
H.2: Number of paper referrals to an ACBH PEI-funded program:	None. GART does not typically refer to PEI programs
H.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	None. GART does not typically refer to PEI programs
H.4: Average number of days between referral and first participation in referred PEI program:	None. GART does not typically refer to PEI programs
H.5: Describe how your program encouraged access to services and follow through on above referrals (500 Characters):	GART is a hybrid PEI and ACBH specialty mental health program. Once services end with GART, clinicians refer to non-PEI programs for long term care and develop a discharge plan with the client to engage their natural support systems.

Box I: For 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:	**0**
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):

MHSA Program #: PEI 4

PROVIDER NAME: Peers Envisioning and Engaging in Recovery Services (PEERS)

PROGRAM NAME: Everyone Counts Campaign (EEC)

Program Outcomes & Impact: PEI Data Report FY 21/22

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
	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).
The Everyone Counts Campaign (ECC) is PEERS' primary anti-stigma program. The ECC aims to reduce stigma and discrimination against people with mental health experiences and to promote social inclusion through three strategies: Empowerment (Spirituality and Special Messages groups), Outreach (Lift Every Voice and Speak (LEVS), the African American ECC (action team, anti-stigma support groups and outreach events), and Communications (website, email, social media).

Box B: Number of individuals served this fiscal year through MHSA funding.	
Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	281
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:	**281**

Box C: Demographics of individuals served this fiscal year through MHSA funding.

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	1
Transition Age Youth (16-25 yrs.)	28
Adult (26-59 yrs.)	55
Older Adult (60+ yrs.)	16
Declined to answer	181
Unknown	
TOTAL	**281**

SEXUAL ORIENTATION	
Gay/Lesbian	8
Heterosexual/Straight	60
Bisexual	4
Questioning/Unsure	1
Queer	2
Declined to answer	15
Unknown	179
Another group not listed	12
TOTAL	**281**
If another group is counted, please specify: Poly	

VETERAN STATUS	
Yes	7
No	99
Declined to answer	175
Unknown	
TOTAL	**281**

CURRENT GENDER IDENTITY	
Female	71
Male	42
Transgender	1
Genderqueer	1
Questioning/unsure of gender identity	0
Declined to answer	164
Unknown	
Another identity not listed	2
TOTAL	**281**
If another identity is counted, please specify:	

PRIMARY LANGUAGE	
English	73
Spanish	5
Cantonese	
Chinese	
Vietnamese	3
Farsi	
Arabic	
Tagalog	5
Declined to answer	179
Unknown	
Another language not listed	16
TOTAL	**281**

If another language is counted, please specify: Hindi, Gujrati, Punjabi, Chinese (not specified), Lithuanian, Tamil, Korean, Fijian

SEX ASSIGNED AT BIRTH	
Male	
Female	
Declined to answer	
Unknown	281
TOTAL	**273**

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	
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	44
Black or African American	42
Native Hawaiian or other Pacific Islander	1
White	16
Other Race	166
Declined to answer	12
Unknown	
TOTAL	**281**
If another race is counted, please specify: More than one race (e.g., Black/Korean, Latinx/Asian), Latino, Hispanic	

Ethnicity/Cultural Heritage (Please choose only one per individual)	
If Hispanic or Latino, please specify:	
Caribbean	1
Central American	
Mexican/Mexican American/Chicano	5
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	1
Total Hispanic or Latino	**7**
If Non-Hispanic or Non-Latino, please specify:	
African	
African American	8
Asian Indian/South Asian	8
Cambodian	1
Chinese	1
Eastern European	2
European	1
Filipino	10
Japanese	2
Korean	2
Middle Eastern	
Vietnamese	3
Other Non-Hispanic or Non-Latino ethnicity not listed	18
Total Non-Hispanic or Non-Latino	**58**
More than one ethnicity	8
Unknown Ethnicity	2
Declined to answer	206
EHTNICITY TOTAL	**281**
If another ethnicity is counted, please specify: Thai, Dravidian, Moor, Creole, Canadian, Caucasian, Tibetan	

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of. Note: 1,000-character limit.
The first year of our Asian American Everyone Counts Campaign was a success. The Asian American peers and subject matter experts serving on the Action Team decided to rename the campaign and its activities. The campaign now is called HOPE – Healing from Our Past and Expectations. The Action Team now is the HOPE Stigma Reduction Committee, and the stigma reduction support groups now are the HOPE Wellness Groups. Comments from HOPE participants include: "PEERS" program is bringing the Asian community together and giving them a sense of true belonging." "Everyone seems to have shared experiences, which helped me feel like I'm not alone." "The program is very informative and educative; it was fun going through it."

Box E: Program challenges of the past year and how did the agency mitigate challenges? Note: 1,000-character limit.
We did not encounter any major challenges in reaching our deliverables this past year. Participation in some groups was lower than we wanted, and we aim to continue to experiment with various outreach methods to increase those numbers.

Box F: Program lessons learned of the past year? Note: 1,000-character limit.
The strong, positive response to our 15-week Buried in Treasures hoarding and cluttering support group is a lesson about the desire for assistance with cluttering among peers in our community. Participants, all of whom have moderate to severe levels of cluttering and hoarding, find peer support, and make progress on their decluttering goals using the structured curriculum. As always, when the cycle ends, participants are reluctant to stop meeting.

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):	We serve mental health consumers, particularly Asian Americans (HOPE ECC campaign) and African Americans (Black Wellness and Resilience), transition-age youth and 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:	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:	**780**
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):
Day of Prayer - virtual	*25 primarily African American consumers and family members, as well as members of faith communities*
Mental Health Association of San Francisco's Real Talk show	*Unknown number of radio show listeners*
Peer-led mental health conference	*75 peers and providers*
Community festival: Black Joy Parade	*160 primarily Black community members*
Lift Every Voice and Celebrate Black History Month virtual event	*12 Black community members*
Warriors Game/Chase Center	*450 community members*
Youth service provider	*8 youth service providers*
Community health fair: BOSS Mental Wellness Day	*50 youth and youth service providers*

MHSA Program #: PEI 12

PROVIDER NAME: Crisis Support Services of Alameda County (CSS)

PROGRAM NAME: Text Line

Program Outcomes & Impact: PEI Data Report FY 21/22

Program Name:	**Text Line Program**	
Organization:	Crisis Support Services of Alameda County (CSS)	
PEI Program # and Name:	PEI 12 Text Line	
Type of Report (Choose one):	Annual	
PEI Category (choose one):	Suicide Prevention	
Priority Area (place and X next to all that apply):		Childhood Trauma
		Early Psychosis
	X	Youth/TAY Outreach and Engagement
		Cultural and Linguistic
		Older Adults
	X	Early Identification of Mental Health Illness

Box A: Please provide a brief program description (character limit 1,000).
The program provides brief crisis intervention and emotional support to individuals via text/SMS modality with emphasis on school aged youths and TAY.

Box B: Number of individuals served this fiscal year through MHSA funding.	
Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	335
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:	**335**

Box C: Demographics of individuals served this fiscal year through MHSA funding.

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	14
Transition Age Youth (16-25 yrs.)	22
Adult (26-59 yrs.)	6
Older Adult (60+ yrs.)	
Declined to answer	
Unknown	293
TOTAL	**335**

VETERAN STATUS	
Yes	
No	
Declined to answer	
Unknown	**335**
TOTAL	**335**

CURRENT GENDER IDENTITY	
Female	9
Male	3
Transgender	1
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	320
Another identity not listed	
TOTAL	**333**
If another identity is counted, please specify: non-binary	

SEX ASSIGNED AT BIRTH	
Male	
Female	
Declined to answer	
Unknown	335
TOTAL	**335**

SEXUAL ORIENTATION	
Gay/Lesbian	
Heterosexual/Straight	
Bisexual	1
Questioning/Unsure	
Queer	1
Declined to answer	
Unknown	333
Another group not listed	
TOTAL	**335**
If another group is counted, please specify:	

PRIMARY LANGUAGE	
English	332
Spanish	3
Cantonese	
Chinese	
Vietnamese	
Farsi	
Arabic	
Tagalog	
Declined to answer	
Unknown	
Another language not listed	
TOTAL	**335**
If another language is counted, please specify:	

DISABILITY*** STATUS	
Communication Domain	
Vision	
Hearing/Speech	
Another type not listed	
Communication Domain Subtotal	**0**
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	
Physical/mobility	
Chronic health condition	
Disability Subtotal	**0**
None	
Declined to answer	
Unknown	
Another disability not listed	
TOTAL	**0**
If another disability is counted, please specify:	

RACE	
American Indian or Alaska Native	
Asian	
Black or African American	
Native Hawaiian or other Pacific Islander	
White	2
Other Race	
Declined to answer	
Unknown	333
TOTAL	**335**
If another race is counted, please specify:	

Ethnicity/Cultural Heritage (Please choose only one per individual)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	
Mexican/Mexican American/Chicano	
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	0
Total Hispanic or Latino	**0**

If Non-Hispanic or Non-Latino, please specify:	
African	
African American	
Asian Indian/South Asian	
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: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of. Note: 1,000-character limit.

The program provides on demand crisis support to individuals including those who may have a history of trauma when interfacing with the mental health system. One texter reported managing frequent and intense suicidal urges, as well as urges to self-harm and use substances to cope. The texter works collaboratively with program staff and volunteers to disable the suicide means and to make a safety plan. The texter shared their identify as an African American woman with mental illness and trauma and "this world is not for me and has never been." Because of her lived experience, the texter often declines referrals to higher level of care. The text line program is available to provide services to people who may not interface with greater behavioral health care system but can still benefit from its support. With the support of the program manager at Sally's Place, the texter agreed to drive herself to Sally's Place to receive a higher level of care.

Box E: Program challenges of the past year and how did the agency mitigate challenges? Note: 1,000-character limit.

The program needs more support with oversight and training. Last year we scheduled a shift supervisor on every shift, and this year we hired a Text Line Coordinator who will provide oversight, training, and supervisor. We hope to expand text line coverage to 16 hours/day by September 1st, 2022 and be 24 hours/ 7 days week by July 2025. The challenge will be to train enough volunteers to cover all the shifts, so we created a paid position called Text Line Counselor. Last year, we hired and trained a bi-lingual Spanish text line shift supervisor who will be able to respond to community members in Spanish during certain hours of the week. This part time position is funded by a Grant from Kaiser. The Spanish text line was utilized only 5 times. The supervisor has done targeted marketing to youth centers and Spanish speaking providers. She also spoke with a reporter from El Tecolote about our services.

Box F: Program lessons learned of the past year? Note: 1,000-character limit.

Young people and their family/support systems continue to impress us with their remarkable resilience and adaptability to an uncertain world during a global pandemic. Although our Text Line serves clients with a variety of struggles, several common themes that our texters have recently approached us about include psychological trauma, interpersonal challenges, and anxiety/stress regarding school. This year was particularly a challenging year for several clients, too, as many of them expressed feelings of isolation and anxiety due to the COVID-19 pandemic. Some youth texters also mentioned experiencing more family conflict because of the lockdown restrictions earlier in the year, along with difficulties focusing on online school

Box G: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
G.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e. mental health treatment services):	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):	NA
G.3: Types of treatment individuals were referred to (list types) (500-character limit):	Crisis stabilization units including: Amber House, Sally's Place, Mobile Crisis Unit, Children's Hospital, Willow Rock
G.4: Unduplicated number of individuals who participated in referred program at least one time:	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:	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):	Our program provides education about crisis resources available to community members. With client's consent, we warm handoff to clinics along the crisis continuum of care in Alameda County.

	Box I: For <u>Outreach, Suicide Prevention, and Stigma Reduction</u> programs, please provide information for unduplicated potential responders (i.e., those who are in a position to identify early signs of potentially severe mental illness provide support, and or refer individuals who need treatment) reached. ***(Note: For Prevention, Early Intervention, Access & Linkage programs, this section is optional.)***	
	Number of Responders:	**30**
	Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):
	Text Line Service	*18 text line counselors*
	Text Line Service	*9 staff members including shift supervisors, coordinators, and community educators*

MHSA Program #: PEI 12

PROVIDER NAME: Crisis Support Services of Alameda County (CSS)

PROGRAM NAME: Community Education Program

Program Outcomes & Impact: PEI Data Report FY 21/22

Program Name:	**Community Education Program**	
Organization:	Crisis Support Services of Alameda County (CSS)	
PEI Program # and Name:	PEI 12 Suicide Prevention-Crisis Support Services Suicide Prevention/Community Education-Crisis Support Services of Alameda County	
Type of Report (Choose one):	Annual	
PEI Category (choose one):	Suicide Prevention	
Priority Area (place and X next to all that apply):		Childhood Trauma
		Early Psychosis
	X	Youth/TAY Outreach and Engagement
		Cultural and Linguistic
		Older Adults
	X	Early Identification of Mental Health Illness

Box A: Please provide a brief program description (character limit 1,000).

The goal of our Community Education Program is to raise awareness that suicide is a national public health issue and that our community is a natural safety net for those that are vulnerable to suicide risk. Providing education and training increases knowledge of suicide warning signs, risk and protective factors, and how to help. Another goal is to eliminate the stigma associated with suicide by talking about this openly and increasing the comfort level of our community to engage and provide support.

Box B: Number of individuals served this fiscal year through MHSA funding.

Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	13,981

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:	100
Grand total of unduplicated individuals served:	**14081**

Box C: Demographics of individuals served this fiscal year through MHSA funding.

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	1063
Transition Age Youth (16-25 yrs.)	28
Adult (26-59 yrs.)	56
Older Adult (60+ yrs.)	4
Declined to answer	47
Unknown	12883
TOTAL	**14081**

SEXUAL ORIENTATION	
Gay/Lesbian	2
Heterosexual/Straight	47
Bisexual	1
Questioning/Unsure	1
Queer	
Declined to answer	6
Unknown	14021
Another group not listed	3
TOTAL	**14081**
If another group is counted, please specify:	

VETERAN STATUS	
Yes	1
No	57
Declined to answer	2
Unknown	14021
TOTAL	**14081**

CURRENT GENDER IDENTITY	
Female	42
Male	13
Transgender	
Genderqueer	1
Declined to answer	4
Unknown	14021
Another identity not listed	
TOTAL	**14081**
If another identity is counted, please specify:	

PRIMARY LANGUAGE	
English	52
Spanish	6
Cantonese	
Chinese	
Farsi	
Arabic	
Tagalog	
Declined to answer	
Unknown	14021
Another language not listed	
TOTAL	**14081**
If another language is counted, please specify:	

SEX ASSIGNED AT BIRTH	
Male	13
Female	43
Declined to answer	3
Unknown	14022
TOTAL	**14081**

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.)	2
Physical/mobility	3
Chronic health condition	1
Disability Subtotal	**6**
None	44
Declined to answer	8
Unknown	14022
Another disability not listed	1
TOTAL	**14081**
If another disability is counted, please specify:	

RACE	
American Indian or Alaska Native	1
Asian	6
Black or African American	6
Native Hawaiian or other Pacific Islander	14050
White	11
Other Race	3
Declined to answer	4
Unknown	
TOTAL	**14081**
If another race is counted, please specify: " More than one"	

Ethnicity/Cultural Heritage (Please choose only one per individual)	
If Hispanic or Latino, please specify:	
Caribbean	1
Central American	5
Mexican/Mexican American/Chicano	14
Puerto Rican	1
South American	2
Another Hispanic/Latino ethnicity not listed	2
Total Hispanic or Latino	**25**
If Non-Hispanic or Non-Latino, please specify:	
African	4
African American	4
Asian Indian/South Asian	2
Cambodian	
Chinese	1
Eastern European	2
European	8
Filipino	4
Japanese	
Korean	1
Middle Eastern	2
Vietnamese	1
Other Non-Hispanic or Non-Latino ethnicity not listed	5
Total Non-Hispanic or Non-Latino	**34**
More than one ethnicity	21
Unknown Ethnicity	13987
Declined to answer	14
EHTNICITY TOTAL	**14081**
If another ethnicity is counted, please specify:	

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of. Note: 1,000-character limit.
We had teachers that valued the impact of our programming that accommodated us virtually even though their stated preference was for us to come in person. We also had teachers that took that extra step to assist with Q&A engagement if their camera was not working, by letting our speakers know if there was a raised hand. We were able to present and engage more than one classroom at a time, which supported our capacity. We were able to gather pre-/post survey data and distribute TFL cards. While we spoke to our resources on our PowerPoint, youth having a tangible card to walk away with is ideal. This spring we created an internship position to host a peer guide through Chabot College. Her name is Marjorie Bartholome. She was tasked with a social media project aimed at increasing awareness on how to provide support to someone at suicidal risk, though the national #BeThe1To campaign.

Box E: Program challenges of the past year and how did the agency mitigate challenges? Note: 1,000-character limit.
Before the onset of the Covid19 pandemic, outreaching to primary care clinics and other healthcare settings in Alameda County was challenging partly due to the inherent nature of community health clinics being very busy and finding time for training. Many of our trainings frequently occurred during a time when a clinic was closed for lunch. In these 2 years of the pandemic, we hosted virtual presentations for health care providers nearly every month and on different days and times to attempt to reach our target population who were among the most important frontline workers against Covid19. A significant challenge was that while registration would be high at times for these workshops, attendance was about 50% or less. Other times, registration would be low, and would need to be cancelled. While attendance was low, we were heartened that healthcare workers were attending and using their time to receive the training.

Box F: Program lessons learned of the past year? Note: 1,000-character limit.
Our attention is also focused on continuing to learn more and adjust our trainings to reflect a cultural lens for suicide prevention. Among those changes include the following: 1) Recognizing that risk and protective factors need to be presented in a socio-ecological context. This model acknowledges that suicide is more than an individual issue and that external factors such as structural racism is a mechanism in producing disparities in risk, protective factors, and access to quality effective intervention among communities of color. 2) Utilizing the Cultural Model for Suicide that 3 principles which include, that culture affects the types of stressors that lead to suicide, and that culture affects how suicidal thoughts, intent, plans, and attempts. 3) We are also looking forward to hiring a Bilingual (Spanish-Speaking) community education trainer who's focus will be on parent engagement and a Bilingual (Spanish-speaking) TFL Health Educator.

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):	
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:	**13,669**
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):
Middle school/high school classrooms	*9899 youth*
School districts	*681 teachers, 48 school mental health counselors, 100 parents*
Community organizations	*1,011 service providers*
Health Care settings	*302 health care providers*
Correctional settings	*277 staff*
Community health fairs	*1196 attendees*
College settings	*6 faculty members, 149 college students*

MHSA Program #: PEI 12

PROVIDER NAME: Crisis Support Services of Alameda County (CSS)

PROGRAM NAME: Clinical Program

Program Outcomes & Impact: PEI Data Report FY 21/22

Program Name:	**Clinical Program**	
Organization:	Crisis Support Services of Alameda County (CSS)	
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
		Older Adults
	X	Early Identification of Mental Health Illness

Box A: Please provide a brief program description (character limit 1,000).

Our program provided individual, group, and family therapy to underserved members of Alameda County. We also provide critical incident stress debriefing following loss or traumatic events in the community. Our services are provided on a sliding scale, and no one is turned away for lack of funds. We receive referrals from a variety of community partners, including COST teams at our partner schools.

Box B: Number of individuals served during this fiscal year through MHSA funding.

Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	188
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:	130

Box C: Demographics of individuals served during this fiscal year through MHSA funding.

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	56
Transition Age Youth (16-25 yrs.)	30
Adult (26-59 yrs.)	30
Older Adult (60+ yrs.)	14
Declined to answer	
Unknown	
TOTAL	**130**

VETERAN STATUS	
Yes	
No	130
Declined to answer	
Unknown	
TOTAL	**130**

CURRENT GENDER IDENTITY	
Female	119
Male	41
Transgender	2
Genderqueer	
Questioning/unsure of gender identity	2
Declined to answer	7
Unknown	5
Another identity not listed	12
TOTAL	**188**
If another identity is counted, please specify:	

SEX ASSIGNED AT BIRTH	
Male	
Female	
Declined to answer	
Unknown	
TOTAL	**163**

SEXUAL ORIENTATION	
Gay/Lesbian	5
Heterosexual/Straight	90
Bisexual	9
Questioning/Unsure	3
Queer	5
Declined to answer	4
Unknown	63
Another group not listed	1
TOTAL	**188**
If another group is counted, please specify:	

PRIMARY LANGUAGE	
English	184
Spanish	4
Cantonese	
Chinese	
Vietnamese	
Farsi	
Arabic	
Tagalog	
Declined to answer	
Unknown	
Another language not listed	
TOTAL	**188**
If another language is counted, please specify:	

DISABILITY*** STATUS	
Communication Domain	
Vision	
Hearing/Speech	
Another type not listed	
Communication Domain Subtotal	**0**
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	
Physical/mobility	
Chronic health condition	
Disability Subtotal	**0**
None	
Declined to answer	
Unknown	188
Another disability not listed	
TOTAL	**188**
If another disability is counted, please specify:	

RACE	
American Indian or Alaska Native	3
Asian	11
Black or African American	41
Native Hawaiian or other Pacific Islander	5
White	62
Other Race	8
Declined to answer	
Unknown	53
TOTAL	**183**
If another race is counted, please specify:	

Ethnicity/Cultural Heritage (Please choose only one per individual)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	
Mexican/Mexican American/Chicano	
Puerto Rican	1
South American	
Another Hispanic/Latino ethnicity not listed	1
Total Hispanic or Latino	**15**
If Non-Hispanic or Non-Latino, please specify:	

African	
African American	4
Asian Indian/South Asian	
Cambodian	
Chinese	1
Eastern European	
European	3
Filipino	1
Japanese	
Korean	
Middle Eastern	
Vietnamese	
Other Non-Hispanic or Non-Latino ethnicity not listed	1
Total Non-Hispanic or Non-Latino	**10**
More than one ethnicity	3
Unknown Ethnicity	159
Declined to answer	1
EHTNICITY TOTAL	**188**
If another ethnicity is counted, please specify:	

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of. Note: 1,000-character limit.

This year we relaunched our survivor of suicide loss group, with a new curriculum and a focus on maintaining connections to loved ones. We also were able to offer this group in person, with COVID safe policies, due to the commitment of the facilitators. The group drew inspiration from John Jordan's Grief After Suicide and focused on the participants telling the stories of their loss, making meaning of the unique experience of suicide, and discussing the impact of cultural discourses related to suicide. The group was well attended, with eight members, and received positive responses from attendees. Due to the lack of suicide loss groups nationwide, the clinical program plans to develop this curriculum and offer it for free on our website in the hope other groups or agencies can also address this need more fully.

Box E: Program challenges of the past year and how did the agency mitigate challenges? Note: 1,000-character limit.

Our program continued to struggle with the restrictions due to COVID, particularly with regards to engaging our school aged clients and their families. This was most notable with our elementary aged youth. Our program offered services via telemedicine, but experienced significant improvements in engagement when school returned to in person instruction. The clinical program collaborated with the agency and with our interns to develop COVID safe practices and ensure as much safety as possible. The increase in frequency in person services across all clinical programs has had a significant impact on intern's positive engagement with clients and with the training environment. Telemedicine continues to be an option when needed, and our cloud based electronic health system allows interns to work remotely, but the return to office has resulted in more compliance with documentation.

Box F: Program lessons learned of the past year? Note: 1,000-character limit.

We have learned to be flexible and adaptive, such as transferring all documentation to our cloud-based system, re- creating Google forms of hard copies, and transferring some meetings to an online platform. We have also learned that remote learning provides significant barriers and that some interns require in person meetings. We have also realized that our clients can be adaptive as well, and can create community on virtual platforms, but that there continues to be a preference for in-person services across all age categories. There will likely be an ongoing need for both in person and virtual services, and so there will be additional trainings on telemedicine along with how to respond to stressors connected to the COVID pandemic.

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 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 once:	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:	**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 17A

PROVIDER NAME: Youth Uprising

PROGRAM NAME: Early Intervention

Program Outcomes & Impact: PEI Data Report FY 21/22

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
	X	Early Identification of Mental Health Illness

Box A: Please provide a brief program description (character limit 1,000).
Youth UpRising Wellness is providing prevention and early intervention counseling services to youth and TAY ages 14-24. We serve the entire Alameda County and have found that most of the youth utilizing our services are those attending schools or living in the East Oakland area. In addition to these services, youth can utilize the Youth UpRising facility where we have programming in visual arts, dance, multi-media and well as online/virtual workshops in these areas as well.

Box B: Number of individuals served this fiscal year through MHSA funding.	
Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	35
Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	30

Number of unduplicated individual family members served indirectly by your program:	11
Grand total of unduplicated individuals served:	**76**

Box C: Demographics of individuals served this fiscal year through MHSA funding.

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	9
Transition Age Youth (16-25 yrs.)	31
Adult (26-59 yrs.)	8
Older Adult (60+ yrs.)	3
Declined to answer	
Unknown	7
TOTAL	**58**

SEXUAL ORIENTATION	
Gay/Lesbian	
Heterosexual/Straight	15
Bisexual	6
Questioning/Unsure	1
Queer	
Declined to answer	
Unknown	25
Another group not listed	
TOTAL	**47**
If another group is counted, please specify:	

VETERAN STATUS	
Yes	
No	
Declined to answer	
Unknown	
TOTAL	

CURRENT GENDER IDENTITY	
Female	29
Male	12
Transgender	
Genderqueer	
Questioning/unsure of gender identity	1
Declined to answer	
Unknown	4
Another identity not listed	
TOTAL	**46**
If another identity is counted, please specify:	

PRIMARY LANGUAGE	
English	27
Spanish	11
Cantonese	
Chinese	
Vietnamese	
Farsi	
Arabic	
Tagalog	
Declined to answer	
Another language not listed	9
TOTAL	**47**
If another language is counted, please specify:	

SEX ASSIGNED AT BIRTH	
Male	
Female	
Declined to answer	
Unknown	
TOTAL	

DISABILITY*** STATUS	
Communication Domain	
Vision	
Hearing/Speech	1
Another type not listed	
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	
Physical/mobility	
Chronic health condition	1
Disability Subtotal	**1**
None	
Declined to answer	
Unknown	
Another disability not listed	
TOTAL	**27**
If another disability is counted, please specify:	

RACE	
American Indian or Alaska Native	
Asian	1
Black or African American	14
Native Hawaiian or other Pacific Islander	
Other Race	
Declined to answer	
Unknown	
TOTAL	**15**
If another race is counted, please specify:	

Ethnicity/Cultural Heritage (Please choose only one per individual)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	
Mexican/Mexican American/Chicano	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	
Eastern European	
European	
Filipino	
Japanese	
Korean	
Middle Eastern	
Vietnamese	
Other Non-Hispanic or Non-Latino ethnicity not listed	
Total Non-Hispanic or Non-Latino	
More than one ethnicity	
Unknown Ethnicity	
Declined to answer	
EHTNICITY TOTAL	**17**
If another ethnicity is counted, please specify:	

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of. Note: 1,000-character limit.
(1) We continue to strengthen our relationship with community partners, particularly with the COST team at Castlemont High School. When attending their weekly meetings, in addition to being a support to those youth that the school-based clinicians do not have the capacity to see, we have been able to share wellness programming ideas that have helped youth members in our center that the school is considering. (2) With the return to school we have found that many youth are struggling with re-socialization into crowds and often feeling unsafe when needing to come to us for their session. So, our clinicians walk over to Castlemont to meet them and then walk with them back to our center. Youth have been very reception to this process, and we will continue to do this if we see the need for youth support in this way. (3) We have seen an increase in youth who are utilizing our wellness services needing clothing. Given the pandemic and many places who have stopped services in this area, we have been giving gift cards to local stores so youth can purchase clothing.

Box E: Program challenges of the past year and how did the agency mitigate challenges? Note: 1,000-character limit.
Youth UpRising has experienced challenges around hiring, particularly a permanent hire for the Mental Health & Wellness Director role. To mitigate this challenge, we have hired a consultant in this role, and it has been working out very well. The consultant has provided great supervisorial support in addition to helping in our wellness programming. We've also had some challenges with getting groups started as youth have not been receptive to being in a crowd, while small, and sharing things they may be going through from a wellness perspective. What we have done in this area is collaborated with the UCSF/Castlemont Health Clinic for a Grief & Loss Group as they reached out requesting the partnership.

Box F: Program learned of the past year? Note: 1,000-character limit.
NA

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 referrals out for high service necessity. Clients have had high suicidality, been on juvenile probation, and/or had severe early childhood trauma. In addition, some clients are referred to therapists they already have.
G.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system):	3
G.3: Types of treatment individuals were referred to (list types):	Clients have predominantly been referred to Blue Shield. One client was referred to Alta Bates. Client on probation was referred to ACBH. Others were referred to Medi-Cal contracted CBO's.

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:	Unknown
G.6: Average number of days between referral and first participation in referred treatment program:	30

Box H: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
H.1: Who is/are the underserved target population(s) your program is serving (e.g. TAY, Southeast Asian) (500 Characters):	The uninsured population is the highest underserved population we are encountering. We are also serving the monolingual Spanish speaking community.
H.2: Number of paper referrals to an ACBH PEI-funded program:	
H.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	
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):	

Box I: For Outreach, Suicide Prevention, and Stigma Reduction programs, please provide information for unduplicated potential responders (i.e., those who are in a position to identify early signs of potentially severe mental illness provide support, and or refer individuals who need treatment) reached. ***(Note: For Prevention, Early Intervention, Access & Linkage programs, this section is optional.)***	
Number of Responders:	**NA**
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):

MHSA Program #: PEI 17B

PROVIDER NAME: REACH Ashland Youth Center

PROGRAM NAME: Early Intervention

Program Outcomes & Impact: PEI Data Report FY 21/22

Program Name:	**REACH Ashland Youth Center**	
Organization:	Alameda County- Center for Healthy Schools and Community	
PEI Program # and Name:	PEI 17B TAY Resource Center- REACH Ashland	
Type of Report (Choose one):	Annual	
PEI Category (choose one):	Early Intervention	
Priority Area (place and X next to all that apply):		Childhood Trauma
	X	Early Psychosis
	X	Youth/TAY Outreach and Engagement
		Cultural and Linguistic
		Older Adults
	X	Early Identification of Mental Health Illness

Box A: Please provide a brief program description (character limit 1,000).

REACH serves youth ages 11 through 24 who live throughout Alameda County with a focus on the Ashland and unincorporated areas, a community that is known for poverty, crime and chronic health conditions. We help our members overcome the immediate and prevalent obstacles in their lives by cultivating their own strengths and promise. In the process, they develop resiliency and the skills they need to take positive action and thrive, even amidst ongoing personal trauma and social disadvantage.

Box B: Number of individuals served this fiscal year through MHSA funding.

Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	22
Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	50

Number of unduplicated individual family members served indirectly by your program:	60
Grand total of unduplicated individuals served:	132

Box C: Demographics of individuals served this fiscal year through MHSA funding.

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	37
Transition Age Youth (16-25 yrs.)	41
Adult (26-59 yrs.)	
Older Adult (60+ yrs.)	
Declined to answer	
Unknown	1
TOTAL	**79**

VETERAN STATUS	
Yes	
No	
Declined to answer	
Unknown	79
TOTAL	**79**

CURRENT GENDER IDENTITY	
Female	48
Male	31
Transgender	
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	
Another identity not listed	
TOTAL	**79**
If another identity is counted, please specify:	

SEXUAL ORIENTATION	
Gay/Lesbian	
Heterosexual/Straight	
Bisexual	
Questioning/Unsure	
Queer	
Declined to answer	
Unknown	79
Another group not listed	
TOTAL	**79**
If another group is counted, please specify:	

PRIMARY LANGUAGE	
English	36
Spanish	14
Cantonese	
Chinese	
Vietnamese	
Farsi	3
Arabic	
Tagalog	
Declined to answer	
Unknown	26
Another language not listed	
TOTAL	**79**
If another language is counted, please specify:	

SEX ASSIGNED AT BIRTH	
Male	
Female	1
Declined to answer	
Unknown	78
TOTAL	**79**

DISABILITY*** STATUS	
Communication Domain	
Vision	
Hearing/Speech	
Another type not listed	
Communication Domain Subtotal	
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	
Physical/mobility	
Chronic health condition	
Disability Subtotal	
None	
Declined to answer	
Unknown	79
Another disability not listed	
TOTAL	**79**
If another disability is counted, please specify:	

RACE	
American Indian or Alaska Native	
Asian	3
Black or African American	30
Native Hawaiian or another Pacific Islander	
White	10
Other Race	31
Declined to answer	
Unknown	5
TOTAL	**79**

If another race is counted, please specify:
Another Race reflects youth who identified their race as Latinx (but not as white, multiracial, or another race) as well as youth identified as multiracial/mixed race.

Ethnicity/Cultural Heritage (Please choose only one per individual)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	
Mexican/Mexican American/Chicano	
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	
Total Hispanic or Latino	
If Non-Hispanic or Non-Latino, please specify:	
African	
African American	27

Asian Indian/South Asian	
Cambodian	
Chinese	
Eastern European	
European	2
Filipino	2
Japanese	
Korean	
Middle Eastern	3
Vietnamese	
Other Non-Hispanic or Non-Latino ethnicity not listed	1
Total Non-Hispanic or Non-Latino	**35**
More than one ethnicity	7
Unknown Ethnicity	6
Declined to answer	
EHTNICITY TOTAL	**79**
If another ethnicity is counted, please specify: Another Hispanic/Latino ethnicity=people who did not specify their ethnicity in more detail than Latinx.	

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of. Note: 1,000-character limit.
We continue to provide in-person stable groups for youth despite the increase in COVID cases and the new variant. Additionally, we have started to host community event (outdoors) to celebrate youth graduations, Dia de Los Muertos and community health fairs including a push to get community members to get vaccinated and boosted. We were able to collaborate with CBOs and reach various segments of the community that were weary to get vaccinated. We have continued bi-monthly food distribution and have added fresh vegetable options for our community. We have seen a significant increase in food needs.

Box E: Program challenges of the past year and how did the agency mitigate challenges? Note: 1,000-character limit.
The ever-changing guidelines for COVID continue to be challenging. At times, we have also struggled with staff capacity and pandemic fatigue. We normalize the ever-changing guidelines and protocols and increase transparency on why guidelines need to be followed. We have shifted staff around to provide support in different capacities and encourage staff to engage in self-care and take the necessary time off. Increase and prioritize appreciations in staff meeting

Box F: Program lessons learned of the past year? Note: 1,000-character limit.
We have learned that our youth and family screeners will need to be updated to correlate services specific to support provided at REACH and outside referrals. We are also looking into our data system to create increased accountability with documentation. We will closely with internal technical support as well as the data vendor.

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):	50
G.3: Types of treatment individuals were referred to (list types) (500-character limit):	Individual therapy, family therapy, housing including shelters, and educational services
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:	3.9
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 age youth (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:	60
H.4: Average number of days between referral and first participation in referred PEI program:	3.7
H.5: Describe how your program encouraged access to services and follow through on above referrals (500 Characters):	We have increased our outreach services by promoting on the organization various social media platforms, as well as during community events.

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 1F

PROVIDER NAME: East Bay Agency for Children

PROGRAM NAME: Fremont Healthy Start Program

Program Outcomes & Impact: PEI Data Report FY 21/22

Program Name:	**Fremont Healthy Start Program**	
Organization:	East Bay Agency for Children	
PEI Program # and Name:	PEI 1F Fremont Healthy Start	
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).
East Bay Agency for Children's (EBAC) Fremont Healthy Start Program engages, encourages, and trains potential community responders, primarily family members of youth and children but also school staff and community members, about ways to recognize and respond to early signs of mental illness.

Box B: Number of individuals served this fiscal year through MHSA funding.	
Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	204
Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	41
Number of unduplicated individual family members served indirectly by your program:	321
Grand total of unduplicated individuals served:	566

Box C: Demographics of individuals served this fiscal year through MHSA funding.

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	
Transition Age Youth (16-25 yrs.)	16
Adult (26-59 yrs.)	138
Older Adult (60+ yrs.)	91
Declined to answer	
Unknown	
TOTAL	**245**

VETERAN STATUS	
Yes	1
No	98
Declined to answer	
Unknown	146
TOTAL	**245**

CURRENT GENDER IDENTITY	
Female	134
Male	55
Transgender	
Genderqueer	1
Questioning/unsure of gender identity	
Declined to answer	
Unknown	55
Another identity not listed	
TOTAL	**245**
If another identity is counted, please specify:	

SEX ASSIGNED AT BIRTH	
Male	75
Female	170
Declined to answer	
Unknown	
TOTAL	**245**

SEXUAL ORIENTATION	
Gay/Lesbian	1
Heterosexual/Straight	188
Bisexual	
Questioning/Unsure	
Queer	
Declined to answer	
Unknown	56
Another group not listed	
TOTAL	**245**
If another group is counted, please specify:	

PRIMARY LANGUAGE	
English	70
Spanish	70
Cantonese	11
Chinese	3
Vietnamese	1
Farsi	9
Arabic	
Tagalog	
Declined to answer	
Unknown	
Another language not listed	21
TOTAL	**188**
If another language is counted, please specify:	

DISABILITY*** STATUS	
Communication Domain	
Vision	
Hearing/Speech	
Another type not listed	
Communication Domain Subtotal	**0**
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	
Physical/mobility	4
Chronic health condition	11
Disability Subtotal	**3**
None	83
Declined to answer	
Unknown	
Another disability not listed	3
TOTAL	**104**
If another disability is counted, please specify:	

RACE	
American Indian or Alaska Native	1
Asian	2
Black or African American	44
Native Hawaiian or other Pacific Islander	
White	1
Other Race	11
Declined to answer	224
Unknown	
TOTAL	**283**
If another race is counted, please specify:	

Ethnicity/Cultural Heritage (Please choose only one per individual)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	1
Mexican/Mexican American/Chicano	5
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	
Total Hispanic or Latino	**6**
If Non-Hispanic or Non-Latino, please specify:	
African	2
African American	34
Asian Indian/South Asian	
Cambodian	1
Chinese	
Eastern European	
European	2
Filipino	
Japanese	
Korean	
Middle Eastern	
Vietnamese	1
Other Non-Hispanic or Non-Latino ethnicity not listed	2
Total Non-Hispanic or Non-Latino	42
More than one ethnicity	14
Unknown Ethnicity	
Declined to answer	221
EHTNICITY TOTAL	283
If another ethnicity is counted, please specify:	

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of. Note: 1,000-character limit.
"Mr. Omar" arrived recently from Afghanistan with 4 children ages 3-12 and his wife. As the Family Resource was assessing his situation, she realized the children were not in school. She added school enrollment as a goal for the family after explaining that it is against the law for children to not attend school. Mr. Omar broke down when he heard this because he did not know how he could even think about school when he did not even know if he would have a place for his family to live. He explained that as the father, it was his responsibility to be the provider. He shared that ever since the family arrived in the United States, he has not stopped worrying, he did not have a car, he was unfamiliar with the area, and he spoke little English. He clearly was experiencing a great deal of anxiety. Our Family Resource Specialist spent 2.5 hours with Mr. Omar reviewing all of his needs. Our staff informed him that they would call the case worker in charge of immigration to follow-up with his case. We also assured him that we would help meet the family's basic needs such as health insurance, clothing, and food. That day he went home with hope. Our Family Resource Specialist immediately called the case worker and was provided with the information Mr. Omar needed. Our staff also began resource stabilization, the first step in an ongoing process to support this family. Building rapport and having success help to create a positive experience that then leads to further goals on family wellness.
Box E: Program challenges of the past year and how did the agency mitigate challenges? Note: 1,000-character limit.
There continues to be a lack of counseling services available in Dari, Pashto, Urdu, and Punjabi, resulting in long delays for people seeking mental health services. In some cases, clients do not show interest in receiving mental health support because their other needs take precedence. Our staff explain to these clients the various ways to take care of their health when clients share that they are experiencing anxiety or depression. Working families are ineligible for services such as rental assistance, which exacerbates serious mental health issues. Encounters with Afghan refugees are time-consuming because of the issues and needs that they have. This adds stress on staff as they are part-time. Staff also experience vicarious trauma.
Box F: Program lessons learned of the past year? Note: 1,000-character limit.
We have learned that patience is key, and boundaries are necessary. We also have learned that everyone who visits our program has an expectation to receive something tangible from their encounter. This can be an appointment, for example, but must be more than simply a business card with a telephone number. Staff taking the initiative to call people is much more helpful, positive, and impactful for those seeking 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):	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 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 TAY
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):	Our work is predicated on the specific niche of making music. If there is a red flag or an incident that unearths emergent needs, we support youth in the moment and facilitate reconnecting with existing support workers, or we will arrange support.

Box I: For Outreach, Suicide Prevention, and Stigma Reduction programs, please provide information for unduplicated potential responders (i.e., those who are in a position to identify early signs of potentially severe mental illness provide support, and or refer individuals who need treatment) reached. ***(Note: For Prevention, Early Intervention, Access & Linkage programs, this section is optional.)***

Number of Responders:	**206**
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):
Fremont Healthy Start Program office	Parents, caregivers, general community members
Fremont Family Resource Center Welcome Center	Parents, caregivers, general community members
Schools	School staff, teachers, parents, caregivers
Client's Homes	Parents, caregivers, general community members

MHSA Program #: PEI 20A

PROVIDER NAME: Beats, Rhymes, and Life (BRL)

PROGRAM NAME: Beats, Rhymes, and Life

Program Outcomes & Impact: PEI Data Report FY 21/22

Program Name:	**Beats Rhymes and Life (BRL)**	
Organization:	BEATS RYHMES AND LIFE, INC.	
PEI Program # and Name:	PEI 20A culturally responsive PEI programs for African American Comm.-Beats, Rhymes and Life	
Type of Report (Choose one):	Annual	
PEI Category (choose one):	Prevention	
Priority Area (place and X next to all that apply):		Childhood Trauma
		Early Psychosis
	X	Youth/TAY Outreach and Engagement
	X	Cultural and Linguistic
		Older Adults
		Early Identification of Mental Health Illness

Box A: Please provide a brief program description (character limit 1,000).

Box B: Number of individuals served this fiscal year through MHSA funding.

Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	283
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:	283

Box C: Demographics of individuals served this fiscal year through MHSA funding.

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	87
Transition Age Youth (16-25 yrs.)	168
Adult (26-59 yrs.)	
Older Adult (60+ yrs.)	
Declined to answer	27
Unknown	
TOTAL	**283**

VETERAN STATUS	
Yes	2
No	59
Declined to answer	222
Unknown	
TOTAL	**283**

CURRENT GENDER IDENTITY	
Female	13
Male	28
Transgender	
Genderqueer	2
Questioning/unsure of gender identity	
Declined to answer	220
Unknown	
Another identity not listed	
TOTAL	**263**
If another identity is counted, please specify:	

SEX ASSIGNED AT BIRTH	
Male	29
Female	14
Declined to answer	220
Unknown	
TOTAL	**263**

SEXUAL ORIENTATION	
Gay/Lesbian	3
Heterosexual/Straight	41
Bisexual	9
Questioning/Unsure	1
Queer	1
Declined to answer	228
Unknown	
Another group not listed	1
TOTAL	**283**
If another group is counted, please specify:	

PRIMARY LANGUAGE	
English	62
Spanish	1
Cantonese	
Chinese	
Vietnamese	
Farsi	
Arabic	
Tagalog	
Declined to answer	220
Unknown	
Another language not listed	
TOTAL	**283**
If another language is counted, please specify:	

DISABILITY*** STATUS	
Communication Domain	
Vision	2
Hearing/Speech	
Another type not listed	
Communication Domain Subtotal	**2**
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	2
Physical/mobility	
Chronic health condition	1
Disability Subtotal	**3**
None	29
Declined to answer	222
Unknown	
Another disability not listed	7
TOTAL	**263**
If another disability is counted, please specify:	

RACE	
American Indian or Alaska Native	1
Asian	2
Black or African American	44
Native Hawaiian or other Pacific Islander	
White	1
Other Race	11
Declined to answer	224
Unknown	
TOTAL	**283**
If another race is counted, please specify:	

Ethnicity/Cultural Heritage (Please choose only one per individual)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	1
Mexican/Mexican American/Chicano	5
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	
Total Hispanic or Latino	**6**
If Non-Hispanic or Non-Latino, please specify:	
African	2
African American	34
Asian Indian/South Asian	
Cambodian	1
Chinese	
Eastern European	
European	2
Filipino	
Japanese	
Korean	
Middle Eastern	
Vietnamese	1
Other Non-Hispanic or Non-Latino ethnicity not listed	2
Total Non-Hispanic or Non-Latino	**42**
More than one ethnicity	14
Unknown Ethnicity	
Declined to answer	221
EHTNICITY TOTAL	**283**
If another ethnicity is counted, please specify:	

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of. Note: 1,000-character limit.
Felt proudest about establishing strong relationships with MET WEST Oakland High School and in particular Oakland School for the Arts. OSA opened opportunities to engage with large numbers of their youth through engagements with their assemblies, therapeutic activity groups, and mental Health awareness presentations, with their middle school and High school aged students. We also have had continued success building with school faculty and stakeholders through coordination of services teams (COST).

Box E: Program challenges of the past year and how did the agency mitigate challenges? Note: 1,000-character limit.
Covid protocols caused our agency to rely mostly on online engagement through zoom. Though youth prefer to meet in person we were able to provide training to staff regarding online engagement tools to increase participation. We adapted artist skill building activities for online engagement via zoom. During the second of the fiscal year, we restarted some in person opportunities and transitioned to hybrid models thereafter.

Box F: Program lessons learned of the past year? Note: 1,000-character limit.
We were able to actualize a stronger strategy to increase participation by coordinating all engagements in a way where they all funnel youth into actual program in one of our various intervention models (1:1 individual therapy, life skills workshops, therapeutic activity groups and mental health awareness presentations and workforce development for high school alum).

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):	African American TAY
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):	Our work is predicated on the specific niche of making music. If there is a red flag or an incident that unearths emergent needs, we support youth in the moment and facilitate reconnecting with existing support workers, or we will arrange support.

Box I: For Outreach, Suicide Prevention, and Stigma Reduction programs, please provide information for unduplicated potential responders (i.e., those who are in a position to identify early signs of potentially severe mental illness provide support, and or refer individuals who need treatment) reached. ***(Note: For Prevention, Early Intervention, Access & Linkage programs, this section is optional.)***

Number of Responders:	**NA**
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):
Met West	Students staff counselors and teachers
Oakland School for the Arts	Students staff counselors and teachers
Youth Employment Services	Students staff counselors and teachers
Private Industry Council	Students staff counselors and teachers
Unity Council	Students staff counselors and teachers

T.U.P.E.	Students staff counselors and teachers
Berkeley College Underground Scholars Initiative	Students staff counselors and teachers
Chabot College	Students staff counselors and teachers
First Place for Youth	Students staff counselors and teachers
Westcoast Clinic	Students staff counselors and teachers
OUSD Credit Academic Recovery	Students staff counselors and teachers
UCSF Oakland Children's Hospital	Students staff counselors and teachers
ACBH Crisis Services	Students staff counselors and teachers
Castlemont	Students staff counselors and teachers

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 21/22

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 reduces stigma and discrimination against people with MH experiences by empowering African Americans to share their personal stories of hope and recovery in our community.

Box B: Number of individuals served this fiscal year through MHSA funding.	
Number of unduplicated individuals your program served who are at-risk of developing serious mental illness:	9985
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:	**9985**

Box C: Demographics of individuals served this fiscal year through MHSA funding.

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	1000
Transition Age Youth (16-25 yrs.)	
Adult (26-59 yrs.)	2500
Older Adult (60+ yrs.)	1500
Declined to answer	
Unknown	4985
TOTAL	**9985**

VETERAN STATUS	
Yes	
No	
Declined to answer	
Unknown	9985
TOTAL	**9985**

CURRENT GENDER IDENTITY	
Female	3600
Male	2200
Transgender	
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	945
Unknown	3240
Another identity not listed	
TOTAL	**9985**
If another identity is counted, please specify:	

SEX ASSIGNED AT BIRTH	
Male	3500
Female	2385
Declined to answer	1517
Unknown	2583
TOTAL	**9985**

SEXUAL ORIENTATION	
Gay/Lesbian	
Heterosexual/Straight	
Bisexual	
Questioning/Unsure	
Queer	
Declined to answer	
Unknown	9985
Another group not listed	
TOTAL	**9985**
If another group is counted, please specify:	

PRIMARY LANGUAGE	
English	5500
Spanish	1000
Cantonese	
Chinese	
Vietnamese	100
Farsi	
Arabic	
Tagalog	
Declined to answer	
Unknown	3385
Another language not listed	
TOTAL	**9985**
If another language is counted, please specify:	

DISABILITY*** STATUS	
Communication Domain	
Vision	
Hearing/Speech	
Another type not listed	
Communication Domain Subtotal	**0**
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	
Physical/mobility	
Chronic health condition	
Disability Subtotal	**0**
None	
Declined to answer	
Unknown	9985
Another disability not listed	
TOTAL	**9985**
If another disability is counted, please specify:	

RACE	
American Indian or Alaska Native	
Asian	
Black or African American	
Native Hawaiian or other Pacific Islander	
White	
Other Race	
Declined to answer	
Unknown	9985
TOTAL	**9985**
If another race is counted, please specify:	

Ethnicity/Cultural Heritage (Please choose only one per individual)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	
Mexican/Mexican American/Chicano	3300
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	
Total Hispanic or Latino	**3300**
If Non-Hispanic or Non-Latino, please specify:	
African	
African American	4400
Asian Indian/South Asian	
Cambodian	
Chinese	
Eastern European	
European	
Filipino	150
Japanese	
Korean	
Middle Eastern	
Vietnamese	
Other Non-Hispanic or Non-Latino ethnicity not listed	
Total Non-Hispanic or Non-Latino	**4550**
More than one ethnicity	
Unknown Ethnicity	2135
Declined to answer	
EHTNICITY TOTAL	**9985**
If another ethnicity is counted, please specify:	

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of. Note: 1,000-character limit.
We have partnered with the Wendell Al Amin Show. Speakers do live interviews, share their stories, which are filmed and televised. Also, we have had success in events at DeFermery Park with more speaker participation. We are also participated in outreach by delivering food boxes to homebound and disabled members. Held December Toy Give Away at Love Center Baptist Church and gave coats away on 5th St. in West Oakland. BMS Had great success joining in Fruitvale Day of the Dead Celebration. We participated in POCC program at Ashby Bart to provide information and speakers. More speaking engagements this quarter. Joined Inner City Youth & R-Entry Council of CA. community Benefit program. BMS also participated in POCC Conference with a tour of Alcatraz Prison, ending with the national conference at Oakland Hilton. BMS sponsored an event at Meeks State Park, providing mental health information and support to the Hayward community.

Box E: **Program challenges of the past year and how did the agency mitigate challenges? Note: 1,000-character limit.**
BMS (Black Men Speak) challenges have been around meeting our required speaking engagements due to COVID19 restrictions. We embraced Zoom meetings as a way of completing some deliverables. As things opened and some restrictions removed, we have had more success in getting survey information by hosting outdoor events. We are continuing to develop plans to have an engagement at Santa Rite Jail and Alameda County Juvenile Facility. We have opened our members to give feedback and what their expectations are for Black Men Speak, Inc.

Box F: Program lessons learned of the past year? Note: 1,000-character limit.
We adapted to a new way of fulfilling our deliverables by using Zoom, for our program to continue 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, POCC, BOP, REACH, and Boss we have continued to increase visibility of BMS and empowerment in target populations in different ways. Through BMS presentations we have seen much support of men released from incarceration including employment, housing, and self-sufficiency in the current Quarter we have not had to use Zoom to do our deliverables as many places have opened up as we provided our services outside.

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) you 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):	We encourage access to services by giving referrals for housing, employment, and mental health counseling with warm handoffs.

Box I: For <u>Outreach, Suicide Prevention, and Stigma Reduction</u> programs, please provide information for unduplicated potential responders (i.e., those who are in a position to identify early signs of potentially severe mental illness provide support, and or refer individuals who need treatment) reached. ***(Note: For Prevention, Early Intervention, Access & Linkage programs, this section is optional.)***	
Number of Responders:	**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 20C

PROVIDER NAME: MHAAC

PROGRAM NAME: Culturally Responsive Programs for African Americans – Family Outreach Program

Program Outcomes & Impact: PEI Data Report FY 21/22

Program Name:	**African American Family Outreach Program**	
Organization:	Mental Health Association of Alameda County (MHAAC)	
PEI Program # and Name:	PEI 20C Culturally Responsive PEI Programs for African American Community - Family Outreach	
Type of Report (Choose one):	Annual	
PEI Category (choose one):	Outreach	
Priority Area (place and X next to all that apply):		Childhood Trauma
		Early Psychosis
		Youth/TAY Outreach and Engagement
	X	Cultural and Linguistic
		Older Adults
		Early Identification of Mental Health Illness

Box A: Please provide a brief program description (character limit 1,000).

MHAAC provides five workshops for African American families. Workshops engage family members and provide professional and peer support to families helping their loved ones living with mental health conditions. Family members receive information about mental health/specific mental health disorders, information about services throughout alameda county for individuals with mental health and/or substance use disorder and are made aware of the importance of self-care to reduce stress.

Box B: Number of individuals served this fiscal year through MHSA funding.

Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	NA

Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	NA
Number of unduplicated individual family members served indirectly by your program:	207
Grand total of unduplicated individuals served:	**207**

Box C: Demographics of individuals served this fiscal year through MHSA funding.

