MENTAL HEALTH SERVICES ACT ALAMEDA COUNTY

FY 2024-2025

ANNUAL PLAN UPDATE (APPROVED)

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: FY24-25 ANNUAL PLAN UPDATE

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alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

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MESSAGE FROM THE ACBH DIRECTOR

Welcome to Alameda County Behavioral Health Care Services (ACBH) Department's Fiscal Year (FY) 2024 - 2025 Mental Health Services Act (MHSA) Program and Expenditure Plan!

Fiscal Year 2024-2025 marks the second year of our current and final MHSA Three-Year Plan cycle under the existing MHSA regulations (FY 2023/24-2025/26). This Plan Update is an opportunity for ACBH to provide both fiscal and programmatic information, as well as to document changes from FY 23/24 and highlight key accomplishments. We are pleased to report that the programs and approaches included with our plan align with our department's highest vision for our services; our True North Metrics: *Quality, Investment in Excellence, Accountability, Financial Sustainability, and Outcome-Driven Goals.*

As the Director of Alameda County's Behavioral Health Department, I personally invite you and all of our many valued stakeholders to explore our newly developed Plan Update, and to provide public comment through our various forums. The voices of both our peers/those with lived experience and local community members, in addition to our data sources, affirm that our beneficiaries and communities are benefitting from our services and supports. While this Plan spotlights our accomplishments, we also recognize that there remains an ever-growing need for equitable and community focused behavioral health services, especially considering the unprecedented challenges of the past few years and the complex opportunities that lie ahead.

Given that the March 2024 ballot measure, Proposition 1, has now been passed by voters, this will be the final Plan that will be developed with new changes being considered and under the current structure of MHSA. Proposition 1 renames the MHSA to the "Behavioral Health Services Act (BHSA)," which will now include Substance Use Services as an approved population that may be served by these funds. Although no new funding will be provided to serve individuals with substance use conditions, the department will re-evaluate services to determine how best to meet this need and opportunity over the next several years. Additionally, the measure will expand reporting requirements, moves forward with the implementation of a behavioral health infrastructure bond, and changes funding categories (including the elimination of Prevention services as an allowable component as they will instead be administered by the state of California).

In future Plans, other changes associated with Proposition 1 will include a required increase of a specific type of client support referred to as Full-Service Partnership (FSP) programs and a shift in funding towards support related to housing. Internal planning has already begun to ensure that future plans are compliant with the new requirements related to BHSA and will continue in FY 2024-2025 given the pending changes, reductions, or elimination of previously supported programs required by June 30, 2026, to be implemented on July 1, 2026 with the beginning of the first BHSA Three Year Plan FY 2026/27-2028/29.

To ensure that the Alameda County community continues to be well informed, more information on community engagement opportunities will be announced in future months. ACBH team members approach this new Plan Update and fiscal year as an opportunity to assess our cumulative progress, as well as look toward and prepare for our future. Following an extensive community engagement process and ongoing internal system reviews, we continue to address four strategic priorities:

Infrastructure and Service Planning for Behavioral Health Continuum Infrastructure Program (BHCIP) projects, Care Courts, BHSA, Expansion of California's conservatorship laws (SB 43) and Peer Support Specialist Certification (SB803);

Workforce Engagement

Quality Improvement projects and New Programming (particularly for justice involved individuals and their families, the LGBTQI community and Early Childhood programming), and

Health Equity.

As we continue to face the challenges and opportunities of these extraordinary times, ACBH is here to support our peers/those with lived experience and family members while upholding the core values of MHSA: *Community Collaboration, Cultural Responsiveness, Consumer and Family Driven, Wellness Recovery and Resiliency, and Integrated Services.*

We invite your feedback and look forward to ongoing ways to promote partnership and community engagement. We are committed to continuously and competently improving our service delivery system, and we look forward to advancing the values, activities, and programs listed in this Annual Plan Update.

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

Sincerely,

Karyn L. Tribble, PsyD, LCSW, Director

Alameda County Behavioral Health Care Services

A Department of Alameda County
Health Care Service Agency

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 they represent.