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	
Transition Age Youth (16-25 yrs.)	1
Adult (26-59 yrs.)	49
Older Adult (60+ yrs.)	75
Declined to answer	
Unknown	82
TOTAL	**207**

SEXUAL ORIENTATION	
Gay/Lesbian	
Heterosexual/Straight	
Bisexual	
Questioning/Unsure	
Queer	
Declined to answer	
Unknown	207
Another group not listed	
TOTAL	**207**
If another group is counted, please specify:	

VETERAN STATUS	
Yes	
No	
Declined to answer	
Unknown	207
TOTAL	**207**

CURRENT GENDER IDENTITY	
Female	105
Male	17
Transgender	
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	84
Another identity not listed	1
TOTAL	**207**
If another identity is counted, please specify:	

PRIMARY LANGUAGE	
English	122
Spanish	
Cantonese	
Chinese	
Vietnamese	
Farsi	
Arabic	
Tagalog	
Declined to answer	85
TOTAL	**207**
If another language is counted, please specify:	

SEX ASSIGNED AT BIRTH	
Male	
Female	
Declined to answer	
Unknown	207
TOTAL	**207**

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	207
Another disability not listed	
TOTAL	**207**
If another disability is counted, please specify:	

RACE	
American Indian or Alaska Native	1
Asian	
Black or African American	100
Native Hawaiian or other Pacific Islander	
White	1
Other Race	3
Declined to answer	
Unknown	102
TOTAL	**207**
If another race is counted, please specify:	

Ethnicity/Cultural Heritage (Please choose only one per individual)	
If Hispanic or Latino, please specify:	
Caribbean	1
Central American	
Mexican/Mexican American/Chicano	3
Puerto Rican	1
South American	
Another Hispanic/Latino ethnicity not listed	6
Total Hispanic or Latino	**14**
If Non-Hispanic or Non-Latino, please specify:	
African	14
African American	86
Asian Indian/South Asian	3
Cambodian	1
Chinese	
Eastern European	
European	1
Filipino	
Japanese	
Korean	
Middle Eastern	
Vietnamese	
Other Non-Hispanic or Non-Latino ethnicity not listed	5
Total Non-Hispanic or Non-Latino	**110**
More than one ethnicity	
Unknown Ethnicity	91
Declined to answer	
EHTNICITY TOTAL	**207**
If another ethnicity is counted, please specify:	

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of. Note: 1,000-character limit.

In FY 21-22 AAFOP conducted five outreach workshops on Zoom for African American families. The program successfully achieved a record 60% participant evaluation survey response. Results indicated that an average of 98% of the respondents were adult/older-adult and an average of 82% of the respondents identified as Black or African American. The success of the five workshops was reflected: 98% of respondents found the presentations useful: a participant commented: "I really enjoyed the Workshop and there was a lot of content I did not know." An average of 100% of respondents found the presenters were accessible and had skillfully answered questions. An average of 98% of respondents rated the registration process a 9+ out of 10 (best experience); an average of 98% of the respondents rated the overall workshop 9+ out of 10 (best experience). The program was highly successful in garnering community feedback which informed choice of presenters and was shared with ACBH.

Box E: Program challenges of the past year and how did the agency mitigate challenges? Note: 1,000-character limit.

The program implemented a re-design in 2022 with the goal of enhancing the warmth and safety of the workshops. An "I see you" grounding piece and a poetry reading were added to each workshop. A clinician was piloted in the February workshop. She held a breakout support room for participants who desired consultation on current issues. Although our total workshop attendance did not change from FY 2020-21, we felt challenged by promoting the workshops. To mitigate this, the program hired a local African American PR Firm to promote the February 5th workshop. The result of this promotion increased the average workshop attendance (33 participants) by 57%. Although this solution was successful, we found it not sustainable due to cost. We anticipate this outreach issue will be mitigated by the increased staffing for the program in FY 2022-23. Finally, the program was challenged in attracting a gender diverse participant cohort across the year. We look forward to mitigating this in FY 2022-23.

Box F: Program lessons learned of the past year? Note: 1,000-character limit.

The program learned that the efforts we implemented (at the end of quarter 2) to make the zoom workshop a positive experience for participants were successful (98% zoom high satisfaction rate from evaluations). A second lesson learned came from our pilot of including a clinician during the February workshop for urgent consultations. 5% of attendees utilized this resource. The clinician reported the strategy was not effective: no crises were brought forward. We learned that a re-thinking of our use of the clinician is needed. We also learned that the community is very concerned about the grievance process for their loved ones, especially for those living in licensed Board and Care residences. AAFOP will partner with the MHAAC Grievance program to address this in FY 2022-23. Finally, we learned that across the year, 42% of our participants had loved ones living with both MI and SUD. We will address this need in FY 2022 – 23.

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)	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 program:	NA
G.3: Types of treatment individuals were referred to (list types)	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)	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:	**53**
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):
Zoom workshop, October 9, 2021	*Executive director; FERC Director; 3 Presenters; FERC Outreach Coordinator; 4 volunteers*
Zoom workshop, November 20, 2021	*Executive director; FERC Director; 2 Presenters; FERC Outreach Coordinator; 4 volunteers*
Zoom workshop, February 5, 2022	*Executive director; FERC Director; 2 Presenters; FERC Outreach Coordinator; 4 volunteers*
Zoom workshop, April 23, 2022	*FERC Director, 1 presenter, FERC Outreach Coordinator; 4 volunteers*
Zoom workshop, June 25, 2022	*Executive director; FERC director; 1 presenter, 4 panelists; FERC Outreach Coordinator; 4 volunteers*

MHSA Program #: PEI 20F

PROVIDER NAME: RJOY

PROGRAM NAME: Culturally Responsive Programs for African Americans – Africentric Healing Circles

Program Outcomes & Impact: PEI Data Report FY 21/22

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).

The RJOY African American Healing Circles Program provides culturally responsive mental health support to individuals in Alameda County. The circles draw on indigenous and Africentric healing practices in combination with the ACBH MHSA Prevention and Early Intervention (PEI) plan. Healing Circles explore community, celebration, mental health, social justice, racial justice and other systemic issues in an affinity group format.

Box B: Number of individuals served this fiscal year through MHSA funding.

Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	5
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:	25
Grand total of unduplicated individuals served:	**35**

Box C: Demographics of individuals served this fiscal year through MHSA funding.

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	8
Transition Age Youth (16-25 yrs.)	43
Adult (26-59 yrs.)	83
Older Adult (60+ yrs.)	24
Declined to answer	
Unknown	822
TOTAL	**980**

SEXUAL ORIENTATION	
Gay/Lesbian	5
Heterosexual/Straight	38
Bisexual	2
Questioning/Unsure	
Queer	7
Declined to answer	106
Unknown	822
Another group not listed	
TOTAL	**980**
If another group is counted, please specify:	

VETERAN STATUS	
Yes	
No	
Declined to answer	
Unknown	822
TOTAL	**822**

CURRENT GENDER IDENTITY	
Female	90
Male	66
Transgender	
Genderqueer	2
Questioning/unsure of gender identity	
Declined to answer	
Unknown	822
Another identity not listed	
TOTAL	**980**
If another identity is counted, please specify:	

PRIMARY LANGUAGE	
English	156
Spanish	1
Cantonese	
Chinese	
Vietnamese	
Farsi	
Arabic	
Tagalog	
Declined to answer	
Unknown	822
Another language not listed	1
TOTAL	**980**
If another language is counted, please specify:	

SEX ASSIGNED AT BIRTH	
Male	66
Female	90
Declined to answer	2
Unknown	822
TOTAL	**980**

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	980
Another disability not listed	
TOTAL	**980**
If another disability is counted, please specify:	

RACE	
American Indian or Alaska Native	1
Asian	20
Black or African American	800
Native Hawaiian or other Pacific Islander	1
White	64
Other Race	94
Declined to answer	
Unknown	107
TOTAL	**980**
If another race is counted, please specify: In RJOY's data collection efforts, some respondents have listed Latinx under race.	

Ethnicity/Cultural Heritage (Please choose only one per individual)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	
Mexican/Mexican American/Chicano	76
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	
Total Hispanic or Latino	**76**

If Non-Hispanic or Non-Latino, please specify:	
African	
African American	800
Asian Indian/South Asian	
Cambodian	
Chinese	20
Eastern European	
European	64
Filipino	
Japanese	
Korean	
Middle Eastern	1
Vietnamese	
Other Non-Hispanic or Non-Latino ethnicity not listed	2
Total Non-Hispanic or Non-Latino	**887**
More than one ethnicity	8
Unknown Ethnicity	9
Declined to answer	
EHTNICITY TOTAL	**980**

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of. Note: 1,000-character limit.

Despite the impact of Covid 19 on the mental, physical, and emotional well-being of RJOY Circle participants we were able to engage them through events and discussions that explored the range of responses to issues they currently face. During events participants often expressed joy and optimism for the future, while they may have felt differently months or weeks prior. In addition, for participants living in racially marginalized bodies, the circles offer a place of safety and belonging. For example, we had a successful Youth Circle with EOYDC that created a space for young people to express themselves through art and restorative justice. They looked forward to spending time with us each week. The structure provided a space to express challenges particular to young people and personal conflicts. The Circle was led by RJOY youth leaders and supported by adult staff.

Box E: Program challenges of the past year and how did the agency mitigate challenges? 1,000-character limit.

Circle participants continue to express feeling isolated and overwhelmed by the pandemic, community violence, housing, and food insecurity. We have been able to cast a wide net for outreach virtually. Some participants are eager to gather in person, while others remain hesitant. To best support mental health and social needs, we share resources and information through emails, social media, and community bulletins. We also partner with Black led organizations. For example, we have utilized the poll, question, and insert link feature on Instagram to connect with the community and direct them to the RJOY website along with Circle descriptions. Staff frequently attend Instagram and Twitter livestreams.

Box F: Program lessons learned of the past year? Note: 1,000-character limit.

Participants who have attended RJOY Circles, events, and trainings feel connected to the organization and each other. In addition, they are often interested in leading and supporting restorative Circles engaged in Indigenous and Africentric forms of healing. Furthermore, participants want and need strategies for self-development and healing to break generational patterns and interrupt community violence. Through participant feedback we have learned that despite the systemic and technological challenges, there is a deep yearning to connect. Participants express continued interest in ancestral healing and developing strategies to address mental health and trauma in their daily lives. In combination with healing circles, participants receive holistic care that addresses mental health, food insecurity, and other pressing needs. Providing these resources gives participants a better outlook on life and illustrates the possibilities for positive outcomes.

Box G: **For programs that refer individuals with severe mental illness, please provide information for the categories below:**	
G.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e. mental health treatment services):	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):	5
G.3: Types of treatment individuals were referred to (list types):	Family Therapy, Individual Therapy, and Substance Abuse Treatment
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:	1
G.6: Average number of days between referral and first participation in referred program:	5-7

Box H: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
H.1: Who is/are the underserved target population(s) your program is serving (e.g. TAY, Southeast Asian) (500 Characters):	The healing circles predominantly serve people of African descent, but all are welcome to participate. We have seen an increase in middle school-aged youth ranging from 12-14 with the development of the Black Boys Circle.
H.2: Number of paper referrals to an ACBH PEI-funded program:	11
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:	3-5
H.5: Describe how your program encouraged access to services and follow through on above referrals (500 Characters):	Circle keepers frequently advise participants about multiple referral opportunities and how participants can access services. Such announcements and information is given at the beginning and end of each group.

Box I: For <u>Outreach, Suicide Prevention, and Stigma Reduction</u> programs, please provide information for unduplicated potential responders (i.e., those who are in a position to identify early signs of potentially severe mental illness provide support, and or refer individuals who need treatment) reached. ***(Note: For Prevention, Early Intervention, Access & Linkage programs, this section is optional.)***	
Number of Responders:	**NA**
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):

MHSA Program #: PEI 20E

PROVIDER NAME: Tri Cities Community Development Center

PROGRAM NAME: Culturally Responsive Programs for African Americans – Faith Based

Program Outcomes & Impact: PEI Data Report FY 21/22

Program Name:	**Culturally Responsive Programs for African Americans – Faith Based**	
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):	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).

MHFC is a community best practice program that provides a bridge to connect the spiritual and clinical approach to mental health to eliminate stigma and discrimination and to improve outcomes for African American consumers and family members residing in Alameda County utilizing a faith-based strategy to harness the invaluable and historical role of faith in the African American Community. The Core principles of a Mental Health Friendly Communities Congregation is embodied in the Ten Commitments of a Mental Health Friendly Congregation. The MHFC Training Team works collaboratively the African American Faith leaders, their congregations/communities of faith and community stakeholders to dispel myths, build trust and relationships to provide culturally responsive services and partnerships to better serve African American consumers and family members.

Box B: Number of individuals served this fiscal year through MHSA funding.

Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	89
Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	70
Number of unduplicated individual family members served indirectly by your program:	350
Grand total of unduplicated individuals served:	**509**

Box C: Demographics of individuals served this fiscal year through MHSA funding.

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	35
Transition Age Youth (16-25 yrs.)	50
Adult (26-59 yrs.)	250
Older Adult (60+ yrs.)	188
Declined to answer	
Unknown	
TOTAL	**523**

VETERAN STATUS	
Yes	52
No	
Declined to answer	
Unknown	
TOTAL	**52**

SEXUAL ORIENTATION	
Gay/Lesbian	5
Heterosexual/Straight	350
Bisexual	
Questioning/Unsure	
Queer	
Declined to answer	125
Unknown	
Another group not listed	
TOTAL	**480**
If another group is counted, please specify:	

CURRENT GENDER IDENTITY	
Female	330
Male	177
Transgender	
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	10
Unknown	
Another identity not listed	
TOTAL	**517**
If another identity is counted, please specify:	

SEX ASSIGNED AT BIRTH	
Male	112
Female	336
Declined to answer	135
Unknown	
TOTAL	**583**

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	10
Chronic health condition	38
Disability Subtotal	**48**
None	
Declined to answer	
Unknown	
Another disability not listed	
TOTAL	**48**

PRIMARY LANGUAGE	
English	488
Spanish	
Cantonese	
Chinese	
Vietnamese	
Farsi	
Arabic	
Tagalog	
Declined to answer	
Unknown	
Another language not listed	
TOTAL	**488**
If another language is counted, please specify:	

RACE	
American Indian or Alaska Native	
Asian	
Black or African American	500
Native Hawaiian or other Pacific Islander	
White	5
Other Race	
Declined to answer	5
Unknown	
TOTAL	510
If another race is counted, please specify:	

Ethnicity/Cultural Heritage (Please choose only one per individual)	
If Hispanic or Latino, please specify:	
Caribbean	8
Central American	
Mexican/Mexican American/Chicano	3
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	
Total Hispanic or Latino	**11**
If Non-Hispanic or Non-Latino, please specify:	
African	15
African American	500
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	**515**
More than one ethnicity	
Unknown Ethnicity	
Declined to answer	
EHTNICITY TOTAL	**526**
If another ethnicity is counted, please specify:	

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of. Note: 1,000-character limit.
One success story involved the ongoing work of one of our anti-stigma campaigns sponsored by Covenant Worship Center in Union city. They have assembled a team of Mental health professionals, peers, and family members focusing on the TAY community using art therapy, group sessions, and support groups for TAY in addition to their work with African American Men.

Box E: Program challenges of the past year and how did the agency mitigate challenges? Note: The box has a 1,000-character limit.
The primary challenge we continue to experience during the year involved adapting working with our mini grant recipients to modify their original project plans to develop a hybrid virtual platform and process for accomplishing initial goals to impact their targeted community. Working with our Grantees we developed a parallel in person platform that will launch per County guidelines. We also experienced some challenges balancing the congregational trainings & community responses to the COVID 19 vaccine hesitancy within the African American Community and the surge experienced between December '21 and January'22. We are currently planning a Hybrid Mental Health 101 for both North and South County with the intention to pilot congregational models throughout the county. We successfully worked with two of our MHFC partners to host hybrid anti stigma events during the year!

Box F: Program lessons learned of the past year? Note: 1,000-character limit.
Flexibility is essential to respond to the very fluid landscape caused by COVID 19 restrictions and guidelines. We have worked very closely with each MHFC Congregation to implement strategies that are unique to their faith community and accessible to the larger MHFC Community. Each faith community's capacity to implement virtual platforms for their congregants and community varies. The smaller congregations are more limited than the larger congregations. We are working with each faith center to assure that each can maximize resources, access information to bridge the challenges of social distancing and shelter in place guidelines. Additionally, there was a growing need to address the mental health implications raised by social justice issues, policing in the Black Community amidst the political landscape of a "Post Trump" America. Mental Health Ministries within our congregations are carry a heavy load.

Box G: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
G.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e. mental health treatment services):	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:	**193**
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	*43 pastors, 50 deacons, 49 ministers, 51 teachers and children, youth, TAY, and adult ministry leaders*
Congregational mental wellness teams	*30 mental health professionals who are members of each MHFC Congregations Mental Wellness Ministry*

MHSA Program #: PEI 20E

PROVIDER NAME: Peers Envisioning and Engaging in Recovery Services (PEERS)

PROGRAM NAME: Culturally Responsive Programs for African Americans – Hope & Faith

Program Outcomes & Impact: PEI Data Report FY 21/22

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):	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).

The Hope & Faith - African American Mental Wellness and Spirituality Campaign comprises three unique mini- campaigns hosted by at least 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 Hope & Faith Campaign is informed by an advisory board that includes representatives from each of the faith communities.

Box B: Number of individuals served this fiscal year through MHSA funding.

Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	164

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:	
Grand total of unduplicated individuals served:	**164**

Box C: Demographics of individuals served this fiscal year through MHSA funding.

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	18
Transition Age Youth (16-25 yrs.)	
Adult (26-59 yrs.)	3
Older Adult (60+ yrs.)	1
Declined to answer	
Unknown	142
TOTAL	**164**

SEXUAL ORIENTATION	
Gay/Lesbian	
Heterosexual/Straight	3
Bisexual	
Questioning/Unsure	
Queer	
Declined to answer	160
Unknown	1
Another group not listed	
TOTAL	**164**

If another group is counted, please specify: Black female

VETERAN STATUS	
Yes	
No	4
Declined to answer	160
Unknown	
TOTAL	**164**

CURRENT GENDER IDENTITY	
Female	1
Male	3
Transgender	
Genderqueer	
Questioning/unsure of gender identity	

PRIMARY LANGUAGE	
English	3
Spanish	1
Cantonese	
Chinese	
Vietnamese	

Declined to answer	160
Unknown	1
Another identity not listed	
TOTAL	**164**
If another identity is counted, please specify:	

Farsi	
Arabic	
Tagalog	
Declined to answer	160
TOTAL	**164**
If another language is counted, please specify: unknown 770	

SEX ASSIGNED AT BIRTH	
Male	
Female	
Declined to answer	
Unknown	164
TOTAL	**164**

DISABILITY* STATUS**	
Communication Domain	
Vision	
Hearing/Speech	
Another type not listed	2
Communication Domain Subtotal	**2**
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	
Physical/mobility	
Chronic health condition	
Disability Subtotal	**0**
None	2
Declined to answer	160
Unknown	
Another disability not listed	
TOTAL	**164**
If another disability is counted, please specify:	

RACE	
American Indian or Alaska Native	
Asian	
Black or African American	20
Native Hawaiian or other Pacific Islander	
White	1
Other Race	1
Declined to answer	142
Unknown	
TOTAL	**164**
If another race is counted, please specify:	

Ethnicity/Cultural Heritage (Please choose only one per individual)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	
Mexican/Mexican American/Chicano	
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	1
Total Hispanic or Latino	**1**
If Non-Hispanic or Non-Latino, please specify:	
African	
African American	1
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	**1**
More than one ethnicity	
Unknown Ethnicity	
Declined to answer	162
EHTNICITY TOTAL	**164**
If another ethnicity is counted, please specify: Black/St. Thomas	

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of. Note: 1,000-character limit.
The response to the mental health support and education the program offers was enthusiastic among both church leadership and congregation members. The Hope & Faith advisory board had in-depth discussions around the benefits to faith communities of addressing Black mental health from strength-based and non-stigmatizing perspectives, making connections between spirituality and mental health. PEERS worked with four new churches, so that we could bring the anti-stigma work to new African American faith communities. We were pleased to have forged new partnerships with the following churches: Christian Community Church of California, Ebenezer Missionary Baptist Church, Imani Community Church, and Memorial Tabernacle Church.

Box E: Program challenges of the past year and how did the agency mitigate challenges? Note: 1,000- character limit.
The primary challenge was making contacts with churches new to the Hope & Faith campaign at the beginning of the year. Given the intense challenges of the pandemic, for some churches, the timing was not right for engaging with the campaign: some churches simply were overwhelmed, some had been fully occupied by returning to in person services, and others saw declines in participation during the time they were operating remotely. Our primary strategies for mitigating this challenge were persistence in outreach and mobilizing the deep community connections of PEERS' Hope & Faith staff leaders. We are proud that we were able to increase from three churches to four during this challenging time.

Box F: Program lessons learned of the past year. Note: 1,000- character limit.
The clearest lesson that emerged from the Hope & Faith Campaign this past year is that the campaign's success is dependent upon staff who have deep personal connections in African American faith communities. The PEERS staff who work on this program, who have lived experience as Black people with mental health challenges, have longstanding, trusting networks in these communities, and were able to draw on those networks to forge relationships with new churches.

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:	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:	11
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):	

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:	**108**
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 (in person and virtual)	*108 members of African American faith communities, including clergy, lay leaders, and members*

MHSA Program #: PEI 22

PROVIDER NAME: Pacific Center for Human Growth

PROGRAM NAME: Older and Out

Program Outcomes & Impact: PEI Data Report FY 21/22

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):	Outreach	
Priority Area (place and X next to all that apply):		Childhood Trauma
		Early Psychosis
		Youth/TAY Outreach and Engagement
		Cultural and Linguistic
	X	Older Adults
		Early Identification of Mental Health Illness

Box A: Please provide a brief program description (character limit 1,000).

The Older & Out program offers free, drop-in therapy groups for LGBTQI2-S adults over the age of 60. Pacific Center partners with two senior centers in Alameda County, as well as the Oakland LGBTQ Center, to provide three Older & Out service locations when in-person. Groups are facilitated by 1-2 Pacific Center clinicians and trained peer specialists. Topics may include: loss of friends, aging, invisibility in the LGBTQIA+ community, loneliness, and resilience.

Box B: Number of individuals served this fiscal year through MHSA funding.

Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	24
Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	4

Number of unduplicated individual family members served indirectly by your program:	0
Grand total of unduplicated individuals served:	**28**

Box C: Demographics of individuals served this fiscal year through MHSA funding.

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	
Transition Age Youth (16-25 yrs.)	
Adult (26-59 yrs.)	
Older Adult (60+ yrs.)	28
Declined to answer	
Unknown	
TOTAL	**28**

VETERAN STATUS	
Yes	2
No	22
Declined to answer	15
Unknown	
TOTAL	**28**

SEXUAL ORIENTATION	
Gay/Lesbian	23
Heterosexual/Straight	
Bisexual	2
Questioning/Unsure	
Queer	2
Declined to answer	1
Unknown	
Another group not listed	1
TOTAL	**28**
If another group is counted, please specify: Fluid, Pansexual	

CURRENT GENDER IDENTITY	
Female	9
Male	15
Transgender	1
Genderqueer	3
Questioning/unsure of gender identity	
Declined to answer	
Unknown	
Another identity not listed	
TOTAL	**28**
If another identity is counted, please specify: Non-binary	

PRIMARY LANGUAGE	
English	26
Spanish	
Cantonese	
Chinese	
Vietnamese	
Farsi	
Arabic	
Tagalog	
Declined to answer	2
Unknown	
Another language not listed	
TOTAL	**28**
If another language is counted, please specify:	

SEX ASSIGNED AT BIRTH	
Male	17
Female	10
Declined to answer	
Unknown	1
TOTAL	**28**

DISABILITY*** STATUS	
Communication Domain	
Vision	1
Hearing/Speech	
Another type not listed	
Communication Domain Subtotal	**1**
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	1
Physical/mobility	3
Chronic health condition	2
Disability Subtotal	**5**
None	14
Declined to answer	7
Unknown	
Another disability not listed	
TOTAL	**28**
If another disability is counted, please specify:	

RACE	
American Indian or Alaska Native	
Asian	2
Black or African American	1
Native Hawaiian or other Pacific Islander	
White	19
Other Race	3
Declined to answer	
Unknown	1
TOTAL	**28**
If another race is counted, please specify: More than one race	

Ethnicity/Cultural Heritage (Please choose only one per individual)	
If Hispanic or Latino, please specify:	
Caribbean	
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	1
African American	1
Asian Indian/South Asian	
Cambodian	
Chinese	1
Eastern European	1
European	1
Filipino	1
Japanese	
Korean	
Middle Eastern	
Vietnamese	
Other Non-Hispanic or Non-Latino ethnicity not listed	2
Total Non-Hispanic or Non-Latino	**8**
More than one ethnicity	1
Unknown Ethnicity	
Declined to answer	18
EHTNICITY TOTAL	**28**
If another ethnicity is counted, please specify: 1 Peruvian, 2 Jewish	

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of. Note: 1,000-character limit.
Our Older & Out groups have continued to be a dynamic virtual offering to the community, consistently offering a meaningful service. We implemented some changes to the design, responding to the desire of many group members to have deeper conversations during group as well as have access to social spaces. Other design changes addressed our need for continuity within the group facilitator role, filled by our clinicians-in-training. An example of the strong connections being made through the group experience as well as the accessibility brought by utilizing virtual platforms, is apparent in one of our groups, in which a member, in his 80's, is being treated for a cancer with a very poor prognosis. He continues to attend despite frequent moves (hospital, rehab, assisted living). Some group members and PC staff phone him regularly and a co-facilitator made an in-person visit to him. He continues to participate as best he can as a valued member of the group, reducing his isolation and grief.

Box E: Program challenges of the past year and how did the agency mitigate challenges? Note: 1,000-character limit.
To be expected, some challenges were influenced by the pandemic. For example, still unable to meet in-person, we responded by continuing to offer our Older & Out service virtually. Since our program design relies on our clinicians-in-training to facilitate the groups, we were faced with a challenge when none were able to continue after their training year ended. This prompted us to pause the services for a month and return with 9–12-week segments of closed sessions. Our intention is to contact the new trainees at the start of their training year to recruit them to Older & Out. This way there will be increased continuity and consistency as well as creating an opportunity for safer space more conducive to deep conversation and connection. If another ethnicity is counted, please specify: 1 Peruvian, 2 Jewish

Box F: Program lessons learned of the past year? Note: 1,000-character limit.
As we work to weave Older & Out in with our training program for mental health clinicians, we are learning how to bolster the strengths brought forward and support the areas needed to be strengthened. Our hope is that more of the group facilitators will stay on after the training year ends, giving more continuity to the program, and more support for the new trainees entering, thereby creating a more consistent experience for the group members. Another lesson learned is that the Older & Out group members desire social spaces outside of the therapy sessions. On their own, they have invited each other to socialize in-person outside and one member has offered to hold a virtual social space when group has been on a pause. We made changes to the job descriptions for the Peer Specialist position to accommodate this need.

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):	The underserved target population our program serves are LGBTQAI2-S Older 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):	0

Number of Responders:	**6**
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):
Community mental health agency	Direct service staff, clinicians, administrators, program managers, volunteers, board members
Community senior centers	District service staff, administrators, volunteers, clinicians
Community family and youth services	Direct service staff, clinicians, administrators, program managers

MHSA Program #: PEI 22

PROVIDER NAME: Pacific Center for Human Growth

PROGRAM NAME: Peer Mentorship Project

Program Outcomes & Impact: PEI Data Report FY 21/22

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
	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 Peer Group program seeks to provide prevention and early intervention supports to transition age youth, adults and older adults through peer facilitated support groups for the lesbian, gay, bisexual, transgender, queer, questioning, intersex, and/or two-spirit (LGBTQQI2-S) community. Contractor shall refer clients who may need additional services to resources such as primary health care or advanced mental health services.

Box B: Number of individuals served this fiscal year through MHSA funding.

Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	105

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:	
Grand total of unduplicated individuals:	**123**

Box C: Demographics of individuals served this fiscal year through MHSA funding.

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	
Transition Age Youth (16-25 yrs.)	55
Adult (26-59 yrs.)	193
Older Adult (60+ yrs.)	12
Declined to answer	9
Unknown	
TOTAL	**269**

VETERAN STATUS	
Yes	3
No	264
Declined to answer	2
Unknown	
TOTAL	**269**

SEXUAL ORIENTATION	
Gay/Lesbian	44
Heterosexual/Straight	25
Bisexual	61
Questioning/Unsure	22
Queer	88
Declined to answer	6
Unknown	6
Another group not listed	121
TOTAL	**373**

If another group is counted, please specify: Asexual, Demisexual, Fluid, Pansexual

CURRENT GENDER IDENTITY	
Female	60
Male	15
Transgender	110
Genderqueer	42
Questioning/unsure of gender identity	12
Declined to answer	5
Unknown	
Another identity not listed	48
TOTAL	**292**

If another identity is counted, please specify: Agender, Non-binary, Genderfluid

PRIMARY LANGUAGE	
English	266
Spanish	2
Cantonese	
Chinese	
Vietnamese	
Farsi	
Arabic	
Tagalog	
Declined to answer	
Unknown	1
Another language not listed	
TOTAL	**269**

SEX ASSIGNED AT BIRTH	
Male	
Female	
Declined to answer	
Unknown	
TOTAL	

If another language is counted, please specify:

Box C Continued: Demographics of individuals served this fiscal year through MHSA funding.

DISABILITY*** STATUS	
Communication Domain	
Vision	7
Hearing/Speech	8
Another type not listed	
Communication Domain Subtotal	**15**
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	28
Physical/mobility	8
Chronic health condition	17
Disability Subtotal	**53**
None	205
Declined to answer	1
Unknown	
Another disability not listed	
TOTAL	**274**
If another disability is counted, please specify:	

RACE	
American Indian or Alaska Native	5
Asian	39
Black or African American	17
Native Hawaiian or other Pacific Islander	
White	154
Other Race	26
Declined to answer	
Unknown	
TOTAL	**241**

If another race is counted, please specify: More than one race

Ethnicity/Cultural Heritage (Please choose only one per individual)	
If Hispanic or Latino, please specify:	
Caribbean	7
Central American	2
Mexican/Mexican American/Chicano	23
Puerto Rican	3
South American	10
Another Hispanic/Latino ethnicity not listed	
Total Hispanic or Latino	**45**

If Non-Hispanic or Non-Latino, please specify:	
African	15
African American	
Asian Indian/South Asian	12
Cambodian	
Chinese	5
Eastern European	16
European	77
Filipino	7
Japanese	
Korean	3
Middle Eastern	5
Vietnamese	2
Other Non-Hispanic or Non-Latino ethnicity not listed	10
Total Non-Hispanic or Non-Latino	152
More than one ethnicity	41
Unknown Ethnicity	
Declined to answer	74
EHTNICITY TOTAL	**312**
If another ethnicity is counted, please specify: Jewish, Taiwanese, Indonesian	

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of. Note: 1,000-character limit.

Opportunities for outreach have increased dramatically. It's exciting to get back out connecting with others. We keep utilizing our website as well as our Meetup, Instagram, and Facebook accounts. We continue to offer, through our Diversity, Equity, and Inclusion initiatives, quarterly DEI training. The peer group facilitators showed up with fair attendance to the three DEI trainings provided: Intersectionality, Addressing Microaggressions and Communication Skill-Building. Though our groups remain virtual, participants have expressed that our ability to hold space has given them connection and they've "found the group understanding and supportive and makes [them] feel [they are] not alone on an island". We have also received requests to start new groups and restart groups that have paused, like our Thursday Night Men's Group.

Box E: Program challenges of the past year and how did the agency mitigate challenges? Note: 1,000-character limit.

Only one of our peer groups at the San Leandro Senior Center has moved back to in-person meetings. We noticed that some of our community members who left groups when we moved online, have returned to this space. Unfortunately, due to gentrification, the Pacific Center's space is in transition, and we are unsure when we may be able to transition back to in-person meetings at our home. This is hard because some of our facilitators, are experiencing Zoom fatigue and online groups has increased the amount of communication they have to engage in via emails and reminders. Also, some groups would like to be hybrid. That will require PC to engage in major technological upgrades. In addition to physical transitions, during FY22-23, Pacific Center experienced leadership changes in the Executive Director, Clinical Director, Finance Director, and Community Programs Director positions. These shifts impacted staff capacity and some schedule changes.

Box F: Program lessons learned of the past year? Note: 1,000-character limit.

Moving forward, Pacific Center is onboarding new peer facilitators to allow some facilitators to rotate out or step back to prevent burn out. We also noted that a few groups have been dealing with crisis situations amongst group members and we are scheduling training with our Clinical Director to provide our facilitators with resources. One area of note is crisis services for our Latinx/Spanish-speaking population. We have identified a gap in crisis services for our Latinx community members in their home language and we are looking at how we can partner with CBOs to ensure that they can support communities who sit at the intersection of the LGBTQIA and Latinx identities, including prioritizing bilingual clinicians in our training program. To address the need for increased outreach, the community programs and operations staff meet monthly to boost our public outreach, especially to our community members who live at intersections of disabled, trans, and BIPOC communities.

Box G: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
G.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e. mental health treatment services):	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):	71
G.3: Types of treatment individuals were referred to (list types) (500-character limit):	24 Primary health care/ advanced mental health services 1 Housing 17 Other: examples: EEOC for harassment; Information on joining Facebook groups for finding housing; NAMI and LGBTQ groups from Oakland, Sacramento, and San Diego
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:	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):	Individuals who identify as LGBTQQI2-S, TAY, persons of color, may have physical disabilities, and have been previously engaged in publicly funded behavioral health services, but are not actively receiving mental health treatment.
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:	Unknown
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):	Peer group facilitators refer members to relevant services based on discussions in group and from resource lists provided by Pacific Center.

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:	

MHSA Program #: PEI 22

PROVIDER NAME: Pacific Center for Human Growth

PROGRAM NAME: Technical Assistance Program

Program Outcomes & Impact: PEI Data Report FY 21/22

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).
Contractor's outreach services shall provide culturally responsive services which includes engaging and training potential responders and the general population to recognize and respond effectively to early signs of severe and disabling mental illness by reducing stigma and discrimination related to mental health issues, providing services in an environment of inclusion and acceptance, improving and expanding contracted providers' cultural responsiveness to the LGBTQIA+ community.

Box B: Number of individuals served this fiscal year through MHSA funding.	
Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	NA
Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	NA
Number of unduplicated individual family members served indirectly by your program:	NA
Grand total of unduplicated individuals served:	**0**

Box C: Demographics of individuals served this fiscal year through MHSA funding.

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	
Transition Age Youth (16-25 yrs.)	8
Adult (26-59 yrs.)	162
Older Adult (60+ yrs.)	14
Declined to answer	2
Unknown	
TOTAL	**186**

VETERAN STATUS	
Yes	1
No	180
Declined to answer	
Unknown	2
TOTAL	**183**

CURRENT GENDER IDENTITY	
Female (Cis-Woman)	52
Male (Cis-Man)	52
Transgender ((Women & Men)	5
Genderqueer	20
Questioning/unsure of gender identity	
Declined to answer	2
Unknown	7
Another identity not listed	50
TOTAL	**188**
If another identity is counted, please specify: Two-Spirit, ENBY (Non-Binary)	

SEX ASSIGNED AT BIRTH	
Male (Cis-Woman)	
Female (Cis-Man)	
Declined to answer	
Unknown	
TOTAL	

SEXUAL ORIENTATION	
Gay/Lesbian	46
Heterosexual/Straight	31
Bisexual	26
Questioning/Unsure	1
Queer	88
Declined to answer	1
Unknown	4
Another group not listed	38
TOTAL	**235**
If another group is counted, please specify:	

PRIMARY LANGUAGE	
English	187
Spanish	
Cantonese	
Chinese	
Vietnamese	
Farsi	
Arabic	
Tagalog	
Declined to answer	
Unknown	
Another language not listed	
TOTAL	**187**
If another language is counted, please specify:	

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.) Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	40
Physical/mobility	8
Chronic health condition	16
Disability Subtotal	**64**
None	123
Declined to answer	2
Unknown	
Another disability not listed	
TOTAL	**190**
If another disability is counted, please specify:	

RACE	
American Indian or Alaska Native	
Asian	28
Black or African American	26
Native Hawaiian or other Pacific Islander	3
White	105
Other Race	1
Declined to answer	1
Unknown	20
TOTAL	**184**
If another race is counted, please specify:	

Ethnicity/Cultural Heritage (Please choose only one per individual)	
If Hispanic or Latino, please specify:	
Caribbean	42
Central American	
Mexican/Mexican American/Chicano	
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	
Total Hispanic or Latino	**42**

If Non-Hispanic or Non-Latino, please specify:	
African	
African American	26
Asian Indian/South Asian	28
Cambodian	
Chinese	
Eastern European	
European	81
Filipino	
Japanese	
Korean	
Middle Eastern	1
Vietnamese	
Other Non-Hispanic or Non-Latino ethnicity not listed	4
Total Non-Hispanic or Non-Latino	**140**
More than one ethnicity	1
Unknown Ethnicity	
Declined to answer	7
EHTNICITY TOTAL	**190**
If another ethnicity is counted, please specify:	

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of. Note: 1,000-character limit.

Community Based Organizations are maintaining and increasing interest in deeper, more intersectional, integrative learning as it relates to culturally responsive service delivery. Qualitative feedback indicates that participants found the trainings and information shared to be relevant and helpful to their work. In Q3 & Q4, we offered 22 didactic trainings and community stakeholders have expressed increased interest in attending Pacific Center trainings. Our trainings have also drawn participants from other local academic institutions and clinical training programs. Evaluation participation has also increased providing invaluable feedback to our program with respondents noting that PC trainings have increased their scope and given them better understanding of LGBTQIA issues. On June 30th we hosted our 4th Annual Mental Health at the Intersections Conference using a hybrid model where we met in- person and also livestreamed workshops for online participation.

Box E: Program challenges of the past year and how did the agency mitigate challenges? Note: 1,000-character limit.
The Pacific Center has gone through several personnel transitions this year. With a new Organizational Training Program Manager joining the team in February there was a need to quickly get them up to speed as didactic trainings and CBO trainings were already scheduled out and in progress for the fiscal year. With COVID-19 variants, many CBO and partner sites remain completely remote or have recently introduced hybrid models. Pacific Center was not able to do site visits and policy reviews for the CBO's receiving training from us. While we have had increased participation in evaluation surveys, we still are not able to capture information from all our participants. We continue to allot 5 minutes before the end of the training session for participants to complete the evaluation before signing out of the ZOOM session though not everyone completed an evaluation
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.
While COVID-19 infections continue to ebb and flow, with the return of our Mental Health at the Intersections conference as a hybrid experience, we are looking into how Pacific Center can offer and deepen our practice to see what is possible as we embark on the next cycle of CBO trainings. Also, as we think of hybrid options for training, Pacific Center is assessing what technological upgrades will be necessary for more effective delivery of services. We have received feedback that our pay rates for trainers should be increased especially for BIPOC trainers who are in high demand. In terms of our program design, PC is looking into how our trainings can further reach the community. We have identified a gap in crisis services for our Latinx community members in their home language and we are looking at how we can partner with CBOs to ensure that they can support communities who sit at the intersection of the LGBTQIA and Latinx identities.

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:	
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 24

PROVIDER NAME: Roots Community Health Center

PROGRAM NAME: Sobrante Park

Program Outcomes & Impact: PEI Data Report FY 21/22

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
		Early Identification of Mental Health Illness

Box A: Program description (character limit 500).
Roots Community Health Center seeks to address long-standing health inequities in the Sobrante Park community by partnering with the Sobrante Park Resident's Action Committee and Higher Ground to provide culturally responsive, comprehensive physical and mental health services, education, employment and training, and wraparound services that build self-sufficiency and promote community empowerment.

Box B: Number of individuals served this fiscal year through MHSA funding.	
Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	6
Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	10

Number of unduplicated individual family members served indirectly by your program:	24
Grand total of unduplicated individuals served:	40

Box C: Demographics of individuals served during this fiscal year through MHSA funding.

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	
Transition Age Youth (16-25 yrs.)	8
Adult (26-59 yrs.)	24
Older Adult (60+ yrs.)	8
Declined to answer	
Unknown	
TOTAL	**40**

SEXUAL ORIENTATION	
Gay/Lesbian	
Heterosexual/Straight	38
Bisexual	
Questioning/Unsure	
Queer	
Declined to answer	1
Unknown	1
Another group not listed	
TOTAL	**40**
If another group is counted, please specify:	

VETERAN STATUS	
Yes	
No	20
Declined to answer	
Unknown	20
TOTAL	**40**

CURRENT GENDER IDENTITY	
Female	21
Male	19
Transgender	
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	
Another identity not listed	
TOTAL	**40**
If another identity is counted, please specify:	

PRIMARY LANGUAGE	
English	21
Spanish	19
Cantonese	
Chinese	
Vietnamese	
Farsi	
Arabic	
Tagalog	
Declined to answer	
TOTAL	**40**
If another language is counted, please specify:	

SEX ASSIGNED AT BIRTH	
Male	
Female	
Declined to answer	
Unknown	
TOTAL	

DISABILITY*** STATUS	
Communication Domain	
Vision	6
Hearing/Speech	2
Another type not listed	
Communication Domain Subtotal	**8**
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	1
Physical/mobility	
Chronic health condition	3
Disability Subtotal	**4**
None	
Declined to answer	
Unknown	
Another disability not listed	
TOTAL	**12**

RACE	
American Indian or Alaska Native	
Asian	
Black or African American	19
Native Hawaiian or other Pacific Islander	
White	14
Other Race	2
Declined to answer	
Unknown	
TOTAL	**40**
If another race is counted, please specify:	

Ethnicity/Cultural Heritage (Please choose only one per individual)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	10
Mexican/Mexican American/Chicano	11
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	
Total Hispanic or Latino	**21**
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	
Declined to answer	
EHTNICITY TOTAL	**40**
If another ethnicity is counted, please specify:	

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of. Note: 1,000-character limit.
Wrap around support is key to how Roots provide services to Sobrante Park residents guided by the principle that the primary services we offer must be buttressed by supporting services and activities to ensure the wellness of the whole person. Although providing access to mental health and wellness is the primary deliverable, this service must be boosted by additional efforts that address other felt needs like food.

Box E: Program challenges of the past year and how did the agency mitigate challenges? Note: 1,000-character limit.
When necessary, Roots has continued to utilize virtual platforms to connect with clients, community partners, and engage in community outreach. However, due to the persistence of the virus and the emergence of new variants Roots has adjusted to the need to be flexible and willing to change when the situation demands. While we have been able to have more in-person engagement with our clients.

Box F: Program lessons learned in the past year? Note: 1,000-character limit.
Although Roots was able to pivot when needed and find alternative ways to stay connected to the Sobrante Park community, the pandemic made even more clear the disparities in areas such as access to technology that made it difficult to have a consistent presence with some residents.

Box G: For programs that refer individuals with severe mental illness, information about those that referred:	
G.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e. mental health treatment services):	10
G.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e. mental health treatment services):	1
G.3: Types of treatment individuals were referred to (list types) (500-character limit):	Referred clients received weekly 1:1 sessions with a mental healthcare provider, or in some cases group therapy depending on the level and kind of treatment determined by clinician.
G.4: Unduplicated number of individuals who participated in referred program at least one	10

G.6: Average number of days between referral and first participation in referred treatment program:	1 week depending on appointment availability

Box H: For programs that work to improve timely access to mental health services for underserved populations, information about those programs:	
H.1: Who is/are the underserved target population(s) your program is serving (e.g. TAY, Southeast Asian) (500 Characters):	Individuals and families of African-American and Latino/a/x descent who live, attend school, or work in Sobrante Park.
H.2: Number of paper referrals to an ACBH PEI-funded program:	10
H.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	10
H.4: Average number of days between referral and first participation in referred PEI program:	One week depending on whether the service requires an appointment.
H.5: Describe how your program encouraged access to services and follow through on above referrals (500 Characters):	Through the collaboration with our community partners, Sobrante Park Residents Action Council, Higher Ground, and Madison Park Academy Primary community members are referred to Roots for a variety of services. A Roots navigator will then work with that community member to help facilitate matching the appropriate service.

Box I: For Outreach, Suicide Prevention, and Stigma Reduction programs, information for unduplicated potential responders (i.e., those who are in a position to identify early signs of potentially severe mental illness provide support, and or refer individuals who need treatment) reached. ***(Note: For Prevention, Early Intervention, Access & Linkage programs, this section is optional.)***	
Number of Responders:	**At least 29**
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Type of responders (e.g. 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police office at a school). (100 Characters)
Roots: 12 touchless produce distributions	*5 Roots staff*
Sobrante Park Residents Action Council (RAC): Back to School Backpack Event	*8 Roots staff*
Roots & Madison Park Academy (MPA) Primary: Back to School Resource Distribution	*4 Roots staff, 2 MPA Administrators*
Roots: Black Thought Wall Activation	*3 Roots staff, 2 Black Thought Project members*

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 21/22

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
	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).
Alameda County's 10X10 campaign will promote services, activities, and policies, incorporating the 8 dimensions of wellness, that seek to increase the life expectancy of mental health consumers by 10 Years. HHREC coordinates and implements this project for Alameda County Behavioral Health Care Services as part of their Mental Health Services Act funding. The Get Fit Program which includes exercise and Nutrition instruction (Yoga and Walking) completed Cohort #2 (Oct 11th - Nov18, 2021

Box B: Number of individuals served this fiscal year through MHSA funding.	
Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	14
Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	

Number of unduplicated individual family members served indirectly by your program:	
Grand total of unduplicated individuals served:	**14**

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	
Transition Age Youth (16-25 yrs.)	
Adult (26-59 yrs.)	11
Older Adult (60+ yrs.)	3
Declined to answer	
Unknown	
TOTAL	**14**

VETERAN STATUS	
Yes	
No	
Declined to answer	
Unknown	14
TOTAL	**14**

CURRENT GENDER IDENTITY	
Female	11
Male	2
Transgender	
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	1
Another identity not listed	
TOTAL	**14**
If another identity is counted, please specify:	

SEX ASSIGNED AT BIRTH	
Male	11
Female	3
Declined to answer	
Unknown	
TOTAL	**14**

SEXUAL ORIENTATION	
Gay/Lesbian	
Heterosexual/Straight	13
Bisexual	
Questioning/Unsure	
Queer	
Declined to answer	
Unknown	1
Another group not listed	
TOTAL	**14**
If another group is counted, please specify:	

PRIMARY LANGUAGE	
English	14
Spanish	
Cantonese	
Chinese	
Vietnamese	
Farsi	
Arabic	
Tagalog	
Declined to answer	
Unknown	
Another language not listed	
TOTAL	**14**

If another race is counted, please specify:

DISABILITY*** STATUS	
Communication Domain	
Vision	
Hearing/Speech	
Another type not listed	
Communication Domain Subtotal	**0**
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	
Physical/mobility	
Chronic health condition	1
Disability Subtotal	**1**
None	
Declined to answer	
Unknown	
Another disability not listed	
TOTAL	**1**
If another disability is counted, please specify:	

RACE	
American Indian or Alaska Native	
Asian	
Black or African American	7
Native Hawaiian or other Pacific Islander	3
White	3
Other Race	1
Declined to answer	
Unknown	
TOTAL	**14**
If another race is counted, please specify:	

Ethnicity/Cultural Heritage (Please choose only one per individual)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	
Mexican/Mexican American/Chicano	
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	1
Total Hispanic or Latino	**1**

If Non-Hispanic or Non-Latino, please specify:	
African	
African American	7
Asian Indian/South Asian	
Cambodian	
Chinese	
Eastern European	
European	3
Filipino	
Japanese	
Korean	
Middle Eastern	
Vietnamese	
Other Non-Hispanic or Non-Latino ethnicity not listed	**2**
Total Non-Hispanic or Non-Latino	**12**
More than one ethnicity	1
Unknown Ethnicity	
Declined to answer	
EHTNICITY TOTAL	**14**
If another ethnicity is counted, please specify:	

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of. Note: 1,000-character limit.
The 10X10 Wellness maneuvered through personnel changes and the Covid'19 Pandemic. Programs had to be altered and administered in an on-line virtual format. However, through those changes we were still able to continue to offer programs to the community. For the Month of Oct - Nov 2021 we held Cohort #2- Get Fit class with a total of 23 signed up but 10 Consumers completed program and graduated. Graduation was held on November 18th (see photos below). One participant continued to take the Walking Class well after the program ended. The Eight Dimensions of Wellness was stressed during this class and included healthy food demo and instructions. Session included Rethink Your Drink presentation. Of the past year we are very happy with the outcome of the We Move for Health Event. The 10x10 CAB members also helped to plan the first-time virtual event Over 135 in attendance.

Box E: Program challenges the past year and how the agency mitigated the challenges? Note: 1,000-character limit.
The challenges we faced included starting employment at the end of the last Get Fit cohort and wrapping up items for the past Program Manager. In addition, staff had to learn the skills of working from home given the shelter in place order from the Alameda County Public Health Depart. learning how to use the 'GoToMeeting (GTM)' platform to host CAB and Get Fit meetings. The programs largest event We Move for Health was a challenge; this was taking an outdoor event to a virtual one.

Box F: Program lessons learned of the past year? Note: 1,000-character limit.
Knowing the limitations of the new GoToMeeting platform, the Program Manager was able to creatively take photos of the class during meetings to validate the class was given and there were participants in attendance. Each participant signed a media release granting HHREC the ability to take the photos and store them on our confidential Google Drive for audit purposes.

Box G: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
G.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e., mental health treatment services):	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:	
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):
PEERS	
Telecare Corp./Villa Fairmont	

City of Berkeley Asian Health Services Specialty Mental Health	
Alameda County of Network of Mental Health Clients	
City of Berkeley Mental Health	
NAMI Alameda County	
Pool of Consumer Champions	
Bay Area Community Services	
Mental Health Association for Chinese Communities	
PEERS Envisioning and Engaging in Recovery Services.	
Black Men Speaks	
Asian Health Services Specialty Mental Health Division Program	

MHSA Program #: PEI 27

PROVIDER NAME: Health and Human Resource Education Center

PROGRAM NAME: Health Through Art

Program Outcomes & Impact: PEI Data Report FY 21/22

Program Name:	**Health Through Art (Report Reflects Semi-Annual Data)**	
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):		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).

Through the program Health Through Art, we reach out to low-income communities (previously through partnerships with schools, community-based organizations, and ACBH non-profits) and facilitate workshops that cater to the communities' needs, where they can use art to freely express their emotions or mental shape. Health Through Art is well known for its work with the Alameda County population, as it hosts the annual "Call for Art," a contest where individuals will submit their best works of art which highlight mental health and receive rewards if their submissions prove more popular than the others. During our last Call for Art, individuals of all ages submitted art pieces with an overwhelming contribution from schools and mental health facilities. The winners were awarded a $500 gift card and their art will be part of media campaigns spreading positive imagery through billboards at BART stations, bus stations, and posters overlooking major cities and neighborhoods in Alameda County.

Box B: Number of individuals served this fiscal year through MHSA funding.

Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	2
Number of unduplicated individuals your program served who show early signs of forming a more severe mental illness:	4
Number of unduplicated individual family members served indirectly by your program:	7
Grand total of unduplicated individuals served:	**13**

Box C: Demographics of individuals served this fiscal year through MHSA funding.

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	
Transition Age Youth (16-25 yrs.)	9
Adult (26-59 yrs.)	4
Older Adult (60+ yrs.)	
Declined to answer	
Unknown	
TOTAL	**13**

VETERAN STATUS	
Yes	
No	
Declined to answer	
Unknown	
TOTAL	

SEXUAL ORIENTATION	
Gay/Lesbian	
Heterosexual/Straight	
Bisexual	
Questioning/Unsure	
Queer	
Declined to answer	
Unknown	
Another group not listed	
TOTAL	

If another group is counted, please specify:

CURRENT GENDER IDENTITY	
Female	
Male	
Transgender	
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	
Another identity not listed	
TOTAL	
If another identity is counted, please specify: non-binary	

PRIMARY LANGUAGE	
English	9
Spanish	3
Cantonese	
Chinese	1
Vietnamese	
Farsi	
Arabic	
Tagalog	
Declined to answer	
Unknown	
Another language not listed	
TOTAL	**13**
If another language is counted, please specify:	

SEX ASSIGNED AT BIRTH	
Male	
Female	
Declined to answer	
Unknown	
TOTAL	

DISABILITY*** STATUS	
Communication Domain	
Vision	
Hearing/Speech	
Another type not listed	
Communication Domain Subtotal	
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	
Physical/mobility	
Chronic health condition	
Disability Subtotal	
None	
Declined to answer	
Unknown	
Another disability not listed	
TOTAL	
If another disability is counted, please specify:	

RACE	
American Indian or Alaska Native	
Asian	2
Black or African American	7
Native Hawaiian or another Pacific Islander	
White	2
Other Race	2
Declined to answer	
Unknown	
TOTAL	**13**
If another race is counted, please specify:	

Ethnicity/ Cultural Heritage (Please choose only one per individual)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	
Mexican/Mexican American/Chicano	2
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	
Total Hispanic or Latino	**2**
If Non-Hispanic or Non-Latino, please specify:	
African	
African American	7
Asian Indian/South Asian	2
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	**9**
More than one ethnicity	
Unknown Ethnicity	2
Declined to answer	
EHTNICITY TOTAL	**23**
If another ethnicity is counted, please specify: Taiwanese	

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of. Note: 1,000-character limit.
Our program manager facilitated an Art Therapy Workshop (Dates are from September 2, 2021 to October 7,), our program was challenging because the program manager went on maternity leave and then resigned because she decided to be a stay-at-home mother. The success was that our current workshop facilitator was able to recruit over 50 applicants for the upcoming art workshops and did outreach to multiple high schools. He was able to plan out four new art workshops. Another success was our HTA Podcast session.

Box E: Program challenges of the past year and how did the agency mitigate challenges? Note: 1,000-character limit.
NA

Box F: Program lessons learned of the past year? Note: 1,000-character limit.
We learned that using more social media, podcast, and investing in more Google ads was good for our HTA program.

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):	TAY, low-income populations, seniors
H.2: Number of paper referrals to an ACBH PEI-funded program:	3
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:	Unknown
H.5: Describe how your program encouraged access to services and follow through on above referrals (500 Characters):	The HTA program conducted outreach through emails, social media posts (Facebook/Instagram), and phone calls to individuals and community-based organizations. Outreach content included flyers and infographics of HTA events and HHREC workshops.

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:	**14**
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):
Skyline High School	1 teacher, 1 artist
Castlemont High School	2 teachers, 5 artists
San Leandro High School	1 teacher, 2 artists
Laney College	1 teacher, 1 artist

MHSA Program #: PEI 28

PROVIDER NAME: Health and Human Resource Education Center

PROGRAM NAME: Downtown TAY

Program Outcomes & Impact: PEI Data Report FY 21/22

Program Name:	**Downtown TAY**	
Organization:	Health and Human Resource Education Center	
PEI Program # and Name:	Downtown TAY	
Type of Report (Choose one):	Annual	
PEI Category (choose one):	Prevention	
Priority Area (place and X next to all that apply):		Childhood Trauma
		Early Psychosis
	x	Youth/TAY Outreach and Engagement
		Cultural and Linguistic
		Older Adults
		Early Identification of Mental Health Illness

Box A: Please provide a brief program description (character limit 1,000).

Downtown TAY provides culturally responsive and trauma- informed programs, workshops, and outings to Transitional Age Youth of the African Diaspora in Alameda County between the ages of 18 – 24. Our mission is to empower our young adult community by connecting them to their culture, inspiring hope, promoting critical thinking and cultivating creativity while supporting their overall health and wellness.

Box B: Number of individuals served this fiscal year through MHSA funding.

Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	48
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:	**48**

Box C: Demographics of individuals served this fiscal year through MHSA funding.

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	
Transition Age Youth (16-25 yrs.)	48
Adult (26-59 yrs.)	
Older Adult (60+ yrs.)	
Declined to answer	
Unknown	
TOTAL	**48**

SEXUAL ORIENTATION	
Gay/Lesbian	
Heterosexual/Straight	
Bisexual	
Questioning/Unsure	
Queer	
Declined to answer	48
Unknown	
Another group not listed	
TOTAL	**48**
If another group is counted, please specify:	

VETERAN STATUS	
Yes	
No	48
Declined to answer	
Unknown	
TOTAL	**48**

CURRENT GENDER IDENTITY	
Female	28
Male	19
Transgender	
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	
Another identity not listed	
TOTAL	**48**
If another identity is counted, specify	

PRIMARY LANGUAGE	
English	40
Spanish	7
Cantonese	1
Chinese	
Vietnamese	
Farsi	
Arabic	
Tagalog	
Declined to answer	
TOTAL	**48**
If another language is counted, please specify:	

SEX ASSIGNED AT BIRTH	
Male	19
Female	29
Declined to answer	
Unknown	
TOTAL	**48**

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	8
Black or African American	18
Native Hawaiian or another Pacific Islander	
White	
Other Race	22
Declined to answer	
Unknown	
TOTAL	**48**
If another race is counted, please specify:	

Ethnicity/Cultural Heritage (Please choose only one per individual)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	
Mexican/Mexican American/Chicano	12
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	
Total Hispanic or Latino	**12**
If Non-Hispanic or Non-Latino, please specify:	
African	2
African American	11
Asian Indian/South Asian	
Cambodian	
Chinese	1
Eastern European	
European	
Filipino	2
Japanese	
Korean	
Middle Eastern	2
Vietnamese	
Other Non-Hispanic or Non-Latino ethnicity not listed	
Total Non-Hispanic or Non-Latino	**18**
More than one ethnicity	
Unknown Ethnicity	
Declined to answer	
EHTNICITY TOTAL	**30**
If another ethnicity is counted, please specify:	

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of. Note: 1,000-character limit.
Successfully hosted two virtual internships for groups of students. Successfully created a strong media presence utilizing participant stories to intrigue potential clients virtually. Hosted virtual cooking classes physical activities for students Recruited new staff, that included a new coordinator and two interns and a facilitator for our Sista2Sista and Job Readiness Training. Assessed Inventory and revamped supplies, developed new strategies for outreach that included scripts and flyers for marketing purposes. We are increasing our retention rate for TAY participants. This is leading to an expansion of programming. We are utilizing enthusiastic TAY participants to join our community advisory board to improve the experience of the program from the participants point of view.

Box E: Program challenges of the past year and how did the agency mitigate challenges? Note: 1,000-character limit.
We noticed that students who had been with the agency for several years and who were aging out were apprehensive with their next chapter in life and in leaving the program. We had a student who reached 26 but was still benefiting from our resources. The goal was to ensure that students felt equipped and prepared to utilize the skills gained from their time here and Downtown TAY. I created a Transition plan for this participant and participants who may feel the same in the future. The plan consisted of a 30-day time period after turning 26 in which a TAY will focus on ensuring they are utilizing their time and the agency's resources, to ensure they have all of their needs met.

Box F: Program lessons learned of the past year? Note: 1,000-character limit.
We have learned that TAY students are increasingly interested in finding new activities that will keep them productive and engaged especially during this pandemic resurgence. With schools and activities finding different ways of engaging with students, we must be creative in our approach with introducing curriculum in an interesting way. It is also vital to work around the busy schedules of the youth. We have realized that our evening sessions that are after school hours are the most popular. We may have to investigate finding new activities outside of the traditional work hours.

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):	TAY of color (16-26)
H.2: Number of paper referrals to an ACBH PEI-funded program:	2
H.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	1
H.4: Average number of days between referral and first participation in referred PEI program:	1-2 days
H.5: Describe how your program encouraged access to services and follow through on above referrals (500 Characters):	Shayna/Serenity House

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:	**18**
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):
Castlemont and Oakland Technical High Schools	Students for internships

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 21/22

Program Name:	**Black Women's Media and Wellness Project (Report Reflects Semi-Annual Data)**	
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
		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 BWMWP increases awareness among African American women and their families and older African American adults about mental health issues, wellness and co-occurring conditions. BWMWP promotes mental health education and resources; and develops and promotes recovery and wellness through relevant culturally appropriate messages about self-care, family involvement and culturally responsive community activities.

Box B: Number of individuals served this fiscal year through MHSA funding.	
Number of unduplicated individuals your program served who are at-risk of developing serious mental illness (SMI):	144
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:	**144**

Box C: Demographics of individuals served this fiscal year through MHSA funding.

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	4
Transition Age Youth (16-25 yrs.)	4
Adult (26-59 yrs.)	25
Older Adult (60+ yrs.)	14
Declined to answer	2
Unknown	94
TOTAL	**144**

SEXUAL ORIENTATION	
Gay/Lesbian	
Heterosexual/Straight	
Bisexual	
Questioning/Unsure	
Queer	
Declined to answer	
Unknown	144
Another group not listed	
TOTAL	**144**
If another group is counted, please specify:	

VETERAN STATUS	
Yes	
No	
Declined to answer	
Unknown	144
TOTAL	**144**

CURRENT GENDER IDENTITY	
Female	140
Male	4
Transgender	
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	
Another identity not listed	
TOTAL	**144**
If another identity is counted, please specify:	

PRIMARY LANGUAGE	
English	144
Spanish	
Cantonese	
Chinese	
Vietnamese	
Farsi	
Arabic	
Tagalog	
Declined to answer	
TOTAL	**144**
If another language is counted, please specify:	

SEX ASSIGNED AT BIRTH	
Male	4
Female	140
Declined to answer	
Unknown	
TOTAL	**144**

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	144
Another disability not listed	
TOTAL	**144**
If another disability is counted, please specify:	

RACE	
American Indian or Alaska Native	
Asian	
Black or African American	188
Native Hawaiian or other Pacific Islander	
White	
Other Race	
Declined to answer	
Unknown	26
TOTAL	**144**
If another race is counted, please specify:	

Ethnicity/Cultural Heritage (Please choose only one per individual)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	
Mexican/Mexican American/Chicano	4
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	
Total Hispanic or Latino	**4**
If Non-Hispanic or Non-Latino, please specify:	
African	
African American	118
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	**118**
More than one ethnicity	2
Unknown Ethnicity	20
Declined to answer	
EHTNICITY TOTAL	**144**
If another ethnicity is counted, please specify:	

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of. Note: 1,000-character limit.
Black Women's Media has been successful in maintaining great participation from the community. Whether the event is virtual or in-person there has been a favorable response and a clear indication that new community members are interested in our programming. With every small change made to programming, it has been an improvement and there has been favorable feedback. The demand for more interpersonal activities has sparked the interest in starting a Facebook group for participants and creating a workbook to accompany our existing magazine. With just two Be still Retreats we have already reached over 100 community members. We have been able to collaborate with the B.H. Brilliant Minds Project and host an interactive wellness retreat which included wellness stations, face painting, writing workshop, Aromatherapy, and meditation. BWM has also received 5 new CAB members who are very connected to the community and interested in the promotion of mental health awareness of Black women.

Box E: Program challenges of the past year and how did the agency mitigate challenges? Note: 1,000-character limit.
The program faced challenges in collecting survey responses following program activities. As most events were held online, there is little control on how quickly a participant will provide feedback. BWM moved its surveys to an online format and found a way to gather demographic data through the registration process. Through the registration process on Eventbrite, we were able to collect demographic information up front. During online events, feedback can be received through a Q&A session. Also, links to feedback surveys were included in the chat, making it easy for participants to respond. So far, there has been an improvement. I believe with time the changes made will prove even more successful. Moving forward, BWM will continue to collect data in a way that is not daunting for participants. Here is the link to our current book club and retreat survey: https://www.surveymonkey.com/r/BMSVLKQ and https://www.surveymonkey.com/r/988SF9V.

Box F: Program lessons learned of the past year? Note: 1,000-character limit.
For the past six months, flexibility and planning has been the key. With flexibility, it's important to be able to meet the needs of the community from their perspective. There had been an interest to slowly incorporate in person program activities and we were able to meet that request safely. For those who preferred to remain virtual, most of the programming remained online. Adequate planning to produce great programming had been the most instrumental. BWM was easily continued in the brief absence of its program manager. Due to the dynamic programming previously scheduled and the purposeful selection of speakers who are invested in the work that HHREC and BWM are doing, a community has been established and our network has furnished a litany of fresh programming. With a clear foundation of program goals already set, activities were easily executed.

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
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):	African American women of all ages living in Alameda County
H.2: Number of paper referrals to an ACBH PEI-funded program:	0
H.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	0
H.4: Average number of days between referral and first participation in referred PEI program:	0

H.5: Describe how your program encouraged access to services and follow through on above referrals (500 Characters):	Online magazine is available to program participants that encourages mental health awareness and resources for treatment.

Box I: For <u>Outreach, Suicide Prevention, and Stigma Reduction</u> programs, please provide information for unduplicated potential responders (i.e., those who are in a position to identify early signs of potentially severe mental illness provide support, and or refer individuals who need treatment) reached. ***(Note: For Prevention, Early Intervention, Access & Linkage programs, this section is optional.)***	
Number of Responders:	**50**
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 center	*50 participants at a Be Still Retreat who learned how to identify the signs of mental stress*

INNOVATION

Innovation
"Solution Focused Activities"

Innovation (INN) Programs are intended to provide mental health systems with an opportunity to learn from innovative approaches. Innovations Programs are not designed to support existing or ongoing programs or services, but rather to provide the mental health system with innovative demonstration projects that will support system change in order to increase access to services and improve client/consumer outcomes.

An Innovation Project may introduce a novel, and/or ingenious approach to a variety of mental health practices. Innovation Projects can contribute to learning at any point across the spectrum of an individual or family's needs relating to mental health, from prevention and early intervention to recovery supports which includes supportive housing. An Innovative Project must meet the following criteria:

1. It is new, meaning it has **not** previously been done in the mental health field; Innovation Projects must promote new approaches to mental health in one or more of the following ways:

    - Introducing a new mental health practice or approach, or
    - Adapting an existing mental health practice or approach, so that it can serve a new target population or setting, or modifying an existing practice or approach from another field, to be used for the first time in mental health.

2. It has a learning component, which will contribute to the body of knowledge about mental health.

    - The learning component is represented in the application's Learning Question.

Before INN funds can be spent on an INN project, the project idea must be vetted through a 30-day public review process, approved by the County Board of Supervisors and then approved by the Mental Health Services Oversight and Accountability Commission (MHSOAC). The first two steps may take place as part of a Three-year Plan, a Yearly Plan Update or may be implemented as a stand-alone process.

Budget Summary

INNOVATION PROJECTS		
Project Name	**Fiscal Year**	**Projected Budget**
CATT	2023-2024	$5,341,778
SHCLA	2023-2024	$2,336,799
INN CPPP Project	2023-2024	$150,000
Forensic Alternatives: Clinical Focus	2023-2024	Pending MHSOAC approval
Forensic Alternatives: Peer Focus	2023-2024	Pending MHSOAC approval

INN Project Goals

Community Assessment Treatment Team (CATT): Currently, Fremont, San Leandro, Hayward, Union City, and Oakland currently have CATT teams to be pilot tested.

Pilot Project Community	*Achieved Services/year 2 2021 – 2022*	*Projected Services/year 3 2022 – 2023*	*Pilot Expiration December, 2024*
San Leandro, Oakland, and Hayward remain to have overwhelming majority of call response locations	1,317 calls; 1,201 clients served	1,898 clients served	End goal is to have 12 – 15 teams serving entire county
	67% of persons served who did not require emergency medical services.	**70%** of persons to be served who do not require emergency medical services.	**75%** of persons to be served who do not require emergency medical services.

Supportive Housing Community Land Alliance: Housing for individuals with serious mental illness (SMI):

Community	*Achieved Goals for FY22- 23*	*Projected Goals for FY22-23*	*Goals for FY23-24*
SMI individuals whose income is 200% below federal poverty level ($27,450 annually or less)	Completed federal tax exemption applications which was finalized in October, 2022	Initial property to be purchased; initial consumers identified and housed.	Additional consumers to be housed; Financing models for sustainability being utilized.

INN Program Summaries

Completed Innovation Projects:
Mental Health Technology

Current Innovation Projects:
Community Assessment Treatment Team
Supportive Housing Community Land Alliance

Future Innovation Projects:
Forensics: Alternatives to Confinement Continuum of Forensic Services (Clinical Focus)
Peer- Led Continuum of Forensic Services
Consumer Empowerment: Peer-Based Strategies, Consumer Empowerment using CT-R

COMPLETED INNOVATION 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.

Trauma is a deeply distressing or disturbing experience. Many traumas arise from a brief encounter/experience, or it can last for months, even years because of an individual's set of circumstances. The County, through community input through its 2017 Community Program Planning Process, focused on the trauma created by a number of specific factors that are currently affecting its residents. These factors are:

1) Role of caregivers due to a result of an increasing shift of psychiatric care to the community supplemented by an ever-aging population;
2) Physical violence and gun violence;
3) Rising rate of suicide especially in youth, transitional age youth, and older men; and
4) Influx of immigrants, asylees, and refugees into the County.

Furthermore, each of these factors overlap with each other: caregivers slipping into major depression may feel suicidal ideation or become violent towards the person they are caring for; or suicide among refugees and asylee youth because of feelings of there's no way out.[2]

[1] https://www.mayoclinic.org/healthy-lifestyle/stress-management/in-depth/support-groups/art-20044655

[2] Child refugees in Lesbos are increasingly self-harming and attempting suicide | MSF

This two and half years (2.5) project ended June 30, 2022 after a seven (7) month extension. This project's intention was 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 was about offering new opportunities for outreach, and engagement, and support to the communities listed below by testing a technology-based delivery system for mental health solutions.

There were five (5) grantees who created mental health mobile apps for four (4) identified populations. Of the five (5) grantees, two (2) of them are doing a single identified population while the remaining three (3) are doing multiple populations. The identified populations and the awarded grantees, Diversity in Health Training Institute (DHTI); Korean Community Center of the East Bay (KCCEB); Mental Health Association for Chinese Communities (MHACC); NAMI; and Niroga Institute, are listed below with their respective targeted population and their website or presentation video.

The grantees' websites or presentation videos are summarized in the below table:

Grantee	Targeted Population	Status
DHTI	TAY (Youth/Transition Age Group)	https://allynetwork.org/
	Immigrants, Asylees, and Refugees	https://allynetwork.org/
KCCEB	Caregivers of Individuals with SMI or SED	https://www.youtube.com/watch?v=FzvqQDum6-M&t=1s M&t=1s (turn on closed caption for English as it is in Chinese)
	Immigrants, Asylees, and Refugees	https://www.youtube.com/watch?v=iSiFgYQQKV8
MHACC	Caregivers of Individuals with SMI or SED	https://www.youtube.com/watch?v=WNgEKyjPMmo
	Attempted Suicide Survivors	https://www.youtube.com/watch?v=e7oDJqdNgLQ
NAMI	Attempted Suicide Survivors	https://www.dinobi.org/
Niroga Institute	TAY (Youth/Transition Age Group)	https://www.youtube.com/watch?v=fxXmDX7WEgk

MH Tech 2.0 Summary of Challenges and Outcomes

This project was set to expire in January, 2022. ACBH notified MHSOAC that the county will be extending the project (no-cost extension) until June 30, 2022. After this expiration, MHSA was able to secure funding from MHSA's Prevention and early Intervention (PEI) funding for a one (1) year contract. The project will be under the purvey of PEI for fiscal year 2022-2023. Before this funding ends, MHSA will reevaluate if PEI funding remains to be the most appropriate funding stream or if the applications can be sustained under Community Services and Supports (CSS).

As the pilot has drawn to a close, evaluation of the project's intended outcomes has been completed. it was not an easy task to develop good mental health focused apps. The subjects of the apps, individuals who are suffering with mental health issues, are subjects that are even more sensitive to the targeted

populations identified in the grantees' pilots (i.e. Chinese caregivers; Korean business owners). The intended outcomes included:

1. Decreased internalized stigma;
2. Increased empowerment;
3. Increased quality of life (QOL)
4. Enhance social connectedness; and
5. Increased mental health recovery.

Although there was varied results depending upon the grantee's targeted population and their developer, overall, outcomes were positive. However, the intended outcomes could not always be readily be gleaned by all evaluations. The ability to answer questions regarding how the apps affected mental health help seeking behaviors was difficult to ascertain due to a number of barriers.

Not surprisingly, the pandemic created a number of unforeseeable barriers to the project. The pandemic made it difficult for outreach; staff or staff family becoming ill with covid; and the discovery of maintaining the projects culturally competency to name a few obstacles. Certainly, the idea of what an opportunity the pandemic was also giving the project was discussed: the world shutting down and the main connection to other people or resources was through technology. Here, the project was creating mental health technology to help people seeking mental health assistance. Although, this was an opportunity that everyone attempted to use to their advantage, one individual user commented that they did not want to use DHTI's online network because they did not want to connect with someone during covid. Whether this individual was under the impression that only in person resources were being touted is unknown. Another individual commented they did not realize the site was live because it had been referred to as a pilot. It is clear from these comments, that in the future, more precise language is required for everyone's understanding.

Other challenges involved the expected reliance on external vendors versus in-house expertise. One grantee changed their app developer three times because the grantee was not satisfied with the developers understanding of the grantee's vision of their app. Implementation delays were mostly beyond grantee's controls due to the inability of a developer to understand needs of the project. The grantees who were designing non-English options within their app, and were working with English language app developers, found it difficult because it required the organization playing the cultural expert role. Playing this role created an even *greater burden in design and educating the designer on cultural aesthetics on look and feel…we did not realize the extent of our staff resources and time that would be required to meet design needs from a cultural…perspective.*

The evaluations demonstrated that the apps are well-designed and easy to use. This is not to say that design and development of the apps was easy. As mentioned, progress of the design and development of the apps proved to be more challenging to the grantee than originally perceived. Comments from users described the installation process was easy and straightforward. Privacy options, which was a high priority, were described as satisfactory and easy to understand.

There were several suggested improvements and observations from the evaluation:

- *Effective dissemination strategies might include broad public information campaigns targeting entire communities of interest, as well as targeting key opinion leaders within the communities of interest that can effectively spread information about the resource to all corners of their community;*

- *Add some functions, such as allowing caregiver to communicate with the one he or she care about via the apps;*
- *Add more peer support options;*
- *The app developer should have a linguistic and cultural knowledge of the app's targeted population;*
- *There was a lot of staff time that was not originally budgeted so overestimating for staffer time should have a higher valuation;*
- *Additional time should have been buffered because the IRB review can be time consuming with its long wait time; and*
- *The app development process would have been substantially easier and more efficient had more funding that reflected the true cost of the project with top-tier app developers.*

A few of the grantees have expressed interest in interlacing apps together which would enable collaboration for maximum user impact. The exploration for these partnerships will be done within the next fiscal year during its support through PEI.

PROJECT NAME: COMMUNITY ASSESSMENT TREATMENT TEAM (CATT)

Project Description: Alameda County's existing system for responding to behavioral health crises in the community is inefficient in terms of expense, time and connecting clients to appropriate services. A vast majority of transports for individuals on a psychiatric hold are conducted by ambulance, which is expensive and requires law enforcement to wait for an ambulance to arrive. These calls are lower priority since they are generally not life-threatening, therefore increasing the wait time. In addition, the existing system transports an individual who qualifies for a 5150 involuntary hold, but those who do not qualify are left on site without a connection to services. The goal of CATT is to improve access to services in Alameda County by combining efforts to significantly transform the response to behavioral crises in the community.

The CATT program is using a mobile crisis transport staffing model that accesses technological support to enable the CATT program to connect clients to a wider and more appropriate array of services. The CATT team consists of:

- A licensed mental health clinician who is teamed up with an Emergency Medical Technician (EMT) in an unmarked vehicle specially designed for the CATT team. Together, this team can provide mental and physical assessment to individuals in crisis and transport them to appropriate services required in the moment; and
- Technology supports, ReddiNet, are used to identify current availability of beds and Community Health Records to provide the most accurate information about the client's physical and mental health history.

By bringing together the right staffing and the right technology, this innovative crisis response teams' goals are to *reduce unnecessary 5150 holds, transportation to medical facilities for medical clearance, and the many hours of waiting for clients and first responders.* In addition, the goal to increase access to appropriate services by connecting and transporting clients whether or not they are on a 5150 hold.

In the second year of the CATT program there were 1,185 requests for a CATT team response. A CATT team provided services to 758 clients (64% of all calls). Of the 758 clients served, 465 (62%) resulted in a

transport. Approximately 40 CATT responses per month avoid what would likely have been an unnecessary hospital transportation 5150 involuntary hold.
The second-year evaluation final report has been completed by the CATT project evaluator, Public Consulting Group (PCG). A report brief was created by PCG and can be found in the appendix. The brief contains highlights and summary of the CATT program background and overview; process evaluation findings; outcome evaluation findings; response, transport, and involuntary hold dispositions; and program recidivism.

CATT Summary of Challenges and Resolutions

As with any pilot project, challenges continue to arise as new ideas are tested or challenges that were not anticipated arise. The following challenges are being addressed with resolutions:

1. **Staff Hiring and Retention** has been an ongoing challenge throughout the project. A number of process improvements have been made to hiring and retention. "*CATT leadership collaborated to design clear requirements and expectations for the field employee positions, which has led to an increase in applications."* Enhancements added to hiring include:
    a. Salary Increase;
    b. Sign-On Bonus;
    c. Holiday Pay;
    d. Paid Time Off; and
    e. Clinical Supervision
2. **Training Academy and Professional Development** have had a number of changes to the two (2) week training academy all field employees must complete before they can be responding to calls on a CATT team. In addition to virtual trainings, Crisis Intervention Training (CIT Training) provided by Oakland Police Department; and one (1) day of field training with experienced CATT teams these trainings were added:
    a. Training topics related to documentation, self-care, and policy and procedure overviews to better support staff; and
    b. Community Organization for Drug Abuse Control (CODAC) de-escalation and basic maneuver training is taught to all field CATT responders.
3. **Policy and Procedure** changes include:
    a. Response time change requirement from 20 to 30 minutes (completed);
    b. Hiring associate social workers working towards licensing (completed);
    c. Updating CATT clinician documentation system and requirements (in progress); and
    d. Alignment of Bonita House CARF (Commission on Accreditation of Rehabilitation Facilities) Standards for accreditation to bill to private insurance (in progress).
4. **CATT Program Collaborators** have noted a number of improvements to collaboration in the second year of the CATT pilot. There have been barriers to collaboration since launching the pilot. However, many interviewees have noted they feel the program is finally gaining momentum in a forward direction especially since positive results in program outcomes are being seen.

Despite challenges that have arisen and/or continue to persist, all CATT pilot interview participants agree that the "*CATT program is a vital countrywide behavioral health services that is necessary for the ongoing care and support of the community and behavioral health system*."

PROJECT NAME: Supportive Housing Community Land Alliance (SHCLA)

Across the Bay Area, an inadequate supply of housing stock, particularly affordable housing, has contributed to rising home prices, rental rates, evictions, displacement and homelessness. Over the past five years, there have been significant declines in the number of licensed board and care facilities, residential hotels, and room and board facilities frequently utilized by individuals living on fixed incomes. Individuals with severe mental illness living on fixed Social Security disability incomes experience some of the greatest challenges in finding and maintaining housing in this region.

Project Description: The Supportive Housing Community Land Alliance (SHCLA) (aka CLA; Land Trust; Land Trust Program), is based on a community land trust model, is a nonprofit, community-based organization designed to ensure community stewardship of land. Community land trusts are often associated with conservation efforts. However, the significant effort to ensure affordable long-term housing through this form of ownership is the SHCLA's mission. The SHCLA will acquire land and maintain ownership of it permanently. The SHCLA will enter into long-term, renewable leases with residents. If the resident leaves, the resident earns a portion of the increased property value. The remainder is kept by the trust, preserving the affordability and purpose of the property for future households.

The proposed Innovation Project is promoting interagency collaboration in order for the **Alameda County Supportive Housing Community Land Alliance to develop and maintain supportive housing units.** ACBH will be partnering with Alameda County Housing and Community Development Department, housing and real estate legal and financial experts, consumer/client representatives, family member representatives, and existing nonprofit affordable housing developers to develop a land trust focused on supportive housing that incorporates unique aspects in order to address local conditions.

The SHCLA began its anticipated partnership with the Office of Homeless Care and Coordination (OHCC) in July 2022. The project's grantee, Northern California Land Trust (NCLT) was given a seven (7) month no-cost extension until December 31, 2022 in order to support the project until it received its determination letter from the IRS making the SHCLA a fully recognized 501(c)(3) non-profit entity. The extension expiration will parallel the departure of the subject matter expert, Burlington Associates, whose contractual expiration will also be December 31, 2022. Although both of these important supporting parties are departing the project, the new entity, SHCLA, will enter into its own standard service agreement to complete the remaining two (2) years of the project.

SHCLA Summary of Challenges and Resolution

The Supportive Housing Community Land Alliance team has been working since October, 2020. Currently the SHCLA has been incorporated and filed its Form 1023, Application for Recognition of Exemption Under Section 501(c)(3) of the Internal Revenue Code (IRS) in December, 2021. The Form 1023 is used by the IRS to issue a determination letter or ruling letter that recognizes an organization's exemption from federal income tax. This is a final step for SHCLA to become a full-fledged non-profit entity enabling the county to contract with SHCLA directly.

This determination letter from the IRS did take much longer than anticipated. The IRS, who governs this type of determination, has been greatly behind schedule on these types of requests. However, SHCLA received its determination letter in October, 2022. Since non-profit status is approved, SHCLA intends to file the Board of Equalization's Welfare Exemption form BOE-277. This claim form

filed by a non-profit organization, seeks the welfare exemption from the county assessor, to request the issuance of an organizational clearance certificate to the organization. This clearance provides SHCLA tax exemption and the ability to purchase property and services under non-profit status.

The Advisory Committee began the project very strong with up to fifteen members. Since the previous plan update, many members have fulfilled their one (1) year commitment and have exited. The departure of many founding Advisory Committee members has left the committee with less than five (5) members. SHCLA executive director and NCLT have done a recruitment push and been successful. Although the Advisory Committee has yet to reach its previous heights, recruitment continues to seek out new members.

There have also been several board of directors who have resigned including the board president. These resignations have been due to personal reasons or to align the board membership in accordance to county regulations. Currently, there are a number of individuals being engaged to fulfill these positions.

Procurement of a project evaluator has been completed. The evaluator's contractual agreement will run concurrently with the remaining time of the project which concludes December, 2024. The evaluator and the county are currently in contractual negotiations.

The project's next steps include plans on strategic partnership to acquire properties with non-profits that are buying property, serving clients with SMI and delivering supportive services. There is continued pursuit to make request for information from organization to facilitate various models of partnership with existing organization for the SHCLA's prototype.

Additionally, a request for Capital Facilities and Technological Needs (CFTN) funding has been included in this plan update. The CFTN funding was identified in SHCLA's approved proposal to assist in purchasing board and care(s). Refer to the CFTN section for more information on MHSA's request for funding.

PROJECT NAME: Community Program Planning Process (CPPP)

Project Description: Alameda County Behavioral Health (ACBH) continues to be fully invested in having a dynamic community process that is inclusive of all community with 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.

The Community Project Planning Process (CPPP) occurs every three (3) years as per MHSA Innovation regulations. Alameda County's 3-Year CPPP was held between October – December, 2022 for community input for its MHSA 3-Year Plan Update FY2023-2026.

Information for the CPPP events and outcomes are documented in this plan update.[3]

[3] CCR, 9 CA ADC § 3200, 3200.060, 3200.270, 3200.90, 3300, 3315, 3320 & WIC 5848(a,b,f) & 5604.2(4)

Future INN Prospects

MHSA core values of community collaboration, cultural responsiveness, being consumer and family driven, system integration and resiliency and recovery focused all steer the direction that INN projects are to follow. MHSA staff has been vetting the many suggestions received to identify potential successful INN projects that will meet these core values, address the community priorities, and meet INN requirements. These potential projects will be presented to ACBH Systems of Care for further screening to ensure the potential projects additionally address external factors such as rates of crisis, substance use trends, community violence, trauma, staffing capacity and alignment with ACBH core values of **A**ccess, **C**onsumer & Family Empowerment, **B**est Practices and **H**ealth & Wellness.

There are two innovation ideas currently being developed to bring to the MHSOAC for approval in January, 2023. These are the forensics projects listed below. The third idea, listed below as INN idea 3 Peer-Based Strategies, Consumer Empowerment using CT-R, has an approach change and has been brought back to the community for input. All three (3) of these projects involve peer contribution and involvement for success:

New INN Programs under Development for Possible Future Procurement (see *Appendix B-5 for future proposals)*

INN IDEAS	Population	Problem Trying to Solve	Strategies
1. Peer- Led Continuum of Forensic Services	Peer focused; Mental health consumers at risk of or are justice involved	Many ACBH clients discharged from Santa Rita have few resources and supports, leading to potentially high recidivism rates	Peer Respite for at risk or Justice Involved Individuals
2. Alternatives to Confinement Continuum of Forensic Services	Clinical focused for mental health consumers at risk of or are justice involved	Prevention of incarceration and divert individuals from criminal justice system into mental health services	Provide alternative treatment setting for people who do not require services in a locked environment to stabilize
3. Peer-Based Strategies, Consumer Empowerment using CT-R	Peers and Consumers	How to engage more of our ACBH clients in using CT-R therapeutic supports while utilizing peers	Web-based CT-R skills trainings developed for peer to facilitate online and in person CT-R skills practice groups

Forensic Services Summary

Alameda County faces the issue of people with serious mental illness (SMI) experiencing incarceration as one of the most prominent challenges facing the behavioral health and cranial justice communities. It is more likely that an individual will be booked into jail than be engaged in treatment thus creating jails as large mental health institutions.

The two forensic proposals were born out of Alameda County Behavioral Health Services and Forensic System Redesign Plan Update, May, 2021[4]. The two innovation plans, *Peer-led Continuum of Forensic Services* and *Alternative to Confinement Continuum of Services,* arose out of the county's efforts to divert individuals with mental health challenges from the justice system into mental health services. Both of these innovation plans were developed for and by community stakeholders, including the County's Justice Involved Mental Health Task Force.

1. Peer-led Continuum of Forensic Services

The Peer-led Continuum of Forensic Services is a collection of four (4) components: Reentry Coaches, WRAP for Reentry, Forensic Peer Respite, and Family Navigation and Support. Three are peer-led and one is family focused. The project specifically seeks to:

- Support mental health consumers who are justice involved by helping them transition back into the community following an arrest or incarceration;
- Identify and address the issues that led up to their arrest and/or incarceration, and connect with mental health and other services to support them in their recovery and reentry journey; and
- Seeks to build the capacity of family members to advocate on behalf of their loved one with a serious mental illness who has become justice involved.

As a result of the continuum of services, we expect that individuals will experience fewer episodes of arrest and/or incarceration and will have increased participation in ongoing mental health and other services.

2. Alternatives to Confinement Continuum of Forensic Services

The Alternatives to Incarceration Continuum of Forensic Services is a collection of three (3) services that work together and are intended to prevent incarceration and divert individuals from criminal justice system into mental health services. These services are Forensic Crisis Residential Treatment, Arrest Diversion/Triage Center, and Reducing Probation/Parole Violations. This continuum of care specifically seeks to divert individual from incarceration when:

- A mental health consumer who is forensically involved begins to exhibit early warning signs of a crisis with behaviors that may lead to police contact;
- At the moment of police contact that may result in arrest, and
- The person has fallen out of compliance with their probation or parole and is subject to re-arrest.

[4] http://www.acgov.org/board/bos_calendar/documents/DocsAgendaReg_5_10_21/HEALTH%20CARE%20SERVICES/Regular%20Calendar/Item_1_ACBH_Services_Forensic_sys_5_10_21.pdf

Using models from mental health and other disciplines, these three interventions collectively provide an opportunity to divert forensic mental health consumers from police contact that may result in being detained, from being arrested or booked into the jail if detained, and from being re-arrested if unable to comply with the terms and conditions of their release. These priorities for diversion arose out of the sequential intercept mapping process with Alameda County's Justice Involved Mental Health Task Force and focus on preventing entry into the criminal justice system as well as promoting exit from the criminal justice system.

The proposals for the Peer-led and the Alternative to Confinement forensic continuums of care are listed in the Appendix.

3. Consumer Empowerment Using CT-R (Recovery-Oriented Cognitive Therapy) Summary

The consumer empowerment proposal originally came out of the County's Community Program Planning Process (CPPP) meetings during February – May 2020 identifying Dialectical Behavior Therapy (DBT) as the training mental health approach. During a larger webinar focus group, DBT online training was presented as an idea for uplifting peers. The webinar included stakeholders, and the County's Peers Organizing Community Change (POCC, and formerly known as Pool of Consumer Champions) agreed that this would be a good pilot project to support. However, in the spring and summer of 2022, it was decided to change the treatment approach that would be taught online from DBT to Recovery-Oriented Cognitive Therapy (CT-R). The change was brought forth because CT-R allows clients to find their own through life's challenges while in recovery. Peers have an intimate understanding to these challenges and are well-suited to learn CT-R skills.

The CT-R project will develop an online Recovery-Oriented Cognitive Therapy (CT-R) Peer to Peer training program to train peers with the skills of CT-R. This program is to provide new skills as peers enhance their hire ability and increase their skills as peers when practicing within peer to peer groups. ACBH wishes to provide a learning environment that is removed from restrictive time and space. An online training program is able to provide an avenue that is self-paced, recovery-oriented mode of learning for peers to cultivate relationships with others committed to learning, practicing, educating others about, and building mastery of the CT-R skill sets.

There are a number of ideals that coincide with the peer recovery philosophy that make it an excellent fit with peers:

- CT-R focuses on empowering individuals with serious mental health conditions to live the life they want to be living;
- CT-R is grounded in the premise that recovery is possible for everyone no matter how long it may take;
- Implementation of CT-R can be utilized in either individual or group-based settings and especially useful in the treatment setting;
- CT-R is particularly applicable for people who would not engage in treatment due to mistrust, chronic institutionalization, limited access to motivation, limited verbalization, or intensity of symptom presentation falls within the POCC's ideals of personhood: individuals in recovery are whole human beings and deserve removal of stigma and discrimination; and

- The shared human potential focused view of recovery and resiliency, CT-R, like mutual peer support, nurtures hope and empowers individuals with serious mental health conditions to actively experience the type of flourishing life they want to live.[5]

It is these parallels in philosophy that makes CT-R training to peers very appealing to refresh and broaden the skills of peer support specialists. At this time, CT-R continues to be vetted in the County's current CPPP. An in-depth proposal will be submitted in the next fiscal year plan update after community stakeholders have had sufficient time to review and comment during the CPPP.

[5] These parallels were drawn from The Beck institute's website: https://beckinstitute.org/blog/what-is-recovery-oriented-cognitive-therapy-ct-r/

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 Success Story

Sharnell Smothers: Ohlone College Mental Health Advocacy Program

Sharnell Smothers is one of the Ohlone Community College students who has participated in many of the behavioral/mental health career pipeline programs. *We are inspired to share her achievements and success!*

"When I enrolled at Ohlone Community College I chose Business Administration as my major due to my background in finance. I had also recently been diagnosed with depression. At the time I did not understand what the diagnosis meant for me; all I knew was that I could finally put a name to what I was experiencing.

Like most people who have dealt with mental health challenges, I faced a great deal of stigma. Many of my family & friends expected me to "snap out" of my symptoms. The stigma I was subjected to caused me to go into isolation which worsened my condition. It was not until my mental health started to affect my parenting that I decided to research my illness. Through research, I was able to gain a better understanding of my personal situation, which ultimately ignited my interest in Psychology, which I later changed my major to, as I was eager to learn more about behavioral health.

In the Fall of 2020, I was fortunate enough to be accepted into Ohlone College's Mental Health Advocacy Program. It was here that I learned about the different dynamics of mental health. As an African American student, I identify the most with challenges that directly affect the African American community, such as being disproportionately impacted by the stigma associated with mental health. For my service-learning project I ran a campaign called Stamp Out Stigma; Seek support. I presented to a small group of UMOJA students. One of my main goals was to educate my peers how to identify symptoms of mental illnesses so they know when it is time to seek or provide support.

Shortly after, I was accepted into the Mental Health Equity Scholars program. It was in this program that I was exposed to the mental health challenges of different people groups. I developed a sense of compassion for each group as I could easily identify with their struggles. I later became a Senior Student Wellness Ambassador where I organized special projects for my peers at Ohlone. We teamed up with local agencies to connect students with resources.
STEPUp Ohlone programs have been a driving force behind my desire to pursue a career in social work. Each program that I have participated in has greatly contributed to my professional growth. With

everything I learned, I've always reverted it back to myself. I realized that not everyone struggling with their mental health can find the strength to do the research for themselves. Many obstacles that may impact a person's mental health can be solved with the right resources. Therefore, it is my purpose as a future Social Worker to help improve the lives of others with the hope of reducing mental health issues.

Presently, I am happy to say that I was recently accepted into the 2022/23 BASW program at San Francisco State University! My overall goal is to pursue an MSW and eventually become a Psychiatric Social Worker. As a single parent, I am so grateful to be receiving the Alameda County Behavioral Health Career Pipeline scholarship. Receiving a scholarship that contributes directly to mental health heightens my motivation to make an impact in the field. I am also very thankful for the mentorship portion of the program as I believe having the guidance of a mentor throughout this journey will inspire me to remain on the path to achieving my goals.

Thank you for this life-changing opportunity and for the positive impact the Ohlone Step-Up program has made in my life."

Client Success Story

Prem Pariyar: Center for Empowering Refugees and Immigrants (CERI)

Prem Pariyar is originally from Nepal, and was one of CERI's Wellness in Action's first program participants. He holds a Bachelor's degree in Education from Nepal and completed his MSW at Cal State East Bay in 2021. He is now working full-time as an Associate Mental Health Clinician at Hume Center, providing mental health services to Nepali and other South Asian communities. Prem is also an active Nepali community member and an advocate against caste-based discrimination. *This is his success story*:

"When I first arrived to the United States in 2015 seeking asylum from caste-based persecution, I worked in many kinds of service jobs. Not long after, I heard about a program called Richmond Leadership Institute, thanks to community leader Anupama Chapagain, Wellness in Action (WIA) program manager. At that time, I had the opportunity to work with Patricia, WIA co-founder. When Wellness in Action launched in the Fall of 2016, I was very motivated to apply. There were two other Nepali participants in the program, and we understood firsthand the stigma surrounding mental health in Nepal. We decided to hold a focus group to learn more from our community. It was very eye-opening, and was a launching point to do more! People became curious and engaged in the conversation. This was the first time that community leaders, academic partners, and many others from the Nepali community in the Bay Area came together to talk about mental health openly.

We discovered there was a gap in services in the Nepali community and began thinking of ways in which we could creatively address them. Wellness in Action supported our work, helped us develop community input questions, and taught us to strengthen facilitation skills.

The experience with Wellness in Action was foundational for me. I began to grow as a community leader to serve my community at other organizations in different capacities. My desire to pursue a mental health career became stronger as I developed confidence in my abilities. I went on to complete a graduate degree in Social Work at California State University. It was at Cal State that I began advocacy work against caste-based discrimination, and my department adopted "caste" as a protected category. Not only that, but the Academic Senate passed the Caste Resolution unanimously! Hence, all 23 universities in the CSU system adopted caste as a protected category in the anti-discrimination policy, with many more universities discussing this too!

I currently work at the Hume Center and with Equality Lab, an organization that fights caste-based stigma. I continue to be a passionate advocate to break down mental health stigma. I am also an elected delegate in the National Association of Social Workers from California and serve as the Human Relations Commissioner in Alameda County. Through this commission, I would like to bridge the gaps in the community through policy - the right policies matter for underrepresented communities. I continue to have higher education goals as well. Recently, I applied and was admitted to some doctoral programs in the Bay Area. Wellness in Action gave me the confidence to continue building my career and aspire to do more in this field.

I had lost hope, but I became aware of many things thanks to Wellness in Action and the opportunities they offered me. What was key to my learning, development, and growth was that other Mental Health professionals came alongside me, giving me to the chance to work alongside people from other communities. This is not an experience I had in my own country; to be able to address stigma across caste systems. To this day, I carry the motto of Wellness in Action, "When "I" becomes "WE", illness becomes wellness" (Malcolm X)."

Client Success Story

Gabriela Agulair: Mental Health Navigator Program at Ohlone College

Gabriela Agulair was a student participant at the Alameda County Behavioral Health Navigator Program at Ohlone College and is a current scholarship recipient of the Alameda County Behavioral Health Career Pipeline and Mentorship Program.

She is a full-time student, mom of three, and member of Active Minds' Student Advisory Committee, working to change the conversation about mental health. She is currently CSUEB transfer student working on her

Bachelor's with a major in psychology. We are inspired to share her passionate story about “Mental Health in My Hispanic Home: Breaking Generational Cycles”.

“Imagine coming home to your mom and asking her to do something you know she would never let you do, but you still ask. You feel that knot in your stomach, and your voice starts to quiver. Growing up, this is how I – and many other Hispanic children and young adults I knew – felt when asking our parents for help with our mental health. When we’re not feeling good, when we’re feeling depressed, or when we can’t or don’t want to get out of bed, our parents constantly remind us of their struggles. They remind us of how hard they’ve had it, and how they just snapped out of it, and we should be able to “get over it, too”. That’s precisely how for many of us, mental health was treated in our Hispanic homes.

The unfortunate reality is that for many in the Hispanic community, there’s no such thing as mental health or constructs for healthy family dynamics. That was my reality growing up as a Hispanic undocumented girl in California, living between low and middle-class households, around abuse, alcoholism, and abandonment. I had no idea for a long time what I was missing, and didn’t even know about the existence of mental health services until I met my middle school counselor. She was the main reason I began understanding my many struggles, reality, and circumstances. But to be honest, the inequities I experienced with **limited resources and nearly impossible support due to the stigma in the Hispanic community** around mental health were highly discouraging, and greatly delayed my ability to get the help I needed even when I learned of the resources available.

Fast forward to today: I am 37 years old, a mother of three, still unable to qualify for affordable medical care, and mental health services available to me remain almost non-existent. I am able to receive a few sessions per semester at my college, and after that, it’s back to the system that also has limited resources. I decided to be part of the solution.

While they haven’t always completely understood mental health in the way I needed, my family has been a tremendous resource to me in adulthood and has always reinforced my resilience by reminding me of how strong I’ve been and how strong I should continue to be. And as important as that resilience is, I’m done with having that be the only support I allow myself, I’m done with the silence, and I’m done perpetuating this generational cycle around mental health. It’s taken me a while to get here, but I’m ready to not only tell my children that it is okay not to be okay, but that it’s okay to take a day off and be with your thoughts, mend your feelings, and tend to your soul and needs. I’m ready to show them through example, vulnerability and truth.

To think that I was not only traumatized by my own life experiences, but that I had also begun to subconsciously mirror the life that my mother had lived, experienced, and suffered was and is painful. Being an immigrant, a woman, and a mom to three kids, I can only imagine what she felt through her experiences. I know that a lot of my resilience and inquisitiveness to fight for injustice and equity for my community is rooted in the pain I saw in my mother’s eyes, not knowing how to cope with life at times and dissociating from much of her trauma. I know that most of my desire and drive to pursue psychology and become a family and marriage therapist was because I always saw the need for more Hispanic women to model positive mental health behaviors, especially to **destigmatize the topic of mental health services.**

Life at times has led me down pathways that might have derailed my career. Still, I know they have brought me to the right place in the end, and with the right mindset to move forward with the hope that I can make a difference and support other women, mothers, and immigrants to find healing.”

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 Development and Staffing
2. Training/Technical Assistance
3. Mental Health Career Pathways
4. Internship Coordination and Residency Programs
5. Financial Incentive

1. Workforce Development and Staffing

Program Description: Provides infrastructure to manage the development, implementation and evaluation of all Workforce Education and Training (WET) programs and initiatives. Spearheads partnerships with community-based organizations, peer-run agencies, educational institutions and local, regional and state agencies.

FY 21-22 Outcomes, Impact, and Challenges:

- Workforce Education and Training (WET) has been transferred from the Mental Health Service Act (MHSA) division to the Office of the Alameda County Behavioral Health (ACBH) Director effective October, 2021. This transformation highlights an opportunity to further support WET, both externally and within the community, through a broader departmental perspective.

- As part of the organizational structural changes within ACBH, in October, 2021; the WET team transitioned to be under the leadership of the Office of the Behavioral Health Director. The director's vision is to have a more coordinated effort for trainings across the department and to develop a departmental training plan.

- WET being under the leadership of the Office of the Behavioral Health Director, it's anticipated that there will be more coordination of trainings being offered by the various ACBH units and programs and there will also be department-wide trainings.

- ACBH is committed to continue WET activities. WET is currently funded through the MHSA Community Support Services (CSS) component and is focusing on workforce capacity building through behavioral health career pipeline development, training opportunities, and addressing strategies to recruit and retain hard to fill positions, increasing diversity, bridging gaps in skills set and improving language capacity.

- On March 24, 2020, Alameda County and California Mental Health Services Authority (CalMHSA) executed a participation agreement (PA) to implement *the local Alameda County Loan Repayment Program (ACLRP)* with ACBH WET. On October 8, 2020, Alameda and CalMHSA mutually amended the ACLRP agreement by which CalMHSA agreed to continue to act as administrative and fiscal intermediary in the implementation of a second cycle of the ACLRP.

- In FY21/22, Alameda County Workforce Education and Training (WET) local Loan Repayment Program (ACLRP) was transitioned into the State-funded Regional Workforce Education and Training (WET) Partnership Program (RP). The loan repayment program opportunity started as a local program (Alameda County Loan Repayment Program - ACLRP) and was then transferred to the Workforce Education and Training Program, overseen by the Department of Healthcare Access and Information (HCAI). Each ACLRP applicant who initially applied through CalMHSA's "Bonfire" portal was asked to re-apply and be re-evaluated through the HCAI application portal.

- In FY21/22, Alameda County WET implemented the Behavioral Health Loan Repayment Program (BHLRP) and the Alameda County Behavioral Health Career Pipeline and the Scholarship and Mentorship Program for undergraduate students funded by the State Department of Health Care Access and Information (HCAI).

- ACBH WET hired a new Training Officer effective May 16, 2022 following the retirement of the previous Training Officer in January, 2022.

- The WET team continues to prioritize, develop and implement projects based on the 2017 workforce needs assessment survey outcomes.

FY 22-23 Progress Report:

- ACBH WET is increasing WET infrastructure to support department wide trainings to ACBH staff and contracted community-based providers. ACBH WET is in the process of hiring three additional staff including a program coordinator for the Pipeline projects, and a program coordinator as well as an administrative assistant for the WET training unit.

- The current Workforce Education and Training Manager has been in this position since January 2012 and will be retiring from the County in February 2023. The WET team will continue to support all operations as required by the state and all other entities. The Office of the ACBH Director will launch a recruitment for an Interim WET Manager and an eventual formal permanent recruitment process.

- ACBH and CalMHSA executed the Regional Partnership (RP) Loan Repayment and the Behavioral Health Career Pipeline Scholarship and Mentorship Program Participation Agreement (PA) funded by the State Department of Health Care Access and Information (HCAI) on May 26, 2022. Both parties executed a first amendment of the ACBH RP Participation Agreement (PA) on September 27, 2022 morphing it into a PA that works for the WET Regional Partnership (RP) activities. The first restated agreement of the Behavioral Health Career Pipeline Scholarship and Mentorship Program was executed between the Ohlone Community College and ACBH WET on November 10, 2022.

- The total OSHPD/HCAI grant allocation for Alameda County Partnership Agreement is $2,102,701.02 from July 1, 2020 through June 30, 2025. There is a matching amount required for all Greater Bay Area (GBA) participating counties and Alameda's total County Match Fund requirement under the 2020-2025 WET RP is $521,722.91. Upon signed agreement, Alameda County reallocated funds previously allocated to the local Alameda County Loan Repayment Program (ACLRP) toward the OSHPD/HCAI WET RP for the purpose of fulfilling its County Match Fund requirement. Alameda County used the ACLRP contract funds (2nd cycle, FY21-22) with CalMHSA towards Alameda's match amount of $521,722.91.

- Alameda County worked with CalMHSA on transitioning the ACLRP cycle 2 applicants into the WET RP round 1 of the Behavioral Health Loan Repayment Program (BHLRP), in order to bring the ACLRP in alignment with the WET RP funding, program timeline, and other program requirements.

- Alameda County launched the State funded Behavioral Health Loan Repayment Program (BHLRP) round two application cycle from October 1 through November 30, 2022. Recently the date has been extended through December 15, 2022 as a result of a decision made at the RP Lead level in efforts to increase the volume of applications received.

- Every five years, OSHPD develops a WET plan to address specific workforce needs. The State allocates funding to the five Regional Partnerships across California, including the Greater Bay Area Region based on the MHSA funding formula. The 2020-2025 State Workforce Education and Training (WET) program aims to address the shortage of mental health practitioners in the public mental health systems (PMHS) through a framework that engages Regional Partnerships and supports individuals through five categories including: Pipeline Development, Loan Repayment Program, Undergraduate College and University Scholarships, Clinical Master and Doctoral Graduate education stipends, and Retention Activities.

- Based on local Alameda County WET programming and previous Mental Health Service Act Community Program Planning Process (CPPP) information, Alameda County WET opted to implement the Behavioral Health Loan Repayment Program (BHLRP) for eligible clinical staff and the Behavioral Health Career Pipeline Scholarship and Mentorship Program for undergraduate students following OSHPD's framework.

FY23-24 Anticipated Changes:

- ACBH WET will conduct a workforce needs assessment survey in FY 23/24 to inform any program implementation changes during FY 23-24.

2. Training/Technical Assistance

Program Description: Provides a coordinated, consistent approach to training and staff development. Develops, researches and provides a broad array of training related to mental health practice; wellness, recovery and resiliency; peer employment and supports and management development.

1. ACBH Training Unit

FY21-22 Outcomes, Impact and Challenges:

- From the period of July 1, 2021 – June 30 2022, the ACBH Training Unit (TU) provided or collaborated in a total of 71 training activities; trained a total of 2469 ACBH and contracted provider (CBO) staff. The TU sponsored and provided a total of 302 continuing education (CE) credits to LCSWs, LMFTs, LPCCs, LEPs, Addiction Professionals, and RN's, and 252.5 CE hours for Psychologist.

- Training topics covered a variety of issues including, but not limited to, Mental Health First Aide; Adult and Youth Suicide Assessment & Intervention; Preventing, De-Escalating, and Managing Aggressive Behavior in Behavioral Health Settings; Tobacco Cessation Interventions; Legal and Ethical issues; and

trainings related to Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS).