BEST PRACTICES we value clinical excellence through the use of best practices, evidence-based practices, and effective outcomes, including prevention and early intervention strategies to 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.

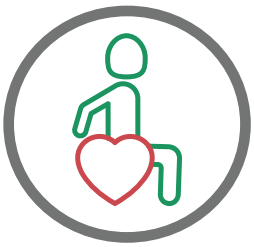
HEALTH & WELLNESS we value the integration of emotional, spiritual and physical healthcare to promote the wellness and resilience of individuals recovering from the biological, social and psychological effects of mental illness and substance use disorders.

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 use to engage our communities.

SOCIALLY INCLUSIVE we value advocacy and education to eliminate stigma, discrimination, isolation and misunderstanding of persons 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 choice, where they can live, learn, love, work, play and pray in safety and acceptance.

MHSA Guiding Principles

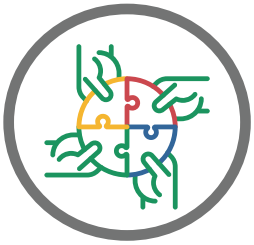
There are 5 principles which guide all MHSA planning and implementation activities:



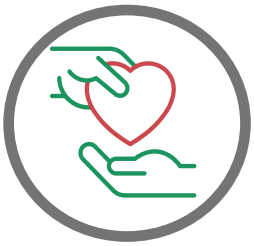
Cultural Competence
Services should reflect the values, customs, beliefs, and languages of the populations served and eliminate disparities in service access.

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.

Alameda County Behavioral Health Care Services (ACBH) is pleased to present the Mental Health Services Act (MHSA) Annual Update for fiscal year 2024-2025.

This Annual Plan Update ("*The Plan*") describes MHSA funded programs including: the program purpose; the monies allocated to fund these programs; and the measures taken to evaluate plan effectiveness and ensure that the programs meet the Mental Health Services Act requirements. The 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

The Mental Health Services Act is funded by levying a one percent tax on personal annual incomes exceeding one million dollars. Also known as Proposition 63, this act, passed by California voters in 2004, provides increased funding to support mental health services through five components described above for individuals with **both** mental illness **and** inadequate access to the traditional public mental health system.

Proposition 1: This Proposition was on the ballot in March 2024 and was passed by a small margin of 50.2% of California voters. The passage of Prop 1 has set in motion a significant level of change for the MHSA funding stream and for County Behavioral Health Departments.

Proposition 1: Passed in March 2024 Will Create Significant Changes To MHSA

Proposition 1 has two major components related to providing mental health care and drug and/or alcohol treatment to people, as well as addressing homelessness issues. This proposition:

- Changes the Mental Health Services Act that was passed by voters in 2004, with a focus on how the money from the act can be used. Under Prop 1 there is a wider service focus, and as such the name of the funding stream will change to the Behavioral Health Services Act (BHSA).
- Approves a $6.4 billion bond to build (1) more places for mental health care and drug or alcohol treatment and (2) more housing for people with mental health, drug, or alcohol challenges.

It should also be noted that as counties are initiating planning processes to begin adhering to the new BHSA regulations starting on July 2026, these new requirements *do not come with any new funding*. Alameda County, like all other California counties, will need to develop plans for expansion in some areas such as Full Service Partnerships, but will also need to reduce and/or eliminate services in other areas such as prevention, workforce, outpatient treatment and primary care coordination. Initial planning for service changes have begun internally at ACBH, with a much broader planning process planned for later in 2024. Implementation of BHSA will take place with the subsequent FY 26/27-28/29 Three-Year Plan.