- Provided trainings related to trauma informed care including "Surviving Compassion Fatigue a.k.a Secondary and Vicarious Trauma"; "Understanding Nervous System Regulation and Culturally Sensitive Restorative Practices for Providers and Clients in Times of Crisis." The training "Trauma Informed Standards, Practices, and Strategies for Healthcare Organizations: Safety Talk in the Context of CLAS and Cultural Competency" was provided by the Office of Ethnic Services and supported by the training institute.
- Provided five (5) trainings in Adult Mental Health First Aid (MHFA) and two (2) Youth MHFA trainings thereby certifying 75 ACBH and provider staff. An additional six (6) MHFA trainings were provided to the community including two (2) that were provided to 23 staff of the Fremont, Union City, and Albany City Library branches.
- Provide continuing education credits for the California State University East Bay two-year post graduate Infant and Early Childhood Mental Health certificate program in which 15 students are enrolled.

- Provided five (5) trainings in Adult Mental Health First Aid (MHFA) and two (2) Youth MHFA trainings thereby certifying 75 ACBH and provider staff. An additional six (6) MHFA trainings were provided to the community including two (2) that were provided to 23 staff of the Fremont, Union City, and Albany City Library branches.

- Training outcomes are measured using self-administered evaluations. Each training proposes measurable learning objectives to be achieved by the end of the training. Following the training, attendees evaluate whether the objectives are met using a Likert scale from 1-5 (strongly disagree to strongly agree). They also evaluate the training content, instructor, technology, accessibility, and program administration. At the end of every training, participants are encouraged to complete an evaluation and if they want continuing education credit, it is required. For all trainings, evaluation data results indicate all outcome measures are being met on an average of at least a 4 or 5 of the Likert scale, with 5 being "strongly agree."

Challenges:

- For the Mental Health First Aid (MHFA) trainings, the transition from in person trainings to the online platform presents a challenge and limitation because participants need to complete 2-hours of pre-work prior to the instructor-led online training. For all scheduled trainings an average of 2-4 out of 20 registrants did not complete the prework. There are always a number of no shows for in person trainings as people's schedules and circumstances change, but the requirement of prework plus the ability to use an online platform presents additional hurdles for persons who want to get certified in MHFA.
- There continues to be challenges related to the Learning Management System (LMS), SumTotal, that was purchased in 2019. Although there was a plan to "go-live" with the new system in May 2020, because of system glitches and challenges with getting user accounts for the 4,000+ contracted provider staff, the number of licenses has been reduced to 400 which has limited its use. Currently the LMS's use in the Training Unit is creating accounts for contracted ACBH employees to complete mandatory HIPPA/Privacy courses during their on-boarding.

FY22-23 Progress Report*:*

- For FY 2022, beginning July 1, 2022: As of November 7, 2022, the Training Unit has thus far provided or collaborated in a total of 16 training activities and trained 496 ACBH and contracted provider staff. The

Training Unit has sponsored and provided 56.5 continuing education (CE) credits to LCSWs, LMFTs, LPCCs, LEPs, Addiction Professionals, and RNs, and 44 CE hours for Psychologists.

- Training topics were provided on a variety of issues including adult and youth suicide assessment & intervention, mental health first aid, de-escalating and managing aggressive behavior, and trainings related to trauma, responding to crisis, and using a telehealth platform.
- Continue to maintain provider accreditation and offer required continuing education (CE) credit for Licensed Clinical Social Workers, Licensed Marriage and Family Therapists, Licensed Professional Clinical Counselors, Licensed Educational Psychologists, Licensed Clinical Psychologists, Registered Nurses.
- By the end of the 21/22 fiscal year eight mental health first aid trainings will be provided virtually for between 140 and 150 county and contracted provider staff. Five of the trainings are Adult Mental Health First Aid and three are Youth Mental Health First Aid.
- ACBH WET hired a new Training Officer effective May 16, 2022 following the retirement of the previous Training Officer in January, 2022.

FY23-24 Anticipated Changes:

- As part of organizational structural changes within ACBH, in October the Workforce Education and Training (WET) team transitioned to be under the leadership of the Office of the Behavioral Health Director. The director's vision is to have a more coordinated effort for trainings across the department and to develop a departmental training plan.
- The training unit is in the process of hiring a program coordinator and an administrative assistant. It is anticipated that due to the growth in its capacity; TU will be able to step-up, support and coordinate additional systemwide trainings.
- While training for the foreseeable future continues to be Internet based, the training unit is looking forward to some version of in person training and anticipates the development of hybrid sessions that give the learner a choice between online or in person training experience.
- The training unit looks forward to expanding training topics and offering curriculum that meet the needs of our systems of care as well as our community-based organizations. The use of focus groups as well as surveys will help us better understand community need and create new partnerships that will enhance delivery of educational services throughout the system.
- The training unit sees the consolidation of SumTotal and Cornerstone as an opportunity to revisit the ways the training unit utilizes the LMS system. We are hoping that issues of data collection as well as the ability to use the system will be addressed in more creative and effective way. We are excited about the opportunity to provide online learning content including but not limited to courses, videos and other training materials

To view the detailed report of training offerings for FY 2021-22, see:
"Appendix 1 _FY 2021-22_MHSA WET_TrgInst_Summary of Trainings"

2. <u>ACBH Office of the Medical Director - Workforce Development and Training Activities</u>

Alameda County Behavioral Health, Office of the Medical Director (OMD), Workforce Development Programs and Services are aimed at building the skill set of the behavioral health and primary care workforce in Alameda County to deliver high quality culturally responsive care management services to complex and high need behavioral health clients. The following types of "on-site" workforce development trainings and mentoring opportunities for primary care and behavioral health Safety Net providers illustrates the continuous commitment of ACBH to providing quality care services to its underserved and low-income residents during FY 2021/2022:

- The continuous funding of a yearlong on-site clinical Fellowship experience for one (1) selected UCSF School of Psychiatry student at the Health Care Services Agency, Healthcare for the Homeless Services, TRUST Primary Care Clinic.

- The embedding of ACBH, Primary Care Psychiatric Consultation Program (PCPCP) in eight Alameda County, Federally Qualified Health Centers (FQHCs) and one HIV Specialty Health Center to help primary care providers and behavioral health clinicians improve their skills in treating and diagnosing psychiatric conditions that are often presented in the primary care setting. With the Consultant Psychiatrists having access to and understanding of the County's specialty behavioral healthcare system, they continue to be a bridge for care coordination for Alameda County's primary care Safety Net System. The program continues to help improve service capacity in the primary care clinics by helping their medical and behavioral health providers improve skills and comfort level when diagnosing and treating primary care patients with complex behavioral health conditions.

- During the last six months of PYS, the Primary Care Psychiatric Consultation Program (PCPCP) staff were able to provide 2,683 consultations services and 37 training presentations to primary care providers and behavioral health clinicians in nine Alameda County Community Health Centers.

- During 20/21, the Primary Care Psychiatric Consultation staff were able to provide 2,683 consultations services and 37 training presentations to primary care providers and behavioral health clinicians in eight Alameda County Community Health Centers and one HIV Specialty Care Health Center. With the Primary Care Psychiatric Consultants being ACBH staff, they have also helped to improve care coordination by assisting Safety Net primary care providers and behavioral health clinicians learn how to properly complete the required screening documents for the ACBH, ACCESS Office that will facilitate a high need patient's approved admission into the County's Specialty Mental Health or SUD Systems of Care.

- ACBH has continued to fund 12 Integrated Behavioral Health Care Coordinators (IBHCCs) positions in eight Alameda County FQHCs. During the past fiscal year, the ACBH funded IBHCCs provided 1,775 client care coordination referrals to ACBH, Specialty mental health services and 107 client referrals to ACBH, Substance Use Disorders services.

Pediatric Care Coordinator Pilot

In January, 2021, ACBH approved Alameda Health Consortium's (AHC) request to fund a new pilot Workforce Development Project to support one Pediatric Care Coordinator (PCC) position in eight Alameda County, community health centers. The PCCs are responsible for linking pediatric clients to medical, behavioral, and social services, as well as act as the liaison between the client and the community, and serve to dissolve the silos between the health center's medical and BH departments' staff. They are also working to support young clients with the basic health and social needs to minimize their risks for entering

the criminal justice system as adults. In May, 2022, AHC requested MHSA funding for three additional PCC positions with one being placed in La Clinica de la Raza, Tiburcio Vasquez Health Center, and Asian Health Center starting July, 2022. The PCCs provided 9,6T8 care coordination services to pediatric patients and their families during FY 21/22:

1. Number of clients referred to wraparound services: 5,052
2. Number of clients given BH, pediatric, or trauma screenings: 3,426
3. Number of clients that screen positively for ACEs, and are given appropriate follow-up resources: 1,200

3. Mental Health Career Pathways

Program Description: Develops a mental health career pipeline strategy in community colleges, which serve as an academic entry point for consumers, family members, ethnically and culturally diverse students, and individuals interested in human services education, and can lead to employment in the ACBH workforce.

FY21-22 Outcomes, Impact and Challenges: MHSA WET provided funding to FACES for the Future, Ohlone Community College, Center for Empowering Refugees and Immigrants (CERI), Beats Rhymes and Life and California State University East Bay (CSUEB) to develop Mental Health Career Pathways. ACBH WET has partnered with the contracted organizations and programs and implemented the following programs and/or activities:

1. FACES for the Future

- Bright Young Minds (BYM)conference introduces students to careers in behavioral health. The FACES for the Future successfully implemented the Bright Young Minds virtual conference in partnership with Alameda County Behavioral Health and Eden Area Regional Occupational Programming. Serving students from across Southern Alameda County, the event was held April 19 and April 20, 2022 and included workshops on trauma informed practice, wellness and grief recovery. 150 students from Hayward, San Leandro, San Lorenzo, and Castro Valley participated in the two-day virtual event. Also, 90 seniors were certified in Mental Health First Aid to support advancement in their professional and college pathway.
- The FACES for the Future team supported the teachers and staff at Skyline High School in Oakland by participating in senior capstone project panels and FACES Deputy Director has joined the Advisory Committee for the health pathway. This participation will include providing trainings for students, working with teachers to identify opportunities to learn more about career pathways into behavioral health and so on. FACES will continue their partnership with the Skyline community in FY22/23.
- FACES supported Behavioral Health pipeline program alumni this year by including them in the Youth Advisory Council (YAC). The YAC supports students with direct mentorship, youth leadership opportunities and a stipend for their participation. Interested alumni are recruited during the Fall and are accepted into the program in December, 2021. In FY21-22 six alumni participated in the YAC and attended many meetings. The students also completed a video highlighting wellness strategy that was distributed throughout the FACES network.
- FACES continued its deep partnership with Eden Area Regional Occupational Programming (ROP) and implemented its FACES Public Health Youth Corps project on-site. This work provides students with some introductory training and certification in 4 professional skills: Mental Health First Aid, Basic Life Support/CPR,

Narcan (for opioid overdose intervention) and Stop the Bleed (for trauma and injury). This program not only helps students be more competitive as they enter the fields of behavioral health but also provides needed safety net crisis and emergency management skills in high need communities. FACES will continue this work moving into the next fiscal year beginning July 1, 2022.

2. <u>Ohlone Community College Mental Health Programs</u>

A. Mental Health Advocacy Program

- In March 2021, Ohlone Community College in collaboration with ACBH WET hosted an online behavioral health career panel and mentoring event to bring awareness of the wide variety of behavioral health careers to students already serving in their school as mental health navigators and advocates. The larger goal was to foster and grow students into a career pipeline with interactive experiences in order to attract an emerging, diverse workforce to the behavioral health care field.

- Ohlone College hosted two cohorts of the Mental Health Advocacy Program which included nineteen students from a wide range of affinity groups, including Student Accessibility Services, Puente Learning Community, Veterans, and undocumented students.

- Students' service learning projects included events and campaigns such as "Caring for Burmese Community Mental Health", mental health promotion for veteran students, and a resiliency-focused campaign.

- A proposal was submitted to Ohlone College's Curriculum Committee to transition the Mental Health Advocacy Program into a two-series noncredit certificate program titled 'Certificate of Completion in Community Mental Health" I and II.

B. Mental Health Navigator Program

- The 2021-22 navigator cohort consisted of eight students representing four community colleges: Berkeley City College, Chabot College, Las Positas College, and Ohlone College; this was the second cohort of the program.

- Mental health navigators provided a total of 91 case management services to their peers across all four participating campuses. Among those that received navigator services, 66% were female clients; 76% needed mental health counseling services; 20% needed health insurance coverage support; 11% needed housing resources.

- A mentorship component was added to the program that included guest speakers who shared their career trajectory during team meetings and at Saturday morning breakfast roundtable convenings.

- Mental health navigators contributed a special 'Navigator Take Over' podcast series as part of Ohlone's 'Note to Self' podcast program. They produced a total of six episodes on topics such as "How to approach family or friends struggling with mental health," "What's with these long wait lists for services?" and "Lack of affordable housing." Episodes can be found on Spotify and SoundCloud.

- A peer reviewed manuscript describing the navigator's first year pilot program titled "Community College Mental Health Navigators: A Pilot Program to Improve Access to Care" was published in the

May 2022 issue of *Health Promotion Practice* journal. The article can be found here: https://journals.sagepub.com/doi/full/10.1177/15248399221090917

C. Alameda County Behavioral Health Career Pipeline Scholarship and Mentorship Program

- The Alameda County Behavioral Health Career Pipeline Scholarship and Mentorship Program was launched in Spring 2022 with a team consisting of a program director and two student assistants who conducted outreach to eligible campuses and programs.
- Outreach efforts included presentations to the Alameda County Mental Health Forum, six drop-in information sessions via Zoom, seven presentations to stakeholder groups, and twelve presentations and tabling events to select clubs and classes.
- Outreach materials were developed which included a scholarship program webpage, a brief promotion video, an informational PowerPoint slide deck; and various flyers.
- A total of nineteen scholarship applications were received; eleven students have been awarded financial scholarships to support their undergraduate education and participate in a mentorship program.

FY22-23 Progress Report:

- The StepUp Mental Health Program at Ohlone College explored the curriculum approval process with the College Curriculum Committee Chair in response to the WET manager proposing institutionalizing of the Wellness, Recovery and Resiliency curriculum.
- Ohlone College's Curriculum Committee approved the proposed request to transition the Mental Health Advocacy Program into a two-series noncredit certificate program titled 'Certificate of Completion in Community Mental Health" I and II. The certificate program is based on ACBH's commissioned curriculum on wellness, resiliency, and recovery. The college's Curriculum Committee approved the proposals which means that Ohlone will no longer need funding of Alameda County Behavioral Health; instead, the college will benefit from receiving apportionment dollars from the state for enrollment.
- In March 2022, Ohlone Community College in collaboration with ACBH WET hosted an online behavioral health career panel and mentoring event to bring awareness of the wide variety of behavioral health careers to students already serving in their school as mental health navigators and advocates. The larger goal was to foster and grow students into a career pipeline with interactive experiences in order to attract an emerging, diverse workforce to the behavioral health care field.

FY23-24 Anticipated Changes: ACBH WET is anticipating expansion of the Mental Health Navigator Program in FY23/24.

3. CERI: Center for Empowering Refugees and Immigrants

- ACBH WET funded Wellness in Action (WiA), a workforce development program, at the Center for Empowering Refugees and Immigrants (CERI). WiA develops career pathways in the mental health field and improve mental health access for underserved refugees and immigrants. WiA works with *community*

leaders from indigenous, refugee, and immigrant communities interested in promoting mental health and wellness. WiA offered eleven mini-grant awards to support grassroots community leaders and provided technical and clinical consultation and skill building trainings for careers in community mental health. To view the Wellness in Action mid-term report, see:
Appendix 2_MHSA WET_FY 2021-22_CERI MiniGrant Midterm Report

4. Beats Rhymes and Life

- Beats Rhymes and Life (BRL) is a newly funded MHSA WET Program to increase educational pathways and training for Transition Age Youth (TAY) to enter the human services professions such as social work, psychology, nursing, education, and our Hip-Hop Therapy model. BRL supports TAY in their educational and vocational development. Participants learn skills in how to work with youth as peer monitors and artistic instructors. The 1st 12 weeks of instruction focus on facilitation skills, group work and artistry skills while the second half gives participants the opportunity to engage BRL's community of care through direct practice (mental health awareness presentations, one-time workshops, etc.).
- Target Population: Alameda youth 17-24, who have graduated from High School, earned a GED or are interested in earning their GED. BRL prioritizes African American or those of diverse African ancestry but serve anyone who met the other above-mentioned general stipulations.

FY21-22 Outcomes, Impacts, and Challenges

- **Staffing:** BRL filled the workforce education specialist position which was the final missing piece of the program staff
- **Client Enrollment:** BRL met the program goal of engaging 20 TAY youth, during the 21/22 fiscal year. BRL used a rolling admission model: Six participants, or Fellows, launched and have completed the 12 weeks of classes and readying for direct practice and there is a second cohort of six in the pipeline completing intake and assessment and about to start their cycle of classes. BRL recruited enrolled and engaged the final 8 before the end of the fiscal year.
- **Training**: The program provided 36 hours of training on work readiness, social skills, trust, safety, emotional regulation, self-efficacy, self-regard, accountability, facilitation, group, peer mentorship and the use of artistry for rapport building and healing. Cohort members received direct practice, as well as shadowing opportunities, case management and or therapeutic supports as requested.
- **Field Exposure:** All Fellows shadow or make site visits with professionals in the social services field. Each Fellow received up to six shadowing or guest lecture opportunities overall over the course of their year in the program. Guest lecturers/mentors were a mix of social service practitioners: ER clinicians, organizational psychologists, therapists, high school counselors, and consultants. This gave participants access and opportunity to hear how mentors figured out their purpose and the path challenges and benefits from their chosen profession.
- **Case Management:** All academy fellows received a MAPS assessment, BRL's own internal assessment tool. This assessment covers mental health, academic, physical, and other areas where urgent needs can be highlighted, and goals set for case managers. Fellows received an average of six sessions each of case management and/or individual therapy support. Categories of support have included grant applications,

stability supports, mental/emotional care, college applications, job readiness, career exploration and goal setting.

Challenges

- BRL leadership and staff are still processing the pandemic. Staff were in telehealth services exclusively for two years and are striving to give participants what they want and need which is in person engagement while maintain fair standards that promote safety for all.
- This program was funded as of July 1, 2021, therefore BRL needed to launch the program while still working on startup objectives such as recruitment of staff and curriculum development. As a result, the program had to push back intended August start to September. The current staff have worked above and beyond to fill all the vacant roles and responsibilities. BRL anticipates the program in the spring to run more at capacity due to fuller staffing and having more of the programming already in place.
- Recruitment, and more specifically, finding precise recruitment partners for long term collaboration toward building sustainable pipelines for TAY, is an ongoing process. Some of the most interesting things that came up were participants' need for stability and mental/emotional supports while very much needing to activate as gainfully employed adults. Whereas the program is built for youth who actively seek to be in human services, for some of the participants, this is the first time they are being introduced to human services as a field. They are often getting started on their learning journey of professional fields and professionalism simultaneously. The program is also seeing that more high schools offer experiential/internship models earlier.
- Beats, Rhymes, and Life's program is designed developmentally for young adults, but the captive audience seems to present earlier in these alternative model High Schools. BRL is continuing to look at ways to build into these schools through corresponding Hip Hop Therapy prevention programs and build the pipelines from three to five high schools and colleges.

FY22-23 Progress Report

- Continuing with the rolling format for recruitment we have engaged five new members for the fall. This was fed from BRL Summer Junior Academy which is part of a new strategy to introduce youth to both Prevention and Pathway programs.
- BRL have expanded High School outreach partner scope to include Rudsdale, Skyline, and Latitude high schools (This is in addition to BRL's regular HS partners: Oakland High, Met West, Oakland School of the Arts, & Castlemont). Rudsdale High School reached out after the violent disruption they experienced and BRL is planning supportive mental health presentations as well as workshops to support their population to process and support restoring a sense of stability. BRL's goal is to create a sustainable pipeline into the wet program using the OUSD pathway system. Specifically, Arts Media and Entertainment, Education Child Development & Family, and Health Science & Medical Technology **https://www.ousd.org/domain/5451**

- BRL filled the workforce education specialist this past summer. This was a key position that was missing from the first fiscal year.

FY 23-24 Anticipated Changes

- BRL has made the following adjustments to its program recruitment strategy:
  1. Focused more on high school recruitment changed contract to so that 17-year-old high school seniors can participate if school schedule aligns.
  2. Offer stipend rewards for successful referrals
  3. Create more video content to better tell and share our story.

- BRL has decided to rename the case management position title to wellness coach. We have experienced adverse reaction and negative association with the case management title. Especially by system involved youth.

5. CSUEB - Early Childhood Mental Health Postgraduate Certificate Program

FY 21-22 Outcomes, Impacts, and Challenges

- MHSA WET provided funding in FY18/19 to launch a two-year pilot Early Childhood Mental Health Post Graduate Continuing Education Certificate Program *at* Cal State University, East Bay. The overarching goal is to build capacity in a culturally diverse early childhood mental health workforce to meet the social, emotional and developmental needs of young children, ages birth to five, and families in Alameda County.

- In FY 2018/19 Alameda County Behavioral Health (ACBH) and California State University East Bay (CSUEB) launched the pilot *Early Childhood Mental Health Post Graduate Continuing Education Certificate Program* which focused on the developmental foundations of infant and early childhood mental health.

- The program began with a cohort of fifteen (15) students, fourteen (14) of whom were subsidized by Mental Health Services Act Workforce, Education & Training (MHSA WET) funds and one (1) paid out of pocket. Of the fifteen (15) students, eleven (11) were clinicians of color, ten (10) spoke one of the identified threshold languages, and all fifteen (15) worked in Alameda County early childhood community-based organizations (CBOs).

- In year two (FY 19/20), Cohort 1 saw the fifteen (15) members of the original cohort return intending to complete the second year of the program. However, one (1) student dropped in Fall 2019 and fourteen (14) of the fifteen (15) students completed the program in December 2020.

- In year three (FY 20/21), a new second cohort of 16 students was recruited (22 applicants and 16 accepted into the program). The recruitment process started in Spring of 2020. In the spirit of collaboration, meetings were conducted with CYASOC Leadership Team and the CSUEB Cohort Instructor to review the recruitment and selection criteria, the steps and resources needed and the timeline. A rubric was developed to assess students that meet criteria. The planning team also discussed lessons learned from

the last cohort cycle to apply best and improving practices for the new cohort.

- In year four (FY2021-2022), ACBH and CSUEB hosted a competitive application process (in Fall 2020) and recruited 15 students (from 19 applicants) for Cohort 2. Recruitment announcements elicited individuals who focus on early childhood skill development as well as exhibit cultural competencies that can meet the unique needs of the diverse Alameda County child and family populations. Recruitment outreach extended to the Alameda County network of service provider agencies, to networks of CSUEB staff, and to employees an interns at current clinic and outpatient service sites. The range of interest from CBO employees increased; and as such, there is a wider range of organizations represented in the second cohort.

Program Evaluation

- The program was evaluated by a unique survey developed by UCSF Benioff Children's Hospital Oakland in the first year of the pilot. In the second year of the cohort, the corresponding evaluation survey was administered by UCSF Benioff Children's Hospital, Oakland evaluator, Dr. Laura Frame, and in years three and four it was administered by ACBH staff. The evaluation focused on methodological approaches used for student training. To this end, the evaluation provides ongoing feedback for managers to ensure continuous quality improvement. Evaluation methods used to assess the program include: a training evaluation (online student satisfaction survey); the Learning Curve Survey in year one (to assess student measurement of knowledge, skills, and integration/application of core concepts), and reflective writing assessments.

- To view the full report and evaluation of the pilot of this program see: ***Appendix 3_MHSA WET_FY 2021-22 CSUEB Early Childhood Pilot Cohort_Final Report***

FY 23-24 Anticipated Changes

- This program will be concluded at the end of December 2022, with the graduation of the second cohort of post-graduate students. ACBH and CSUEB have had discussions regarding sustainability of the program beyond this pilot ending in December 2022.

6. Internship Coordination and Residency Programs

Program Description: Coordinates academic internship programs across the ACBH workforce. Outreaches to educational institutions to publicize internship opportunities.

1. UCSF Public Psychiatry Fellowship Program

FY21-22 Outcomes, Impact and Challenges (UCSF):

- 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 21-22, UCSF recruited one psychiatry fellow to place in the BHCS clinical education and training program at the Trust Clinic.
- The selected UCSF School of Psychiatry fellow successfully participated and completed the fellowship in the yearlong on-site clinical fellowship experience at the Health Care Services Agency, Healthcare for the Homeless Services, Trust Primary Care Clinic.

FY22-23 Progress Report (UCSF):

- In FY 2022-23, ACBH did not host a fellow as UCSF was unable to recruit a participant for the Program.

FY23-24 Anticipated Changes (UCSF):

- UCSF School of Psychiatry is currently in the process of recruiting a psychiatry fellow and we're anticipating hosting one participant in FY23-24.

2. ACBH Graduate Clinical Internship Program

FY21-22 Outcomes, Impact and Challenges (Graduate Internship):

- Manage and facilitate the onboarding process for Children Young Adult System of Care (CYASOC), Adult and Older Adult System of Care (AOASOC), Adult Forensic Behavioral Health and Vocational Rehabilitation, Nursing, and other programs/units within the ACBH department.
- The mission and goal of the internship program is to provide training that optimizes student learning, leadership, and overall support and development. Ongoing relationship building efforts between the internship coordinator, HR, Finance, clinical coordinator, and clinical intern supervisors positively *impacts* efficiency and value to the Internship Program. The competing priorities of multiple internal and external stakeholders requires a higher level of coordination and standardization.
- Due to the COVID 19 pandemic there was a need to pivot all internship program operations to electronic and virtual platforms. The shift to a mostly virtual internship program was swift and necessary. We are entering the 3rd year of the pandemic and the internship program functions continue to be mostly virtual and electronic. We will be moving towards making most of the processes electronic and paperless.
- Transition of previous internship clinical coordinator and introductory training for new incoming internship clinical coordinator and training officer positions.
- Provided updates and revision of documents to the "Onboarding Resource Manual" which was created to provide guidance, structure, and compliance for the internship program.
- Developed necessary forms and/or documents as needed to address new program policies, procedures and applicable laws, regulations, and ethical standards of practice.
- Effectively managed and facilitated the amendments to two (2) practicum agreements for schools in collaboration with county counsel.

FY 21-22 Impacts (Graduate Internship Program):

- Eighteen (18) students were onboarded and placed within ACBH programs and units. The number of interns was slightly lower than the previous year, more than likely due to the pandemic. Five (5) interns with the Children's and Young Adults System of Care, Nine (9) with Adult & Older Adult System of Care, Eight (8) of those Nursing students, Three (3) with CONREP, One (1) Other.

2021-22 ACBH Intern Statistics– Ethnicity (Number of interns= 18)

African American	4 – 22%
Asian	2 - 11%
Caucasian	5 – 28%
Hispanic/Latino	5 – 28%
No response	2 – 11%

2021-22 ACBH Intern Data – Language (Number of interns= 18)

English	10 – 56%
Cantonese	0
Mandarin	0
Spanish	5 – 28%
Tagalog	0
Vietnamese	0
Other	2 – 11%
No response	1 - 5%

One (1) intern declined internship assignment, and Four (4) interns were exposed to a total of eighteen (18) virtual trainings, including:

- A Better Way - Telehealth, Early Childhood Assessment; Expressive Arts, Documentation Training; HANDLE (Holistic Approach to Neuro Development and Learning Efficiency); Strengthening Relationships Through Partnerships; Pediatric Psychopharmacology and Suicide Assessment and Intervention, CBT, DBT, etc.
- All in-service trainings were virtual through ZOOM.
- In-service training evaluations indicates a positive *impact*. In-service trainings and trainers were extremely beneficial and well received by the interns again this year

Annual internship fairs and internship orientations – Coordination, Facilitation, Representation:

- Represented ACBH at local internship fairs for bay area colleges and universities virtually which provided potential student interns a first impression of ACBH in a welcoming, low-pressure, and informative settings. These are marketing impact activities, publicizing various learning opportunities and offering information and materials about ACBH's systems of care. All internship fairs were conducted virtually.

- ACBH Internship Program Representative for (2) virtual internship fairs (approximately 20 students) from Cal State East Bay and SJSU.
- The ACBH Intern Orientation is a full two (2) day collaborative effort with clinical supervisors and clinical director to provide a positive and successful start to the internship assignment. Students are provided with presentations, tours, and group interaction. ACBH Intern Orientation was conducted virtually.

FY 21-22 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 African Americans and Latinos, particularly 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.
- Recruiting and retaining in-service trainers for both Fall & Spring schedules.
- Recruitment *challenges* include identifying potential interns who speak ACBH's threshold languages and who reflect Alameda County's cultural diversity and committing adequate staff to cover two-day orientation events.

FY22-23 Progress Report

- Developing improved system to collect and manage training and program evaluation results to inform program planning, intern recruitment, placement and follow up.
- Continuing to collect and manage training and program evaluation results to inform program planning, intern recruitment, placement and follow up
- Facilitation of the post-internship program evaluation forms for data preservation. This effort seeks to gather information from the intern perspective for continuous enhancement of internship program.
- Improvement of onboarding efforts, in conjunction with system leaders, to create standard guidelines, practice, and protocol for onboarding interns for all systems of care.

FY23-24 Anticipated Changes

- In the process of creating a more formal and inclusive intern recruitment strategy under the guidance of the ACBH Director's office.
- Developing internship program formal procedures and policies to further enhance program services.
- Social media presence is imperative for the internship program to better communicate and promote program.

- Developing an online protocol for the Internship Program and onboarding process.

- Update and enhance internship website to reflect most current internship positions available to support students in their program search.

2. Korean Community Center of the East Bay – Mental Health Asian Workforce Pipeline Program

FY 21-22 Outcomes, Impacts, and Challenges

- KCCEB trained 6 MSW/MA/MFT students for Mental Health Asian Pipeline's (MHAP) second cohort (4 first-year and 2 second-year; 1 male, 5 female). Interns came from CSU East Bay, Dominican University, and Palo Alto University. This year's intern cohort spoke Korean, Japanese, Cantonese and Mandarin in addition to English. Services were offered in Korean, Cantonese, Mandarin and English. Four interns focused on school-based services at Alameda Science and Technology and San Leandro High School, API community children, families, and adults and two interns supported Korean and Chinese seniors. KCCEB operated a hybrid-model so that some interns saw clients in-person and others remained online or used the phone. In-person clients were seen at home, at KCCEB's center and also at senior housing sites and schools.

- KCCEB's graduate interns were all "returning adult" students. Three were first-generation college students and three were first-generation people living in the U.S. Another student was white-American, working in an Asian-serving organization for the first-time. For three-fourths of the students, KCCEB was their first experience in a primarily Asian-serving organization. Many were passionate about wanting to serve the API community and have a strong desire to use their bilingual and bicultural skills and cultural lived experience to fill the gap of services in their community. Many shares that they heard of KCCEB through word of mouth from their fellow classmates who were former KCCEB interns who had such positive experience in interning at KCCEB and the culturally responsive rich experience and support received through their internship. Some of these students mentioned that their own backgrounds and struggles (i.e., first-generation immigrants, struggles with lack of resources and challenges in navigating the US system, challenges with acculturation and family intergenerational conflicts and traumas) motivated them to serve their community.

- It is noteworthy to mention that the former and current interns are pursuing their clinical path in community mental health, joining non-profit organizations that focus on serving marginalized communities. One MSW intern will be continuing her second-year internship at Asian Health Services Specialty Mental Health to provide treatment services to clients with moderate to severe mental health symptoms. Two interns will continue their second-year internship at KCCEB to expand on their clinical skills serving monolingual speaking Chinese and Korean community members. Another MSW intern deferred her second year due to maternity leave, but plans to return to complete her internship at KCCEB Spring of 2023. Lastly, our MA intern is graduating Fall of 2022 and plans to pursue community mental health work in the near future. This year, another intern has moved into KCCEB as a staff role providing clinical case management and counseling services to monolingual Korean speaking immigrants and other API youth, adults, and family. KCCEB is exploring applying for Medi-Cal contracts in order to be able to support moderate-to-severe clients in language and also have a place for interns to continue serving this population.

- KCCEB's internship program is becoming more well-known through the Bay Area in supporting bilingual/bicultural clinicians. This year, we had to turn away 6 -7 interns who applied. We are also growing our partnerships with other schools and this year will be pursuing a relationship with Golden Gate University in addition to our current partner list of 6 schools across California.
- KCCEB has been recruited to be part of a five-year grant opportunity with University of Southern California (USC) to develop a Center of Excellence, advancing behavioral healthcare for Asian American, Native Hawaiian and Pacific Islander communities while reducing behavioral health-related disparities.

FY 21-22 Impact

- Interns provided mental health outreach and engagement (1000+ Korean, Chinese, and other API), senior wellness checks (100 Korean seniors and 50 Chinese seniors), wellness support groups and psycho-educational workshops, and had one-on-one case management and PEI clients (total of 60 clients). First-year students held a case load of 8-12 clients and second-year students held caseloads of 10-15 clients. Finally, our interns had a unique opportunity to be actively involved in advocacy efforts including the Behavioral Health Equity Coalition, Senior Prevention Injury Partnership, East Bay Immigrant and Refugee Forum, API Coalition Contra Costa County, State Oral Health Alliance, Health Justice Network, and California Pan-Ethnic Health Network.
- Interns' support was especially critical due to the pandemic and anti-Asian violence. Interns work ensured that the Korean Community seniors' needs were being met and that they did not fall through service cracks. Interns provided a safe and trusting space for community members to talk to and share their experiences and challenges, especially those who were exposed to Anti-Asian sentiments, experienced vicarious trauma from Anti-Asian violence, pandemic collective trauma, and increased mental health symptoms. Interns played an essential role in Senior Wellness Checks to isolated Korean and Chinese elders including offering concrete and tangible resources to address their immediate crises and creating a safety net for isolated limited English proficient community members.
- Interns were also actively involved in advocating for essential bilingual and bicultural mental health services and mental health professionals to support the increased mental health needs of the Asian and Pacific Islanders community. Compared to last year, KCCEB is seeing an increase in referrals: 52 referrals compared to 30 from last year. With the support of interns, KCCEB provided counseling services to 47 clients.
- This is the first year KCCEB have received self-referrals for mental health counseling and had a total of 15 Korean self-referrals, compared to last year's number of 2 referrals. They included elders, children, youth and couples. In the past, community referrals have been through proxy or indirect methods (i.e. friends or family calling on behalf of other individuals) due to stigma. We believe community members self–referring is a significant indicator that there is a dire need in the community. We also believe our mental health services are increasing in visibility so that people know they can come seek mental health support in Korean-language at KCCEB.

FY 21-22 Challenges

- There has been an increase in mental health service needs both from youth and from the Korean community. Due to the COVID-19 pandemic, peoples' mental health has been impacted and KCCEB is seeing more complex cases.
- KCCEB has received requests for mental health services outside of Alameda County and even outside of California, needing Korean bilingual and bicultural services.

FY 23-24 Anticipated changes (KCCEB): With feedback from the interns, KCCEB is changing the training model in the following ways:

1. KCCEB will be providing a more comprehensive clinical onboarding and training which is changing from 9 days to 21-day intensive training.
2. Increasing group supervision from bi-weekly to weekly to create a more robust clinical training and support
3. Incorporating more holistic and traditional healing practices in our clinical training curriculum
4. Expanding collaborative partnership with other graduate educational institutes

3. Consumer and Family Member Training, Education and Employment – BestNow

FY21-22 Outcomes, Impact and Challenges

- BestNow is funded by MHSA Workforce Education and Training (WET) to provide training, education and employment services to Peers.
- BestNow focused on recruitment and preparation for the Peer Support Specialist class and successfully recruited 52 Peer Support Specialist Training participants.
- Provided employment support to a total of 15 graduates, who are contemplating employment for the first time or who are re-entering the job market.
- Employment support focused on interviewing skills, cover letter/resume building, financial literacy, overcoming stress, benefits of returning to work, and emotional skillfulness.
- Focused heavily on outreach to consumers and collaborated with ACBH and other agencies within the mental health and substance use disorder systems of care, to support student access to Peer Support specialist training.
- Conducted three orientation sessions for each training cycle. Total 35 individuals showed up to get their questions answered by BestNow.
- Changed trainee selection process allowing larger class size.
- Restructured training program, including editing curriculum materials to meet CalMHSA required core competencies. BestNow took this opportunity to update materials and strengthen training curriculum and training slides.

- BestNow transitioned the peer support training program to utilize Canvas as the program learning platform and assisted all students in registering for Canvas and showed them how to use it. We do all our grading in Canvas, and it has become a useful component in strengthening our participants digital literacy.

FY 21-22 Challenges

- Several orientation sessions had a much lower number of participants show up than the number of people who registered using the Zoom link provided on the program outreach materials. This could be due to technology-related challenges from participants or individuals registering too far in advance.
- BestNow attempted to have a first fully Spanish speaking training cycle but were not able to get enough applicants. We also quickly realized that if we had hosted the course, we would not have been able to assist the graduates with employment related services due to lack of opportunities.
- BestNow made the decision to shorten the length of each training session because of trainee and facilitator limits on how long they could stay engaged in each Zoom session. Saturday training sessions were removed due to continued feedback from participants. Current training is now offered Monday through Thursday from 5:00pm to 8:30pm.
- With the BestNow team switching to Canvas we realized we needed to let individuals at orientation know how important it is to have a reliable device to complete assignments, and for those who did not have a device, for us to coordinate how to lend them one at the BestNow office.
- In general, some participants struggled with skills such as sending email attachments, navigating the Zoom platform, and even saving and downloading documents.
- BestNow attempted to address these challenges in various ways including adding a "How to Use Zoom," section into our orientation in order to support the participation of people who were new to using Zoom. We have also done a lot of one-on-one support talking with participants through commonly used skills such as saving documents to their devices and attaching documents (such as assignments) to emails.
- Additionally, because of the continued challenges posed by the COVID-19 pandemic many agencies which previously hosted BestNow interns declined to do so. This made it very challenging to find appropriate internship opportunities for our trainees. We were able to place 4 individuals into an internship after graduating. However, this number was low compared to other fiscal years. We realized that another key factor that contributed to less internships was due to the change in our training cycles. With our training being 80-hours long and with SB 803 going into full affect, we have had many students enroll in our training who are already working in the behavioral health field and do not need an internship. Furthermore, a continued challenge for our trainees is related to criminal justice records.
- We continue to have highly qualified trainees rejected from internships/employment opportunities because they have convictions on their record, without regard to the time that has passed since their convictions or the nature of their convictions.
- We maintain that Peer Support Specialists who have personal lived experience with incarceration and the criminal legal system have valuable insights to share from their experiences and should be given equal opportunities for internships/employment opportunities as those trainees without these experiences.

FY22-23 Progress Report

- In the Fiscal year of 2022-2023, there have been many great changes. The BestNow team is fully staffed with 4 program trainers and 1 program manager. Due to this it has allowed us to really revamp all of our training slides and make them more interactive. It has also allowed us to make corrections in our curriculum, and restructure assignments/readings in Canvas.
- We began the fiscal year off by hosting our first training cycle in June. For our June cycle there was a large focus on outreach which was a success. We had our largest class up until that point and successfully graduated 35 individuals. Since our June training cycle, we have hosted an additional 2 trainings. Both of our trainings have had over 30 students in attendance.
- Additionally, BestNow ran cycles with a very diverse demographic group. So far in FY2022-2023, we have had 35.3% of our participants identified as African American, 20.2% as European American, 22.2% as Latino, 10.3% as Asian American, 5.1% as middle eastern, 5.1% as Native American, and 2% identified as Pacific Islander.
- We also successfully hosted two BestNow graduations. Allowing for graduates to celebrate their accomplishment with friends and family. Our most recent graduation had close to 90 people in attendance.
- As a team we began to see peers struggle with getting the 6-hour law & ethics continuing education requirement. Due to this we created a 6-hour law & ethics training to support our peers to meet this requirement. Since July of this year, we have host 5 Law & ethics trainings. These trainings have consistently had over 70 peers in attendance each time.
- Additionally, we seen peers struggling with the initial scholarship and grandparenting scholarship applications. Due to this we decided to host scholarship webinars showing our peers step by step how to apply and helped them with the application in real time. Since June we have hosted 3 scholarship webinars and have had 25-30 peers in attendance each time. We did have to limit the number of peers that could be in our scholarship webinar to no more than 30 at a time. This was due to the difficulty of the application process and because some individuals needed additional tech support.
- BestNow is expecting to go into 2023 with hosting study guide sessions to help peers prepare for the state exam. As well as continuing to do our 6-hour law & ethics trainings. We also plan on adding additional training's that we can offer to peers; however, we have not fully decided as a team what those additional trainings will be.

FY23-24 Anticipated changes

- BestNow is anticipating many changes for the 2023-2024 fiscal year such as restructuring the trainings to make them more interactive. This consists of adding more videos into our presentations as well as more role plays.
- BestNow is considering having 3 different training courses. Two of those will be 80-hour training specifically for individuals already working in behavioral health care services. This type of training could also be used as refresher training for BestNow alumni who might have graduated many years ago. The third type of training we would offer would be between 120-180 hours (TBD) and it would be for Peers who want to work in behavioral health care services. This training would be more in-depth and would consist of presenters coming to teach certain portions of the curriculum as well as teaching the participants about community building and networking.

- Moving forward BestNow will make the Peer support training orientation mandatory to all students in order to be accepted into the BestNow course.
- BestNow anticipates to add additional trainings for peers to aid in their continuing education.

7. Financial Incentives

Program Description: Offer financial incentives as workforce recruitment and retention strategies, and to increase workforce diversity. Financial Incentives are offered to eligible clinical staff employed in ACBH and to graduate interns placed in ACBH and contracted community-based organizations, and who are linguistically and or culturally able to serve the underserved and unserved populations of the County. The Behavioral Health Loan Repayment Program is for eligible clinical staff who complete a service obligation in public behavioral health in Alameda County.

1. ACBH Graduate Intern Stipend Program

FY21-22 Outcomes, Impact and Challenges

- Executed, administered and facilitated the 10th cycle of the Graduate Intern Stipend Program (GISP). Launch date August 2021.
- Awarded 21 stipends for up to $6,000 each for 720 internship hours worked within the year. Of the 21 awardees, 98% represent the diverse communities of Alameda County.

Impact (GISP):

2021-22 Graduate Intern Stipend Awardees – Ethnicity (Number of awardees =21)

African American	5 – 24%
Asian	5 – 24%
Caucasian	2 – 9%
Hispanic/Latino	9 – 43%

2021-22 Graduate Intern Stipend Awardees – Threshold Language (Number of awardees=21)

English	4 – 19%
Mandarin	1 – 5%
Spanish	12 –57%
Vietnamese	1 – 5%
Other	3 – 14%

Challenges

- Having the ability to pivot during high stress times of the pandemic was imperative
- Reverted all GISP communications to an electronic process.
- The ability to recruit and retain a GISP application reviewer team of at least 7-9 members which is comprised of internal staff and CBO members.

FY22-23 Progress Report

- Launched the 11th cycle of Graduate Intern Stipend Program in September 2022 with a focus on interns across systems, including behavioral health interns in primary care settings. The goal is to increase the number of interns who speak one or more threshold languages such as: Spanish, Cantonese, Mandarin, Vietnamese, and Tagalog.

FY23-24 Anticipated Changes

- Use of more modern technology and social media presence to effectively communicate to wider student audience.
- Make necessary updates and changes to the GISP application as needed

2. Alameda County Behavioral Health Career Pipeline Scholarship and Mentorship Program

FY21-22 Outcomes, Impact and Challenges

- Over the past 10 years, the ACBH Workforce Development, Education, and Training (WET) has been collaborating with educational institutions to address behavioral healthcare workforce gaps and build up infrastructure for students to be able to study and find career paths into public behavioral/mental health; i.e. a workforce pipeline. One such partnership is with Ohlone College, which has championed the development of strong student engagement and workforce pipeline development programs.
- In partnership with Ohlone Community College, the Alameda County Behavioral Health Career Pipeline Scholarship and Mentorship Program was launched in Spring 2022. A total of nineteen scholarship applications were received; eleven students have been awarded financial scholarships to support their undergraduate education and participate in a mentorship program.
- WET in collaboration with Ohlone Community College hosted a scholarship awards ceremony and reception on August 11, 2022, to celebrate eleven community college students who were awarded a scholarship from the Alameda County Behavioral Health Career Pipeline Scholarship and Mentorship Program. The program is funded by the State Workforce Education and Training Program, overseen by the Department of Health Care Access and Information (HCAI), with California Mental Health Service Authority (CalMHSA) serving as the fiscal and administrative intermediary. Among the 11 recipients, seven were recent Ohlone College students/graduates. The unique aspect of the program is that in addition to tuition support, awardees are participating in a mentorship program where they are

connected to professionals in the field, building a supportive community with each other, and gaining practical skills to improve their academic success and job prospects.

FY21-22 Progress Report

- The second Scholarship and Mentorship Program application cycle will begin in January, 2023. Ohlone College started its outreach efforts promoting the upcoming program application opportunity.

FY23-24 Anticipated Changes

- Alameda County WET is not anticipating any significant program changes at this time. The program will continue with funding from the State Department of Health Care Access and Information (HCAI).

3. Behavioral Health Loan Repayment Program (BHLRP)

FY21-22 Outcomes, Impact and Challenges

- In FY21/22, Alameda County local Loan Repayment Program (ACLRP) was transitioned into the State-funded Regional Workforce Education and Training (WET) Partnership Program (RP). The loan repayment program opportunity started as a local program (Alameda County Loan Repayment Program - ACLRP) and was then transferred to the Workforce Education and Training Program, overseen by the Department of Healthcare Access and Information (HCAI). Each ACLRP applicant who initially applied through CalMHSA's Bonfire portal was asked to re-apply and they were evaluated through the HCAI application portal.

- In FY21/22, Alameda County WET implemented the Behavioral Health Loan Repayment Program (BHLRP) funded by the State Department of Health Care Access and Information (HCAI).

- ACBH and CalMHSA executed the Regional Partnership (RP) Loan Repayment and the Behavioral Health Career Pipeline Scholarship and Mentorship Program Participation Agreement (PA) funded by the State Department of Health Care Access and Information (HCAI) on May 26, 2022. Both parties executed a first amendment of the ACBH RP Participation Agreement (PA) on September 27, 2022 morphing it into a PA that works for the WET regional partnership (RP) activities.

- Alameda County worked with CalMHSA on transitioning the ACLRP cycle 2 applicants into the WET RP round one Behavioral Health Loan Repayment Program (BHLRP) in order to bring the ACLRP in alignment with the WET RP funding and program timeline and other program related requirements.

- Alameda County launched the State funded Behavioral Health Loan Repayment Program (BHLRP) round two application cycle from October 1 through December 15, 2022. In an effort to increase the volume of applications received, the RP Leads extended the application cycle from November 30, 2022 through December 15, 2022.

- Alameda County completed the first round of the loan repayment program funded by the State Department of Health Care Access and Information (HCAI). 25 individuals who represent the diverse communities of Alameda County applied and 17 clinicians from County and contract Community Based Organization (CBO) settings received up to $10,000 towards their outstanding student loans.

Challenges

- The loan repayment program opportunity started as a local program called the Alameda County Loan Repayment Program (ACLRP) and was then transferred to the Workforce Education and Training Program, overseen by the Department of Healthcare Access and Information (HCAI). Each ACLRP applicant who initially applied through CalMHSA's Bonfire portal was asked to re-apply and given the opportunity to get evaluated through the HCAI application portal. This process created a delay of several month before award determinations could be made.

- Alameda County Behavioral Health needed to shorten the required service obligation to 3 months instead of 12 months for the round one BHLRP awardees. This one-time decision was made uniquely for this set of awardees due to the length of time it took to make award determinations as well as to align with the HCAI second round application cycle timeline.

- The shortened service obligation for the round one award recipients allowed the eligible awardees to apply again for the second round of the Alameda County Loan Repayment Program when the new cycle opened in October 2022.

FY22-23 Progress Report

- The round two of the State Department of Health Care Access and Information (HCAI) funded Alameda County Behavioral Health Loan Repayment Program application cycle opened from October 1, 2022 through December 15, 2022.

FY23-24 Anticipated Changes (BHLRP):

- ACBH WET is not anticipating any significant program implementation changes in FY23/24.

CAPITAL FACILITIES & TECHNOLOGICAL NEEDS

Capital Facilities & Technological Needs
"Bringing People and Resources Together"

The *Capital Facilities & Technological Needs (CFTN*) component of the MHSA "works towards the creation of a facility that is used for the delivery of MHSA services to mental health clients and their families or for administrative offices. Funds may also be used to support an increase in peer-support and consumer-run facilities, development of community-based settings, and the development of a technological infrastructure for the mental health system to facilitate the highest quality and cost-effective services and supports for clients and their families".

It should be noted that CFTN funding was originally a 10-year block grant, which ended on June 30, 2017. However, ACBH continues to transfer CSS funds to the CFTN component for various programs and projects. Pursuant to Welfare and Institutions Code Section 5892(b), *Counties may use a portion of their CSS funds for WET, CFTN, and the Local Prudent Reserve. The total amount of CSS funding used for this purpose shall not exceed 20% of the total average amount of funds allocated to that County for the previous five years.*

ACBH's MHSA funded Capital Facilities projects are in alignment with Alameda County's Vision 2026. More on this vision can be seen at https://vision2026.acgov.org/index.page

New Projects Approved for Funding, Implementation FY 23/24

Medical Respite Expansion Projects (CF2)

ACBH in collaboration with the Office of Homeless Care and Coordination, a division within the county's parent agency Health Care Services Agency, continue to develop new medical respite opportunities. The remaining funds within this workplan's original three-million-dollar allocation will be directed toward the ongoing renovation work for the Alameda Point Collaborative (workplan #CF4) and a new project called the St. Regis. The St. Regis is a multi-building site located in mid-county purchased by a local non-profit where ACBH hopes to develop multiple residential mental health services including medical respite. The multi-service project hub also received $19M in State Community Care Expansion (CCE) funding intended to support acquisition, construction, and rehabilitation of adult and senior care facilities that serves individuals who are at risk of or experiencing homelessness and those who have behavioral health conditions, expanding the state's housing and care continuum and ensuring better treatment outcomes and preventing the cycle of homelessness or unnecessary institutionalization. More information will be provided in the FY 24/25 MHSA Plan Update.

MHSA Technology Project (TN1)

Procurement process for new Behavioral Health Management Information System (EHR) (non-billing portion): ACBH is set to begin planning the procurement process for the additional clinical components of an EHR system in Fall 2023. More information on this process will be shared in the FY 24/25 MHSA Plan Update.

Below, please see the following section for updates on ongoing CFTN programs and projects that are in various stages of implementation.

Ongoing Projects

During FY 22/23 the following CFTN projects were in process. These projects were listed as new programs/projects in previous Plan Updates (FY 18/19 and 19/20) and/or the previous MHSA Three Year Plan FY 20/21-22/23. Updates on progression of these programs and projects were provided in last year's MHSA Plan Update FY 22/23 under the ongoing section of the Plan. Several of these projects will be completed this fiscal year (FY 22/23) and others will be continued and completed in FY 23/24 and beyond.

CFTN Program Summaries

PROJECT NAME: CF2 Respite Bed Expansion

Project Description: *Adeline Street Recuperative Care program*: Capital Project Investments to Expand Respite Beds for Individuals with Serious Mental Illness and Physical Health Care Needs

ACBH proposed in its FY 18/19 Plan Update to allocate up to three million dollars of 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 Adeline Street Recuperative Care program began in FY 19/20 (September 2019) and is run by LifeLong Medical Care, a Federally Qualified Health Center and a partner to ACBH on multiple programs.

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. The maximum length of stay is 90 days.

FY 22/23 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. Approximately 30-40 unduplicated clients are served per quarter, however this number can fluctuate. For July 1. 2022-September 30, 2022, the first quarter of FY 22/23, 61 people were served.

It is anticipated that FY 23/24 will be the last year that this program is documented under CFTN as all of the Medical Respite capital funding for this workplan will have been utilized.

PROJECT NAME: CF2 Respite Bed Expansion

Project Description: *Oak Days Care program*: Capital Project Investments to Expand Respite Beds for Individuals with Serious Mental Illness and Physical Health Care Needs

The Health Care for the Homeless (HCH) unit under the Alameda County Health Care Services Agency (HCSA) continues to develop a new medical respite project called Oak Days utilizing these CFTN funds.

Oak Days is currently running as a non-congregate emergency shelter with 60 beds set aside for very medically fragile clients who have complex physical and mental health care needs.

To be eligible for one of the 60 beds at Oak Days clients must meet ALL THREE of the following criteria:

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

These beds were created to meet a need that doesn't exist.

FY 22/23 Progress: The majority of start-up costs have been provided through Alameda County's Whole Person Care Program, however, MHSA-CTFN funds were used to purchase a Home Health License on March 17, 2022. The Home Health License purchased by Cardea Health allows Cardea to bill Medi-Cal through the HCBA waiver for home-based nursing and caregiver services. This license also gives Cardea the capacity to provide these services to individuals who have been traditionally unable to access home health, such as those who are unsheltered, residing in transitional or temporary housing, experiencing unstable social conditions, or who have active substance use disorder and mental health issues.

It is anticipated that FY 23/24 will be the last year that this program is documented under CFTN as all of the Medical Respite funding for this workplan will have been utilized.

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 22/23 Progress: This project for $424,000 was the ongoing costs to lease the 3 new suites. Pre-COVID, the plan was to negotiate and include the 3 suites in our lease renewal for ACBH Administration at the Embarcadero Cove location. Due to COVID, it was decided to not include the 3 suites with the lease negotiations/renewal. The CFTN funds identified for this project will be transferred to the TN1 project listed below for the implementation of the new ACBH EHR project. This project is considered closed and will not appear in future MHSA Plans or Plan Updates.

PROJECT NAME: CF4. Alameda Point Collaborative

Project Description: Starting in FY 18/19 ACBH allocated three million dollars in 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. Located on a 3.6 acre-campus, 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 22/23 Progress: Beginning in 2021 County support of the project transitioned from Health Care Services Agency to Housing and Community Development (HCD). Following the close of the fiscal year, APC Wellness Center received notification of $15M in State Community Care Expansion (CCE) funds; CCE funds, coupled with remaining CFTN funding which will support the final phase of the capital campaign to construct the Medical Respite Center and Health Clinic. Construction on the first phase of the project is delayed from the projected start in July 2022. The Alameda Wellness Campus is anticipated to pioneer one of the nation's first centers with integrated services for unhoused individuals with complex health conditions.

It is anticipated that FY 23/24 will be the last year that this program is documented under CFTN as all of the Medical Respite funding for this workplan will have been utilized.

PROJECT NAME: CF5: African American Wellness Hub Complex

Project Description: The African American Wellness Hub Complex will be a beacon of hope and energy for the African American community in Alameda County. The development of the complex began in FY 20/21 and is ongoing.

ACBH has budgeted a total of $14.8M in one-time funding ($10.7M in MHSA and $4.1M in non-MHSA) 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 22/23 Progress: ACBH, in partnership with the Alameda County General Services Agency (GSA) department, continues to work on the development of the African American Wellness Hub Complex (HUB) by exploring and examining the inventory of County owned facilities for the HUB and other potential suitable sites.

In addition to the ongoing exploration of space and facilities, ACBH has created a video to chronicle the years long effort to build a wellness center that focuses on the mental and behavioral health needs of the African American community. Once the video is released the link will be included in this document and on the **MHSA website**

In preparation for the Wellness Hub, the Office of Health Equity will conduct multiple listening sessions in spring 2023 to better understand what types of services the community would like to see in the Hub once it's ready for operations. Results from these listening sessions will be available later in the calendar year of 2023.

More information will be available on the progress of either a land purchase or building purchase/renovation as it becomes available and will be posted on the MHSA website and in the next MHSA Plan Update FY 24/25.

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 22/23 Progress: ACBH, through the General Services Agency (GSA), successfully purchased the land in January 2019. ACBH had planned 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. However, through a feasibility study, the cost to develop the parking lot was estimated to be $2.5M for drainage, electrical, fencing, new walkway, etc. Due to funding limitations, ACBH does not have the funding to support the parking lot project. Since there is a small balance remaining in this workplan there has been a joint decision between ACBH and the Office of Homeless Care and Coordination to pivot and transform the space into a garden and gathering space for shelter clients. The operator of the shelter, Building Opportunities for Self Sufficiency (BOSS), and shelter clients will be involved with the development of the space.

More information on the implementation and completion of the garden project will be available in the next MHSA Plan Update FY 24/25.

PROJECT NAME: TN1. MHSA Technology Project

Program Description: Purchase, installation, design, development, and maintenance of a new Behavioral Health Practice Management System (EHR) to include: Medi-Cal Short-Doyle billing, managed care, claims processing, client referral, registration, data interoperability and functions as needed to support clinical and fiscal operations of ACBH. Additional support for staff during the implementation process, and other dependent projects that provide access to consumers and family members to their personal health information and other wellness and recovery supports.

FY 22/23 Progress: ACBH has utilized CFTN funds to develop and implement the Practice Management billing module of the EHR.

Since April 2021, ACBH has been partnering with the vendor Streamline Healthcare Solutions, LLC, to formally initiate the effort to provide a fully integrated billing system on the SmartCare Platform to replace INSYST (the department's current registration and billing platform).

Streamline and the integrated SmartCare Platform will incorporate all the functionality necessary to ensure staff and contracted providers work together within and across organizational boundaries. SmartCare will also provide our system with options to resolve system challenges and facilitate enhanced flexibility for data sharing.

ACBH has completed discovery and finalizing design and development. Testing and training started at the end of 2022 and this billing portion of the EHR will go-live July 1, 2023, to meet CalAIM Payment Reform requirements and other initiatives. After go-live, additional work will continue for another three years, per the RFP agreement, to customize and enhance the system to meet ACBH business, state, and federal requirements.

Other CFTN Projects

Additionally, under the CFTN Component ACBH has been utilizing CFTN funds for the following items that have assisted ACBH in being more efficient and effective with utilization and outcome data:

- TN1: Behavioral Health Management Contracting System (to assist with the contracting process), called Apttus (phases 1-4)
- TN1: Computer/Technology Technical Assistance
- TN1: Electronic File Storage and Document Imaging (Veeam Software)
- TN2: Web-based dashboard System, called YellowFin
- TN3: County Equipment and Software Update (includes GoToMeeting software)
- TN4: Clinician's Gateway (CG) Interface and Consulting Services for CG
- CFTN Administration

PERFORMANCE MANAGEMENT INITIATIVES

Performance Management Initiatives
"Data Driven Actions"

MHSA Performance Management (PM) is a process of ensuring activities and outputs meet goals in an efficient and effective manner. The process focuses on the performance of various Alameda County Behavioral Health Care services (ACBH) units that support the administration of MHSA, MHSA funded programs and services, employees, and associated tasks. The following sections provided an overarching summary of significant quality assurance and improvement activities directed towards improving the administration of MHSA components.

Alameda County Health Care Services Agency: Results-Based Accountability (RBA) Initiative

Project IMPACT began in July 2014 as an effort that supports programs throughout the Alameda County Health Care Services Agency (HCSA) to measure and report their outcomes[1]. The Project IMPACT team consists of a total of 17 program staff and managers from every Department in HSCA, including members who have worked closely with the RBA implementation efforts in their own Departments. The Agency Leadership Team (ALT), which includes the Agency Director of HCSA and the Directors, Deputy Directors and Finance Directors of each of the Agency's departments, is monitoring and guiding the development of Project IMPACT.

RBA is a program evaluation framework that is data-driven and uses a simple iterative process to help organizations assess current performance, identify strategies to improve, and facilitate rapid implementation of action plans. Since 2014, ACBH has been utilizing RBA in various capacities to monitor program performance and assess impacts on the clients who come into contact with department and/or contracted services. ACBH has integrated RBA into MHSA contracting efforts with Full-Service Partnerships (FSPs), adopted the framework as part of its Prevention & Early Intervention (PEI) services evaluation, and made strides to include it as part of the Juvenile Justice Center and Crisis Services program work. A summary of RBA examples for MHSA are included in *Appendix C-1.*

Alameda County Behavioral Health Department Initiatives

*Reorganization Efforts***.** ACBH conducted a thorough inventory of all contractual and legal obligations for the administration and delivery of behavioral health care services[2] . ACBH leaders examined the requirements included in three contracts with the California Department of Health Care Services, and interviewed ACBH managers in an effort to understand current strengths and challenges staff face in fulfilling our obligations. At the conclusion of this process, ACBH has hired the following new key positions:

- Two Deputy Directors: Including the **Plan Administrator** who oversees and create linkages among ACBHS's core administrative functions (e.g. MHSA, quality Improvement/Quality Management, Information Systems, and financial Services)

[1] Project IMPACT (2016). Project IMPACT FAQ. Retrieved from http://achcsa.org/hcsa/project-impact.aspx
[2] Communication from the Office of the Agency Director (2020). ACBH Departmental Reorganization-UPDATE.

- Public Information Officer: Help to promote and raise awareness of MHSA activities including community engagement efforts, development of press releases, liaison with media groups, and supporting media campaigns.

- Health Equity Officer: Partner with MHSA program in the development and implementation programs to ensure they are culturally and linguistically appropriate with elements that address inequities and promotes access to care. This individual will also support the inclusion of peers and family members in the community program planning process.

- Compliance and Privacy Officer: Support the MHSA program to adhere with federal, state and local guidelines.

*Future strategic planning activities***.** In light of the impact of COVID-19, the MHSA program will develop more electronic platforms like social media sites to ensure our stakeholders are engaged in the program planning. The above-mentioned new positions will also: 1) support MHSA efforts; 2) develop real time dashboards to keep the community informed on the MHSA programs in Alameda County; 3) work closely with the Finance team to ensure effective budget management; 4) continue advocacy at the State level (e.g. DHCS, MHSOAC) and 5) develop new Innovation projects to inform the delivery of mental health services in Alameda County. ACBH has also launched strategic planning activities which will begin 2023 until 2028.

Alameda County Behavioral Health: Trauma Informed Systems Initiative

ACBH's Trauma-Informed Systems (TIS) efforts have focused primarily on the training components of the *Healing Systems of Care Conceptual* framework – establishing a cohort of embedded trainers within ACBH and training staff in the TIS 101 foundational curriculum. TIS is in the beginning stages of adapting the training so that it's more responsive to the needs of staff during this period of sheltering-in-place

Over the next three years, ACBH and Trauma Transformed (T2) will shift focus towards the practice change and leadership components of the framework. In particular, T2 will support the creation of an ACBH cohort of champions and catalysts who will gather new and existing data from ACBH to determine priorities for policy and practice change within ACBH. TIS hopes to work more directly with ACBH leadership – directors, managers and supervisors – to increase their understanding of TIS principles and implement best practices for leading others in a trauma-informed way.

The goal of all these activities is to help ACBH move closer to being a healing organization. The overarching benefit of these activities will be to improve collaboration within ACBH and with their MHSA contractors, to take more proactive steps to include contractor and community voice in decision-

making, and to anticipate and work to prevent predictable stresses, harm and trauma experienced by ACBH staff, MHSA contractors, and community members**.**

Financial Services Division

The MHSA Trust Fund Account (MHSA Trust) was established to maintain the MHSA monthly allocation and interest earnings. All expenditures are charged to the County General Fund (CGF) with the related MHSA program code. Finance prepares a quarterly projection report to identify the net MHSA revenue, and then develop a journal to move funds from the MHSA Trust to the CGF to offset the expenditures.

Finance has assigned a MHSA Plan number for each plan component and its projects; and have set up 29 program codes in the County financial system to associate with the MHSA projects. For community-based organizations/providers (CBO), the Division assigns a reporting unit number (RU#) for their projects. The program codes and RU#s can be used to keep track the payment status.

In each fiscal year, the Finance Division creates what is called *The Green Sheet* to identify all MHSA projects for that year including the Plan number, total budget, MHSA budget portion, estimated Medi-Cal revenue, program code and reporting unit (RU)#. The provided data helps support the preparation of the MHSA Plan and the Annual Revenue and Expenditure Report to the Department of Health Care Services.

Communication. Finance establishes monthly meetings with the ACBH Leadership Team to provide information, discuss issues and concerns, and communicate with the MHSA Director for relevant updates.

Fiscal Accountability. The Finance Division follows a set of policies and procedures to avoid supplantation of MHSA funding. All expenditures, encumbrances and revenue are reconciled every quarter, as part of the quarterly projections process. The Division requires two signatures when signing housing assistance checks over $5,000. Each Invoice and deposit require one signature.

Procurement & Contract Compliance Activities

The ACBH Contracts Unit operates under the auspice of the Finance Division. The Contracts Unit is undergoing an organizational restructure in which all contracts will reside within this Unit. These changes are part of an overall response to federal and state health care policy changes which affect county behavioral health in California. In order to meet the demands of these changes, ACBH is proactively preparing to adapt to and thrive in the new behavioral health environment by more fully aligning ACBH's compliance with the following federal and state requirements:

- The state-county Mental Health Plan Contract, Performance Contract, and Drug Medi-Cal Contract;

- Expanded Federal Medicaid Managed Care regulations; and
- Expanded covered services and contract requirements in Drug Medi-Cal.

The Contracts Office has seven Program Contract Managers also known as Program Specialists and eight Fiscal Contract Managers. Each Contract Manager manages between three and fifteen MHSA funded programs. The Contracts Office has one Program Contract Manager who serves as the liaison between the Contracts Unit and the ACBH MHSA Division. In this role the Contract Manager reviews the MHSA plan and updates, coordinates with the MHSA staff on reporting requirements and timelines, coordination of audit requirements on behalf of the Contracts Unit and communicates emerging changes that would impact the Contracts Unit.

Roles & Responsibilities. Contract Managers are responsible for monitoring programs from various aspects; Fiscal: reviewing units of services from the electronic claiming system in comparison to the allocation. Program: technical assistance (phone calls, meetings, or emails), reviewing reports (quarterly or annually) against the contracted deliverables.

Performance Measures. Contract Managers work in collaboration with the MHSA staff, and the provider to develop process, quality, and impact objectives for each type of program. For example, Full-Service Partnerships (FSPs) are measuring the percent of providers who can achieve a 50% reduction in the following: 1. Psychiatric hospitalization admissions 2. Psychiatric hospital days and 3. Psychiatric emergency visits 12 months prior to FSP admission and 12 months post admission. Additional metrics have been implemented more recently tied to a pay for performance fiscal model.

Contract Compliance. ACBH formalized a policy in June 2018, "Contract Compliance Plan and Sanctions for ACBH Contracted Providers". This policy supports ACBH in holding providers accountable for implementing County, State, and Federal requirements. Examples may include by not limited to: lack of achievement in meeting performance standards, substantive underperformance on meeting contracted deliverables, failure to meet contractual requirements such as staffing, timelines, required certifications and/or licensure. Additionally, ACBH responded to an audit finding in 2017 which resulted in the development of the MHSA Monitoring Guidelines in 2018 to strengthen the process in which ACBH are monitoring MHSA funded programs.

MHSA Data Management Systems

ACBH uses a web-based data and outcome reporting system called YellowFin. MHSA staff partnered with System of Care staff and the ACBH Data Services team to update the FSP outcomes dashboard to include the Service Teams. The Service Team impact metrics are used for the FY 20/21 Report and to make decisions on transforming the teams. The reporting dashboard covers hospitalizations, incarcerations, primary care linkage, and system costs. The Service Teams were added because of the success of the FSP dashboard.

The Underserved Ethnic Language Programs (UELPs), Evaluation Workgroup has finished it's first round of changes to the yearly UELP evaluation. The workgroup redesigned the logic model and worked with a graphic designer to create a graphical version of it and re-worded and updated both the Pre/Post Health Assessment and Participant Satisfaction Surveys. Both of these have been implemented during FY 21/22 using Survey Monkey and the results will be used during the evaluation.

During the FY 18/19 In Home Outreach Teams (IHOT) evaluation, the need for a dashboard in Yellowfin was identified to track client's discharge outcomes, how long the client works with the IHOT, and pre-IHOT and post-IHOT hospitalizations, incarcerations, crisis and subacute admissions. The IHOT Program Specialists is now using the dashboard to track the clients in the program and their outcomes.

Prevention & Early Intervention (PEI) Unit Performance Efforts

The MHSA PEI Unit is committed to working in collaboration with contracted providers to identify program outcomes and evaluation processes that are aligned with MHSA and the PEI system's values and regulatory requirements. 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.

The next audit is scheduled for Spring 2023.

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:

Afghan Coalition

African American Family Support Group (MHAAC)

Alameda-Contra Costa Medical Association (ACCMA)

Alameda County Behavioral Health Care Services (ACBH) Department

Alameda County Board of Supervisors, District 4

Alameda County Health Care Services Agency

Alameda County Mental Health Advisory Board

Amymade Graphic Design

Bryan Kring Design

City of Fremont Human Services Department

Community & Faith-Based Organizations

District Attorney's Office

East Bay Agency for Children (EBAC)

Health & Human Resource Education Center (HHREC)

Mental Health Association of Alameda County (MHAAC)

Mental Health Services Act (MHSA) Division

MHSA Community Program Planning Process Steering Committee

MHSA Stakeholder Group

Pacific Islander Wellness Initiative (RAMS, Inc.)

Peers Envisioning & Engaging in Recovery Services (PEERS)

The Behavioral Health Collaborative of Alameda County

Swords to Plowshares

APPENDICES

Appendix A-1 MHSA Stakeholder Meeting Calendar

alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

MENTAL HEALTH SERVICES ACT (MHSA)

STAKEHOLDER GROUP MEETING CALENDAR, 2022 rv8

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

DATE	TIME	LOCATION	MEETING THEMES
January 28, 2022	2:00-4:00pm	Go To Meeting	• Program Spotlight: Mental Health Peer Coach • Annual Plan Update • MHSA Community Planning Meetings (CPM) Outreach & Focus Group
February 25, 2022	2:00-4:00pm	Go To Meeting	• MHSA Goal Setting/Finding A Common Link • Program Spotlight: STRIDES • Review Operating Guidelines
March 25, 2022	2:00-4:00pm	GoToMeeting	• Presentation: ACT Fidelity
April 22, 2022	2:00-4:00pm	Go To Meeting	• CPPP/INN recommendations • Program Spotlight: INN Proposals (Project Indigo)
June 24, 2022	2:00-4:00pm	Go To Meeting	• Program Spotlight: Veterans Services & OESD 33/Deaf Community • Quarterly Data Review: Veterans
July 22, 2022	2:00-4:00pm	Go To Meeting	• Compliance- HIPAA for family members • Program Spotlight: Telecare LPS Conservatorship
September 23, 2022	2:00-4:00pm	Go To Meeting	• Presentation: Office of Homeless Care & Coordination Supportive Housing
October 28, 2022	2:00-4:00pm	Go To Meeting	• Leg Review • Presentation: Peer supportive Services & Cert Process • CPPP Report & FY23/26 Listening Session
November 18, 2022**	2:00-4:00pm	Go To Meeting	• Presentation: Collaborative Court • Program Spotlight/Presentation: • MHSA Policy & Legislation Review • End of Year Celebration/Retreat

MHSA STAKEHOLDER MEETING CALENDAR v8
Mariana Real, MPH, MCHES
Revision Date: 10/28/2022

Appendix A-2 MHSA CPPP Planning Committee Meeting Calendar

alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

MENTAL HEALTH SERVICES ACT (MHSA)

CPPP PLANNING COMMITTEE MEETING CALENDAR, 2022 rv3

DATE	TIME	LOCATION	MEETING THEMES

September 12, 2022 (Monday)	10:00-11:30	GoToMeeting	• MHSA CPPP Overview
			• Review:
			  ○ Outreach Plan
			  ○ Surveys
			  ○ Listening Session Toolkit

September 26, 2022 (Monday)	10:00-11:30	GoToMeeting	• Demographic Survey Review • Listening Session Stakeholder group brainstorm
October 10, 2022 (Monday)	10:00-11:30	GoToMeeting	• Listening Session Brainstorm Demographic Survey Review • CPPP Report
October 24, 2022 (Monday)	10:00-11:30	GoToMeeting	• CPPP Survey
November 7, 2022 (Monday)	10:00-11:30	GoToMeeting	• CPPP & 30-Day Outreach Strategy • MHSA Podcast Ideas
December 5, 2022 (Monday)	10:00-11:30	GoToMeeting	• Outreach
December 19, 2022 (Monday)	10:00-11:30	GoToMeeting	• Wrap Up

** This schedule is subject to change. Please contact Mariana.Dailey@acgov.org for questions

Please join the meeting from your computer, tablet or smartphone: https://meet.goto.com/412991397

You can also dial in using your phone.
Access Code: 412-991-397
United States: +1 (312) 757-3129

Join from a video-conferencing room or system.
Meeting ID: 412-991-397
Dial in or type: 67.217.95.2 or inroomlink.goto.com
Or dial directly: 412991397@67.217.95.2 or 67.217.95.2##412991397

MHSA Commmunity Input/Public Comment
Outreach & Marketing Plan
(Updated: May 19, 2022)

	programs/services within 5 months of CPPP activities				• **ACMHSA Website hits: (4/1/22 – 4/30/22): 1,032 users (82% new users) and 4,433 page views** • **# residents reached via outreach: at least 340,000**
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 4/1/22** • **# HHREC/POCC hotline calls: 0** • **# INN forms received: 0**
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 April 30, 2022.** 2. **Send press release package to media outlets and post on MHSA CIP website**	• **# media outlets receiving press release & social media kit***: KCCEB, Dr. Donna White Carey***,** *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,*	• KCCEB (3/15/22): 3,000-5.000 subscribers • Dr. Donna White Care (3/16/22): 100-300 views +1,000 church association + 20 medical associated CBO • Easy Bay Express	• **Start date: 4/1/22** • **# Subscribers HCSA newsletter: 9,000** • **# Media Outlets Contacted: 9** • **# PSAs: 1 (HHREC YouTube)** • **# Podcasts/Interviews Completed: 1; 43,838 views**

MHSA Commmunity Input/Public Comment
Outreach & Marketing Plan
(Updated: May 19, 2022)

	programs/services within 5 months of CPPP activities				• **ACMHSA Website hits: (4/1/22 – 4/30/22): 1,032 users (82% new users) and 4,433 page views** • **# residents reached via outreach: at least 340,000**
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 4/1/22** • **# HHREC/POCC hotline calls: 0** • **# INN forms received: 0**
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 April 30, 2022.** 2. **Send press release package to media outlets and post on MHSA CIP website**	• **# media outlets receiving press release & social media kit***: KCCEB, Dr. Donna White Carey***,** *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,*	• KCCEB (3/15/22): 3,000-5.000 subscribers • Dr. Donna White Care (3/16/22): 100-300 views +1,000 church association + 20 medical associated CBO • Easy Bay Express	• **Start date: 4/1/22** • **# Subscribers HCSA newsletter: 9,000** • **# Media Outlets Contacted: 9** • **# PSAs: 1 (HHREC YouTube)** • **# Podcasts/Interviews Completed: 1; 43,838 views**

			Native American Health Center, Asian • **# PSAs completed by ACBH staff:** *0* • **# interviews completed by ACBH staff:** *0*	(3/28/22): 49,799 e-readers & 35,000 newspaper readers • Bay Area News Group (11 outlets): 70,000 e-readers • El Mundo (3/23/22): 4,500 newspaper readers • Oakland Post (3/25/22): 55,000 newspaper readers	
Social Engagment/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 develops podcasts** **3. HHREC pay for Facebook advertisements (Send in Blue) and paid aids in**	• **# Facebook social media hits:** *N/A* • **PR Firm/LJ:** *N/A*	**$500 for 3 blast packages to a subscriber list**	• **HCSA/ACBH social media posts via Hootsweets: multiple** • **# HHREC Social media PR Blasts: multiple (initiated on 4/1/22** • **# HHREC Google Ads (initiated on 4/1/22)**

		online newspapers (e.g. Oakland Post) **4. ACBH Hootsweets app (social platforms)** **5. Utilize YouTube as a platform**			
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 lists, HCSA intranet page, DA, BOS/ CAO/ Court/ MHSA/ INN distribution lists & MHSA-SG lists (NAMII, Swords to Plowshares)**	• **Complete register of distribution lists:** • **Listservs:** *LANIECE JONES Listserv (7,500); POCC (1,600); Jenifer Link (250); 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); 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*		○ **Webmaster emails sent weekly beginning 3/30/22: 950 recipients** ○ **Webmaster notices: 1,000+**

			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 rea Chapter of the Association of Black Psychologists; AECreative Consulting Partners; Nurse with Doctors without Borders; Political Community Activist NPHC		
GOAL 3: Target and motivate the historically underserved and unserved communities/populations to participate in MHSA-funded activities					
Convene Listening Sessions (LS)	**Identify, recruit, host 10 community listening sessions by January 31, 2022.**	**1. Develop LS materials** **2. Coordinate LS Facilitator Training** **3. Develop LS tip sheet and Questionnaire** **4. Host 10 LS and target:** *ACBH Leadership, MHSA-SG, MHAB, AA/Faith-Based, Latinx, UELP/ API/ immigrant/*	• **# LS Trainings** • **# and name of participating agencies** • **# focus groups** • **# participants per agency** • **# consents received** • **# completed (paper only):** ○ *MHSA/MHAB: 1* ○ *POCC Volunteers* ○ *HHREC*		• **Focus Group Toolkit posted: 5/2020** • **# Trainings: 6** ○ MHSA (5/11/20): 3 ○ SM meeting (5/20/20): XX ○ PEERS (5/12/20): 2

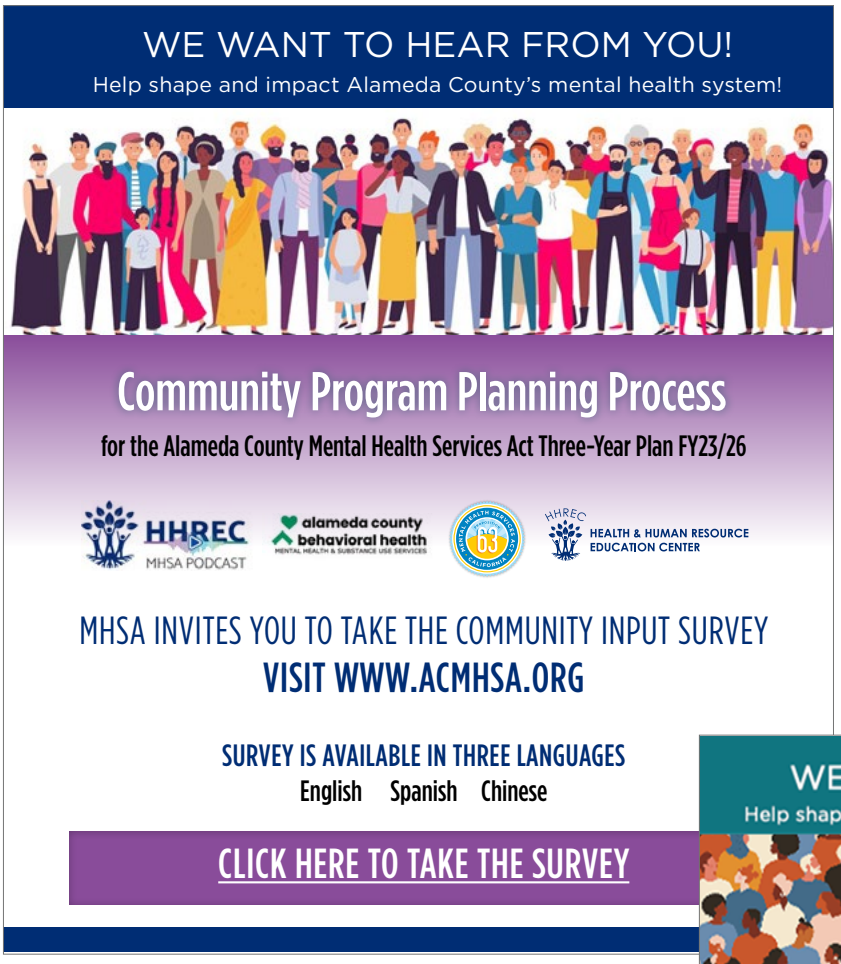
		refugee , Children/TAY, Adult, LGBTQQI+, VA, Reentry)	○ *BOS 4*		○ All MHAB (5/16/20): XX ○ MHAB Children (5/XX/20): 2 ○ POCC (5/26/20): 7 • **# Listening Sessions/ attendees: 18 FG/ 307+**
System of Care/Providers	**Educate providers on MHSA efforts and utilize providers to facilitate information to 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, 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:**	• **# attendees** (roster) • **# meetings presented** • **# clinicians (55,817)**		• **ACBH-HHREC E-blast:** 250 providers

MHSA Commmunity Input/Public Comment
Outreach & Marketing Plan
(Updated: May 19, 2022)

		○ *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** **2. Proctor consents/assents and surveys to respondents**	• **# unduplicated calls to center** • **# surveys completed with consent/assent forms**		
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**		• **Community Forums for Young Men of Color: 60 attendees**

		(COVID-19 alt. online YouTube)			
MHSA 101 Toolkit	**Develop educational toolkit for community members, providers, and consumers**	**1. Develop/Post educational PowerPoint, MHSA FAQ, MHSA Unit Profile Sheets, and INN web form to MHSA website.**	• **# materials distributed to providers** • **# materials distributed at CPMs (# LS participants)**		○ **See # LS participants** ○ **# INN forms: 0 web forms submitted**

Appendix B-2 MHSA CPPP: Outreach Flyers




WE WANT TO HEAR FROM YOU!
Help shape and impact Alameda County's mental health system!
COMMUNITY PROGRAM PLANNING PROCESS & 30-DAY PUBLIC COMMENT NOTICE
for the Alameda County Mental Health Services Act Annual Update FY22/23
HHREC
MHSA PODCAST
alameda county
behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES
HHREC
HEALTH & HUMAN RESOURCE
EDUCATION CENTER
MHSA is funded by a 1% tax on individual incomes over $1 million.


ALAMEDA COUNTY BEHAVIORAL HEALTH SERVICES INVITES YOU TO:
Contribute ideas about how to improve the County's mental health services between 10/1/21 – 1/31/22
Share information about the Mental Health Services Act.
Learn more about MHSA podcasts and events,
read the MHSA plans, and provide public comment at
acmhsa.org
HHREC
HEALTH & HUMAN RESOURCE
EDUCATION CENTER
alameda county
behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

Appendix B-3 MHSA Focus Group Question & Answer Sheet

Participant Survey

Thank you for taking the time to complete this survey. When answering the questions, please think about your experiences in any of the following:

- *workshop(s) or community event(s) you attended*
- *group(s) you participated in*
- *and/or on-going support you have received.*

If you have participated in this program for a long time or just once, your feedback is valuable to us. Taking this survey is voluntary and will not affect your ability to receive services or support. Your responses will remain anonymous and will be used to improve the quality of programs.

If you **cannot** complete this survey, please indicate reason:
□ No time
□ Refused
□ Not interested
□ Language unavailable
□ Other reason not listed
_____

Agency/Program: _____ **Date:** Month ☐☐ Day ☐☐ Year ☐☐☐☐

Please check off the appropriate response.

Because of the services and supports I've received in this program or group(s)/workshop(s)/event(s)...	**Yes**	**Somewhat**	**No**	**Not Applicable**
1. I am more prepared to seek out support when I need it.	☐	☐	☐	☐
2. I have someone to turn to when I need to talk about my problems.	☐	☐	☐	☐
3. I have learned more ways to manage stress or emotional challenges.	☐	☐	☐	☐
4. I feel like I am part of a community.	☐	☐	☐	☐
5. I feel better about my life.	☐	☐	☐	☐
6. I am more aware of the resources in my community.	☐	☐	☐	☐

Please tell us more about you.

Race/Ethnicity: _____ **Age:** _____

City Where You Live: _____ **Gender:** _____

Appendix B-4 MHSA CPPP: Survey (English)

ALAMEDA COUNTY BEHAVIORAL HEALTH Mental Health Services Act (MHSA) 3-Year Program and Expenditure Plan Community Participation and Feedback Survey (FY23/26)

Survey Instructions

The Alameda County Mental Health Services Act (MHSA) Division wants your input and innovative ideas to help strengthen its mental health and wellness programs to better serve you and your community over the next three years.

This survey is part of a larger community program planning process (CPPP) that may include community input meetings throughout Alameda County. To learn more about local MHSA activities, please visit https://acmhsa.org/

There are 21 questions in the survey and it takes about 10 minutes to complete. All responses are anonymous and confidential. For questions, please contact the MHSA Division at MHSA@acgov.org.

Thank you for your help with this community effort!

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

	1=Absolutely Essential	2=Very Important	3=Moderately Important	4=Somewhat Important	5=Not a Priority at this Time
a. Chronic Health Condition(s)	◯	◯	◯	◯	◯
b. Community Violence & Trauma	◯	◯	◯	◯	◯
c. Depression	◯	◯	◯	◯	◯
d. Education/Academic Support	◯	◯	◯	◯	◯
e. Employment, Job/Vocational Training	◯	◯	◯	◯	◯
f. Family Support/Resources	◯	◯	◯	◯	◯
g. Housing & Homelessness	◯	◯	◯	◯	◯
h. Ongoing Multiple Hospitilizations	◯	◯	◯	◯	◯
i. Social Isolation/Feeling Alone	◯	◯	◯	◯	◯
j. Substance Use/Abuse	◯	◯	◯	◯	◯
k. Suicide	◯	◯	◯	◯	◯

Please identify other important health services/needs that should be prioritized for the **Adult/Older Adult** age groups:

2. What are the top or most pressing mental health challenges related to **early childhood (ages 0-5)** are most important to you and/or your family member(s)? (Rate in order with 1 as "Absolutely Essential" to 5 as being "Not a Priority at this time").

	1=Absolutely Essential	2=Very Important	3=Moderately Important	4=Somewhat Important	5=Not a Priority at this time
a. Depression	◯	◯	◯	◯	◯
b. Discipline (Suspension/expulsion)	◯	◯	◯	◯	◯
c. Family Conflict/Stress	◯	◯	◯	◯	◯
d. Housing & Homelessness	◯	◯	◯	◯	◯
e. Out-of-home Placement/Foster Care	◯	◯	◯	◯	◯
f. Screening/Assessment	◯	◯	◯	◯	◯

Please identify other important health services/needs that should be prioritized for the early childhood age groups:

3. What are the top or most pressing mental health challenges related to y**oung children (ages 6-12)** that are most important to you and/or your family member(s)? (Rate in order with 1 as "Absolutely Essential" to 5 as being "Not a Priority at this time").

	1=Absolutely Essential	2=Very Important	3=Moderately Important	4=Somewhat Important	5=Not a Priority at this time
a. Juvenile Justice System Involvement	◯	◯	◯	◯	◯
b. Community Violence & Trauma	◯	◯	◯	◯	◯
c. Depression	◯	◯	◯	◯	◯
d. Discipline (suspension/expulsion)	◯	◯	◯	◯	◯
e. Family Conflict/Stress	◯	◯	◯	◯	◯
f. Housing & Homelessness	◯	◯	◯	◯	◯
g. Out-of-home Placement/Foster Care	◯	◯	◯	◯	◯
h. Social Isolation/Feeling Alone	◯	◯	◯	◯	◯
i. Suicide	◯	◯	◯	◯	◯

Please identify other important health services/needs that should be prioritized for children ages 6-12:

4. What are the top or most pressing mental health challenges related to **Children, middle/high school (ages 13-17)** that are most important to you and/or your family member(s)? (Rate in order with 1 as "Absolutely Essential" to 5 as being "Not a Priority at this time").

	1=Absolutely Essential	2=Very Important	3=Moderately Important	4=Somewhat Important	5=Not a Priority at this time
a. Juvenile Justice System Involvement	◯	◯	◯	◯	◯
b. Community Violence & Trauma	◯	◯	◯	◯	◯
c. Depression	◯	◯	◯	◯	◯
d. Education/Academic Support	◯	◯	◯	◯	◯
e. Employment, Job/Vocational Training	◯	◯	◯	◯	◯
f. Family Conflict/Stress	◯	◯	◯	◯	◯
g. Housing & Homelessness	◯	◯	◯	◯	◯
h. Out-of-home Placement/Foster Care	◯	◯	◯	◯	◯
i. Social Isolation/Feeling Alone	◯	◯	◯	◯	◯
j. Suicide	◯	◯	◯	◯	◯

Please identify other important health services/needs that should be prioritized for children ages 13-17 age groups:

5. What are the top or most pressing mental health challenges related to **Transitional Aged Youth or TAY (ages 18-24)** that are most important to you and/or your family member(s)? (Rate in order with 1 as "Absolutely Essential" to 5 as being "Not a Priority at this time").

	1=Absolutely Essential	2=Very Important	3=Moderately Important	4=Somewhat Important	5=Not a Priority at this time
a. Criminal Justice System Involvement	◯	◯	◯	◯	◯
b. Community Violence & Trauma	◯	◯	◯	◯	◯
c. Depression	◯	◯	◯	◯	◯
d. Education/Academic Support	◯	◯	◯	◯	◯
e. Employment, Job/Vocational Training	◯	◯	◯	◯	◯
f. Family Conflict/Stress	◯	◯	◯	◯	◯
g. Housing & Homelessness	◯	◯	◯	◯	◯
h. Out-of-home Placement/Foster Care	◯	◯	◯	◯	◯
i. Social Isolation/Feeling Alone	◯	◯	◯	◯	◯
j. Substance Use/Abuse	◯	◯	◯	◯	◯
k. Suicide	◯	◯	◯	◯	◯

Please identify other important health services/needs that should be prioritized for TAY ages 18-24 age groups:

6. Are there any i**ndividuals, groups, and/or cultural communities** whom you believe are not being adequately served by the behavioral health system of Alameda County? **(Please select all that apply)**

- [ ] African-American/Black
- [ ] American Indian/Alaskan Native
- [ ] Asian
- [ ] Latinx
- [ ] Pacific Islander/Native Hawaiian
- [ ] Children, Young (ages 0-5)
- [ ] Children, Elementary School Aged (ages 6-12)
- [ ] Children, Middle/High School Aged (ages 13-17)
- [ ] Transitional Age Youth (ages 18-24)
- [ ] Adult
- [ ] Older Adult
- [ ] Criminal Justice Systems Involved Individuals
- [ ] Immigrant & Refugee
- [ ] LGBTQQIA+
- [ ] Parents/Family Member
- [ ] Persons Experiencing homelessness
- [ ] Persons with disabilities
- [ ] Seriously mentally ill (SMI)
- [ ] Veteran/active military

Other population(s), please specify:

7. What are the **barriers and gaps** for people to get mental health resources and appropriate treatment needed for their recovery? **(Please select all that apply)**.

- [ ] Appointment availability
- [ ] Basic needs (e.g. food, shelter, safety concerns, transportation)
- [ ] Embarrassed to ask for help
- [ ] Did not want help
- [ ] Legal concerns
- [ ] Level of services did not match needs
- [ ] Provider changes
- [ ] Resource navigation (e.g. insurance, public benefits)
- [ ] Services not in my community
- [ ] Services not culturally appropriate (e.g. not in my language)
- [ ] Stigma around mental health illness in their community
- [ ] Slow response time

Other, please specify:

8. Which of the following MHSA Service areas do you feel have been effective in addressing our local mental health concerns? **(Please select all that apply)**.

- [ ] Crisis Services
- [ ] Consumer Wellness Centers (serves Adults with wellness/recovery services & links to community supports)
- [ ] Dual Diagnosis Services (services to improve mental health and substance use disorders)
- [ ] Culturally Responsive Prevention Programming & Supports
- [ ] Employment and Vocational Services/Supports
- [ ] Family Education & Support Centers
- [ ] Full Service Partnerships (serves Adults and TAY with mental health issues that result in homelessness, criminal justice system involvement, & frequent use of emergency psychiatric hospitalization)
- [ ] Housing Services
- [ ] Mental Health Outreach Teams
- [ ] Mental Health Services for Re-entry populations
- [ ] School-Based Mental Health Services
- [ ] Anti-Stigma & Anti-Discrimination Campaign
- [ ] Suicide prevention (crisis hotline/training & education)
- [ ] Workforce Development Projects

Other areas you feel have been effective, please specify:

9. MHSA funds **INNOVATIVE SERVICES** such as the proposed Consumer Empowerment Using Recovery Oriented Cognitive Therapy (CT-R). The framework of this peer training project will not change. What innovative ideas do you have to improve mental health services?

Please list innovative ideas which help improve mental health services:

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

	1=Absolutely Essential	2=Very Important	3=Moderately Important	4=Somewhat Important	5=Not Priority at This Time
a. Internship Programs (Undergraduate & Graduate)	○	○	○	○	○
b. Behavioral Health Career Pathways Pipeline programs (High School & Community College)	○	○	○	○	○
c. Undergraduate Scholarship Programs to support community college behavioral health pipeline students	○	○	○	○	○
d. Student Loan Repayment Program to support clinical staff retention	○	○	○	○	○
e. Peer Support Training	○	○	○	○	○
f. Stipend Program to Support Graduate Level Behavioral Health Internships	○	○	○	○	○

Please identify other important workforce development strategies:

11. Is this your first-time providing input and information for our **MHSA Community Program Planning Process**?

12. My **AGE RANGE** is:

13. In which part of Alameda County do you **LIVE?**

Other (please specify)

14. What is your current **GENDER IDENTITY**?

15. What your **SEX** were you assigned at birth?

16. Which of the following **BEST REPRESENTS** how you think of yourself?

17. What is your **ETHNICITY**?

18. What is your RACE? (Please select all that apply)

- [ ] African-American/Black
- [ ] American Indian/Alaskan Native
- [ ] Asian/Pacific Islander or Native Hawaiian
- [ ] White/Caucasian
- [ ] Prefer not to answer

19. If you marked "ASIAN OR PACIFIC ISLANDER" under question 14, please tell us about your nationality or country of origin? (Please select all that apply)

- ◯ Asian Indian
- ◯ Cambodian
- ◯ Chinese
- ◯ Filipino/a
- ◯ Japanese
- ◯ Korean
- ◯ Samoan
- ◯ Taiwanese
- ◯ Tongan
- ◯ Vietnamese
- ◯ I am not Asian or Pacific Islander

Other (please specify):

20. Which of the following stakeholder group(s) do you primarily represent (Please select all that apply).

- ☐ Active Military/Veteran
- ☐ Consumer/Peer with lived experience
- ☐ Faith Community
- ☐ Family member
- ☐ Law enforcement agency
- ☐ Provider

Other (please specify)

21. How did you learn about the **MHSA Community Participation & Feedback Survey?** (Please select all that apply).

- [ ] Alameda County
- [ ] Community-based provider
- [ ] Friend/Family Member
- [ ] Hospital/Healthcare or Other Provider
- [ ] Listserv/Newsletter (online)
- [ ] Media (e.g. Eventbrite, Facebook, Print, Radio)
- [ ] Website (MHSA)

Other (please specify)

22.

Thank you again for taking the time to provide your input on the County of Alameda's MHSA future plans. We appreciate you! To learn about more ways to get involved, please visit our website at https://acmhsa.org/

Mental Health Services Act Community Education & Input Meeting

MHSA Three-Year Plan FY 23/26

Presented by: Alameda County Behavioral Health – MHSA Division and Health & Human Resource & Education Center (HHREC)

Target Audience: Insert
Date: Insert

Community Agreements

- *Microphones have been muted to reduce background noise*
- *Use the chat box to ask a question*
- *Pause/Breathe: We have a variety of people participating using different communication methods (phone, webcam, etc.) we might take time to pause throughout the presentation to address comments/questions*
- *Have fun and participate*

Alameda County Behavioral Health Care Services 2

MHSA Listening Session Agenda

Listening Session Purpose: Education and Information sharing about MHSA, Stakeholder Engagement and Decision Making processes.

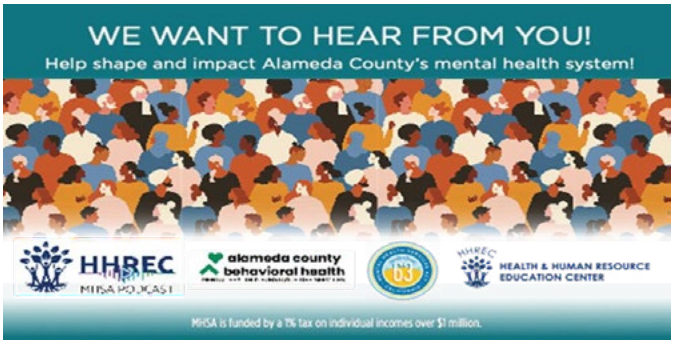
Meeting Focus :

- Welcome & Introductions
- Meeting Logistics
- Education on the Mental Health Services Act
- Listening Session
- Wrap Up and Check-in on how the session went +/Δ
- Raffle & End of the Session

3

CPPP Demographic Survey at:

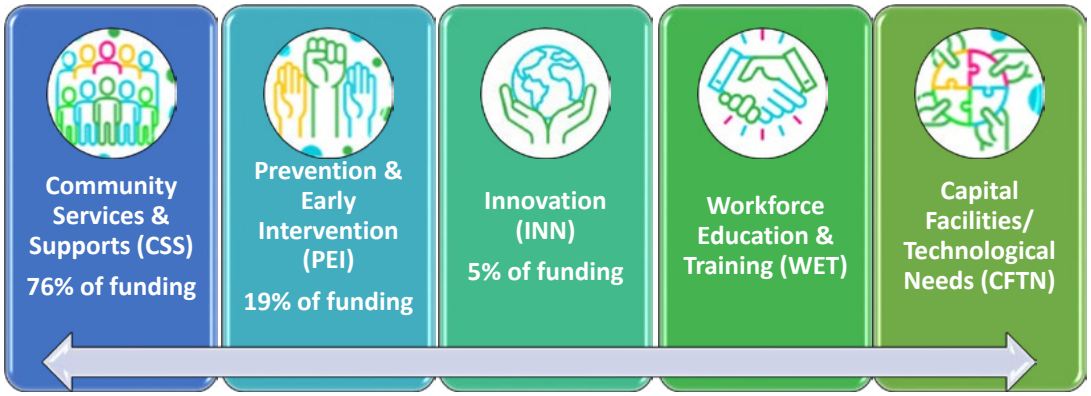
https://www.surveymonkey.com/r/YGNCXL5



4

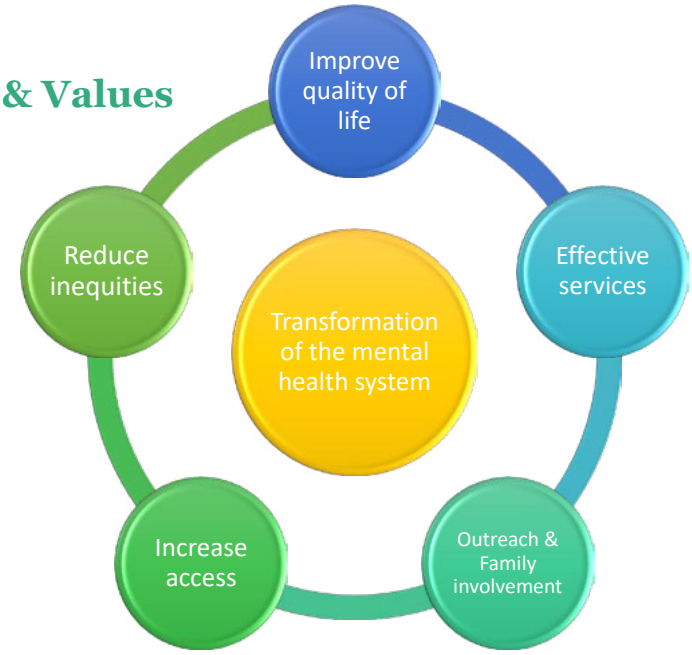
Mental Health Services Act (MHSA) Component Areas

- In 2004, California voters passed Proposition 63, known as the Mental Health Services Act
- Funded by 1% tax on any personal incomes over $1 million
- Here are the 5 Service Categories:



5

MHSA Goals & Values



6

MHSA: Who Does It Serve?

- Individuals with serious mental illness (SMI) and/ or severe emotional disorder (SED)
- Individuals not served /underserved by current mental health system
- Services must be in a voluntary setting, meaning MHSA funds can not be used to provide services in the jail or a locked facility.
- Non-supplantation: MHSA may not replace existing program funding or be used for non-mental health programs.

7

Community Program Planning Process (CPPP)

The County shall provide for a CPPP (also known as Community Listening Sessions or Community Input) as the basis for developing the Three-Year Program and Expenditure Plans and Plan Updates*.

The CPPP shall, at a minimum, include:

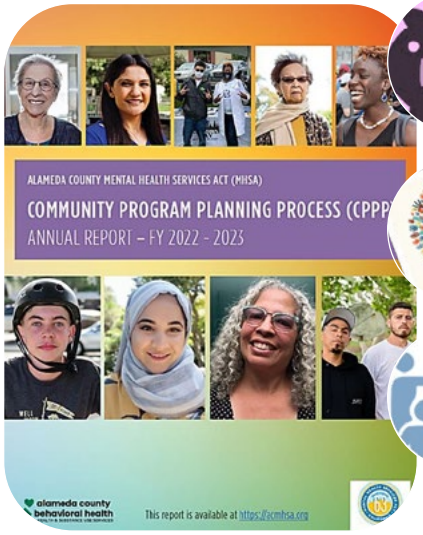
- Involvement of clients with serious mental illness and/or serious emotional disturbance and their family members in all aspects of the Community Program Planning Process.
- Participation of diverse stakeholders.
- Training/Education on MHSA.

Alameda's Community Listening sessions will conclude December 31, 2022

*Title 9 CCR § 3300

8

MHSA Funding from Community Input



Provider contract increases to address workforce crisis

Increased funding for underserved ethnic and language groups

Expand housing rental subsidies

9

Listening Session

10

Community Agreements

- *Mute your microphone to reduce background noise,*
- *Respect diversity of opinions. There is no wrong answer,*
- *1 mic/1 voice- let's avoid talking over one another,*
- *Pause/Breathe: We have a variety of people participating using different communication methods (phone, webcam, etc.) we might take time to pause to allow others to contribute who cannot see our faces,*
- *Step, up step back,*
- *Raise your hand,*
- *Keep answers brief, so to allow maximum participation, and*
- *Participate/Have fun.*

11

Input Questions

1. What are the **top** or **most pressing mental health challenges** right now in your community**?**

2. Are there **individuals, groups** and/or **cultural communities** who you believe are **not being adequately served?**

1. What do you see as **barriers** and/or **gaps** for people to **access** mental health **resources** and appropriate/effective treatment needed for their recovery?
   - *(a) Identify barriers & gaps for mental health consumers (also known as peers with lived experience)*
   - *(b) Identify barriers & gaps for their family member(s)*

2. *R*elated to the challenges described earlier, what are your **ideas** on how to address these challenges or others that you may see to **better serve** your community?

3. What **MHSA-funded services** are you aware of, either as services you or someone you know has taken advantage of or as services you would feel comfortable recommending to others?

4. An **Innovation** project is proposing a title change to **Consumer Empowerment Using Recovery Oriented Cognitive Therapy (CT-R).** The frame this peer training project will not change. What innovative ideas do you have to improve mental health services?

5. **Other comments** people want to share?

12

What worked in this session and what needs improvement? + /Δ

13

Take our CPPP Survey by January 31, 2023 at:

https://acmhsa.org/

14


ac bh
For more information email us at MHSA@acgov.org or visit us at www.ACMHSA.org
Alameda County Behavioral Health Care Services
thank you.
Please visit us at acmhsa.org

C-1 MHSA PEI: Client Survey (English)

Participant Survey

Thank you for taking the time to complete this survey. When answering the questions, please think about your experiences in any of the following:

- *workshop(s) or community event(s) you attended*
- *group(s) you participated in*
- *and/or on-going support you have received.*

If you have participated in this program for a long time or just once, your feedback is valuable to us. Taking this survey is voluntary and will not affect your ability to receive services or support. Your responses will remain anonymous and will be used to improve the quality of programs.

If you **cannot** complete this survey, please indicate reason:
□ No time
□ Refused
□ Not interested
□ Language unavailable
□ Other reason not listed
_____

Agency/Program: _____ **Date:** Month ☐☐ Day ☐☐ Year ☐☐☐☐

Please check off the appropriate response.

Because of the services and supports I've received in this program or group(s)/workshop(s)/event(s)...	**Yes**	**Somewhat**	**No**	**Not Applicable**
1. I am more prepared to seek out support when I need it.	☐	☐	☐	☐
2. I have someone to turn to when I need to talk about my problems.	☐	☐	☐	☐
3. I have learned more ways to manage stress or emotional challenges.	☐	☐	☐	☐
4. I feel like I am part of a community.	☐	☐	☐	☐
5. I feel better about my life.	☐	☐	☐	☐
6. I am more aware of the resources in my community.	☐	☐	☐	☐

Please tell us more about you.

Race/Ethnicity: _____ **Age:** _____

City Where You Live: _____ **Gender:** _____

Alameda County Behavioral Health Prevention and Early Intervention Participant Survey Version 2021

alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

Alternatives to Confinement

MHSA Innovation Project

Amount Requested: $13,432,653

Project Duration: 5 Years

Submitted by:
Alameda County Behavioral Health Care Services

Prepared by:
Roberta Chambers, PsyD
The Indigo Project

Date:
03/18/2022

alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

Section 1: Innovations Regulations Requirement Categories

General Requirement

An Innovative Project must be defined by one of the following general criteria. The proposed project:

- ☐ Introduces a new practice or approach to the overall mental health system, including, but not limited to, prevention and early intervention
- X Makes a change to an existing practice in the field of mental health, including but not limited to, application to a different population
- X Applies a promising community driven practice or approach that has been successful in a non-mental health context or setting to the mental health system
- ☐ Supports participation in a housing program designed to stabilize a person's living situation while also providing supportive services onsite

Primary Purpose

An Innovative Project must have a primary purpose that is developed and evaluated in relation to the chosen general requirement. The proposed project:

- X Increases access to mental health services to underserved groups
- X Increases the quality of mental health services, including measured outcomes
- X Promotes interagency and community collaboration related to Mental Health Services or supports or outcomes
- ☐ Increases access to mental health services, including but not limited to, services provided through permanent supportive housing

Indigo Project

alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

Section 2: Project Overview

Primary Problem

The issue of people with serious mental illness (SMI) and/or substance use disorders (SUD) experiencing incarceration is one of the most prominent challenges facing the behavioral health and criminal justice communities. In many jurisdictions, individuals with mental illness are more likely to be booked into jail than engaged in treatment, and jails have become the largest mental health institutions. **This issue is exacerbated because the legal threshold to arrest and incarcerate someone is lower than is the legal threshold to engage that same individual in treatment if they are unwilling or unable to participate on a voluntary basis.** Because the legal standard for incarceration is much lower than the threshold for involuntary treatment and jail beds are more readily available than treatment beds, either voluntary or involuntary, it has become increasingly common to incarcerate individuals in need of mental health services.[1] Despite intentional efforts to make the mental health system as accessible and recovery-oriented as possible, there remains a group of individuals who will not engage in voluntary services and are more likely to be incarcerated than treated by the community behavioral health system. **Once a person with SMI and/or SUD becomes justice-involved, they are more likely to remain involved and penetrate the justice system further[2], [3].** These individuals typically have minimal financial resources and are more likely to be held in jail awaiting trial or placement for treatment, including competency restoration. They may experience difficulty complying with the terms and conditions of probation or release, and they may be charged with a new criminal offense while confined in jail.