Changes to Alameda's Annual Plan Update Process and Document Format

The Alameda MHSA Team has worked to update both our Community Program Planning Process (CPPP) and our reporting format in order to increase community feedback opportunities and provide the community reader with a revised format that is overall easier to read. The new vision for this Plan Update is that data and information is based in the idea that the information contained within it will be:

Easy to find *Easy to use* *Easy to understand*

Changes to the CPPP include:

- **Internal Data Review:** The MHSA Team decided to review relevant and existing behavioral health data with the CPPP Planning Committee, as opposed to its historical practice of starting from a blank slate with each community listening session. This allowed the community stakeholders to focus on *clearly identified* solutions and strategies for improvement; this in turn yields an overall asset mindset, versus a deficit focus. While the MHSA and CPPP Planning team prioritized reviewing local data needs and information, they were careful to include larger data trends in their assessment.
- **Introduction of Key Informant Interviews:** Using feedback from the MHSA Stakeholder Group, the MHSA Team conducted one-on-one key informant interviews across the County to increase its understanding of the needs of cities, and to generate new relationships with local city jurisdictions.
- **Use of Infographics, Color, Templates and Columns:** The MHSA Team utilized a variety of new formatting tools and practices to increase reading comprehension and understanding of the data and information within this Plan Update.
- **Increase in Performance Metrics:** The MHSA Team provided additional quantitative performance metrics per program where possible. Additionally, the MHSA Team and the ACBH Contracts unit have begun a partnership to develop new reporting templates for future years that will include the performance metrics listed in the CBO provider contracts.
- **Use of the Appendices:** To continue to adhere to all MHSA reporting requirements, and to provide as much transparency and background information as possible, the MHSA Team has continued its use of the Plan's Appendix section. This has helped to reduce in length the body of the Plan Update and made it easier to read and find information.
- **Increase in time dedicated to the Community Public Comment Period:** Based on feedback from the Alameda County Mental Health Advisory Board, ACBH will increase the public comment period from 30 to 45 days, which will allow additional time for community feedback.

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) 24/25, ACBH set aside up to $216,803,036 million in budget authority, which is just slightly higher than the previous fiscal year of 2023-24 at $189.2, but is 25% higher than the FY 22/23 budget. ACBH has been able to continue this positive budget trajectory due to increased allocation amounts from the State.

Furthermore, multiple factors also contributed to this carryover. Such factors include additional MHSA funding being released by the Department of Finance at the end of the previous fiscal when there is no time to spend these funds in their allocated year; workforce shortages and staff vacancies (at the county and CBO level); and slow project start-up due to braided funding where other funding sources such as Behavioral Health Continuum Infrastructure Program (BHCIP) funding have not yet been released. Also, there continues to be a general but continued slow ramp up of services and supports to pre-pandemic levels.

During 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 due to its two-year lag of final allocation amounts. While counties currently receive stable or increased allocations year over year, it remains important for ACBH to monitor the allocation estimates closely, and to adjust funding as needed to ensure that Alameda communities receive the maximum possible funding amount.

At this time, The Department of Finance has estimated that the FY 24/25 MHSA county allocation will be slightly lower than the allocation in FY 23/24, which was $176.8. However, the allocation in FY 24/25 is still estimated to be higher than FY 22/23. As such, MHSA revenue continues its upward, fiscally positive trajectory.

These increases, as well as the new information on Proposition 1, as well as any new information from the Governor's budget and/or California Legislature, will be reviewed on a regular basis within ACBH and shared during next year's Community Program Planning Process and ACBH budget process. ACBH strives to balance community need in collaboration with fiscal responsibility to avoid a fiscal "cliff," a condition where dramatic reductions will be needed. Rather, ACBH will proactively work to allocate to mental health services funding within Alameda County to the fullest possible extent. As an example of this accountability, ACBH has developed two budget workgroups: one for county staff and one for contracted provider/peers/family members. These workgroups meet to discuss MHSA spending strategies and guidelines, and then make recommendations 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[1] 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 20-member MHSA Stakeholder Group (MHSA-SG), 13- member CPPP Planning Committee (CPPP-PC) and other representatives to participate in the development of our Plans (see MHSA CPPP Annual Report).