Within California and across the Nation, there is a concerted effort to identify diversion opportunities and to ensure a continuum of services for individuals with mental health issues who are involved with the criminal justice system. Alameda County, along with its partners and community of stakeholders, has invested substantial time and resources on a number of efforts that aim to strengthen forensic and reentry mental health services for people with mental health needs and/or substance use disorders by:

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[1] National Sheriff's Association and Treatment Advocacy Center. *The Treatment of Persons with Mental Illness in Prisons and Jails: A State Survey.* Retrieved from: https://www.treatmentadvocacycenter.org/storage/documents/treatment-behind-bars/treatment-behind-bars.pdf.

[2] Fellner J: (2006), A corrections quandary: mental illness and prison rules. Harv CR-CL L Rev 41:391–412,

[3] Abramsky & Fellner, supra note 3, at 59 (citing Letter from Keith R. Curry, Ph.D., to Donna Brorby, Atty. in the Ruiz v. Johnson litigation (Mar. 19, 2002)

alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

Safely diverting people from the justice system into treatment,	Stabilizing and connecting individuals in custody to community behavioral health services, and	Promoting service participation that reduces recidivism.

The department unveiled a Forensic and Reentry Services Plan[4] in May of 2021 and has been systematically working through the short, mid, and long terms actions set forth in the plan. Alameda County was interested in how Innovation funds could assist in addressing the forensic and reentry mental health needs in the County. This Innovation plan arose out of these concerted efforts to divert individuals with mental health challenges from the justice system into mental health services and was developed for and by community stakeholders, including the County's Justice Involved Mental Health Task Force.

Proposed Project

Project Description

The *Alternatives to Incarceration* continuum of services is a collection of three co-located services that are working together intended to prevent incarceration and divert individuals from the criminal justice system into the mental health services. This continuum of services specifically seeks to divert individuals from incarceration in three primary ways:

1. When a mental health consumer who is forensically involved begins to exhibit early warning signs of a crisis with behaviors that may lead to police contact,
2. At the moment of police contact that may result in arrest, and
3. When the person has fallen out of compliance with their probation or parole and is subject to re-arrest.

This continuum of services seeks to provide services that prevent individuals with mental health and criminal justice involvement from being booked into the jail. Services include the following three programs.

Forensic Crisis Residential Treatment (CRT). The Forensic CRT will provide a voluntary, unlocked alternative to hospitalization and/or incarceration for individuals with

[4] http://www.acgov.org/board/bos_calendar/documents/DocsAgendaReg_5_10_21/HEALTH%20CARE%20SERVICES/Regular%20Calendar/Item__1_ACBH_Services_Forensic_sys_5_10_21.pdf

Indigo Project

mental health and criminal justice involvement who require services to re-stabilize and address the issues that place them at higher risk for police contact and/or an involuntary hold or arrest. While this may seem similar to the Muriel Wright Center in neighboring Santa Clara County, Muriel Wright is intended to provide crisis residential services for individuals who receive services through their criminal justice mental health program while Alameda County's proposed CRT is intended to divert individuals with mental health issues from the criminal justice system, regardless of whether or not they are already enrolled in forensic mental health services. While they are both forensic CRTs, Alameda County's proposed program serves to test a different function within the system for individuals who may or may not already be enrolled in public mental health services.

This program will provide 24/7 mental health services and supports that address mental health, substance use, and criminogenic needs in an unlocked environment. The average length of stay will span 5-14 days with the opportunity to extend up to 30 days with Mental Health Plan approval, and the total capacity will be 16. The Forensic CRT will be licensed by Community Care Licensing as a Short Term Social Rehabilitation Facility and certified by Medi-Cal. The Forensic CRT would be available to consumers who are beginning to experience early warning signs of a crisis or other behaviors that place them at high likelihood of police contact. At the Forensic CRT, individuals would be able to stabilize from the crisis and address the issues that were increasing the likelihood of police contact.

The facility will accept consumers ages 18-59 with mental health and criminal justice involvement who meet medical necessity criteria for crisis residential services and do not require services in a locked setting. This program is intended to be a step up from the community as well as step down from a locked environment, and referrals may come from community mental health providers who are serving justice-involved mental health consumers as well as providers from jail mental health, psychiatric hospitals, psychiatric emergency services, local emergency departments, crisis stabilization units, sobering centers and detoxification units, and the arrest diversion program described below. It is also possible that the Forensic CRT will also accept transfers from the existing CRTs if there is an individual with criminogenic needs that would be better served in a forensic environment.

Arrest Diversion/Triage Center. The arrest diversion/triage center is a centrally located program where law enforcement officers can bring someone with a serious mental illness who would otherwise be arrested in order to avoid the jail booking and engage the person in other services. This program is unlocked and is not intended to accept individuals who require services in a locked environment. The arrest diversion center is open 24/7 and staffed with a clinical program supervisor, case managers, and certified forensic peer specialists. When a person is brought to the arrest diversion center, they are welcomed

and offered a snack or other supports to help them feel comfortable and address any imminent basic needs. Once they have settled, the case manager meets with the individual to understand the person's situation and what short term interventions may be most successful in helping the person address whatever issues contributed to law enforcement contact. They may also identify longer term supports that may be useful. Based on this assessment and the person's preferences and willingness to participate, the case manager will make arrangements with and for the person to obtain the agreed upon short term services. They may also complete referrals for the longer term supports, if it makes sense to do so. While there are other programs that provide diversion from the criminal justice system into treatment, the programs are 1) either led by the justice system or 2) if they are led my mental health staff, they are placed in a crisis or emergency setting. Alameda County's proposed arrest diversion/triage center differs from other models in that it is not a crisis or hospital setting, and mental health staff will provide assessment, brief intervention, and service coordination to engage the person in services that help them address the issues that led to the police contact and promote their mental health.

The County, through its stakeholder-led Justice Involved Mental Health Taskforce and Sequential Intercept Mapping Process, has prioritized the need to divert arrest for individuals with mental health challenges in Alameda County. One of the identified barriers to pre-arrest diversion is a location where law enforcement officers can take someone to obtain services that will reduce the likelihood of subsequent police contact. This service provides that alternative drop off location and realigns the need for assessment and case planning back to mental health staff who can determine what a person's needs and preferences are and link them to the appropriate programs and interventions.

Reducing Probation/Parole Violations (RP/PV). People with significant mental health challenges often struggle to comply with the terms and conditions of release and may be more likely to be re-incarcerated as a result of a parole or probation violation. Additionally, providers appear hesitant to interact with the justice system on behalf of their consumers for fear of triggering additional legal challenges for the people they serve. This program provides educational materials and training for mental health providers who work with mental health consumers who are involved with the justice system in order to build their capacity to support the people they work with. Specifically, providers will learn how to support consumers they're working with to comply with the terms and conditions of their release and build the skills and knowledge to help consumers negotiate with their parole or probation officers on how to come into compliance with the terms and conditions of their release without being reincarcerated.

In the training, mental health providers will learn how work with consumers to understand their forensic history, what terms and conditions they have failed to comply with, how they understand why they have failed to comply, what services they have been participating in to address their mental health and criminogenic risk and needs, and what services they are willing to participate in. Staff will also learn how to develop a plan for reaching out to the parole or probation officer with the goal or coming into compliance with the terms and conditions of release without "being violated" or having to be booked into the jail. Staff will also learn how to negotiate directly with the probation or parole officer on behalf of or in partnership with the consumer. Additionally, this program will also support providers to increase knowledge of and comfort in working with legal entities to resolve parole and probation violations.

Project General Requirements

The Alternatives to Confinement continuum of services both adapts an existing mental health practice for the forensic mental health population as well as adapts practices from other disciplines.

The Forensic CRT borrows the CRT model, which provides an alternative treatment setting for people who do not require services in a locked environment to stabilize from a crisis and return to their community. While there is a strong evidence base for reducing avoidable hospitalization for people experiencing mental health crisis, the CRT model has not been piloted for people experiencing crisis who are at risk of arrest or incarceration as a result of their mental health and criminogenic needs. This continuum of services seeks to test whether or not a forensic-focused CRT would reduce incarceration for people experiencing mental health issues that place them at high likelihood of police contact. The continuum of services would also measure the extent to the extent to which the program can connect people to ongoing mental health services, thereby decreasing the likelihood of future justice involvement. Currently, Alameda County has three CRTs for individuals with mental health issues that are experiencing crisis but do not require services in a locked environment. These programs have been successful in preventing avoidable hospitalization and connecting individuals to longer term mental health services and supports. The proposed Forensic CRT would provide the same level of mental health supervision but integrate services that address substance use and other criminogenic risk and need to support mental health consumers who are justice involved.

The Arrest Diversion Center is inspired by triage models from other disciplines. For example, the triage model is used across emergency and jail environments to quickly determine level of need and obtain that level of care. San Francisco used this type of model specifically in their juvenile justice system to avoid booking youth into their juvenile hall. The Centralized Assessment and Referral Center (CARC) operated by Huckleberry

Youth Programs accepted juveniles from police officers and would meet with them and their families to assess their needs and connect them to ongoing services and supports. Contra Costa County used a similar model for individuals experiencing homelessness out of their multi-service drop-in centers (MSCs) where police could transport an individual to a service center rather than book them into the jail. Once at the MSCs, homeless individuals could access a variety of tangible supports (e.g., laundry, shower, food) as well as obtain an assessment and service linkages and referrals. However, these types of programs are rarely led by the mental health system, and when they are mental health led, they are typically set up as an urgent care center or crisis stabilization unit, are subject to rules and regulations for those environments, and do not have or are unable to maintain a specific forensic focus. This program intends to maintain a low barrier for police drop off and service provision with the singular focus to quickly connect mental health consumers with services that will reduce the likelihood of police contact or re-arrest, which may include partnering or negotiating with their family and other natural supports to develop a plan.

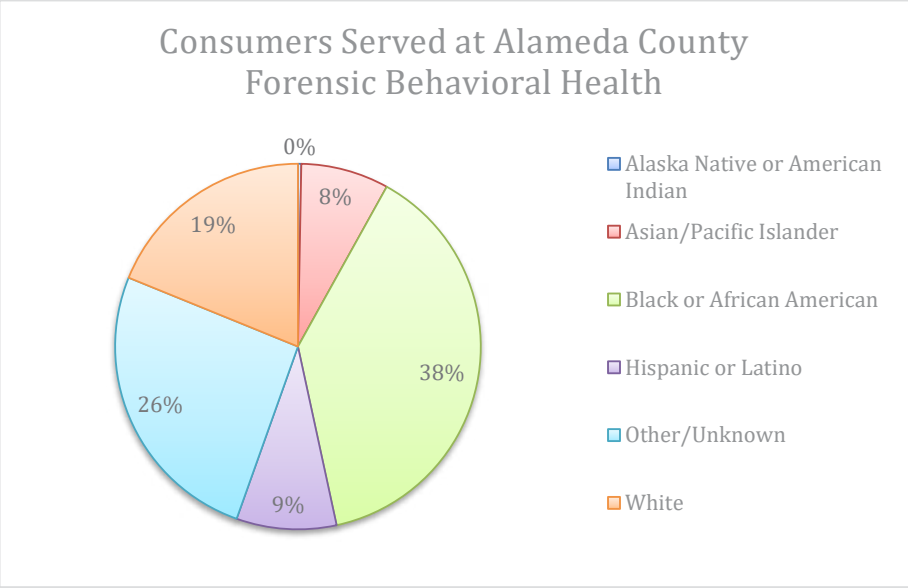
The RP/PV program also takes an existing type of program used across the justice system and applies it specifically to mental health consumers. Santa Cruz has a large and highly successful Reducing Revocations program for individuals on community supervision, and San Joaquin County has significantly reduced their incidence of probation violations resulting in re-arrest as a result of this type of intervention. This program will specifically apply that successful intervention to mental health consumers to determine if the RP/PV training can reduce re-arrest for individuals on community supervision as well as increase the rates of successful probation/parole completion for mental health consumers.

Individuals to be Served

Overall, the Alternatives to Confinement continuum of services will serve 2,279 individuals per year. The arrest diversion center will serve approximately 1,825 individuals per year. This assumes that there will be about 5 individuals per day who are diverted from arrest and jail booking to the center. We expect to serve approximately 700 individuals in the Forensic CRT per year. This assumes that the 16 bed Forensic CRT will operate at 85% capacity with an average length of stay of one week. We also expect to serve about 40 providers in the RP/PV program. However, we anticipate that there is significant overlap between the programs.

This continuum of services will serve transition age youth ages 18-25 and adults ages 26 and up who have significant mental health issues and are involved with the criminal justice system; they may also have co-occurring substance use issues. They may be of any gender or gender identity as well as sexual orientation. We anticipate that consumers will

be predominantly Black or African American with smaller percentages of people who are white, Latinx, or Asian, Pacific Islander, and American Indian. This is based on demographic data of consumers receiving services at Adult Forensic Behavioral Health, which is the outpatient clinic located inside the County jail, as demonstrated in Table 1. We also anticipate that a proportion of individuals will speak Spanish and other languages and will ensure language access is available.



Research on INN Project

The issue of individuals with serious mental illness who are involved with the justice system has become one of the largest problems facing communities across the nation, and the rate of individuals with serious mental illness is two to six times higher among incarcerated populations than it is in the general population.[5] Research clearly demonstrates that outcomes for people with mental illness who become justice involved are better when diverted into treatment than when in custody. The Sequential Intercept Model (SIM)[6] is a conceptual framework that defines a series of opportunities to divert individuals who have contact with or are involved with the criminal justice system into

[5] Cloud, David, and Chelsea Davis. Treatment Alternatives to Incarceration for People with Mental Health Needs in the Criminal Justice System: The Cost-Savings Implications. Vera Institute, 2013. Retrieved from: https://www.vera.org/downloads/Publications/treatment-alternatives-to-incarceration-for-people-with-mental-health-needs-in-the-criminal-justice-system-the-cost-savings-implications/legacy_downloads/treatment-alternatives-to-incarceration.pdf.

[6] https://www.samhsa.gov/criminal-juvenile-justice/sim-overview

treatment. The SIM framework provides a system-wide way in which to organize interventions and resources in order to maximize diversion into treatment at each intercept. Risk Needs Responsivity (RNR)[7] represents an approach to effective interventions within the justice system that allows for a wide variety of programs, services, and interventions to be used. The *risk principle* states that services should be targeted to the assessed risk of reoffending. The *needs principle* states that treatment should target assessed criminogenic needs. The *responsivity principle* states that treatment should be tailored to meet the specific learning style, motivation, abilities, and strengths of the individual. Essentially, RNR states that treatment and supervision decisions should be based on assessed risk and need.

The Alternatives to Incarceration continuum of services co-locates three services that are intended to divert individuals from being arrested and/or booked into the jail in order to divert them into treatment. Using models from mental health and other disciplines, these three interventions collectively provide an opportunity to divert forensic mental health consumers from police contact that may result in being detained, from being arrested or booked into the jail if detained, and from being re-arrested if unable to comply with the terms and conditions of their release. These priorities for diversion arose out of the sequential intercept mapping process with Alameda County's Justice Involved Mental Health Task Force and focus on preventing entry into the criminal justice system as well as promoting exit from the criminal justice system. They are based on the RNR principles in that they do not prescribe a single approach but instead provide opportunities to assess both behavioral health and RNR principles and develop service plans that connect individuals with services that are likely to address behavioral health and criminogenic risk and need as well as reduce the likelihood of sustained or future criminal justice involvement.

At this time, no other jurisdiction has developed a singularly focused Forensic CRT or applied a reducing revocations approach to people with serious mental illness. People with forensic mental health needs may be served in CRT models or general reducing revocation programs, but none specialize in the intersection between behavioral health and justice system involvement and specifically target behavioral health and criminogenic risk and need. While there are myriad versions of a triage center across the nation, none are led by the mental health system, and none are exclusively focused on arrest diversion for people with serious mental illness. To this end, this continuum of services aims to explore the extent to which these programs are able to reduce criminal justice system

[7] Andrews, D., Bonta, J., & Hoge, R. (1990). Classification for effective rehabilitation. *Criminal Justice and Behavior*, *17*, 19–52. https://doi.org/10.1177/0093854890017001004

involvement for people with serious mental illness (e.g., reduced jail bookings, reduced revocations, increased exit from community supervision).

Learning Goals/Project Aims

In Alameda County, 25% of ACBH consumers receive mental health services in the jail, and 10% of consumers only receive mental health services in the jail.[8] This highlights the need to address the over-incarceration of people with mental health issues and support them outside of a jail environment as a key County priority. This continuum of services, along with the other Innovation Plan entitled *Peer Led Continuum of Forensic Mental Health Services,* is one element of a larger Forensic Mental Health and Reentry Plan and represents the service offerings that are relevant to and meet criteria for Innovation projects.

With this continuum of services, Alameda County Behavioral Health seeks to pilot these three co-located services to understand the extent to which these programs, separately and together, increase access to and participation in mental health services for adults with mental health and criminal justice involvement; improve outcomes, including reduced jail bookings, jail days, and probation/parole violations; and increase knowledge and collaboration between mental health and criminal justice providers and agencies.

For the Forensic CRT, we hope to learn the extent to which the Forensic CRT is able to prevent avoidable jail bookings and jail bed days at the moment of intervention as well as following CRT participation. We also hope to learn the extent to which individuals engage in ongoing mental health services following CRT discharge. These are similar to the expected outcomes of a non-forensic CRT except they substitute jail bookings and bed days for crisis and hospitalization.

Similarly, we hope to learn the extent to which law enforcement officers are willing to divert individuals to the arrest diversion center in lieu of booking them into the jail therefore resulting in reduced jail bookings. We also hope to explore if and how individuals participate in ongoing mental health services following participation at the arrest diversion center and whether or not they remain in the community or are re-arrested. We also hope to learn more about their assessed level of need and referred level of care to better share system capacity needs for ongoing program planning.

Finally, we hope to learn whether or not a concerted effort to reduce parole and probation violations for people with serious mental illness reduces booking individuals into the jail as a result of parole or probation violation. We also hope to learn the extent to which the program results in increased knowledge, understanding, and collaboration amongst probation and parole

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[8] http://www.acgov.org/board/bos_calendar/documents/DocsAgendaReg_5_10_21/HEALTH%20CARE%20SERVICES/Regular%20Calendar/Item__1_ACBH_Services_Forensic_sys_5_10_21.pdf

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Evaluation or Learning Plan

This Alternatives to Confinement continuum of services evaluation will explore process and outcome measures related to the three co-located services. The overarching evaluation questions include:

1. What resources are being invested, by whom, and how much?
2. Who is being served, at what dosage, and in what ways, including participation in more than one INN-funded service?
3. To what extent do people who participate in INN-funded services experience reduced jail bookings, jail days, and parole/probation revocations?
4. To what extent to people who participate in INN-funded services experience increased service engagement and participation?
5. How does knowledge, understanding, and collaboration between mental health and criminal justice agencies change over the course of the project? What activities and experiences promote or detract from the working relationship?

The evaluation will explore the following types of quantitative data:

- Socio-demographics of individuals served, including race/ethnicity, age, gender identity, sexual orientation, zip code, income type and amount, housing status, level of education, and veteran status.
- Clinical and justice involved profile of individuals served, including mental health diagnoses and previous service participation; previous arrest, charge, and booking information; substance use and misuse; known trauma history; other clinically relevant information.
- Current program and service participation, including program, service type, procedure code, provider type, dates of service, length of encounter, length of episode, disposition. This includes for INN-funded programs as well as all other MHP-funded services, such as crisis and hospitalization as well as other residential and outpatient services.
- Current justice system interactions, including jail bookings and discharge dates, charges filed, court dispositions. If feasible, police contact and arrest data that did not result in a jail booking may also be included.
- Referrals, including referrals sources into the INN-funded programs as well as referrals and linkages provided from the INN-funded programs into other mental health services.
- Experience of services from consumers, family, behavioral health providers, and justice professionals.

Indigo Project

- Perception of knowledge, understanding, and collaboration between behavioral health providers and justice professionals.

Quantitative data will be collected directly from the County's Electronic Health Record, the Sherriff's Office via existing Memorandum of Understanding, the Community Health Record funded through the Whole Person Care Initiative, and via data request to the courts. Experience of services and perception of knowledge, understanding, and collaboration will be collected via interviews and focus groups; there may also be a brief survey developed for service recipients and their families or involved professionals.

Data will be collected on an ongoing basis and reported annually to providers and partners in order to support communications and continuous quality improvement as well as to the Mental Health Services Oversight and Accountability Commission (MHSOAC) in order to meet INN reporting requirements.

Section 3: Additional Information for Regulatory Requirements

Contracting

The County expects to contract the Forensic CRT to a community-based provider and may also choose to contract for the other services. Additionally, the County intends to contract for an external evaluator for this project to work with our internal data support team in exploring the learning goals and evaluation questions listed above as well as complete required reporting for the project. The County will appoint a contract monitor for each of these contracts to ensure contract compliance as well as a portion of the County project/program manager to supervise the quality of work performed.

Community Project Planning

These projects arose out of a longer term planning and system improvement process dedicated to improving services for justice involved mental health consumers. The Justice Involved Mental Health (JIMH) Task Force included representatives from the Health Care Services Agency, Alameda County Behavioral Health, Public Defender, District Attorney, provider and advocacy organizations, consumer and family representatives, faith based and other community leaders. After a more than year long process, the JIMH Task Force published a report in September 2020 with multiple stakeholder recommendations, including a focus on preventing law enforcement contact and arrest diversion, among other suggestions. Concurrently, ACBH published a Forensic Mental Health and Reentry Plan in October 2020 that was informed by JIMH

and included additional actions informed by evidence based practice and ACBH's strategic direction.

During 2021, ACBH systematically went through the Forensic Mental Health and Reentry Plan and identified aspects of the plan that either warranted further development and/or consideration or may meet criteria for INN funds. As a part of this process, ACBH contracted with the Indigo Project to engage in INN Project planning. The Indigo Project met with a number of internal and external stakeholders to gather information and workshop the ideas and concepts as they evolved, including:

- Consumer representatives and members of the Pool of Consumer Champions
- Family representatives and individuals from NAMI
- Providers who represent communities who are underrepresented because of cultural affiliation and language access
- Members of the African American subcommittee
- Members of the MHSA Stakeholder group
- Healthcare for the homeless providers
- System of Care Directors for Adult, Crisis, and Forensic Mental Health Services
- Consumer and Family Empowerment Managers

With each discussion, the concepts evolved and were further developed and clarified. These projects will be included in the MHSA Annual Update Community Program Planning (CPP) process in 2022 with the hopes of beginning implementation in FY2022.

MHSA General Standards

This project arose out of a community effort to address the needs of mental health consumers who are forensically involved. It was developed by consumers, family, and communities to support wellness and recovery and avoid incarceration.

This project arose out of a community effort to address the needs of mental health consumers who are forensically involved. It was developed by consumers, family, and communities to support wellness and recovery and avoid incarceration. Community collaboration is exemplified in not only how this project was developed but also in how the project itself works to keep individuals within their communities rather than removing them and placing them in a jail environment. Cultural Competency is included as a foundational component in that this project seeks to address the overincarceration of people with mental illness, the majority of whom are BIPOC individuals, by preventing police contact and jail booking as well as supporting individuals to successfully exit the justice system. Additionally, the services themselves will be informed by and primarily staffed by individuals who represent our County's diverse populations. Services will be

client and family driven in that services aim to preserve a person's freedom, independence, and ability to consent to their own services by using person centered planning with family member input that respects an individual's needs and preferences and works in partnership with each individual and their family to discover how they understand the issues that they're facing and helps them develop a plan that they are willing to do to address what is most important to them. The services are wellness, recovery, and resiliency focused in that they are built upon the belief that participation in mental health services is more productive and meaningful than incarceration and that services that respect an individual's ability to invest in their own recovery journey are more likely to result in sustained freedom than "rehabilitation" provided by the jails. Finally, services are intended to be integrated in that these programs seek to strengthen collaboration between mental health and justice organizations so that individuals and families can streamline efforts and communication between mental health services and criminal justice requirements in order to promote community-based recovery and minimize or avoid criminal justice involvement.

Cultural Competence and Stakeholder Participation in Evaluation

On a quarterly basis, ACBH will convene a stakeholder meeting with individuals who are invested in both forensic mental health INN projects, which include this project and the *Peer Led Continuum of Forensic Mental Health Services.* This meeting will serve dual purposes to gather information from stakeholders and partners about their perspectives on the project and its implementation as well as to provide data from the evaluation to support a CQI process. As a part of this project, we will explore the extent to which the project is reaching its intended target population and that people receiving services are reflective of the jail population (i.e., the population receiving services is comparable to the Santa Rita population in terms of race/ethnicity and age). This will be one component of what is discussed in the quarterly meetings as well as overall feedback and evaluation data described in the preceding section.

Innovation Project Sustainability and Continuity of Care

This project will primarily serve individuals with serious mental illness. If this project accomplishes its intended objectives of 1) reducing jail bookings and jail days and 2) increasing participation in ongoing mental health services, the County will continue to fund the project using a combination of MHSA Community Services and Supports funding and Federal Financial Participation (FFP). All of the services described in this plan should be eligible for Medi-Cal reimbursement following completion of the INN project.

Communication and Dissemination Plan

If this project is successful at 1) reducing jail bookings and jail days and 2) increasing

participation in ongoing mental health services, ACBH will apply to present learnings at California-specific conferences, including the forensic mental health association, California Institute of Behavioral Health Services, and California Association of Counties (CSAC) conferences. Additionally, ACBH will request that the contracted evaluator prepare a white paper that can be distributed through the California Behavioral Health Directors Association, California Probation Officers Association, and the MHSOAC listserv.

Keywords include:

1. Jail diversion
2. Pre-arrest diversion
3. Reducing revocations
4. Forensic Crisis Residential Treatment
5. Forensic mental health diversion

Timeline

ACBH proposes a 5 year Innovation project in which the first two years of the project allow for facility start-up. While the non-residential services may be able to be implemented more quickly, we believe that it is important to have all elements available at the same time, particularly with a co-located service model. To that end, ACBH will begin the site identification and procurement process upon MHSOAC approval. This may take up to nine months to facilitate a competitive bid process and then enter into contracts. The second year will focus on preparing the site and program for opening, including preparing the application for Community Care Licensing as well as the materials, including policies and procedures, for Medi-Cal certification. Concurrently, the evaluators will be working with the department and stakeholders to develop the evaluation approach. Years 3-5 will focus on service provision as well as data collection and analysis to support learning. In the final year, ACBH will also develop an ongoing funding strategy using MHSA, realignment, and FFP dollars. In year 5, the evaluators will also draft the summative evaluation report and a white paper detailing project implementation, outcomes, and lessons learned.

Year 1	Project Start-up - County Procurement • Identify program location • Procure mental health provider and evaluator services • Execute INN service provider and evaluator contracts
Year 2	Project Start-up - Facility Preparation

	• Building Modifications • Facility Licensing and Medi-Cal Certification • Staff Hiring and Training • Outreach to justice agencies and mental health providers Project Start-up - Project Evaluation • Evaluation planning, including stakeholder input Milestone: Services Commence Milestone: Evaluation Plan Complete
Year 3	Ongoing: Service provision Ongoing: Data collection Quarterly: Stakeholder convening to support CQI Annual: INN reporting
Year 4	Ongoing: Service provision Ongoing: Data collection Quarterly: Stakeholder convening to support CQI Annual: INN reporting
Year 5	Ongoing: Service provision Ongoing: Data collection Quarterly: Stakeholder convening to support CQI End of Project: Sustainability Plan End of Project: Summative INN report

Section 4: INN Project Budget and Source of Expenditures

INN Project Budget and Source of Expenditures

The next three sections identify how the MHSA funds are being utilized:

A) BUDGET NARRATIVE (Specifics about how money is being spent for the development of this project)
B) BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY (Identification of expenses of the project by funding category and fiscal

year)

C) BUDGET CONTEXT (if MHSA funds are being leveraged with other funding sources)

Budget Narrative

Provide a brief budget narrative to explain how the total budget is appropriate for the described INN project. The goal of the narrative should be to provide the interested reader with both an overview of the total project and enough detail to understand the proposed project structure. Ideally, the narrative would include an explanation of amounts budgeted to ensure/support stakeholder involvement (For example, "$5000 for annual involvement stipends for stakeholder representatives, for 3 years: Total $15,000") and identify the key personnel and contracted roles and responsibilities that will be involved in the project (For example, "Project coordinator, full-time; Statistical consultant, part-time; 2 Research assistants, part-time…"). Please include a discussion of administration expenses (direct and indirect) and evaluation expenses associated with this project. Please consider amounts associated with developing, refining, piloting and evaluating the proposed project and the dissemination of the Innovative project results

A slower start-up will be implemented due to overstaffing and expenditure concerns expressed by the systems of care managers. Managers agreed that expanding staffing as the project progresses will be more efficient and beneficial as appropriate adjustments are identified. The following budget outlines the start-up and projected annual expenditures:

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Staffing				
Position	**Quantity**	**Salary**	**Start-up**	**Annual Cost**
A/DTC Program Director/Clinical Supervisor	1	$ 125,000	$ 46,875	$ 62,500
A/DTC Program Manager	1	$ 92,000	$ 46,000	$ 92,000
A/DTC Clinician - License Eligible	5	$ 85,000	$ 106,250	$ 425,000
A/DTC Case Manager	5	$ 74,000	$ 92,500	$ 370,000
A/DTC Nursing	5	$ 82,000	$ 102,500	$ 410,000
A/DTC Forensic Peer Specialist	5	$ 68,000	$ 85,000	$ 340,000
F-CRT Program Director/Clinical Supervisor	1	$ 125,000	$ 46,875	$ 62,500
F-CRT Program Manager	1	$ 92,000	$ 46,000	$ 92,000
F-CRT Therapist - License Eligible	2	$ 85,000	$ 42,500	$ 170,000
F-CRT Case Manager	1	$ 74,000	$ 18,500	$ 74,000
F-CRT Forensic Peer Specialist	2	$ 68,000	$ 34,000	$ 136,000
F-CRT Mental Health Rehabilitation Specialist	15	$ 62,400	$ 234,000	$ 936,000
Total Salaries			**$ 901,000**	**$ 3,170,000**
CBO Benefits @ 33%			$ 306,340	$ 1,077,800
Total Staffing	**46**		**$ 1,207,340**	**$ 4,247,800**
Operations				
Contractors and Other Staffing Needs				
F- CRT Relief Staff	4000 hours per year	$28/hour	$ -	$ 112,000
Consutant - Psychiatrist (CRT)	16 hours per week	$350/hour	$ -	$ 291,200
Consultant - Licensing and Certification			$ 300,000	$ -
Recruitment			$ 18,000	$ 6,000
Pre-employment Expenses			$ 36,000	$ 8,000
Reducing Revocations Training			$ 12,000	$ 18,000
Programmatic/Staff Training			$ 60,000	$ 20,000
Supplies				
Food			$ 8,000	$ 166,400
Household Supplies			$ 12,000	$ 38,400
Personal Hygeine Items			$ 8,000	$ 14,400
Medical and First Aid			$ 8,000	$ 10,000
Office Supplies			$ 42,000	$ 7,200
Program Supplies			$ 40,000	$ 48,000
Facilities/Utilities				
Lease Payment		$ 20,000		$ 240,000
Gas and Electric		$ 2,000	$ 12,000	$ 24,000
Water		$ 1,800	$ 10,800	$ 21,600
Garbage		$ 600	$ 3,600	$ 7,200
Comcast/Xfinity		$ 1,200	$ 7,200	$ 14,400
Maintenance (Furniture and Equipment)			$ 60,000	$ 12,000
Maintenance (Property)				$ 48,000
Housekeeping		$ 4,000	$ 24,000	$ 48,000
Laundy		$ 2,400	$ 14,400	$ 28,800
Landscaping		$ 2,000	$ 12,000	$ 24,000
Communications				
Telephone		$ 600	$ 3,600	$ 7,200
Cell Phones	20 cell phones	$ 600	$ 3,000	$ 12,000
Digital Signage		$ 1,200	$ -	$ 14,400
Microsoft 365		$ 2,079	$ 1,040	$ 2,079
Transportation				
Vehicle Lease and Fees	2 leased vans	$ 800	$ 4,800	$ 33,600
Vehicle Maintenance (incl gas, oil, etc)			$ -	$ 10,000
Transportation Assistance			$ -	$ 29,200
Other Services				
Insurance			$ 4,500	$ 18,000
Total Operations			**$ 704,940**	**$ 1,334,079**
Total Staffing			**$ 1,207,340**	**$ 4,247,800**
Total Operations			$ 704,940	$ 1,334,079
Total Direct Costs (Staffing + Operations)			$ 1,912,280	$ 5,581,879
Total Indirect (15%)			$ 286,842	$ 837,282
Total Costs			**$ 2,199,121**	**$ 6,419,161**
Potential Medicaid Revenue				$ 3,209,580
Total INN funds needed			**$ 2,199,121**	**$ 3,209,580**

Indigo Project

Appendix D-2 MHSA INN: INN 8 Forensics Alternatives: Peer Focus

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Peer-Led Continuum
Forensic and Reentry Services
MHSA Innovation Project

Amount Requested: $8,615,531

Project Duration: 5 Years

Submitted by:
Alameda County Behavioral Health Care Services

Prepared by:
Roberta Chambers, PsyD
The Indigo Project

Date:
03/18/2022

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Section 1: Innovations Regulations Requirement Categories

General Requirement

An Innovative Project must be defined by one of the following general criteria. The proposed project:

- ☐ Introduces a new practice or approach to the overall mental health system, including, but not limited to, prevention and early intervention
- X Makes a change to an existing practice in the field of mental health, including but not limited to, application to a different population
- ☐ Applies a promising community driven practice or approach that has been successful in a non-mental health context or setting to the mental health system
- ☐ Supports participation in a housing program designed to stabilize a person's living situation while also providing supportive services onsite

Primary Purpose

An Innovative Project must have a primary purpose that is developed and evaluated in relation to the chosen general requirement. The proposed project:

- X Increases access to mental health services to underserved groups
- X Increases the quality of mental health services, including measured outcomes
- ☐ Promotes interagency and community collaboration related to Mental Health Services or supports or outcomes
- ☐ Increases access to mental health services, including but not limited to, services provided through permanent supportive housing

Indigo Project

Section 2: Project Overview

Primary Problem

The issue of people with serious mental illness (SMI) and/or substance use disorders (SUD) experiencing incarceration is one of the most prominent challenges facing the behavioral health and criminal justice communities. In many jurisdictions, individuals with mental illness are more likely to be booked into jail than engaged in treatment, and jails have become the largest mental health institutions. **This issue is exacerbated because the legal threshold to arrest and incarcerate someone is lower thanis the legal threshold to engage that same individual in treatment if they are unwilling or unable to participate on a voluntary basis.** Because the legal standard for incarceration is much lower than the threshold for involuntary treatment and jail beds are more readily available than treatment beds, either voluntary or involuntary, it has become increasingly common to incarcerate individuals in need of mental health services.[1] Despite intentional efforts to make the mental health system as accessible and recovery-oriented as possible, there remains a group of individuals who will not engage in voluntary services and are more likely to be incarcerated than treated by the community behavioral health system. **Once a person with SMI and/or SUD becomes justice-involved, they are more likely to remain involved and penetrate the justice system further[2], [3].** These individuals typically have minimal financial resources and are more likely to be held in jail awaiting trial or placement for treatment, including competency restoration. They may experience difficulty complying with the terms and conditions of probation or release, and they may be charged with a new criminal offense while confined in jail.

Within California and across the Nation, there is a concerted effort to identify diversion opportunities and to ensure a continuum of services for individuals with mental health issues who are involved with the criminal justice system. Alameda County, along with its partners and community of stakeholders, has invested substantial time and resources on a number of efforts that aim to strengthen forensic and reentry mental health services for people with mental health needs and/or substance use disorders by:

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[1] National Sheriff's Association and Treatment Advocacy Center. *The Treatment of Persons with Mental Illness in Prisons and Jails: A State Survey.* Retrieved from: https://www.treatmentadvocacycenter.org/storage/documents/treatment-behind-bars/treatment-behind-bars.pdf.

[2] Fellner J: (2006), A corrections quandary: mental illness and prison rules. Harv CR-CL L Rev 41:391–412,

[3] Abramsky & Fellner, supra note 3, at 59 (citing Letter from Keith R. Curry, Ph.D., to Donna Brorby, Atty. in the Ruiz v. Johnson litigation (Mar. 19, 2002)

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Safely diverting people from the justice system into treatment,	Stabilizing and connecting individuals in custody to community behavioral health services, and	Promoting service participation that reduces recidivism.

The department unveiled a Forensic and Reentry Services Plan[4] in May of 2021 and has been systematically working through the short, mid, and long terms actions set forth in the plan. Alameda County was interested in how Innovation funds could assist in addressing the forensic and reentry mental health needs in the County. This Innovation plan arose out of these concerted efforts to divert individuals with mental health challenges from the justice system into mental health services and was developed for and by community stakeholders, including the County's Justice Involved Mental Health Task Force.

Proposed Project

Project Description

The *Peer Led Continuum of Forensic Mental Health Services* is a collection of four (4) continuum of services, of which three are peer led and one is family focused. The continuum of services specifically seeks to:

1. Support mental health consumers who are justice involved by helping them transition back into the community following an arrest or incarceration,
2. Identify and address the issues that led up to their arrest and/or incarceration
3. Connect with mental health and other services to support them in their recovery and reentry journey, and
4. Build the capacity of family members to advocate on behalf of their loved one with a serious mental illness who has become justice involved.

As a result of the continuum of services, we expect that individuals will experience fewer episodes of arrest and/or incarceration and will have increased participation in ongoing mental health and other services. The included services are described below.

[4] http://www.acgov.org/board/bos_calendar/documents/DocsAgendaReg_5_10_21/HEALTH%20CARE%20SERVICES/Regular%20Calendar/Item__1_ACBH_Services_Forensic_sys_5_10_21.pdf

Indigo Project

Reentry Coaches. In Alameda and across the state, there have been strong outcomes associated with using people with lived experience to support individuals following a crisis or hospitalization to connect to follow-up mental health services. These individuals are sometimes referred to as peer mentors and have shown strong outcomes in increasing service linkage and reducing crisis and hospitalization in Alameda, Orange, and other counties. This project aims to employ forensic peer specialists who can serve as reentry coaches for individuals with serious mental illness to help them transition back into the community. Their role is to help the person with whatever they need, including tangible resources such as linkages for food and shelter or transportation to appointments, as well as encouragement and consciousness raising to actively participate in their own recovery and reentry journey. Referrals into the program may come from service providers supporting reentry planning at the Santa Rita jail, and ideally the reentry coach would be able to make contact with the individual before they are released from jail. However, their first contact may be upon release at the Safe Landing program, which is a drop in center on site at the jail that provides information and referrals to individuals leaving the jail, or at another community location. The reentry coach will work with the individual to develop a personalized reentry plan that addressed the needs and issues that the person feels are most pressing, and the coach can stay involved for up to 90 days providing direct peer support as well as support to engage with other services.

WRAP for Reentry. The Centers for Human Development have a number of curricula based on Wellness Recovery Action Planning (WRAP) for specialty populations, including individuals with mental health challenges who are involved with the criminal justice system. Existing WRAP facilitators as well as identified Forensic Peer Specialists will receive training in WRAP for Reentry. The WRAP for Reentry groups will be available at existing peer led programs as well as offered at the peer respite, Forensic CRT (included as a part of the Alternatives to Confinement continuum of services), and potentially at Santa Rita, if permitted.

Forensic Peer Respite. The Forensic Peer Respite will be available to adult mental health consumers who are justice involved who would benefit from a brief moment of pause to reflect on their recovery and reentry journey, address whatever issues are coming up for them, and receive peer support to connect them with whatever services may be most helpful to support their continued recovery and reentry. This program will provide 24/7 peer support services that address mental health, substance use, and criminogenic needs in an unlocked, peer-led environment. The average length of stay based on other peer respites will span 5-14 days with the opportunity to extend up to 30 days with ACBH approval, and the total capacity will be 6. The Forensic Peer Respite would be available to consumers who are beginning to experience early warning signs of a crisis or other behaviors that place them at high likelihood of police contact.

The program will accept consumers ages 18-59 with mental health and criminal justice involvement who can be safely served in this environment. This program is intended to be a step up from the community as well as step down from the jail, and referrals may come from community mental health providers who are serving justice-involved mental health consumers as well as providers from jail mental health, psychiatric hospitals, psychiatric emergency services, local emergency departments, crisis stabilization units, sobering centers and detoxification units, and the reentry coaching program described above. It is also possible that the program will also accept consumers from the Forensic CRT if there is an individual that would be better served in a peer-led environment.

Family Navigation and Support. Family members of adult children with mental health issues are a critical component of supporting an individual to participate in mental health treatment and exit the justice system. However, family members have to quickly become experts in the justice system and relevant mental health law in order to understand and work within the justice system and process in support of their loved one. The family navigation and support service would develop and disseminate informational materials about the forensic mental health process. This program would collaborate and train existing warmlines, staffed by family partners, to educate and coach families on how to best advocate for their loved ones and would collaborate with ACBH to ensure information materials are translated and accessible for all Alameda County residents. The program would also provide individual and group consultation to families in order to increase knowledge of the justice mental health system and the legal process; the types of specific hearings, legal mechanisms, and appeals for individuals with mental health issues; how competency is determined, what incompetent to stand trial means, and what services may be available; how to provide medical and mental health information to the jail and other legal entities; and how to advocate on behalf of a loved one who has become involved with the criminal justice system.

Project General Requirements

The Peer Led Continuum of Forensic Mental Health Services both adapts an existing mental health practice for the forensic mental health population as well as adapts practices from other disciplines.

The Forensic Peer Respite, Reentry Coaches, and WRAP for Reentry take existing mental health practices and seeks to apply them to adult mental health consumers who are involved with the criminal justice system. Specifically, this continuum of services is inspired by the Peer Respite model which exists in other jurisdictions and in Alameda County, the WRAP curriculum which has a strong evidence base and has been implemented for decades in Alameda County, and peer mentoring programs who support individuals post crisis or hospitalization that are available across the state. In each of

these instances, they have been modified for a justice involved mental health population and seek to promote similar outcomes including reduced arrest and incarceration rather than crisis and hospitalization as well as increased service connectedness.

The Family Navigation and Support component is modeled after other disciplines, specifically the resources and consultation available through advokids[5] for the foster care system or Regional Centers for families with intellectual and/or developmental disabilities. These programs offer a combination of written resources, consultation, education, and support to educate families about the intricacies of the system and equip them to advocate on behalf of their family member.

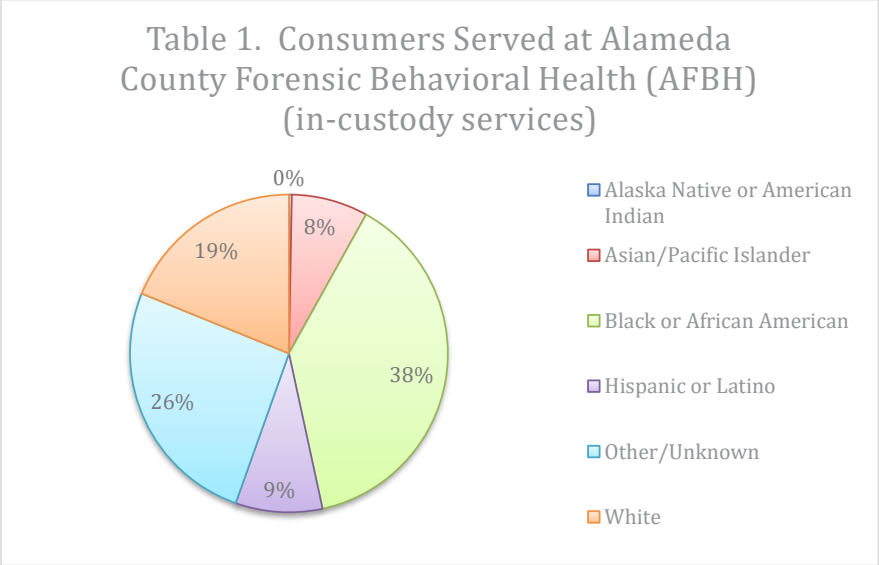
Individuals to be Served

Overall, the Peer Led Continuum of Forensic Mental Health Services project will serve 2,279 individuals per year. We anticipate that the Reentry Coaches will serve approximately 480 individuals per year, which is 15 consumers per coach with an average engagement of 90 days and 8.0 FTE. The WRAP for Reentry program will serve approximately 960 individuals, or 20 unduplicated individuals per month per facilitator, of which there will be 4 facilitators. We expect to serve approximately 122 individuals in the Forensic Peer Respite per year. This assumes that the 6 bed Forensic Peer Respite will operate at 85% capacity with an average length of stay of two weeks. We also expect to reach about 800 families with the written resources through the Family Navigation and Support program, with about 25%, or 200 families, reaching out for consultation or other support. However, we anticipate that there is significant overlap between the programs.

This continuum of services will serve transition age youth ages 18-25 and adults ages 26 and up who have significant mental health issues and are involved with the criminal justice system; they may also have co-occurring substance use issues. They may be of any gender or gender identity as well as sexual orientation. We anticipate that consumers will be predominantly Black or African American with smaller percentages of people who are white, Latinx, or Asian, Pacific Islander, and American Indian. This is based on demographic data of consumers receiving services at Adult Forensic Behavioral Health, which is the outpatient clinic located inside the County jail, as demonstrated in Table 1. We also anticipate that a proportion of individuals will speak Spanish and other languages and will ensure language access is available. Additionally, the Family Navigation and

[5] Advokids is a legal advocacy organization committed to protecting foster children across California and provides a variety of educational materials to support children and families who are navigating the dependency court process.

Support project will work with culturally specific organizations to ensure that they have the capacity to support individuals to advocate on behalf of their family members.



Research on INN Project

The issue of individuals with serious mental illness who are involved with the justice system has become one of the largest problems facing communities across the nation, and the rate of individuals with serious mental illness is two to six times higher among incarcerated populations than it is in the general population.[6] Research clearly demonstrates that outcomes for people with mental illness who become justice involved have better outcomes when diverted into services than when in custody. Peer support has a strong evidence base for supporting individuals to reduce crisis and/or hospitalization as well as engage in mental health and other recovery based services.

[6] Cloud, David, and Chelsea Davis. Treatment Alternatives to Incarceration for People with Mental Health Needs in the Criminal Justice System: The Cost-Savings Implications. Vera Institute, 2013. Retrieved from: https://www.vera.org/downloads/Publications/treatment-alternatives-to-incarceration-for-people-with-mental-health-needs-in-the-criminal-justice-system-the-cost-savings-implications/legacy_downloads/treatment-alternatives-to-incarceration.pdf.

The Peer Led Continuum of Forensic Mental Health Services provides three peer-led and one family-focused services that are intended to support individuals to transition from incarceration to the community and use peer support to address whatever issues may contribute to police contact, arrest, and/or incarceration. Using models from mental health and other disciplines, these four programs collectively provide an opportunity to support individuals to reenter the community and engage in services that reduce the likelihood of future arrests and/or incarceration.

These priorities for diversion arose out of the sequential intercept mapping process with Alameda County's Justice Involved Mental Health Task Force and focus on supporting reentry as well as promoting exit from the criminal justice system. They are based on the principles of peer support provided at opportunities identified through Alameda County's Sequential Intercept Mapping process.

At this time, no other jurisdiction has developed a singularly focused Forensic Peer Respite or applied a peer mentor approach to people with serious mental illness reentering from jail. While WRAP for Reentry is implemented in other jurisdictions, it does not yet have an evidence base supporting its use. People with forensic mental health needs may be served in Peer Respite, peer mentor, or WRAP programs, but none specialize in the intersection between behavioral health and justice system involvement and specifically target behavioral health and criminal justice involvement. While there are myriad versions of parental support, none are solely focused on supporting family members whose loved ones with serious mental illness have become justice involved. To this end, this project aims to explore the extent to which these programs are able to reduce criminal justice system involvement for people with serious mental illness (e.g., reduced jail bookings and jail days, increased service participation, increased exit from the criminal justice system).

Learning Goals/Project Aims

In Alameda County, 25% of ACBH consumers receive mental health services in the jail, and 10% of consumers only receive mental health services in the jail.[7] This highlights the need to address the over-incarceration of people with mental health issues and support them outside of a jail environment as a key County priority. This project, along with the other Innovation Plan entitled *Alternatives to Confinement,* is one element of a larger Forensic Mental Health and Reentry Plan and represents the service offerings that are relevant to and meet criteria for Innovation projects.

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[7] http://www.acgov.org/board/bos_calendar/documents/DocsAgendaReg_5_10_21/HEALTH%20CARE%20SERVICES/Regular%20Calendar/Item__1_ACBH_Services_Forensic_sys_5_10_21.pdf

With this project, Alameda County Behavioral Health seeks to pilot these four services within a continuum of care to understand the extent to which these programs, separately and together, increase access to and participation in mental health services for adults with mental health and criminal justice involvement and improve outcomes, including reduced jail bookings, jail days, and exit from the criminal justice system.

Evaluation or Learning Plan

This Peer Led Continuum of Forensic Mental Health Services project evaluation will explore process and outcome measures related to the four included services. The overarching evaluation questions include:

1. What resources are being invested, by whom, and how much?
2. Who is being served, at what dosage, and in what ways, including participation in more than one INN-funded service?
3. To what extent do people who participate in INN-funded services experience reduced jail bookings, jail days, and are able to exit the criminal justice system?
4. To what extent do people who participate in INN-funded services experience increased service engagement and participation?
5. How does family education and consultation support individuals to move through the justice system?

The evaluation will explore the following types of quantitative data:

- Socio-demographics of individuals served, including race/ethnicity, age, gender identity, sexual orientation, zip code, income type and amount, housing status, level of education, and veteran status.
- Clinical and justice involved profile of individuals served, including mental health diagnoses and previous service participation; previous arrest, charge, and booking information; substance use and misuse; known trauma history; other clinically relevant information.
- Current program and service participation, including program, service type, procedure code, provider type, dates of service, length of encounter, length of episode, disposition. This includes for INN-funded programs as well as all other Mental Health Plan (MHP)-funded services, such as crisis and hospitalization as well as other residential and outpatient services.
- Current justice system interactions, including jail bookings and discharge dates, charges filed, court dispositions. If feasible, police contact and arrest data that did not result in a jail booking may also be included.

- Referrals, including referrals sources into the INN-funded programs as well as referrals and linkages provided from the INN-funded programs into other mental health services.
- Experience of services from consumers, family, behavioral health providers, and justice professionals.
- Perception of knowledge, understanding, and collaboration between behavioral health providers and justice professionals.

Quantitative data will be collected directly from the County's data services in collaboration with the Sheriff's Office via existing Memorandum of Understanding, the Community Health Record funded through the Whole Person Care Initiative, and via data request to the courts. Experience of services and perception of knowledge, understanding, and collaboration will be collected via interviews and focus groups; there may also be a brief survey developed for service recipients and their families or involved professionals.

Data will be collected on an ongoing basis and reported annually to providers and partners in order to support communications and continuous quality improvement as well as to the Mental Health Services Oversight and Accountability Commission (MHSOAC) in order to meet INN reporting requirements.

Section 3: Additional Information for Regulatory Requirements

Contracting

The County expects to contract out all of the services included in this proposal. Additionally, the County intends to contract for an external evaluator for this project to work with our internal data support team in exploring the learning goals and evaluation questions listed above as well as complete required reporting for the project. The County will appoint a contract monitor for each of these contracts to ensure contract compliance as well as a portion of the County project/program manager to supervise the quality of work performed.

Community Project Planning

These projects arose out of a longer-term planning and system improvement process dedicated to improving services for justice involved mental health consumers. The Justice Involved Mental Health (JIMH) Task Force included representatives from the Health Care Services Agency, Alameda County Behavioral Health, Public Defender, District Attorney, provider and advocacy organizations, consumer and family

representatives, faith based and other community leaders. After a more than year long process, the JIMH Task Force published a report in September 2020 with multiple stakeholder recommendations, including a focus on supporting reentry. Concurrently, ACBH published a Forensic Mental Health and Reentry Plan in October 2020 that was informed by JIMH and included additional actions informed by evidence-based practice and ACBH's strategic direction.

During 2021, ACBH systematically went through the Forensic Mental Health and Reentry Plan and identified aspects of the plan that either warranted further development and/or consideration or may meet criteria for INN funds. As a part of this process, ACBH contracted with the Indigo Project to engage in INN Project planning. The Indigo Project met with a number of internal and external stakeholders to gather information and workshop the ideas and concepts as they evolved, including:

- Consumer representatives and members of the Pool of Consumer Champions
- Family representatives and individuals from NAMI
- Providers who represent communities who are underrepresented because of cultural affiliation and language access
- Members of the African American subcommittee
- Members of the MHSA Stakeholder group
- Healthcare for the homeless providers
- System of Care Directors for Adult, Crisis, and Forensic Mental Health Services
- Consumer and Family Empowerment Managers

With each discussion, the concepts evolved and were further developed and clarified. These projects will be included in the MHSA Annual Update Community Program Planning (CPP) process in 2022 with the hopes of beginning implementation in FY2022.

MHSA General Standards

This project arose out of a community effort to address the needs of mental health consumers who are forensically involved. It was developed by consumers, family, and communities to support wellness and recovery and avoid incarceration. Community collaboration is exemplified in not only how this project was developed but also in how the project itself works to support individuals to return to and remain in their communities rather than in a jail environment. Cultural Competency is included as a foundational component in that this project seeks to address the overincarceration of people with mental illness, the majority of whom are BIPOC individuals, by supporting individuals to reenter their communities and successfully exit the justice system. Additionally, the services themselves will be informed by and primarily staffed by individuals who represent

our County's diverse populations. Services will be client and family driven in that services aim to preserve a person's freedom, independence, and ability to consent to their own services by using person centered planning with family member input that respects an individual's needs and preferences and works in partnership with each individual and their family to discover how they understand the issues that they're facing and helps them develop a plan that they are willing to do to address what is most important to them. The services are wellness, recovery, and resiliency focused in that they are built upon the belief that participation in mental health services and supports are more productive and meaningful than incarceration and that services that respect an individual's ability to invest in their own recovery journey are more likely to result in sustained freedom than "rehabilitation" provided by the jails. Finally, services are intended to be integrated in that these programs seek to strengthen each person's ability to renter the community and successfully navigate the service system with peer support.

Cultural Competence and Stakeholder Participation in Evaluation

On a quarterly basis, ACBH will convene a stakeholder meeting with individuals who are invested in both forensic mental health INN projects, which include this project and the *Alternatives to Confinement* continuum of services. This meeting will serve dual purposes to gather information from stakeholders and partners about their perspectives on the project and its implementation as well as to provide data from the evaluation to support a CQI process. As a part of this project, we will explore the extent to which the project is reaching its intended target population and that people receiving services are reflective of the jail population (i.e., the population receiving services is comparable to the Santa Rita population in terms of race/ethnicity and age). This will be one component of what is discussed in the quarterly meetings as well as overall feedback and evaluation data described in the preceding section.

Innovation Project Sustainability and Continuity of Care

This project with its continuum of services will primarily serve individuals with serious mental illness. If this project accomplishes its intended objectives of 1) reducing jail bookings and jail days and 2) increasing participation in ongoing mental health services, the County will continue to fund the project using a combination of MHSA Community Services and Supports funding and Federal Financial Participation (FFP). Most of the services described in this plan should be eligible for Medi-Cal reimbursement following completion of the INN project, assuming peer certification and billing for peer support continue implementation during this INN project.

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Communication and Dissemination Plan

If this continuum of services is successful at 1) reducing jail bookings and jail days and 2) increasing participation in ongoing mental health services, ACBH will apply to present learnings at California-specific conferences, including the forensic mental health association, California Institute of Behavioral Health Services, and California Association of Counties (CSAC) conferences. Additionally, ACBH will request that the contracted evaluator prepare a white paper that can be distributed through the California Behavioral Health Directors Association, California Probation Officers Association, and the MHSOAC listserv.

Keywords include:

1. Mental health reentry
2. Forensic Peer Respite
3. WRAP for Reentry
4. Reentry Peer Support
5. Reentry Family Support

Timeline

ACBH proposes a 5 year Innovation project in which the first two years of the project allow for program start-up. While services may be able to be implemented more quickly, we believe that it is important to have all elements available at the same time, particularly with a service model that requires significant coordination with partner agencies. To that end, ACBH will begin the site identification and procurement process upon MHSOAC approval. This may take up to nine months to facilitate a competitive bid process and then enter into contracts. The second year will focus on preparing the programs for opening, developing written materials, and outreaching and coordinating with our justice partners. Concurrently, the evaluators will be working with the department and stakeholders to develop the evaluation approach. Years 3-5 will focus on service provision as well as data collection and analysis to support learning. In the final year, ACBH will also develop an ongoing funding strategy using MHSA, realignment, and FFP dollars. In year 5, the evaluators will also draft the summative evaluation report and a white paper detailing project implementation, outcomes, and lessons learned.

Indigo Project

Year 1	Project Start-up - County Procurement • Procure mental health provider and evaluator services • Execute INN service provider and evaluator contracts
Year 2	Project Start-up - Program Development Preparation • Site Identification • Written Materials Development • Staff Hiring and Training • Outreach to partner agencies Project Start-up - Project Evaluation • Evaluation planning, including stakeholder input Milestone: Services Commence Milestone: Evaluation Plan Complete
Year 3	Ongoing: Service provision Ongoing: Data collection Quarterly: Stakeholder convening to support CQI Annual: INN reporting
Year 4	Ongoing: Service provision Ongoing: Data collection Quarterly: Stakeholder convening to support CQI Annual: INN reporting
Year 5	Ongoing: Service provision Ongoing: Data collection Quarterly: Stakeholder convening to support CQI End of Project: Sustainability Plan End of Project: Summative INN report

Section 4: INN Project Budget and Source of Expenditures

INN Project Budget and Source of Expenditures

The next three sections identify how the MHSA funds are being utilized:

A) BUDGET NARRATIVE (Specifics about how money is being spent for the development of this project)
B) BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY (Identification of expenses of the project by funding category and fiscal year)
C) BUDGET CONTEXT (if MHSA funds are being leveraged with other funding sources)

Budget Narrative

Provide a brief budget narrative to explain how the total budget is appropriate for the described INN project. The goal of the narrative should be to provide the interested reader with both an overview of the total project and enough detail to understand the proposed project structure. Ideally, the narrative would include an explanation of amounts budgeted to ensure/support stakeholder involvement (For example, "$5000 for annual involvement stipends for stakeholder representatives, for 3 years: Total $15,000") and identify the key personnel and contracted roles and responsibilities that will be involved in the project (For example, "Project coordinator, full-time; Statistical consultant, part-time; 2 Research assistants, part-time…"). Please include a discussion of administration expenses (direct and indirect) and evaluation expenses associated with this project. Please consider amounts associated with developing, refining, piloting and evaluating the proposed project and the dissemination of the Innovative project results

A slower start-up will be implemented due to overstaffing and expenditure concerns expressed by the systems of care managers. Managers agreed that expanding staffing as the project progresses will be more efficient and beneficial as appropriate adjustments are identified. The following budget outlines the start-up and projected annual expenditures:

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Staffing				
Position	**Quantity**	**Salary**	**Start-up**	**Annual Cost**
Program Director/	1	$ 95,000	$ 71,250	$ 95,000
RC Reentry Coach	5	$ 72,000	$ 90,000	$ 360,000
WRAP Facilitator	3	$ 74,000	$ 55,500	$ 222,000
FPR Program Manager	1	$ 85,000	$ 42,500	$ 85,000
FPR Forensic Peer Specialist	10	$ 72,000	$ 180,000	$ 720,000
FNS Navigators	3	$ 74,000	$ 55,500	$ 222,000
Total Salaries			$ 494,750	$ 1,704,000
CBO Benefits @ 33%			$ 168,215	$ 579,360
Total Staffing	**26**		**$ 662,965**	**$ 2,283,360**
Operations				
Contractors and Other Staffing Needs				
FPR Relief Staff	3000 hours	$25/hour	$ -	$ 75,000
Consultant - Legal System			$ 40,000	$ 20,000
Consultant - Materials Dev't			$ 18,000	$ 8,000
Recruitment			$ 12,000	$ 4,000
Pre-employment Expenses			$ 7,500	$ 3,750
Training			$ 30,000	$ 18,000
Supplies				
Food			$ 8,000	$ 62,400
Household Supplies			$ 4,000	$ 4,800
Personal Hygeine Items			$ 6,000	$ 9,600
Medical and First Aid			$ 2,000	$ 3,000
Office Supplies			$ 48,000	$ 4,800
Program Supplies			$ 22,000	$ 7,200
Facilities/Utilities				
Lease Payment		$ 12,000		$ 144,000
Gas and Electric		$ 800	$ 4,800	$ 9,600
Water		$ 990	$ 5,940	$ 11,880
Garbage		$ 600	$ 3,600	$ 7,200
Comcast/Xfinity		$ 1,200	$ 7,200	$ 14,400
Maintenance (Furniture and Equipment)			$ 32,000	$ 12,000
Maintenance (Property)				$ 24,000
Housekeeping		$ 1,500	$ 9,000	$ 18,000
Laundy		$ 1,800	$ 10,800	$ 21,600
Landscaping		$ 1,000	$ 6,000	$ 12,000
Communications				
Telephone		$ 600	$ 3,600	$ 7,200
Cell Phones		$ 600	$ 1,500	$ 6,000
Microsoft 365		$ 2,376	$ 1,188	$ 2,376
Transportation				
Vehicle Lease and Fees		$ 800	$ 2,400	$ 16,800
Vehicle Maintenance (incl gas, oil, etc)			$ -	$ 4,000
Mileage			$ -	$ 2,800
Transportation Assistance			$ -	$ 4,160
Other Services				
Insurance			$ 2,250	$ 9,000
Total Operations			**$ 287,778**	**$ 547,566**
Total Staffing			$ 662,965	$ 2,283,360
Total Operations			$ 287,778	$ 547,566
Total Direct Costs (Staffing + Operations)			$ 950,743	$ 2,830,926
Total Indirect (15%)			$ 142,611	$ 424,639
Total Costs			**$ 1,093,354**	**$ 3,255,565**
Potential Medicaid Revenue				$ 1,106,892
Total INN Funds Needed			**$ 1,093,354**	**$ 2,148,673**

Indigo Project

Appendix D-3 MHSA INN: INN 9 Peer Online Training

Alameda County's Request of Mental Health Services Oversight and Accountability Commission Approval for use of Innovation Funds to Develop a Peer to Peer Dialectical Behavior Therapy (DBT) Online Training and Skills Groups for Peers

Introduction

Alameda County Behavioral Health (ACBH) continues to be fully invested in supporting a dynamic, skilled peer community. Peer involvement from consumers and family members of Alameda County is essential not only to Mental Health Services Act (MHSA) Innovation planning and program development, the Peers Organizing Community Change[1] (POCC) is utilized for, but not limited to, outreach, focus groups, and surveys to assist in developing programs by all systems of care. The POCC's role is to provide a strong consumer voice in Alameda's mental health system and in the community.

Alameda County began a comprehensive peer organization in 2006 holding their first major peer event in 2007 with an undertaking to educate, advocate, and lead. The POCC's mission is to improve the quality of life for the county's residents who have mental health, mental health and substance use issues in whatever setting they find themselves and to provide consumer perspective in transforming the County's behavioral systems of care to a recovery vision that consumer-driven, culturally, responsive, and holistic in its services and supports.[2]

The County is dedicated to robust approaches to ensure opportunities and uplift peers within the county regarding their skill level. Peer delivered health and wellness services are important complements for an integrated care team model working to help a system merge the concepts of recovery with physical well-being and overall recovery.[3] With the passage of California's Peer Support Specialist Certification Program Act of 2020, ACBH is looking to further build trainings and increase employment opportunities of its diverse peer workforce in crisis care.

As the peer support specialist workforce has grown over the years, their roles have evolved, which in turn, has led to gaps in knowledge about their activities within systems of care. ACBH is seeking to develop an online Dialectical Behavioral Therapy Peer to Peer training program to train peers with the skills of DBT. This program is to provide new skills as peers enhance their hire ability. ACBH wishes to provide a learning environment that is removed from restrictive time and space. The overall goal is to deliver a self-paced, recovery-oriented mode of learning for peers to cultivate relationships with others committed to learning, practicing, educating others about, and building mastery of the 4 DBT skill sets: core mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness. The county and POCC is committed to

[1] Formerly known as the Pool of Consumer Champions.
[2] See https://www.pocc.org/about-us/history-mission-values
[3] Swarbrick, M. A. (2013). Integrated care: Wellness-oriented peer approaches: A key ingredient for integrated care. Psychiatric Services, 64, 723–726. http://dx.doi.org/10.1176/appi.ps.201300144

eliminating stigma against people with emotional health challenges by creating hope through sharing stories of recovery and advocating in our communities through enhancing peers' skills. Building peer skills with DBT training, is an excellent addition to the POCC's mission of providing an empowered and informed voice: of, by, and for consumers in the behavioral health care system, related systems, and in the community.[4]

California's Peer Support Specialist Certification Program Act of 2020 has led ACBH to opt-in to:

1) Peers being a provider type under Medi-Cal that could bill for peer services as well as other services; and
2) Providing a process for certification of peer support specialists.

DBT is primarily a cognitive-behavioral treatment, with roots in Eastern and Zen mindfulness practices. DBT generally treats severe emotional dysregulation, suicidality, and non-suicidal self-injury in clients.[5] However, its principles are being expanded to many other populations. DBT's core philosophy includes its basis in mindfulness, clear prioritizing of treatment targets, and a dialectical balance between acceptance and change strategies.

It is well documented that peer supported services provide a unique and beneficial aspect to mental health treatments. With the pandemic unintentionally showing that online meetings, trainings, and learning are feasible, ACBH is progressing forward into the future using technology to develop a DBT online training for peers to improve/add to their skills avoiding high costs and low accessibility associated with standard DBT training; developing peer to peer skills practice groups offered in person or virtually to support the strengthening of mindfulness, distress tolerance, emotional regulation, and interpersonal effectiveness skills; supporting the emerging certification process for peer support specialists empowering peers in their supportive roles; and decrease mental health stigma.

What Has Been Done

During the course of POCC's history, major efforts to get MHSA dollars to fund consumer run programs was first sought so consumers could be hired through MHSA's Workforce, Education and Training funding. The POCC developed a Peer Employment Tool Kit during the planning period, and contributed greatly by participating on the county's initial MHSA planning group that was deciding where resources would go. An initial hire by the county's behavioral health care was done to implement the hiring of consumers' initiative. Eventually the POCC's efforts received approval for a consumer organization to provide the hiring of consumers.

As the POCC grew with more members, more committees were needed to reflect the consumer perspective on system of care changes. These changes were to reflect ethnic diversity, age and gender identity. Additional committees were formed to address important issues in the community. These issues included Healing Trauma, Substance Use Recovery, Public Policy & Education, and Veterans.[6] Today, the

[4] See https://www.pocc.org/about-us/history-mission-values
[5] Koerner K. What must you know and do to get good outcomes with DBT? Behav Ther. 2013 Dec;44(4):568-79. doi: 10.1016/j.beth.2013.03.005. Epub 2013 Apr 6. PMID: 24094782.
[6] Ibid

POCC has its own annual conference each summer.

Why the Need

Peer support has been around for decades. There are thousands of peer support programs in the United States. However, many who need peer support in order to maintain their life, be it treating their diabetes, veterans with PTSD, or maintaining one's recovery, do not always receive the support they need.

Peer support programs all too often have small budgets while trying to help many people. The lack of resources tends to delay development of new approaches especially for peer support programs as these tend to have inadequate funding.

The passing of the Affordable Care Act (2010) has provided a heavy focus on prevention, and created many opportunities for developing and funding peer-delivered whole health and wellness services. This landmark legislation coupled with the unique qualifications peers have brought to behavioral health systems has brought much needed resources to those with mental health challenges. However, as with any profession, as it grows and becomes more established, there is a need to create new opportunities to take advantage of existing expertise, while keeping individuals in the profession interested and feeling like they are advancing their careers.[7]

Peer support is based on the belief that "people who have face, endured and overcome adversity can offer useful support, encouragement, hope, and perhaps mentorship to others facing similar situations…"[8] Peer delivered health and wellness services are important complements for an integrated care team model working to help a system merge the concepts of recovery with physical well-being and overall recovery.[9] Since the beginning, the POCC has operated under this recovery vision along with its commitment to ensure that the consumer viewpoint was a significant part of ACBH.

ACBH and POCC are determined to advance and promote peer support programs. When providing peer support that involves positive self-disclosure, role modeling, and unconditional regard, peer staff have also been found to increase participants' sense of hope, control, and ability to effect changes in their lives; increase their self-care, sense of community belonging, and satisfaction with various life domains; and decrease participants' level of depression and psychosis.[10] Doing so will require testing innovative treatment modalities.

Although DBT was developed to treat borderline personality disorder (BPD), evidence has shown that DBT is not only an effective treatment for BPD, it has successfully been adapted or modified to populations

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[7] Daniels, A. S., Tunner, T. P., Bergeson, S., Ashenden, P., Fricks, L., & Powell, I. (2013, January). Pillars of Peer Support Summit IV: Establishing standards of excellence. Retrieved from www.pillarsofpeersupport.org

[8] Davidson, L., Chinman, M., Sells, D., & Rowe, M. (2006). Peer support among adults with serious mental illness: A report from the field. Schizophrenia Bulletin, 32(3), 443-450. doi: 10.1093/schbul/sbj043.

[9] Swarbrick, M. A. (2013). Integrated care: Wellness-oriented peer approaches: A key ingredient for integrated care. Psychiatric Services, 64, 723–726. http://dx.doi.org/10.1176/appi.ps.201300144

[10] Davidson L, Bellamy C, Guy K, Miller R. Peer support among persons with severe mental illnesses: a review of evidence and experience. World Psychiatry. 2012 Jun;11(2):123-8. doi: 10.1016/j.wpsyc.2012.05.009. PMID: 22654945; PMCID: PMC3363389.

besides those who have BPD.[11] Evidence already shows the benefits of peer inclusion in general is successful for consumers, staff, and peers. Adding DBT to the skills of peers is a natural extension.

There are several DBT techniques that coincide with the recovery philosophy making it a good fit:

- Validation is the non-judgment belief that consumers 'experiences are understandable and important. The peer practices validation by respecting the program participants self-knowledge;
- Radical genuineness is a validation strategy that believes in the client's strengths and capacity for change; and
- Collaboration which in DBT is viewed as a strategy that strengthens the working relationship[12] and coincides with peer process "to arrive at a mutually acceptable plan for moving forward in the treatment process."[13]

It is these parallels in philosophy that makes DBT training to peers very appealing to refresh and broaden the skills of peer support specialists.

No one knows when the pandemic will end or if it will become endemic. What we do know is there are already studies showing the negative impact on mental health the pandemic is afflicting upon our communities. With DBT online training, peers will safely be able to uplift their skills with a practice that is proven to work and assist in alleviating the growing number of community members who need support with their mental health.

Budget

Alameda County is requesting Commission approval to earmark $2,163,844 of MHSA Innovation funds over a four-year timeline for the creation and development of an online DBT training program for peers, peer to peer skills practice groups and research.

Outcomes

Creating and developing DBT online training modules geared for peer support specialists and in person or virtual peer to peer skills practice groups will support the County's commitment to build on its Peer Support Specialist Certification trainings and increase employment opportunities of the diverse peer workforce in its systems of care. The Peer to Peer DBT program is to provide new skills as peers enhance their hire ability; and test if these new skills are effective in practice groups.

Developing an online DBT training will also be complimentary to ACBH's Crisis Care Management Services (CCMU) grant which was awarded to ACBH in December, 2021. The CCMU grant was awarded from the Department of Health Care Services. The funding will provide additional Peer Support Specialist to be trained and certified to respond to those in crisis; develop a crisis training curriculum; and provide funds to

[11] Linehan, M. M. (2015). DBT skills training manual. (2nd ed.). New York: Guilford Press.
[12] Ibid.
[13] Deegan, P. E., & Drake, R. E. (2006). Shared decision making and medication management in the recovery process. Psychiatric Services, 57(11), 1636-1639.

upgrade mobile devices which will allow the county's team to be better equipped to respond to those experiencing crisis.

Conclusion

Alameda County will be adding this request to the County's MHSA Annual Update Fiscal Year 22/23. The annual update is projected to be finalized with an approval by the Alameda County Board of Supervisors in June 2022.

PERSONNEL COSTS (salaries, wages, benefits)						
1.	Salaries	$ 86,361	$ 440,786	$ 454,007	$ 464,384	$ 1,445,538
2.	Direct Costs					
3.	Indirect Costs	$ 12,854	$ 66,118	$ 68,101	$ 69,658	$ 216,831
4.	Total Personnel Costs	$ 99,215	$ 506,904	$ 522,108	$ 534,042	$ 1,662,369
OPERATING COSTS		**FY xx/xx**	**FY xx/xx**	**FY xx/xx**	**FY xx/xx**	**TOTAL**
5.	Direct Costs	$ 143,500	$ 67,000	$ 47,000	$ 29,000	$ 286,500
6.	Indirect Costs	$ 10,275	$ 19,800	$ 5,850	$ 2,850	$ 42,975
7.	Total Operating Costs	$ 153,775	$ 86,800	$ 52,850	$ 31,580	$ 329,475
NON- RECURRING COSTS						
8.	Laptops; technology equipment		$ 12,500	$ 12,500		$ 25,000
9.	Legal Fees	$ 10,000				$ 10,000
10.	Total Non-recurring costs					$ 35,000
CONSULTANT COSTS / CONTRACTS (clinical, training,						
11.	Direct Costs	$ 10,000	$ 10,000	$ 54,000	$ 54,000	$ 138,000
12.	Indirect Costs	$ 3,000	$ 3,000	$ 3,000		$ 9,000
13.	Total Consultant Costs	$ 40,000	$ 29,000			$ 69,000
OTHER EXPENDITURES (please explain in budget narrative)						
14.						
15.						
16.	Total Other Expenditures					
BUDGET TOTALS						
Personnel (line 1)		$ 99,215	$ 506,904	$ 454,007	$ 464,384	$ 1,445,538
Direct Costs (add lines 2, 5 and 11 from		$ 153,500	$ 77,000	$ 101,000	$ 83,000	$ 414,500
Indirect Costs (add lines 3, 6 and 12 from		$ 26,129	$ 88,918	$ 76,951	$ 72,508	$ 268,806
Non-recurring costs (line 10)		$ 10,000	$ 12,500	$ 12,500		$ 35,000
Other Expenditures (line 16)						
TOTAL INNOVATION BUDGET						**$ 2,163,844**

Appendix D-4 MHSA INN: INN Idea Form

alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

2000 Embarcadero Cove, Suite 400
Oakland, Ca 94606
510-567-8100 / TTY 510-533-5018
Karyn L. Tribble, PsyD, LCSW, Director

MENTAL HEALTH SERVICES ACT

Innovation Community Input Form

The Mental Health Services Act (MHSA) provides limited funding for the ***Innovation Component*** of the County's MHSA Plan. ***Innovations*** are defined as novel, creative, and/or ingenious mental health practices/approaches that are expected to contribute to learning, which are developed within communities through a process that is inclusive and representative. The County requests ***YOUR*** feedback to help identify which of the **THREE** innovative concepts to implement. Please submit your suggestions by **April 30, 2022.**

1. **Consumer Empowerment Using DBT (Dialectical Behavioral Therapy)**
The DBT project will develop an online Dialectical Behavioral Therapy (DBT) Peer to Peer training program to train peers with the skills of DBT. An online training program is able to provide an avenue that is self-paced, recovery-oriented mode of learning for peers to cultivate relationships with others committed to learning, practicing, educating others about, and building mastery of the 4 DBT skill sets: *core mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness.*

2. **Peer-led Continuum of Forensic Services**
The Peer-led Continuum of Forensic Services is a collection of four (4) components, three of which are peer-led and one that is family focused: *Reentry Coaches, WRAP for Reentry, Forensic Peer Respite, and Family Navigation and Support*. The project seeks to support mental health consumers who are justice involved transitioning back into the community. This project also seeks to build capacity of family members to advocate for loved ones with a serious mental illness who has become justice involved.

3. **Alternatives to Confinement Continuum of Forensic Services**
The Alternatives to Incarceration Continuum of Forensic Services is a collection of three (3) services that work together and are intended to prevent incarceration and divert individuals from criminal justice system into mental health services. Diversion is sought when early signs of crisis occur, police contact which may lead to arrest, and probation or parole non-compliance. The services include: *Forensic Crisis Residential Treatment, Arrest Diversion/Triage Center, and Reducing Probation/Parole Violations*.

1. Innovative Ideas: Please check the primary concept below that your recommendation will address.

☐ Consumer Empowerment Using DBT ☐ Peer-led Continuum of Forensic Services

☐ Alternatives to Confinement Continuum of Forensic Services

2. Age Groups: Please identify the age group that will be impacted by your recommendation. Please note that funds may support a project that transcends multiple age groups. Check all that apply:

☐ 0 to 18 years ☐ 16 to 25 years

☐ 18 to 59 years ☐ 60 years and above

3. Which of the three innovative ideas should the County test/try out? (Limit: 250 characters)

alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

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Oakland, Ca 94606
510-567-8100 / TTY 510-533-5018
Karyn L. Tribble, PsyD, LCSW, Director

4. What challenging problem does this idea address in the Alameda County mental health community? (Limit: 250 characters)

5. What has prevented solutions to solving this problem in the past? Describe the barriers to resolving the problem. (Limit: 250 characters)

6. What do we want to learn in overcoming the barriers and resolve the identified problem or issue? (Limit: 250 characters)

7. What should be the outcome(s) to show success? (Limit: 250 characters)

8. Has this idea (approach or practice) been tried elsewhere or in other populations? If yes, please describe. (Limit: 250 characters)

9. Contact Information (optional)

Name: Organization:

Phone: Email:

Attach any additional information that describes why this innovative idea should be tested and/or successful. Return input via email to: MHSA@acgov.org, fax to: (510) 567-8130, or mail to: 2000 Embarcadero Cove, Suite 400, Oakland, CA 94606, Attention: MHSA Innovation Unit. Thank you for your participation!

Alameda County CATT Program

Annual Report Brief: Year Two

CATT Program Overview and Goals

Over the last seven years Alameda County has made a concerted effort to transform the ways in which individuals experiencing acute behavioral health crises are engaged and treated. This has meant moving from a system where services are primarily accessed through law enforcement and emergency medical personnel (EMS)—often as a result of an involuntary hold—to coordinated in-community response by behavioral health professionals. Having such teams has supported individuals in need to be connected to the most appropriate level of care and **link them to the right place to receive the right services at the right time.**

Alameda County Health Care Services Agency (HCSA) and Alameda County Behavioral Health (ACBH) recognized the need for an innovative approach to this problem at a county level. They have enhanced partnerships with Bonita House, FALCK, EMS, ACCREC dispatch and other partners to create a client-centered, evidence-based approach through the **Alameda County Community Assessment and Transport Team (CATT) Program.**

The CATT Program goes beyond adding a discrete service to a challenged system; it is a test of concept for how to improve the system through a focused collaborative approach which pairs an innovative staffing model (emergency medical technician (EMT) and behavioral health clinician (Clinicians)) with technological support. If successful, it will contribute to increased efficiency for the emergency response system, more appropriate services for the client, and a model that other counties can adopt or adapt to significantly improve their crisis response systems.

The CATT Program is intended to improve upon the current behavioral health crisis response system, The program goals are to reduce:

- the number of involuntary holds (5150s) written by law enforcement,
- the need for unnecessary use of law enforcement, EMS paramedics and ambulances, and
- perceptions of stigma related to seeking and attaining behavioral health services.

This brief reflects the efforts of the CATT Program in Year Two of implementation, July 21, 2020, through July 20, 2022.

Alameda County CATT Program
Annual Report Brief: Year Two

CATT Program Implementation

The CATT Program was launched in July 2020 after more than two years of rigorous planning among key program collaborators. CATT teams operate out of the cities of **Oakland**, **San Leandro**, **Hayward**, and **Fremont**. The target population of the CATT Program is individuals experiencing a behavioral health crisis in Alameda County which result in 911 response but does not rise to the level of a life-threatening medical or harmful emergency. The program operates seven days a week between the hours of 7:00 a.m. and 11:00 p.m.

Eligibility for the program includes:

- services needed are in a location and during a time that CATT is in service;
- the situation must be assessed as safe by a law enforcement personnel; and
- the individual must be able to be ambulated by a basic or Advanced EMT and not require emergency room medical care.

"The CATT Program, in comparison to other mobile crisis models throughout the County, is a lot more beneficial because it provides the scene safety aspect so the team can get a quick overview from law enforcement regarding what is going on and they can ensure the scene is safe. In addition, if there is a medical issue they can assess and quickly decide if ambulance services are needed and they have direct communication with 911 EMS providers. Finally, I think the biggest benefit of the program is that the teams have the ability to transport both adults and youth to alternative dispositions for ongoing services."

Program Implementor Interview Participant

The goals of this issue brief are to:

- **describe how the interdisciplinary collaboration among different stakeholder groups involved in the implementation of the CATT Program has evolved over the first two years, and**
- **assess updates to policies and procedures of the CATT Program which have been made over the first two years to improve program outcomes.**
- **provide information on how changes in the crisis response system support Alameda County's goals for the CATT Program.**

PCG analyzed:

- **how many collaborative partners have participated in the CATT Program in the first year,**
- **how many clients were diverted to appropriate services, and**
- **how many involuntary holds resulting in ambulance transports to emergency departments medical clearance were able to be avoided.**

ACBH's two primary learning goals of the evaluation are:

1. **Determine if and how collaboration among agencies responding to mental health crisis can contribute to developing an effective and efficient crisis response system.**
2. **Determine if and how the changes in the crisis response system will result in community and county priorities: better client services and more efficiency in the system.**

Alameda County CATT Program

Annual Report Brief: Year Two

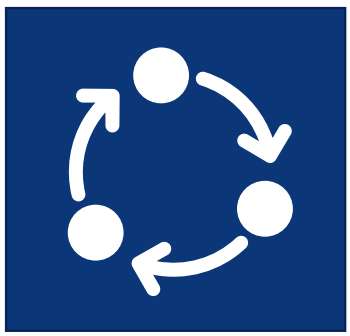
Process Evaluation Findings

1. Currently there are eight teams fully staffed and operating. While all teams posted in Oakland are fully staffed, there are still two vacancies in San Leandro and Hayward and one vacancy in Fremont. CATT Program collaborators are continuing to recruit and hire EMTs and Clinicians until all of the last four units have been staffed. CATT teams can respond to calls received in every city throughout the County.

2. Both Bonita House and FALCK have hired additional administrative support staff to support the operations of the CATT program.

3. Several process improvements have been made to hiring and retention. Bonita House and FALCK have both updated the job descriptions for Clinician and EMT roles. CATT leadership collaborated to design clear requirements and expectations for the field employee positions, which has led to an increase in applications.

4. CATT Program leadership created a CATT Program Field Employee Training Academy Committee led by Bonita House. The goal is by January 2023 the CATT Program will have a fully branded integrated training academy which will be approved by the County so employees can receive continuing education credits for participation. In addition, the Committee is working on aligning the training academy to the Commission on Accreditation of Rehabilitation Facilities (CARF) standards.



Field Employee Hiring	Hired	Staffed	Resigned	Turnover Percentage
Clinicians	18	8	10	56%
EMTs	24	14	10	42%
Total	**42**	**22**	**20**	**48%**

5. There have been numerous policy and procedure changes applied to the CATT Program in Year Two, including:
   - increasing response time requirement from 15 minutes to 30 minutes;
   - allowing Bonita House to hire associate clinicians working towards licensure as CATT clinicians;
   - updating of CATT clinician documentation and reporting requirements; and
   - aligning Bonita House policies and procedures to CARF Standards for Accreditation to enable billing to private insurance.

6. CATT Program Collaborators noted several improvements to collaboration in Year Two. Improvements included increased communication, strategic discussions of barriers and potential solutions and a general perception of a better sense of transparency within the group. It should also be acknowledged that several collaborators were enthusiastic about the leadership changes, indicating those drove increased collaboration and will be crucial for the future direction of the CATT Program.

7. All field employee survey respondents agreed or strongly agreed the CATT program has improved access to behavioral health crisis response services within the larger behavioral health crisis response system and has had an impact on reducing the number of involuntary psychiatric holds in the community.

Alameda County CATT Program
Annual Report Brief: Year Two

Process Evaluation Findings

8. CATT Program Collaborators noted several improvements to interprofessional collaboration (IPC) in Year Two. Improvements included increased communication, strategic discussions of barriers and potential solutions, and a general perception of a better sense of transparency within the group. It should also be acknowledged that several collaborators were enthusiastic about the leadership changes, indicating those drove increased collaboration and will be crucial for the future direction of the CATT Program.

Notable strengths and areas for improvement for IPC measures among CATT collaborators included:

Strengths	Areas for Improvement
▶ Make changes to team functioning based on reflective feedback	▶ Create a professional culture which enables quick change
▶ Strive to achieve mutually satisfying resolutions for differences in opinions	▶ Increase team building to improve trust and rapport across disciplines
▶ Encourage and support open communication	▶ Create a culture of team respect across roles and hierarchy
▶ Includes input from the CATT Field team in service provisions to support the needs of clients	▶ Create a decision-making approach that is equitable and inclusive

Notable strengths and areas for improvement for IPC among CATT field employee teams included:

Strengths	Areas for Improvement
▶ Respect and trust with each other	▶ Create protocols to foster cooperation among different collaborator groups and key stakeholders of the CATT Team
▶ Allows team members the opportunity to learn about collaborative practice and interprofessional collaborative care	▶ Utilize formal and informal procedures for problem-solving
▶ Strive to achieve mutually satisfying resolutions for differences in opinions	▶ Create conflicts resolution processes to solve complex problems
▶ Promotes equality in decision making among interprofessional team members	▶ Communicate and create appropriate boundaries among team members

Service Outcome Measure	Strongly Agree/Agree		Change
	Year 1	Year 2	
The CATT Program has improved access to behavioral health crisis response services within the larger behavioral health crisis response system	**70.6%**	**88.2%**	↑
The CATT Program has an impact on reducing the number of involuntary psychiatric holds in the community	**73.5%**	**70.6%**	↓
The CATT Program has an impact on linking individuals to ongoing behavioral health services in the community	**58.8%**	**94.1%**	↑
The CATT Program reduces the length of time Law Enforcement Agencies need to engage with individuals needing behavioral health services	**64.7%**	**76.5%**	↑

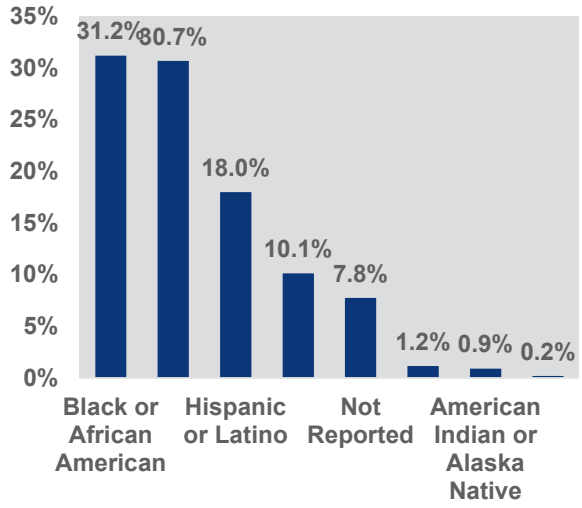
Alameda County CATT Program

Annual Report Brief: Year Two

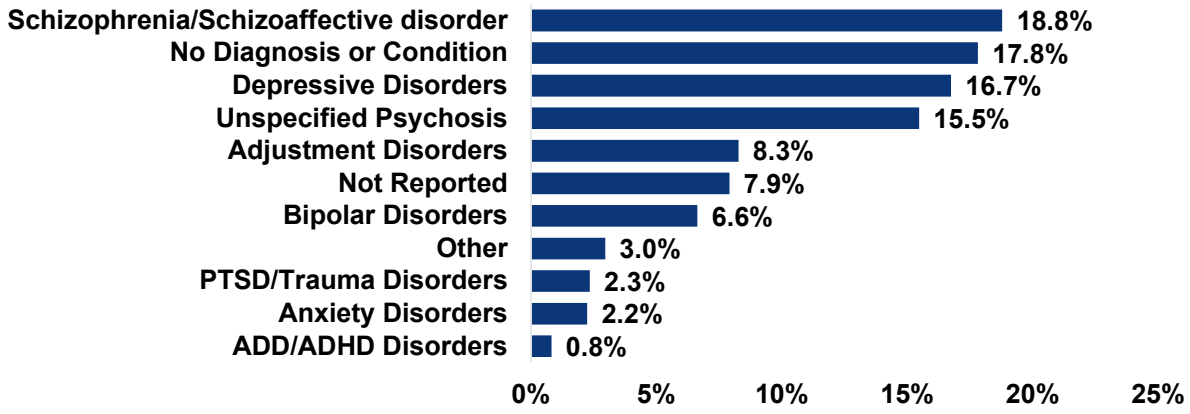
Outcome Evaluation Findings

Client Demographics

35	48%	31%	68%	30%
Median age of clients 14% are ages 10 through 17 7% are 66 or older	Percent of clients who were male	Nearly a third of all CATT clients were Black or African American.	Not in the labor force or unemployed	CATT clients who indicated they were homeless



1. Of those with a known employment status, nearly one-half (49.2%) of CATT clients served were not in the labor force and an additional one-fifth (19.2%) were unemployed. In addition, nearly one-half (46.7%) of CATT clients served reported having no active source of income and nearly one-third (30.1%) were homeless.



Alameda County CATT Program
Annual Report Brief: Year Two

Outcome Evaluation Findings

Response and Transport Dispositions

2. On average, CATT teams responded to 81 calls per month, or between two and three calls per day. This is an increase of about 16 calls per month compared to Year One.

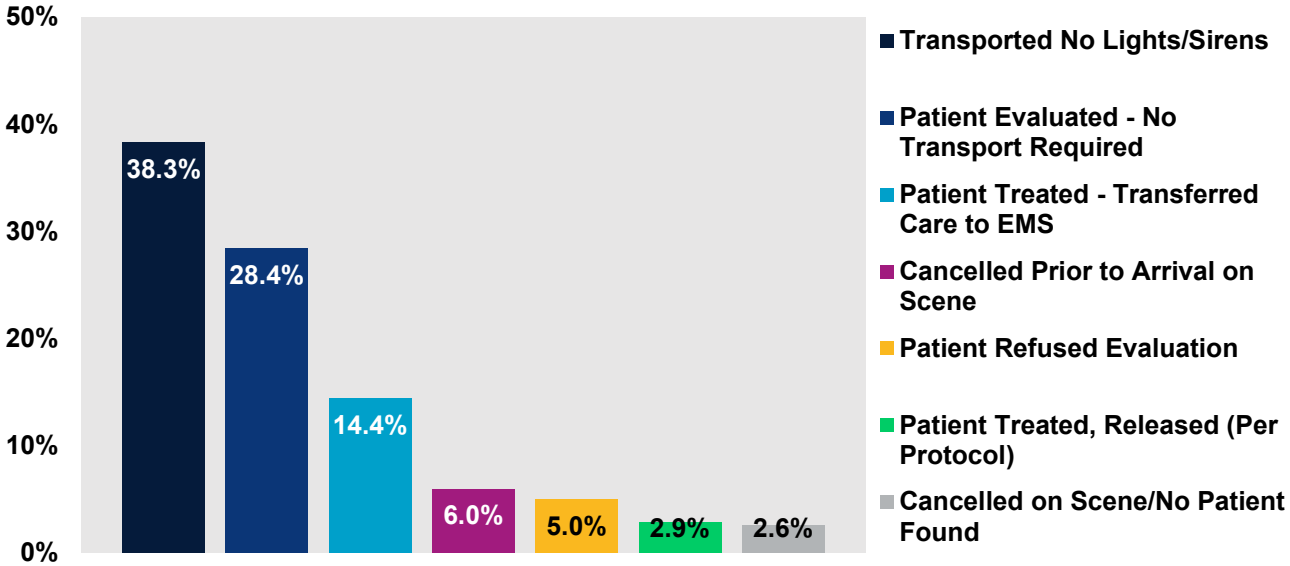
3. On average, there are 65 calls per month and two calls per day. Calls are most numerous in the middle of the week, and less frequent on the weekends

About 66 CATT calls a month avoid what could be an involuntary hold. These avoid traditional responses of sending the client to the hospital. In Year Two, more calls avoided a client hospital transport compared to Year One.

4. The lack of county resources available and places to transport individuals experiencing behavioral health crises has been cited as one of the biggest challenges of implementing the CATT Program by field employees, CATT leadership and other stakeholders such as law enforcement.

5. Nearly all CATT collaborator survey respondents (94.1%) and all Field Employee survey respondents (100%) agreed or strongly agreed the CATT Program has had a positive impact on linking individuals to ongoing behavioral health services in the community. Most collaborators (88.2%) and all field employees (100%) agreed or strongly agreed the CATT Program has improved access to behavioral health crisis response services within the larger behavioral health crisis response system.

The CATT Program received a total of 2,502 calls for service since the program began, of which 1,959 were responded to (78%). Call volume increased in Year Two of the program, especially from May to July 2022, when two additional units were added to the field.



Alameda County CATT Program
Annual Report Brief: Year Two

Outcome Evaluation Findings

Follow-Up and Recidivism

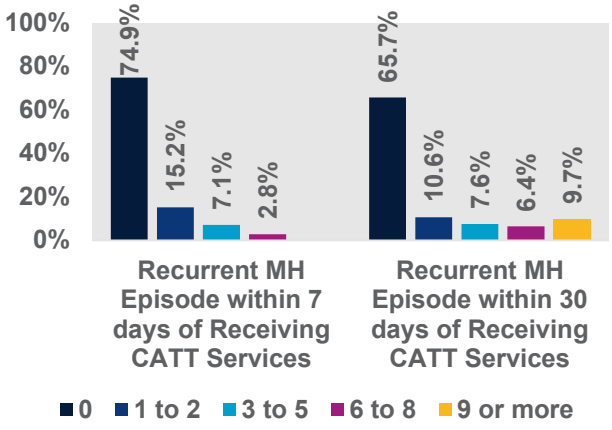
6. The CATT Program is significantly less likely to place individuals on an involuntary hold compared to traditional EMS and law enforcement responses to behavioral health crises. Nearly three-quarters (70.6%) of CATT collaborator respondents agreed or strongly agreed that the CATT Program has had an impact on reducing the number of involuntary and voluntary psychiatric holds in the community.

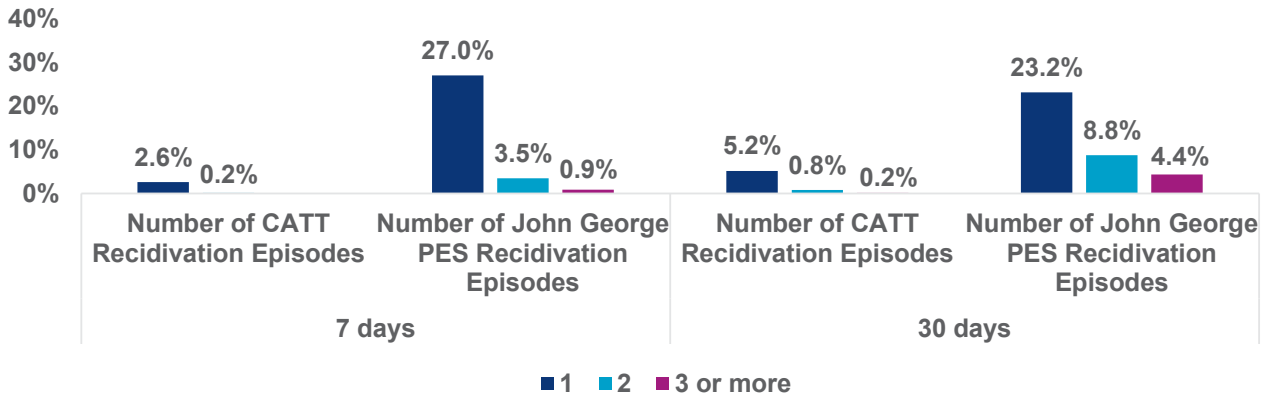
7. Nearly three-quarters (74.9%) of all CATT clients do not have a subsequent mental health episode within seven days of receiving CATT Program services; nearly two-thirds (65.7%) did not have a mental health episode within 30 days of receiving services.

8. Most CATT clients served have been referred to ACBH post-crisis follow-up care services. However, referrals decreased by about one-quarter (25.3%) in Year Two. In Year One 87 percent of CATT clients were referred to ACBH post-crisis follow-up, compared to 67 percent in Year Two.

9. Most CATT Program clients felt the CATT teams listened to them in their time of need (87%) and felt included in conversations and decisions about their care (86.4%). Nearly three-quarters (72.7%) of all CATT clients stated their emotions were in a better state after receiving services from CATT teams.

10. CATT clients' subsequent acute, sub-acute, and other crisis stabilization recidivation episodes have been significantly reduced from Year One to Year Two. Post-CATT services 7-day behavioral health crisis recidivism has decreased 45 percent and 30-day crisis recidivism has decreased 48 percent.





Alameda County CATT Program
Annual Report Brief: Year Two

Recommendations

Develop a Formal CATT Program Leadership Charter and Communication Plan

In an effort to solve complex problems and establish a process of examining alternatives to make decisions together, CATT Program leadership should continue strengthening partnerships and IPC. They should also develop formal documentation aligning goals, value and missions explicitly between CATT collaborator and key stakeholder groups in a formal charter. Documentation should also develop an agreed-upon formal process to resolve conflicts as they arise. Finally, formal policies and procedures for governing the CATT Program should be established.

Timeline	Within the next month

Schedule a Monthly Field Employee Debriefing Meeting with CATT Program Leadership

While field employees communicate often amongst one another, they stated it would be beneficial to establish more frequent ongoing debriefing meetings with all field employees, FALCK EMTs, Bonita House Clinicians and CATT Program Leadership. Currently, Bonita House conducts weekly debriefing meetings with CATT Clinicians and administrative staff. This time should be used to discuss successful and difficult field cases and other challenges and opportunities being experienced by different teams. This would serve as a team building and growth opportunity and potentially reduce burnout and turnover. It could also serve as a helpful modality to share and discuss potential policy and procedural changes and would allow management to get feedback from field employees, empowering them in their roles.

Timeline	Within the next month

Provide Team-Building and Professional Development Opportunities for Field Employees

Both team-building and professional development can help field employees feel supported by their organization and CATT leadership, build confidence in their abilities, and ultimately reduce burnout and turnover. Field employees expressed interest for more team-building opportunities. They suggested CATT leadership organize team-building outings and social events so field employees can strengthen relationships and communication. The newly formed CATT Program Training Committee should also consider developing advanced training courses for tenured field employees. Finally, ongoing supervision and support should be provided to both CATT clinicians and EMTs.

Timeline	Within the next 3 months

Alameda County CATT Program
Annual Report Brief: Year Two

Recommendations

Create a Community Engagement, Client Outreach and Prevention Plan

Suggestions to improve community outreach with CBOs and other providers included developing a social media presence to provide program updates and receive feedback from providers. CATT Program collaborators and field employees also stated more client follow-up and outreach can be done. They suggested administering program packets with mail-in surveys with pre-stamped envelopes as a part of closing episodes to increase consumer feedback. They also suggested incorporating peer supports into the CATT Program model and utilizing them to conduct follow-up with clients. CATT Program collaborators should work together to develop a Community Engagement, Client Outreach and Prevention Plan and select a member of the team to lead the effort of implementing the plan and providing direct assistance to field employees.

Timeline	Within the next 3 months

Establish Strategic Field Employee Partnership and Team Unit Posting Protocols

The CATT Program Training Academy Committee should consider developing team-building activities to assess the quality of fit between CATT clinician and EMT pairing. In addition, CATT Program collaborators should consider developing a short survey to assess what would be the most successful deployment hub location for new hires. Strategically pairing CATT Program clinicians and EMTs and pairing them at deployment hubs which play to their strengths can also make doing community outreach more cohesive, with each team being assigned community outreach and prevention efforts within the communities they serve. CATT teams can foster a positive presence in their assigned communities to foster trust and mutual respect with individuals who have behavioral health disorders. They can also do wellness check-ins with high utilizers of the behavioral health and emergency response system to prevent the onset of crises.

Timeline	Within the next 6 months

Assess the Feasibility of Modifying the Policies and Procedures of Dispatching CATT teams

Many collaborators suggested the CATT Program offer a direct line for dispatching calls and removing law enforcement involvement. Some proposed allowing direct dispatch for specific types of calls, like behavioral health crises at schools or nursing homes. To reduce the amount of time between onset of a crisis and a CATT team deployment, some suggested training ACCREC dispatchers to recognize behavioral health calls, allowing them to dispatch CATT teams at the same time as law enforcement. Multiple collaborators also stated the CATT Program should expand their availability to operate 24/7.

Timeline	Within the next 6 months

Appendix E-1 MHSA WET: Primary Care Integration Evaluation FY20/21

For Fiscal Year 2021-22, the ACBH WET Training Institute produced or collaborated in 71 trainings, with a total of 2469 ACBH and provider staff in attendance, sponsored a total of 302 CE credits for BBS, BRN, and CADC licensees, and 252.5 CEs being for Psychologists.