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

Stakeholder Engagement	CPPP Communication Strategies	Procurement Process	MHSA Service Implementation
CPPP Planning Committee	County Website MHSA Website	Review community need data and develop program scope of work	Collaborate with ACBH Operations staff, service providers and stakeholders to establish performance measurements
MHSA Stakeholder Group	Social Media YouTube Podcast	Publish funding opportunity announcements	
Listening Sessions/ Key Informant Interviews	Public Relations Media Firms	Convene County Selection Committee Review bids	
Community Input Surveys	Stakeholder Outreach	Select qualified bidders	
45-Day Public Comment	Paid Advertisements		
Public Hearings	Online & Print Media		

The CPPP for the MHSA FY24/25 Update utilized inclusive community engagement strategies to enable Alameda County to reach diverse communities. The MHSA team communicated with more than 340 organizations in Alameda County to encourage their clients and extended community to participate in the CPPP. In addition to the CPPP outreach, the MHSA team conducted community engagement through the MHSA website, Listening Sessions, Key Informative Interviews, social media, stakeholder outreach, and the 45-day Public Comment period.

MHSA launched the CPPP activities between October 28, 2023-December 31, 2023, focusing on two mechanisms to capture community feedback: Community Input Survey and Listening Sessions. The Community Input Survey received 611 respondents and provided the opportunity for respondents to provide direct feedback to the MHSA team. The second component of the CPPP was the facilitation of 36 listening sessions throughout the county with a total of 394 participants. 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:

- Access to Services
- Peer Support
- Housing Interventions
- Specialized Support for Vulnerable Populations
- Youth Empowerment
- Stigma Reduction
- Cultural Sensitivity
- Workforce Support
- Trauma-Informed Work
- Data and Transparency
- Community Safety Initiatives
- Collaboration with Law Enforcement
- Crisis Support Teams

Program Update and Changes

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 targeting persons most challenged by serious mental illness were prioritized. These programs include, but are not limited to:

- 2nd Round of MHSA Community Investment Opportunities to help alleviate the workforce crisis;
- The continued transformation of the community-based Service Team and Case Management programs to Full-Service Partnership (FSP) model;
- Implementation of the TAY Forensic Focused Full-Service Partnerships;
- Implementation of the Early Childhood early intervention mental health expansion projects;
- Implementation and fiscal expansion of the Washington Hospital partnership pilot project to address emergency department challenges;
- Implementation of expanded crisis services (to meet the expectations set in the Alameda County Forensic Plan);
- Implementation of two new LGBTQIA+ early intervention youth populations, and
- Implementation and fiscal expansion of the Asian American and Pacific Islander (AAPI) Older Adult Pilot Program with the City of Fremont.

Examples of Performance/Client Satisfaction & Empowerment

The MHSA Team has reviewed a variety of quantitative performance metrics (defined by ACBH Systems of Care) as well as client satisfaction and empowerment outcomes to highlight the benefits of the MHSA funding stream.

Below are a few of the outcomes listed in the FY 24/25 Plan Update:

83% of Full Service Partnership (FSP) partners had more than one type of staff member visit within a two-week period. This metric captures if the FSP team is operating like a hospital without walls, i.e. a team approach to mental health service. The ACT Model benchmark is 60%.

79% of active FSP partners received at least one primary care visit within one year of their participation in the FSP (increase from 65% in previous FY).

70% of clients who were admitted to Amber House Crisis Stabilization program made a connection to outpatient behavioral health services within seven (7) days of discharge. The benchmark is 64% or greater.

73% of PEI clients responded positively to the survey question, "As a result of the services received, I am more prepared to seek out help when needed".

68% of PEI clients responded positively to the survey question, "As a result of the services received, "I have learned more ways to manage stress or emotional challenges".

Closing

In summary, ACBH has led a significant change process for both the CPPP activities and the development and publishing of our draft Plan Update.

This Plan Update is reflective of an ACBH-wide recalibration and incorporation of valuable stakeholder feedback with its mission alignment, communication, and organizational structure. Our goals are to create a basis for future efforts that represent a variety of stakeholder and community needs, such as culturally-relevant, clinically pragmatic, and community-centered support and care. We are pleased to present our process, plans, and commitment to the future of our county with you at this time!