DATE	TITLE	COORDINATING UNIT	# ATTENDED	DELIVERY METHOD	CE'S OFFERED (ALL)	PSYCH CE'S	AUDIENCE
	JULY '21	**2021**					
7/8/21 & 7/9/21	Preventing Vicarious Trauma	Training Unit/RFQ vendor	17	Online - Live Webinar	0.0	0	Clinical ACBH staff and CBO providers
7/19/21 & 7/21/21	Suicide Assessment & Intervention (Adult focused) Parts 1 & 2	Training Unit and Crisis Support Services of AC (CSS)	39	Online - Live Webinar	6.0	6	Clinical ACBH staff and CBO providers
7/29/2021	Adult MHFA for TAY providers	ACBH MHFA trainer, TAY provider	21	Online - Live Webinar	0.0	0	Non-licensed TAY Provider staff
	AUG '21	**2021**					
8/16, 8/18, & 8/20/21	Clinical Documentation Standards Training for Mental Health Master Contract Providers and County Clinics *(offered as Three, 2-hour live-virtual modules over 3-days OR three self-paced recorded modules)*	Trg Unit/Quality Assurance (QA)	33	Online - Live Webinar	6.0	6.0	QA Staff in ACBH and CBOs
8/25/2021	Strategies for Working with Reluctant Clients	ACBH Forensic Services	26	Online - Live Webinar	3.0	3.0	ACBH Forensic Staff
8/27/2021	Brief Tobacco Treatment Intervention for Priority Populations: HIV/AIDS	Trg Unit, SUD, and ATOD contract with Lifelong Medical org.	9	Online - Live Webinar	3.5	3.5	Clinical BH and SUD providers
	SEPT '21	**2021**					
9/8/2021	Neurobiology of Trauma and Coregulation	Training Unit/RFQ vendor	16	Online - Live Webinar	0.0	0	All Staff and CBOs

DATE	TITLE	COORDINATING UNIT	# ATTENDED	DELIVERY METHOD	CE'S OFFERED (ALL)	PSYCH CE'S	AUDIENCE
9/13/21 & 9/15/21	Suicide Assessment & Intervention (Adult focused) Parts 1 & 2	Training Unit and Crisis Support Services of AC (CSS)	34	Online - Live Webinar	6.0	6	Clinical ACBH staff and CBO providers
9/17/2021	Provision of Mental Health Services with Latinx Populations: An Intersectional Approach	Trg Unit, Ethnic Services & ONTRAK	68	Online - Live Webinar	3.0	3	Clinical ACBH staff and CBO providers
9/21/21 & 9/23/21	Suicide Assessment & Intervention (YOUTH Focused); Parts 1 & 2	Training Unit and Crisis Support Services of AC (CSS)	31	Online - Live Webinar	6.0	6	Clinical ACBH staff and CBO providers
9/24/2021	Structural Competence in the Clinical Setting: An Upstream Approach to Delivering Mental Health Services to African Americans	Trg Unit, Ethnic Services & AATA - Pathways to Wellness	68	Online - Live Webinar	3.5	3.5	Clinical ACBH staff and CBO providers
	OCT '21	**2021**					
2021 OCTOBER	Involuntary Psychiatric Holds 5150/5585 (ongoing recorded trg)	ACBH office of Crisis Support	15	Online - Recorded training - independent learning	6.0	6	Clinical ACBH staff and CBO providers who write 5150's
10/12/2021	Preventing, De-Escalating, and Managing Aggressive Behavior in Behavioral Health Care Settings	Training Unit/RFQ vendor	44	Online - Live Webinar	4.0	0	All Staff and CBOs
10/19/2021	Adult MHFA	Training Unit and Crisis Support Services of AC (CSS)	11	Online - Live Webinar	0.0	0	Non-licensed Behavioral Health and CBO staff
10/22/2021	Tobacco Training - Motivational Interviewing Practice Workshop - Evoking Change Talk in clients with Tobacco Dependence	Trg Unit, SUD, and ATOD contract with Lifelong Medical org.	15	Online - Live Webinar	3.5	3.5	ACBH and CBO SUD and Clinical staff
10/22/2021	Promoting Mental Health Among African American Youth During the Pandemic: Addressing Depression, Anxiety, and Other Common Mental Health Disorders	Trg Unit, Ethnic Services & AATA - Pathways to Wellness	77	Online - Live Webinar	4.5	4.5	Clinical ACBH staff and CBO providers
10/28/2021	Child & Family Team (CFT) Facilitation	CYA System of Care	13	Online - Live Webinar	6	0	Child Clinical staff and family members
	NOV '21	**2021**					
2021 NOVEMBER	Involuntary Psychiatric Holds 5150/5585 (ongoing recorded trg.)	ACBH office of Crisis Support	21	Online - Recorded training - independent learning	0.0	0	Clinical ACBH staff and CBO providers who write 5150's
11/3/2021	Adult MHFA	ACBH MHFA Trainers - Cheryl Narvaez & Shannon Singleton-Banks	18	Online - Live Webinar	0.0	0	Non-licensed PEI and UELP Providers
11/8/2021	Youth MHFA	Training Unit and Crisis Support Services of AC (CSS)	19	Online - Live Webinar	0	0	Non-licensed Behavioral Health and CBO staff
11/17/21 & 11/19/21	CANS/ANSA Training for Trainers	CYA System of Care	10	Online - Live Webinar	10.0	10	Clinical ACBH staff and CBO providers
11/18/2021	The Cultural Toolbox: An Indigenous Perspective on Deep Healing	Trg Unit, Ethnic Services & ONTRAK	65	Online - Live Webinar	3.0	3.0	Clinical ACBH staff and CBO providers
11/19/2021	Trauma-Informed and Trauma-Focused Interventions Using Telehealth	Training Unit/RFQ vendor	14	Online - Live Webinar	6.0	6.0	Clinical ACBH staff and CBO providers
	DEC '21	**2021**					
2021 DECEMBER	Involuntary Psychiatric Holds 5150/5585 (ongoing recorded trg)	ACBH office of Crisis Support	15	Online - Recorded training - independent learning	3.5	3.5	Clinical ACBH staff and CBO providers who write 5150's

DATE	TITLE	COORDINATING UNIT	# ATTENDED	DELIVERY METHOD	CE'S OFFERED (ALL)	PSYCH CE'S	AUDIENCE
8/28/21 THRU 12/4/21	CSUEB Infant & Early Childhood Mental Health Postgraduate Certificate Program FALL SEMESTER (August-December 2021, 8 sessions) - 2-year program Jan'21 - Dec'22 (4 semesters)	Children & Young Adult System of Care - Early Childhood program	13	Online - Live Webinar	15.0	15	Licensed clinical staff taking Early Childhood credential at CSU - East Bay
12/9/2021	Clinical Techniques and Best Practices in Using a Telehealth Platform	Training Unit/RFQ vendor	31	Online - Live Webinar	6.0	6	Clinical ACBH staff and CBO providers
12/16/21 & 12/17/21	Clinical Supervision Skills (2-day training)	Training Unit/RFQ vendor	13	Online - Live Webinar	12.0	12.0	Clinical SUPERVISORS from ACBH and CBO providers
	JAN '22	**2022**		**2022**			
2022 JAN	Involuntary Psychiatric Holds 5150/5585 (ongoing recorded trg)	ACBH office of Crisis Support	14	Online - Recorded training - independent learning	3.5	3.5	Clinical ACBH staff and CBO providers who write 5150's
1/7/2022	Toxic Stress, Vicarious Trauma, & Self Care (2 hours)	Training Unit/RFQ vendor	25	Online - Live Webinar	0.0	0	All Staff and CBOs
1/21/2022	Tobacco Treatment for Cancer Patients	Trg Unit, SUD, and ATOD contract with Lifelong Medical org.	0	Online - Live Webinar	0.0	0	SUD Provider Staff - ACBH and PHS
1/21/2022	Trauma Focused Cognitive Behavioral Therapy (TF-CBT)	Trg Unit/ RFQ vendor	38	Online - Live Webinar	6.0	6	Clinical ACBH staff and CBO providers
1/28/2022	The Intersectionality of Diversity and Trauma: Cultural Considerations	Trg Unit/Ethnic Services - AATA trg with Pathways to Wellness	148	Online - Live Webinar	3.5	3.5	Clinical ACBH staff and CBO providers
	FEB '22	**2022**					
2022 FEB	Involuntary Psychiatric Holds 5150/5585 (ongoing recorded trg)	ACBH office of Crisis Support	17	Online - Recorded training - independent learning	3.5	3.5	Clinical ACBH staff and CBO providers who write 5150's
2/1/2022	Engaging Consumers and Families in Behavioral Health Treatment	Training Unit/RFQ vendor	12	Online - Live Webinar	4.0	4	Clinical ACBH staff and CBO providers
2/4/2022	Creating Safer Spaces for Black LGBTQ Youth	Trg Unit, Ethnic Services & AATA - Pathways to Wellness	67	Online - Live Webinar	0.0	0	Clinical ACBH staff and CBO providers
2/7/2022	Linguistically Responsive & Trauma Informed Principles and Interventions for Spanish Speaking Clients *(presented in SPANISH)*	Training Unit/RFQ vendor	15	Online - Live Webinar	3.0	3	SPANISH Speaking Clinical ACBH staff and CBO providers
2/8/2022 & 2/9/2022	Older Adult Training and Certification Program *(2-day training, 9 sections)*	Older Adult System of Care	22	Online - Live Webinar	12.0	0	ACBH and CBO Older Adult Providers
2/15/22 & 2/17/22	Suicide Assessment & Intervention (Adult Focused); Parts 1 & 2	Training Unit and Crisis Support Services of AC (CSS)	24	Online - Live Webinar	6.0	6	Clinical ACBH staff and CBO providers
2/24/2022	Treatment Considerations and Practices when Working with the African American Community	Trg Unit, Ethnic Services & ONTRAK	39	Online - Live Webinar	3	3	Clinical ACBH staff and CBO providers
	MAR'22	**2022**					
2022 MARCH	Involuntary Psychiatric Holds 5150/5585 (ongoing recorded trg)	ACBH office of Crisis Support	27	Online - Recorded training - independent learning	3.5	3.5	Clinical ACBH staff and CBO providers who write 5150's

DATE	TITLE	COORDINATING UNIT	# ATTENDED	DELIVERY METHOD	CE'S OFFERED (ALL)	PSYCH CE'S	AUDIENCE
3/3/22 THRU 4/20/22	Intro to Family-Based Therapy (FTB) for Treating Eating Disorders in Children and Adolescents *(8 sessions, 1.5 hour each, 3/3, 3/9, 3/16, 3/23, 3/30, 4/6, 4/13, 4/20) NOTE: Info session on Jan 26) MINIMUM SESSIONS to attend to earn CE's is 5.)*	Trg Unit/ CYASOC	27	Online - Live Webinar	12	12	Children and Youth Workers
3/4/2022	Adult MHFA	Asian Health Services - Kevin Nituoa and Yeri	6	Online - Live Webinar			Non-licensed Behavioral Health and CBO staff
3/7/2022	Culturally Sensitive Restorative Practices for Professionals	Training Unit/RFQ vendor	22	Online - Live Webinar	5.0	5	Clinical ACBH staff and CBO providers
3/11/2022	The Impact of Discrimination on Mental and Physical Health of the African-American Population - Dr. Karrin Golver	Trg Unit, Ethnic Services & AATA - Pathways to Wellness	54	Online - Live Webinar	3.0	3	Clinical ACBH staff and CBO providers
3/14/2022	Preventing, De-Escalating, and Managing Aggressive Behavior in Behavioral Health Care Settings	Training Unit/RFQ vendor	40	Online - Live Webinar	4.0	4	Clinical ACBH staff and CBO providers
3/14/22 & 3/16/22	Suicide Assessment & Intervention (Youth Focused); Parts 1 & 2	Training Unit and Crisis Support Services of AC (CSS)	23	Online - Live Webinar	6.0	6.0	Clinical ACBH staff and CBO providers
3/17/2022	Adult MHFA for TAY providers	ACBH MHFA Trainers: Shannon Singleton Banks and Kevin Nituoa	7	Online - Live Webinar	0.0	0	TAY Providers
3/18/2022	What happened to you? Trauma-Informed and Culturally-Responsive Practices in Working with Black, Indigenous, and People of Color (BIPOC) Clients (Rubio)	Trg Unit, Ethnic Services & ONTRAK	114	Online - Live Webinar	3.0	3	Clinical ACBH staff and CBO providers
3/22/2022	Grief Recovery – How to Support a Griever	Training Unit/RFQ vendor	40	Online - Live Webinar	0.0	0	All Staff and CBOs
3/25/2022	Emotional Reparations – Not your Average Initiatives for Holistic Healing and Health within the African American Community."	Trg Unit, Ethnic Services & AATA - Pathways to Wellness	46	Online - Live Webinar	3.0	3	Clinical ACBH staff and CBO providers
	APRIL'22	**2022**					
2022 APRIL	Involuntary Psychiatric Holds 5150/5585 (ongoing recorded trg)	ACBH office of Crisis Support	13	Online - Recorded training - independent learning	3.5	3.5	Clinical ACBH staff and CBO providers who write 5150's
APRIL 19 & 20	BRIGHT YOUNG MINDS	Workforce Development	81	Online - Live Webinar	0.0	0	High School Juniors and Seniors - Eden ROP program
4/20/2022	Adult MHFA	Training Unit and Crisis Support Services of AC (CSS)	11	Online - Live Webinar	0.0	0	Non-licensed Behavioral Health and CBO staff
4/22/2022	No Rest for the Weary" : Strategies for Promoting Mental Health Among Black Women During the COVID-19 Pandemic.	Trg Unit, Ethnic Services & AATA - Pathways to Wellness	92	Online - Live Webinar	3	3	Clinical ACBH staff and CBO providers
4/7/2022	QA STRTP Training	Trg Unit/Quality Assurance (QA)	26	Online - Live Webinar	3.0	3	Clinical ACBH staff and CBO providers
4/27/22	Defining Your "New Normal"; Strategizing for the Post-Pandemic in the Workplace and Beyond	Training Unit/RFQ vendor	29	Online - Live Webinar	4.5	4.5	All Staff and CBOs
4/29/22	Child and Family Team (CFT) Facilitator Training	Trg Unit and Children & Young Adult System of Care	8	Online - Live Webinar	6.0	0.0	CYASOC staff and family members
	MAY'22	**2022**					

DATE	TITLE	COORDINATING UNIT	# ATTENDED	DELIVERY METHOD	CE'S OFFERED (ALL)	PSYCH CE'S	AUDIENCE
2022 MAY	Involuntary Psychiatric Holds 5150/5585 (ongoing recorded trg)	ACBH office of Crisis Support	5	Online - Recorded training - independent learning	3.5	3.5	Clinical ACBH staff and CBO providers who write 5150's
5/2, 5/5, & 5/6/2022	UMASS 2022 - Tobacco Treatment Specialist Core Training (TTS)	Linda Nguyen ATOD	18	Online - Live Webinar	27.5	27.5	SUD Providers - ACBH and CBO staff
5/6/2022	Legal & Ethical Issues in Behavioral Health Treatment	Training Unit/RFQ vendor	37	Online - Live Webinar	6.0	6	Clinical ACBH staff and CBO providers
5/12/2022	Youth MHFA	Training Unit and Crisis Support Services of AC (CSS)	12	Online - Live Webinar	0.0	0	Non-licensed Behavioral Health and CBO staff
5/20/2022	Addressing the DATA: Diagnostic, Assessment and Treatment Approaches in Caring for African Americans Experiencing Emotional Race-Based Injustices	Trg Unit, Ethnic Services & AATA - Pathways to Wellness	60	Online - Live Webinar	3.5	3.5	Clinical ACBH staff and CBO providers who write 5150's
5/23/22 & 5/25/2022	Suicide Assessment & Intervention (Adult Focused); Part 1 & 2	Training Unit and Crisis Support Services of AC (CSS)	31	Online - Live Webinar	6	6	Clinical ACBH staff and CBO providers
5/26/2022	Intergenerational Trauma in Comparative Perspective and How Healers Should Approach it	Trg Unit, Ethnic Services & ONTRAK	123	Online - Live Webinar	3	3	Clinical ACBH staff and CBO providers
SPRING 2022 (JAN - MAY)	CSUEB Infant & Early Childhood Mental Health Postgraduate Certificate Program SPRING SEMESTER (January - May 2022)	Trg Unit and Children/Young Adult System of Care	13	Online - Live Webinar	15	0	Licensed clinical staff taking Early Childhood credential at CSU - East Bay
	JUNE'22	**2022**					
2022 JUNE	Involuntary Psychiatric Holds 5150/5585 (ongoing recorded trg)	ACBH office of Crisis Support	16	Online - Recorded training - independent learning	3.5	3.5	Clinical ACBH staff and CBO providers who write 5150's
6/9/2022	Adult MHFA	Training Unit and Crisis Support Services of AC (CSS)	9	Online - Live Webinar	0.0	0	Non-licensed Behavioral Health and CBO staff
6/9/2022	June 9, 2022 - Creating Welcoming Affirming Spaces for LGBTQ+ Populations	Trg Unit, Ethnic Services & ONTRAK	168	Online - Live Webinar	3	3	Clinical ACBH staff and CBO providers
6/16/2022	Youth MHFA	Training Unit and Crisis Support Services of AC (CSS)	16	Online - Live Webinar	0	0	Non-licensed Behavioral Health and CBO staff
6/17/2022	Cultural Psychiatry: Psychiatric Medication Use in the African American Population	Trg Unit, Ethnic Services & AATA - Pathways to Wellness	84	Online - Live Webinar	4.5	4.5	Clinical ACBH staff and CBO providers
6/29-30/2022	Preventing Vicarious Trauma	Training Unit/RFQ vendor	34	Online - Live Webinar	6.0	6	Clinical ACBH staff and CBO providers
71 TRAININGS		**TOTAL**	**2469**	**TOTAL**	**302.0**	**252.5**	

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Overview

Wellness in Action (WiA) is a community mental health workforce training and education program committed to the development of grassroots community leaders from un- and under-served refugee, immigrant and indigenous communities in the Bay Area. WiA launched in 2016 and is a program of the Center for Empowering Refugees and Immigrants (CERI) funded by Alameda County Behavioral Health Care Services.

The following chart provides progress on our deliverables for FY22 organized by performance measure.

Please find Bios of Mini-grant awardees at the end of this report.

Program Services	Performance Measures	Deliverable
Recruitment of Community Leaders/ Wellness in Action Mini-Grant Participants	Outreach to target population using the following strategies: 1. Direct participant outreach through one on one meetings and connections 2. Community presence at meetings/events, partnerships and relationships with local CBOs, and community leaders 3. WiA Arts and Wellness events and listserv	Wellness in Action Mini - Grants ● 4 informational meetings were held via zoom ● 3 presentations at partner CBO's were offered via zoom ● 10+ one on one meetings and calls with potential applicants we conducted ● 21 applications were completed ● 16 people were selected and interviewed ● 11 mini-grants were offered ● 10 community leaders were signed up for 5-month WiA training experience. Human Rights and Trauma Informed Care training ● 10 participants were recruited for Trauma-Informed Care and Human Rights program running July 1, 2021 - December 2021.

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		• 9 participants completed the program
Curriculum Development	Develop new or refine existing 2-6 hour training modules for the Wellness in Action program which are culturally appropriate and support behavioral health promotion and wellness.	• **Expansion of Foundational WiA Curriculum:** Refinement and integration of past participants as facilitators of foundational WiA curriculum. • **Foundations of Somatic Psychology Trauma Work:** This curricula included 4 modules led by a somatic psychotherapy expert. ○ Book clubs, and other experiential workshops organized as stand-alone modules to be developed in Spring 2022 • **Trauma Informed Care & Human Rights:** This curricula focused on the principles of trauma informed care and human rights through a decolonial framework. All materials have been uploaded to a google classroom and have been made accessible to WiA training participants and CERI wide.
Training	Deliver 5 trainings (at least 20 hours)	1. 20 hours of training through the Human Rights and Trauma Informed Care program were delivered July - August, 2021. 2. 8 hours of Foundations of Somatic Psychology and Trauma were delivered. 3. 10 hours of Listen-Share-Create-Act

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		4. 10 hours of tech training on the following topics
		  ○ Canva to create presentations (2 hours)
		  ○ Google Suite (6 hours)
		  ○ Zoom (2 hours)

Mentoring and Community Project Support	Support mini-grant participants with the development and implementation of community projects to lead a community support group.	• 9 participants were mentored to develop and implement Trauma-Informed Care & Human Rights action in the community. Project ended December 2021.
		• 10 mini-grant participants are currently receiving mentorship to provide community support groups
		• Training, meetings, and consultations for mini-grant projects began on January 7, 2022, and will continue until May 28, 2022. They will be distributed as follows:
		  ○ 20+ hours of training
		  ○ 10 individual technical assistance meetings and mentorship
		  ○ 10 group clinical consultations

Participant Stipend	Manage and distribute leadership learning stipends for Wellness in Action participants. Leadership learning stipend to be distributed in equal payments to be paid on a monthly basis to participants.	• Monthly leadership stipends to Trauma-Informed Care and Human Rights participants. • Monthly leadership stipends to new mini-grant participants
Career Pathway	Create resources and linkages to support	1. Develop mentorship opportunities and informational

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Development	career readiness and pathways for Wellness in Action participants.	interviews for mini-grant participants with established practitioners of color in the field. 2. Continue to foster relationships with CBOs and coalitions, to create linkages to networks and career opportunities for participants. 3. Financial assistance to relevant professional development opportunities during the FY22 mini-grant funding cycle.
Arts and Wellness Leadership Awards	Select and award up to 5 Arts & Wellness Leadership awards for artists, healers and community leaders.	Completed workshops: 1. Rulan Tangen: Dancing and movement for community healing - September, 2021 2. Albert Wong: Somatic Approaches to Trauma Care October - November, 2021 3. Anastasia Kim: Empowering immigrants to have difficult conversations October, 2021 4. Decolonizing Mental Health Panel October 26, 2021 5. Stories of Home in partnership with StoryCenter, October, 2021 In progress 1. Healing Hike with Raynelle Rino April, 2022 2. Embodiment workshops with Laura Coelho March-June, 2022 3. Stories of Home May, 2022
Self-Care Group	Plan and facilitate a monthly group for community health workers and mental health providers from local community organizations to build	• 8 Self-care workshops for Afghan service providers • 2 Self-care workshops open to mental health providers in the Bay Area

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	skills in self-care to prevent burnout.	
Educational and promotional material	Develop promotional and educational materials sourcing from 4 years of work.	• 2 WiA Community Newsletters or blog posts have been shared. • In Progress: Develop at least three promotional and/or educational materials to make visible community engagement strategies for wellness and mental health
RE-GROUND	Organize a one-day symposium for mental health practitioners of color.	In progress • Mentor RE-GROUND coordinator • Conduct outreach and engagement with mental health practitioners of color • Develop partnerships with community leaders and organizations to develop and deliver the symposium • Reach approximately 100 practitioners of color with intentional space for networking and building a community of support
5 Year Evaluation	Conduct an evaluation of Wellness in Action program outcomes	• Survey tools have been developed and await review • Past participants are being contacted for focus groups to be conducted.

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Mini -Grant FY 2022 Recipients

Jocelyn DeLeon
I'm an Artist Entrepreneur with experience in business startup, administration and management that is informed by 20+ years of community building, organizing, and activism. As a second generation Filipina, I have served in the bay area Filipino community since youth as a poet, educator, organizer and international activist. Currently, I serve in a local grassroots volunteer-based women's organization dedicated to the ongoing movement for genuine sovereignty in the Philippines. We educate, organize, and mobilize our members and communities to protect human and women's rights in the Philippines and in our U.S. migrant communities while working towards a future of international solidarity. My goal is to offer cultural and decolonial wellness activities to invite healing, upliftment and support for activists, workers, students, educators, LGBTQIA+ and intergenerational Filipinos.

Laxmi Tikhatri
My name is Laxmi Tikhatri. I was born in Nepal. I finished my B.B.S. (Bachelor's degree of Business Studies) from Nepal . I volunteered as a counselor cum caregiver in Nepal Suicide Prevention and Mental Health Research Centre / Children home for 6 years. I served as a mental health / Suicide Prevention activist in Nepal since 2011. I migrated to the United State of America in 2017. Being a member of historically marginalized Dalit community, I like to support Nepali Dalit women living in the San Francisco Bay AreaDalit women are the most vulnerable population in the Bay area. They are marginalized within the marginalized Dalit community. I would like to empower and encourage them to participate in the wellness program and help the needy one with emotional health support to move forward to their path.

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Barbara Silva
Olá! I'm a Brazilian immigrant living in California for the past 11 years. I have two young daughters and everyday I try to juggle with joy (and sometimes despair) all the many responsibilities motherhood brings to my life. After so much time working to find myself in a new country, I began a profound process of self-knowledge and spiritual awareness. Recently, I've taken a big step in my life: I decided to return to the academy, studying in a postgraduate program in Transpersonal Psychology. A complete change of professional path!
A few years ago I joined BRAVE (Brazilian Women in Silicon Valley), a women-led support group, in which we connected and supported women all over the Bay Area, who had a need for a strong, caring community.

Alex Jaga
I am originally from Salvador, Bahia, Brazil I am interested in continuing my career in wellness and I am eager to learn and grow further in the field of community mental health. I want to give immigrants the opportunity to move forward with their lives. My vision is to help other immigrants in the East Bay and in my social network who I think need conversation, life direction, ideas about next steps in their lives. I would like to create a wellness group that would teach people how to support themselves through body work through my work as a massage therapist, and through movement from my practice with Capoeira. I plan to offer music lessons and learning musical instruments, including percussion, as a way to heal.

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Tsering Yangkey

Tsering has had a deep interest in supporting community mental health and well-being throughout her growing life as a Tibetan refugee in India. Tsering's understanding and intuitive wisdom about how to approach mental health issues in the Tibetan community – issues that are highly stigmatized – gave openings for supporting many individuals and families in the community who would not otherwise feel comfortable or safe in pursuing support. Exploring cultural wellness models, Tsering has assisted clients in their immigration, legal and social service needs. Two years ago, Tsering decided to further her education and now has a master's degree in Counseling Psychology. Currently, Tsering is an Associate Marriage and Family Therapist and works at Child Therapy Institute in San Pablo, California.

Georgia Esteves Young

I am a Brazilian immigrant that has lived in California for 9 years. I graduated in Psychology 16 years ago in Rio de Janeiro, Brazil. I worked as a psychologist for 7 years until I moved to the United States. I have always been interested in energy healing and other ways of cultivating health in our lives, such as Yoga, meditation, dance, music and conscious breathing. I also believe spirituality is essential for human growth and to keep our emotional field balanced and healthy. Today I study and follow the practices of Shamanism and use those practices combined with energy healing, meditation, dance and art at my work as a Holistic Therapist and Women's Circle's facilitator. I dedicate my work to women's health with a focus on Brazilian immigrants. My intention is to provide a safe, empowering and creative space where Brazilian women can connect with their identities, their inner power and their sacred beings.

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Goli Hashemi

I am an Iranian- Canadian. I immigrated to Canada when I was 13 years old and moved to the US in 2007 after getting married. I am an Occupational Therapist and have worked in various healthcare settings in Canada and the US mostly with adults and elderly who have had major health conditions. Over the past 3 years I have started volunteering both personally and professionally with refugees/immigrants/undocumented individuals in the East Bay area and would like to be able to use art to serve this population better while also incorporating my training an an OT. With the fall of Kabul in August, I have focused my attention on serving Afghan families. Iran and Afghanistan's geographical, language, and cultural proximity provides me with a privilege to be able to support this community.

Tenzin Sonam

I was born in a small Tibetan refugee camp in northern parts of India, Leh Ladakh, to be specific. I have a bachelor's degree in arts and law and a master's degree in International Law specializing in Human Rights Law and Gender and Law. I am passionate about human rights issues. Currently I work for Center for Empowering Refugees and Immigrants (CERI) as a CalHOPE crisis counselor, where I help my Tibetan community members here in the bay area.

Roger Remera

A documentary/filmmaker focuses his work on human rights issues around the world, wants to fight ignorance and injustice by telling the untold stories of the voiceless through his lenses. His hope is that people will learn from people in conflict zones around the world. He is especially interested in Africa where he is from as a survivor of the 1994 Genocide Against the Tutsi in Rwanda. His experience in America has been in the humanitarian sector, where he worked with different non-profits organizations: technician/interviewer in a neuropsychology practice also focused on mitigation of penalty phase murder convictions and appeals.

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Diler Bilgit

Diler is a graduate student at Palo Alto University, where she is majoring in Clinical Mental Health as well as Marriage, Family & Child Counseling. She is also a mental health intern at the City of Fremont, Youth and Family Services (YFS). For over six years, she held volunteer and director positions at two different nonprofit organizations serving Turkish communities in Boston, Ma., and Austin, Tx. Diler also worked with community leaders to increase awareness about wellness among immigrant, refugee, and indigenous communities in the Bay Area. She comes with rich experiences supporting newcomer families in transitioning to US life.

alameda county behavioral health
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Fiscal Year 21-22 Annual Report:
Post Graduate Continuing Education Certificate Program:
An Alameda County Behavioral Health & Cal State University East Bay Collaboration

Submitted by: Cathy Powell, Early Childhood Mental Health Coordinator
Prepared by: Marthea Alley-Caliz, Special Projects
ACBH Child & Young Adult System of Care
11.15.2022

Post Graduate Continuing Education Certificate Program

Program Description: Mental Health Services Act – Workforce Education and Training (MHSA WET) provides funding that allows for the completion of a two-year *Infant & Early Childhood Mental Health Post Graduate Continuing Education Certificate Program* at Cal State University, East Bay (CSUEB). The overarching goal of this program is to build capacity in the early childhood workforce by increasing the number of qualified practitioners who understand and can address the culturally diverse and specialty early childhood mental health needs of young children and their families in Alameda County. The reporting for the *pilot* follows.

Program Background and Updates

Background
In FY18/19, California State University East Bay (CSUEB) and Alameda County Behavioral Health (ACBH) launched the pilot *Early Childhood Mental Health Post Graduate Continuing Education Certificate Program (*program*)*, which focused on the developmental foundations of infant and early childhood mental health. The program's content examined the developmental foundations of relationship-based clinical work between infants, young children, families, and caregivers, and combined theory and practice. The curriculum places a strong emphasis on working with families from diverse cultural, racial, and ethnic backgrounds, which is especially important given Alameda County's socioeconomic, racial, cultural, ethnic, and immigrant diversity.

Overview
A collaborative effort allowed for the development of this partnership that aims to address an important need, an informed workforce who are culturally and linguistically informed about the challenges of the communities they will serve. For this pilot, ACBH, CSUEB, and evaluators worked to ensure programmatic coordination, recruitment, methodological design, data collection, and reporting. To address challenges identified in year one, ACBH allocated additional funding for curriculum development.

Summary Points

See Program Description, Background, and Overview above.

- Two cohorts have been piloted through this innovative program since the program launched in late 2018. Cohort 1 occurred January 2019 through December 2020 with 14 of 15 students completing the program. Cohort 2 started in January 2021 with 15 students and will complete December 2022. It is anticipated that 11 will complete.
- In 2020, program administrators responded to COVID-19 concerns and moved to an online format to address safety concerns.
- The partnership between ACBH and CSUEB has remained strong through the pandemic as well as through some leadership changes. The instructor, Dr. Valerie Bellas CSUEB Cohort Instructor, has remained a constant strength of the program from its inception and in the completion of this program.
- Various evaluation methods were used to assess the 4 year pilot program including: a unique survey developed by UCSF Benioff Children's Hospital Oakland in year one; a training evaluation (online student satisfaction survey); the Learning Curve Survey in year one (to assess student measurement of knowledge, skills, and integration/application of core concepts), and reflective writing assessments.
- From FY 20/21 and Spring 2022 evaluation data, student evaluations showed:
  - 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.
- Through student feedback, 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.
- Student comments:
  - *"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."*
  - *"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".*
- Student survey responses showed:
  - There was a range of experienced practioners represented including LCSWs, ASWs, and LMFTs with active licenses.
  - Key areas in which students strongly agreed or agreed with included feeling that this

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11.15.2022

Post Graduate Continuing Education Certificate Program

Program Description: Mental Health Services Act – Workforce Education and Training (MHSA WET) provides funding that allows for the completion of a two-year *Infant & Early Childhood Mental Health Post Graduate Continuing Education Certificate Program* at Cal State University, East Bay (CSUEB). The overarching goal of this program is to build capacity in the early childhood workforce by increasing the number of qualified practitioners who understand and can address the culturally diverse and specialty early childhood mental health needs of young children and their families in Alameda County. The reporting for the *pilot* follows.

Program Background and Updates

Background
In FY18/19, California State University East Bay (CSUEB) and Alameda County Behavioral Health (ACBH) launched the pilot *Early Childhood Mental Health Post Graduate Continuing Education Certificate Program (*program*)*, which focused on the developmental foundations of infant and early childhood mental health. The program's content examined the developmental foundations of relationship-based clinical work between infants, young children, families, and caregivers, and combined theory and practice. The curriculum places a strong emphasis on working with families from diverse cultural, racial, and ethnic backgrounds, which is especially important given Alameda County's socioeconomic, racial, cultural, ethnic, and immigrant diversity.

Overview
A collaborative effort allowed for the development of this partnership that aims to address an important need, an informed workforce who are culturally and linguistically informed about the challenges of the communities they will serve. For this pilot, ACBH, CSUEB, and evaluators worked to ensure programmatic coordination, recruitment, methodological design, data collection, and reporting. To address challenges identified in year one, ACBH allocated additional funding for curriculum development.

Summary Points

See Program Description, Background, and Overview above.

- Two cohorts have been piloted through this innovative program since the program launched in late 2018. Cohort 1 occurred January 2019 through December 2020 with 14 of 15 students completing the program. Cohort 2 started in January 2021 with 15 students and will complete December 2022. It is anticipated that 11 will complete.
- In 2020, program administrators responded to COVID-19 concerns and moved to an online format to address safety concerns.
- The partnership between ACBH and CSUEB has remained strong through the pandemic as well as through some leadership changes. The instructor, Dr. Valerie Bellas CSUEB Cohort Instructor, has remained a constant strength of the program from its inception and in the completion of this program.
- Various evaluation methods were used to assess the 4 year pilot program including: a unique survey developed by UCSF Benioff Children's Hospital Oakland in year one; a training evaluation (online student satisfaction survey); the Learning Curve Survey in year one (to assess student measurement of knowledge, skills, and integration/application of core concepts), and reflective writing assessments.
- From FY 20/21 and Spring 2022 evaluation data, student evaluations showed:
  - 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.
- Through student feedback, 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.
- Student comments:
  - *"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."*
  - *"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".*
- Student survey responses showed:
  - There was a range of experienced practioners represented including LCSWs, ASWs, and LMFTs with active licenses.
  - Key areas in which students strongly agreed or agreed with included feeling that this

course…:

- ***Trained me to be equipped with the skills necessary*** to demonstrate knowledge of the transactional nature of development and the centrality of relationships in early childhood using 1-2 frameworks (e.g., development of attachment, secure-base/safe-haven behaviors, reflective practice.)
- ***Trained me to describe the role of environmental stressors***, including trauma, in a developmental context using 1-2 related concepts (e.g., the role of early memory, ghosts and angels in the nursery, the impact of racism, xenophobia, and COVID-19 pandemic.)
- ***Trained me to identify the philosophy and key elements of family-driven care across content and processes using 1-2 approaches to IECMH*** (e.g., centering fatherhood, cultural humility), and had an instructor(s) [who] demonstrated knowledge, promoted clinically sound and ethical treatment of client/customers, and was responsive to participants.

- Instructor comments:
  - Instructor Dr. Valerie Bellas shared feedback on the program. Overall she expressed that several areas of the program have worked well including collaboration, the pedagogy, the transition to an online and subsequent hybrid learning, and the experience of the cohort learning model. . She states that "students have acquired a foundation [in] IECMH [Infant Early Childhood Mental Health] theory and practice approach, including development in relationships, reflective practice, cultural humility, and trauma." She further states that she believes "The county and university partnership is a model that can be disseminated and replicated as a model for IEMCH workforce development and training."

Overall, students, the instructor, administrators, and community stakeholders shared that they felt that students benefitted greatly from the program and that this resource will continue to strengthen quality services offered by their providers. ACBH and CSUEB have had discussions regarding sustainability of the program beyond this pilot ending in December 2022. Various ideas are being explored including shortening the program from two years to (1st year theory and 2nd year practice to be enrolled in separately) and incorporating early childhood curriculum in order to increase exposure into other social service and educational courses and topics to expose more students to the early childhood field, which is still in need of culturally astute practitioners who reflect the communities served.

ACBH and CSUEB thanks the MHSA program for sponsoring this pilot. WET funds have supported these efforts as well as the complimentary evaluation services. The learning by the students and administrators will continue to inform direct and planned services to youth and families in our community.

Cohort 1: 2019-2020

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 paid out of pocket. Of the 15 students, 11 were clinicians of color, 10 spoke one of Alameda County's identified threshold languages, and all 15) worked in Alameda County early childhood community-based organizations (CBOs). Fourteen (14) of the 15 students completed the program in December 2020.

Year two (2020) presented new challenges resulting from COVID-19. COVID-19 required the development of new teaching methods to address safety concerns. In response, some changes occurred including:

- Class instruction was moved online (i.e., CSUEB Zoom) which ensured ongoing instruction.
- Administratively, ACBH staff created a TEAMS administrative page to track requisite student information, grading and reporting.
- ACBH had a leadership transiton from retiring Margie Padilla, Director of Early Childhood Program, who helped develop the program, to Dr. Clyde Lewis, EPSTD Coordinator with support from Marthea Alley-Caliz, Program Specialist.
- ACBH worked with CSUEB to develop a plan for and promote student recruitment for Cohort 2.

Cohort 2: 2021-2022

Jointly, ACBH and CSUEB hosted a competitive application process (in Fall 2020) and recruited 15 students (from 19 applicants) for Cohort 2. Recruitment announcements ellicited individuals who focus on early childhood skill development as well as exhibit cultural competencies that can meet the unique needs of the diverse Alameda County child and family populations. Recruitment outreach extended to the Alameda County network of service provider agencies, to networks of CSUEB staff, and to employees and interns at current clinic and outpatient service sites. The range of interest from CBO employees increased; and as such, there is a wider range of organizations represented in the second cohort.

Given the continued COVID pandemic in 2021, a number of factors had to be addressed including:

- Recruitment, typically done in person, moved to online outreach and a remote selection process by reviewing transcripts and essays.
- Class instruction was adapted to online methods of teaching and learning. The instructor was creative and used different methods to promote engagement. For example, incorporating regular small group activities through the online platforms which allowed interactive problem-solving, sharing of new concepts, and overall connection amongst cohort participants.
- Administrative tracking tools helped to track class attendance and group engagement activities.
- An online course evaluation tool, Survey Monkey, was utilized to collect feedback and

allow for more accuracy and a higher response rate.

In Fall 2022, when some health restrictions had been lifted, in-person learning resumed for some classes for a hybrid online and in-person model. This allowed for the group to share, explore and connect with other practitioners in the early childhood community.

FY 21/22 Outcomes, Impacts and Challenges

Program Evaluation
The program was evaluated by a unique survey developed by UCSF Benioff Children's Hospital Oakland in the first year of the pilot. In the second year of the cohort, the corresponding evaluation survey was administered by UCSF Benioff Children's Hospital, Oakland evaluator, Dr. Laura Frame, and in years three and four it was administered by ACBH staff. The evaluation focused on methodological approaches used for student training. To this end, the evaluation provides ongoing feedback for managers to ensure continuous quality improvement. Evaluation methods used to assess the program include: a training evaluation (online student satisfaction survey); the Learning Curve Survey in year one (to assess student measurement of knowledge, skills, and integration/application of core concepts), and reflective writing assessments.

Student Evaluation Metrics
From FY 20/21 and Spring 2022 evaluation data, student evaluations show overall agreement that the stated learning objectives were met and that instructors were responsive, promoted the ethical and clinically sound treatment of clients. Students felt the content was both current and accurate and that they understood the value of the program. Students agreed that they "…learned something useful from this program that I can put into practice in my work". Further, most students showed high ratings of the instructors demonstrated knowledge/qualifications and clarity of content presentation.

While responses showed an overall agreement that objectives were met, there was a range of responses in several areas including entering student educational experience, instructional delivery method, technology use, program administration, and the physical environment. ACBH and CSUEB management worked together to refine learning objectives and improve technology usage.

Student Feedback
Student feedback from the second-year evaluation helped to inform the second cohort. 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.

Instructor Feedback

During the second cohort, the instructor, Dr. Valerie Bellas shared feedback on the program. Overall she expressed that several areas of the program have worked well including**,** collaboration, the pedagogy, the transition to online and subsequent hybrid learning, and the experience of the cohort learning model . She states that "students have acquired a foundation [in] IECMH [Infant Early Childhood Mental Health] theory and practice approach, including development in relationships, reflective practice, cultural humility, and trauma." She further states that she believes "The county and university partnership is a model that can be disseminated and replicated as a model for IEMCH workforce development and training."

Instructor Responses – December 2021

Q. What components of the first CSUEB Early Childhood Program worked well and any special highlights?

Recruitment: This was a success. Cohort 2 [was recruited in the Fall of 2020 and] is such an active, thoughtful, and diverse group! Students share their perspectives, listen to each other, and bring rich professional, personal, and cultural experiences to our learning. We were able to recruit a full class with variability and commonalities. Students identify as 2 AAPI, 2 Black, 8 Latinx, 3 White, with bi-cultural representation in the group as well, and vary in age and number of years in the field. We recruited a group of students who are primarily mental health direct service providers, which was a focus of our recruitment.

Collaboration: We have built a strong collaboration with CSUEB and ACBHS with regular contact and communication. I have appreciated how we work together and have developed common language and partnered in roles. In addition, we have established longitudinal connections with local agencies many of whom have supported their staff to engage in the IECMH program for this second cohort after hearing good things from their staff who participated in the first cohort. I am so pleased that we have built a reputation in the community as a high quality, engaging, and useful program.

Pedagogy: This was a fantastic learning year! We engaged in a variety of learning activities, including lecture, large and small group discussion, written assignments, and readings. We achieved all of this as we transitioned to telelearning model during the pandemic. Across this first year, students have acquired a foundation IECMH theory and practice approach, including development in relationships, reflective practice, cultural humility, and trauma and resilience.

- Development in relationships: We have covered core content, such as development prenatal to five and attachment. Students have built skills in observation and application of developmental principles to understanding young children's relationships, needs, and strengths in the context of their families, communities, and systems of care.
- Reflective Practice: Students engaged in personal self-reflection and shared with each other cultural and family experiences as they relate to IECMH work. We have explored how to approach the work with families through a lens of family-driven care. The group is creating relationships with each other to serve as collegial support to sustain a diverse workforce.
- Cultural Humility: We have centered health equity and social justice, including the impact of racism, xenophobia, and the COVID-19 pandemic. We have actively identified inequities in models of service delivery and awareness of our social location and the intersectionalies of identities across relationships. We have benefitted from our guest speakers' contributions, including parents who have generously shared their experiences with systems of care.
- Trauma and Resilience: We have come together to understand the impact of trauma on young children and their primary relationships from multiple angles. We have actively engaged in identifying protective factors in children, families, communities, and how our services and systems can uphold these core protective functions. We have highlighted the importance of self-care to mitigate the impact vicarious trauma on the IECMH workforce.

Q: Please include things you deemed important that were both planned and organic.

What was important to me was to balance core content and its application to a dynamic and developing field, alongside personal and group process centering the perspectives and experiences of a diverse workforce to develop a reflective and inclusive approach to IECMH service provision for children, families, and communities.

What spontaneously has arisen is the rich diversity of perspectives and experiences of our workforce and the students' clear passion and commitment to learn about, engage in, and re-envision the IECMH field and to develop their practice with children, families, communities and the systems of care within which they work.

Q. What components of the first CSUEB Early Childhood Program could be improved?

Recruitment: The program could benefit from a larger pool of applicants. Although the class was fully enrolled, there were few applicants above the enrollment cutoff. Increased applications will help to form a group that is both cohesive and diverse for our next cohort. Early consideration of recruitment approaches may be beneficial for our next cohort.

Collaboration: We engaged in strong collaboration, but I believe our process would have benefited from representation by dedicated early childhood coordinator/director at the county. My understanding is that this position has remained unfilled after a staff retirement left a vacancy. In our first cohort, the former early childhood director had a central role in coordination and direction with a focus on early childhood mental health needs. Ongoing, this role could serve to increase collaborative and sustained relationships with community agencies who employ and supervise the IECMH workforce. Additionally, the first cohort had access to an outside evaluator. Re-engaging a collaboration with an outside evaluator would benefit the program, both to keep track of how the students continue to engage in service delivery and apply their learning across time, as well as to more systematically assess the effectiveness of the program, build its sustainability, and support the dissemination of the model.

Pedagogy: Despite its overall success, there are areas that could be improved.

- It is always a challenge to find the right balance of foundational content, reflective process, and applied learning. This is an ongoing focus of curriculum development.
- The group is working toward continuing to find ways to address racism and other forms of systemic oppression and the dynamics power and privilege in our interactions and practice. This is an unfolding process across relationships and within our communities and will be a continued explicit focus of the program, utilizing identified tools, approaches, and centering lived-experience and perspectives of BIPOC and other targeted identities and communities.
- The amount and type of reading for the class did not always fit with the busy lives of students who are working full-time as they complete this program. I am working to tailor the readings to these needs, by identifying accessible, targeted, and useful readings and resources.
- The cumulative impact of the pandemic has increased challenges for students to participate and engage in the program. Supporting students as they navigate personal and professional challenges and provide services during the pandemic is of the utmost importance, including increased opportunities to connect with each other and access to available community resources.

Q. Any other comments or feedback you would like added to the annual report?

I believe that the IECMH program is state of the art. The county and university partnership is a model that can be disseminated and replicated as a model for IEMCH workforce development and training. The program is an invaluable resource in building a diverse IECMH specialty workforce in Alameda County and centralizing training in the crucial area of Early Relational Health. The program offers a foundation for IECMH work, as it centers service providers' perspectives and diversity of experience to increase workforce capacity and retention. These elements are key to building an informed, culturally responsive, ethical, and effective approach to service delivery for the children and families we serve.

Student Survey Feedback

Student surveys were issued and collected at the end of each semester. Of Cohort 2 students completing post-semester surveys, data showed:

- There was a range of experienced practioners represented including LCSWs, ASWs, and LMFTs with active licenses.
- Key areas in which students strongly agreed or agreed with included feeling that this course…:
    - ***Trained me to be equipped with the skills necessary*** to demonstrate knowledge of the transactional nature of development and the centrality of relationships in early childhood using 1-2 frameworks (e.g., development of attachment, secure-base/safe-haven behaviors, reflective practice.)
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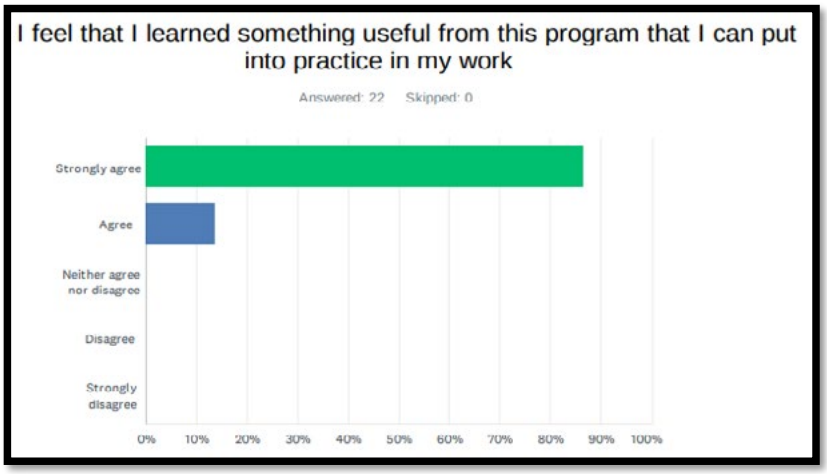
    - ***Trained me to identify the philosophy and key elements of family-driven care across content and processes using 1-2 approaches to IECMH*** (e.g., centering fatherhood, cultural humility), and had an instructor(s) [who] demonstrated knowledge, promoted clinically sound and ethical treatment of client/customers, and was responsive to participants.

December 2021 Students Feedback

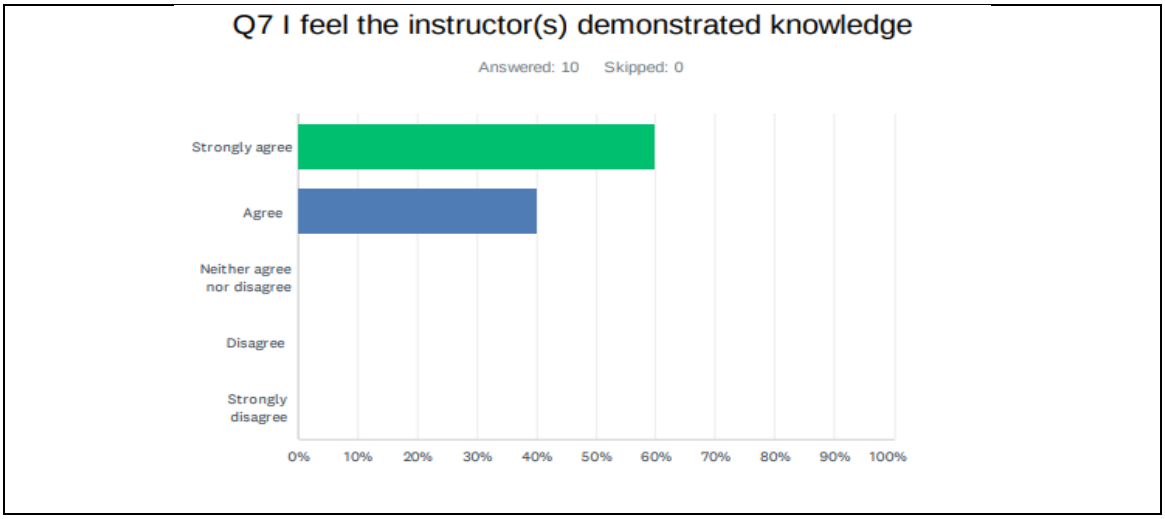


Additional student feedback collected from the survey can be found at the end of this report.

Overall, students, the instructor, administrators, and community stakeholders shared that they felt that students benefitted greatly from the program and that this resource will continue to strengthen quality services offered by their providers. ACBH and CSUEB have discussed the sustainability of the program beyond this pilot ending in December 2022. Various ideas are being explored including shortening the program from two years to 12 or 18 months or two separate one year courses (1st year theory and 2nd year practice to be enrolled in separately) and incorporating early childhood curriculum, and exposure into other social service and educational topics to expose more students to the early childhood field, which is still in need of culturally astute practitioners who reflect the communities served.

ACBH and CSUEB thanks the MHSA program for sponsoring this pilot. WET funds have supported these efforts as well as the complimentary evaluation services. The learning by the students and administrators will continue to inform direct and planned services to youth and families in our community.

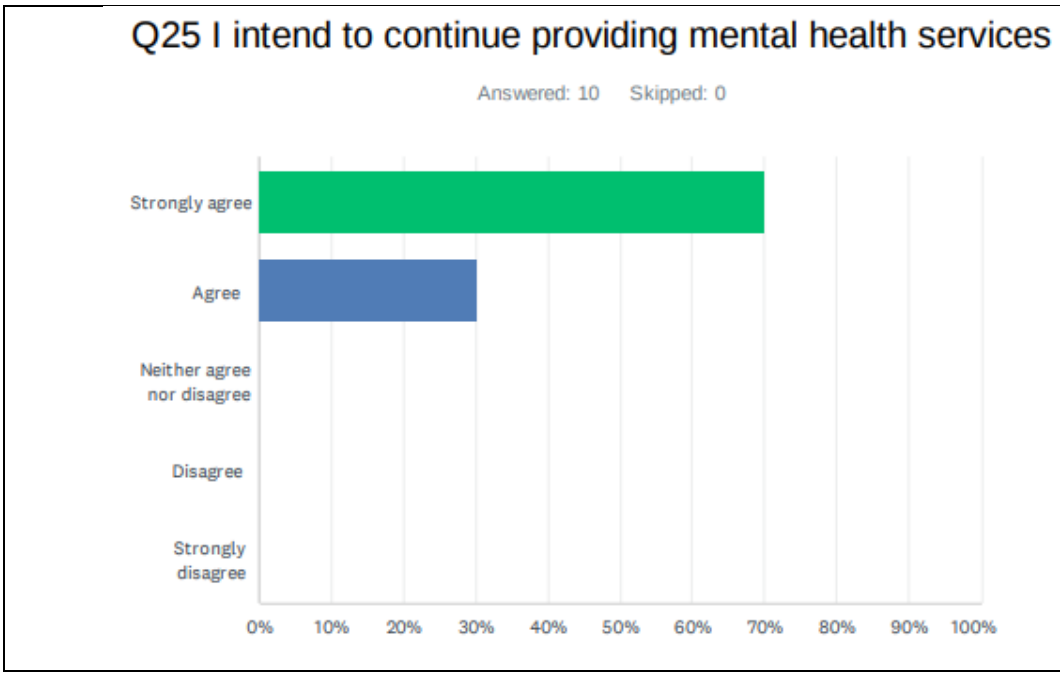
Additional Student Feedback from Spring 2022

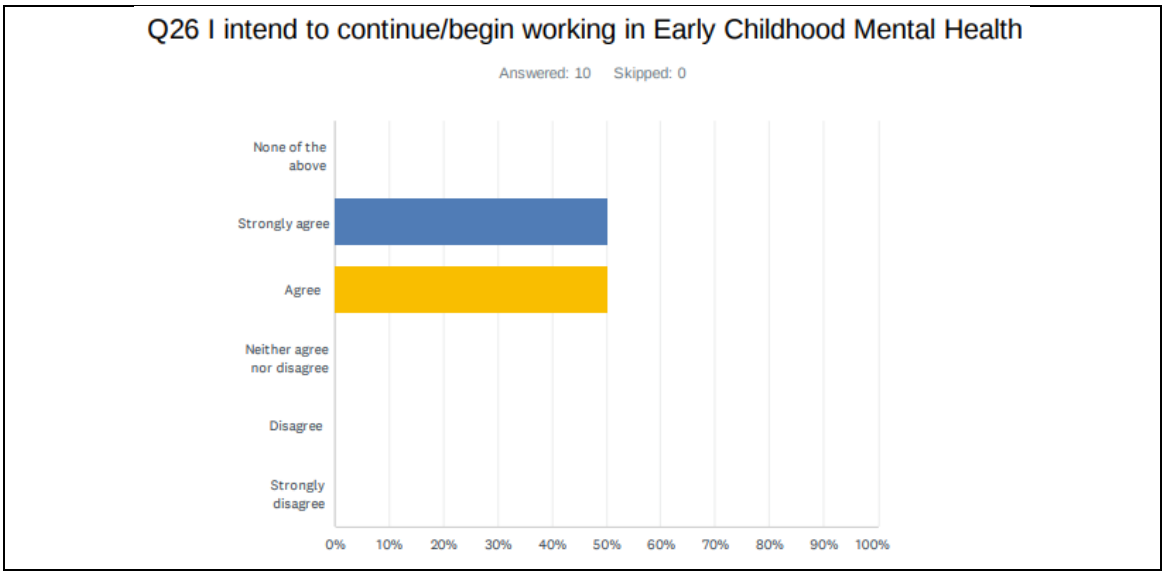


Q16 Please describe how you will apply the knowledge you have gained at this training in your work
RESPONSES
Deepening my self reflection as an essential part of clinical work
I have gained such a greater understanding of tenets that are now guiding my work with working with children under the age of 5years old.
using the Parent Child Relational Competencies (PCRC) framework to conceptualize where the child, parent and the parent-child relationship are at, and what parent-child relationship focused interventions can be considered
Assessing clients on a weekly basis.
take into consideration the importance of the whole person in contest, environment, history, culture, financial, just to mention some.
Greater knowledge, language, and framework to approach communication across cultures, and to address systemic inequities
I will have lots of places that I can look to help me with my assessments. I plan to also bring the diversity tenets into my office.
Bringing more empathy and curiosity in my work with caregivers.
I have been and will continue to use the IWM interview!
More critical about assessment process and including families in the process

Q17 Please give one new understanding or "learning breakthrough" that you gained this semester

RESPONSES
Applying PCRCs to my assessment process, new use of process journaling
I have really been learning about who I am as a therapist and continuing to build my self awareness of how systems operate around a child and family and how I can continue supporting not only their mental health but how they navigate different experiences across systems of support.
the causal rubric introduced by Barbara Stroud (one of the textbooks in this semester) is very helpful way to organize the assessment info gathered, and determine the etiology of issues, which then leads to appropriate level of interventions.
NA
historical trauma impacting the lives of minorities.
The incorporation of the PCRCs into an assessment framework
Not sure.
I really loved the PCRC's and Diversity informed tenants. It was validating and valuable in my work.
My favorite theme from the semester was diving into the PCRCs and look forward to using those to inform my practice moving forward.
The need for common language to describe what's needed for healing but also the dangers of diagnosis for the sake of the system




Q26 I intend to continue/begin working in Early Childhood Mental Health
Answered: 10 Skipped: 0
None of the above
Strongly agree
Agree
Neither agree nor disagree
Disagree
Strongly disagree
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%

For questions or additional information regarding this report, please contact the report developer:

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