Summary of Changes From Previous MHSA Plan Update (FY 23/24)

Alameda County Behavioral Health Care Services (ACBH) began implementation of its MHSA Plan in 2007 upon receipt of the approval of our Community Services & Supports (CSS) component plan by the California Department of Mental Health. 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 . The below programs are planned for implementation over the next several fiscal years. Small icons have been added to each summary to denote if a project is in the development phase, in process, or has been or about to be implemented.

 = in process

 = in development

 = about to be implemented

I. Community Services and Supports (CSS)

a. Continued analysis and transition of Service Team Case Management Model to Full Service Partnership Model Update
b. Transition Age Youth (TAY) Forensic Focused Full Service Partnership Update
c. Early Childhood Mental Health Services and Consultation program Update
d. Washington Hospital: Full Implementation of Pilot FY 23/24-FY 24/25
e. Asian American & Pacific Islander Older Adult pilot with City of Fremont Update
f. Safe Landing Re-entry Project
g. Assessment and Mapping

II. Prevention and Early Intervention (PEI)

a. New PEI/CSS blended program for LGBTQI youth/TAY Update

III. Innovations (INN)

a. Implementation of approved INN Program Update
b. Potential INN Programs under Development

IV. Workforce, Education and Training (WET)

No changes to the WET component from FY 23/24

V. Capital Facilities and Technological Needs (CFTN)

a. African American Wellness Hub Update
b. Electronic Health Record System Update

VI. MHSA Community Investment Opportunity: Second Round

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

I. Community Services and Supports (CSS)

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

In FY 24/25 ACBH will continue its fiscal and program analysis as well as incremental changes 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. The objective is 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 this transition completed by the end of FY 24/25 or early 25/26. With the passage of Proposition 1, ACBH will need to increase it's FSP capacity and the transition of the Service Teams will assist with this process.

As part of this transition, in FY 23/24 the Service Teams were 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 next steps of transition include increasing medical staff and co-occurring staff time as well as documentation training regarding the state required forms.

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.

Progress Information will be provided in the FY 25/26 Plan Update under FSP 23.

Transition Age Youth (TAY) Forensic Focused Full Service Partnership

In FY 23/24 ACBH implemented a new Transition Age Youth (TAY) Forensic, Diversion and Re-Entry FSP program that focuses on TAY that are justice involved including individuals who are in custody, on probation or in diversion programs. This FSP program is called Recovery, Independence with Support and Engagement (RISE) and 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.This program was awarded through a competitive request for proposals (RFP) process in early FY 23/24 to the community-based organization Bay Area Community Services (BACS). Progress Information will be provided in the FY 25/26 Plan Update under FSP 24.

Early Childhood Mental Health Service and Consultation Program

Through an official procurement process in mid FY 23/24 the Children, Youth & Young Adult System of Care (CYASOC) identified a new early childhood (birth to 8) mental health provider to support the work of mental health consultation and early intervention services through the work of peers, family partners, or other paraprofessional or adjunct staff. The provider for this new program is A Better Way.

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. Progress Information will be provided in the FY 25/26 Plan Update under PEI 1C.

Washington Hospital: Full Implementation of Pilot FY 23/24-FY 25/26

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 $2,000,000. The provider identified through an official procurement process to implement this program is the Portia Bell Hume Center. The pilot will run between mid FY 23/24 through mid FY 25/26. Before the 2-year pilot ends, the program will be analyzed and reviewed to determine program sustainability. Progress Information will be provided in the FY 25/26 Plan Update under OESD 25.

Funding to Plan and Implement Multiple ACBH Forensic Plan Programs Update

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 is using 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**: This project is still in process due to infrastructure issues and further review of utilization of the service data.
- **Overnight mobile crisis services**: This has been implemented with 24/7 coverage Sunday – Wednesday as of the end of 2023. The Crisis System hope to staff the 2nd half of the week by the end of the January 2025.
- **Overnight crisis support services**: This has been implemented with phone support 24/7, text is currently 18hrs with plans to expand to 24/7 the first quarter of 2024. Our Crisis Stabilization Units (Amber House and John George Pavilion) admit 24/7 as well.

Two other programs listed in the Forensic Plan have been implemented or are in process, including the TAY FSP and the new forensic focused Peer Respite program.

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 data will be included in the MHSA FY25/25 Plan Update.

= in process = in development = about to be implemented

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

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.

ACBH is working with our existing partners in the City of Fremont. They have hired three (3) additional bilingual full-time clinicians to provide Specialty Mental Health Services to the older adult AAPI community. This culturally specific program expansion allows 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 have begun providing 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. Once fully operational the clinicians will maintain an average caseload size of 35.

FY 23/24 service data on this pilot will be included in the MHSA FY25/26 Plan Update under OESD 4a.

Safe Landing Re-entry Project

Starting in FY 24/25 MHSA funding will be used to support the Santa Rita Jail Safe Landing pilot Project. This project is run by Roots Community Health Center (Roots) and began in January 2020. This is a three-year pilot intended to serve as a safe space to provide immediate release support services and connections to additional community resources for people released from Santa Rita Jail, especially for people with mental illness, co-occurring disorders, substance use disorders, or who are homeless or unhoused at time of release. Year three data (July 2022 to June 2023) highlight that 1,557 people were served at SLP (411 with a brief encounter and 1,146 for post release engagement). This is 156% of the contract goal of 1,000 individuals. Of the services provided, 50% were at the SLP trailer, 37% on the shuttle and 14% at both the SLP site and on the shuttle. In future Plans, this project will be listed under the OESD 37 workplan or Re-entry Treatment Teams.

Assessment and Mapping

ACBH is in the process of developing a system map that provides an overview of the Alameda County Behavioral Health System of Care. The map will illustrate how people with severe mental illness (SMI) or substance use disorder (SUD) can enter ACBH services, the programs and services available, and how people may move from one level of care to another. The intention is that the map will serve as a useful resource to support service navigation, care coordination, and decision-making among the general public, providers, and policy-makers. This mapping process is in response from community input and the Mental Health Advisory Board.

II. Prevention and Early Intervention (PEI)

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

ACBH conducted a public procurement request for two new LGBTQI youth and young adult early intervention programs. The two new providers for these services are Horizon Services and Side by Side. 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 begin implementation and program operation in summer 2024.

Services 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

= in process = in development = about to be implemented

set of early intervention services for LGBTQI youth and young adults. 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 Update

ACBH is currently 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 is being 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.

III. Innovation (INN)

Approval and Implementation 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.

INN 7: Forensic Alternatives: Clinical Focus

This approved project is in development and awaiting additional funds to be released from the Behavioral Health Continuum Infrastructure Program (BHCIP), as the Forensic Crisis Residential Treatment program is a combination of MHSA INN funds and BHBIP funds. 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.

This continuum of programs is currently being implemented.

New INN Programs under Development

ACBH is in the development phase of seeking input to develop and possibly join the multi- county MHSA INN project on Psychiatric Advance Directives (PADs). PADs is a self-directed document that details a person's specific instructions or preferences regarding future mental health treatment. A PAD plans for the possibility that an individual may lose the capacity to give or withhold informed consent to treatment during a mental health crisis.

Currently, there is a Multi-County Mental Health Services Innovation Collaborative pilot project for PADs. There are seven counties who are a part of this innovation project. The outcomes this project is looking to achieve are improved compliance; increased adherence to treatment requests; increase in individual wellness scores; reduction in incarceration/criminal justice involvement as a result of crisis; and reduction in long-term hospitalization. The website with more extensive information can be located here: https://www.padsca.org/

ACBH has surveyed stakeholders during its community planning process seeking interest and support. The results can be found in the CPPP section.

More information on the PADs project can be found in the INN section.

IV. Workforce, Education and Training (WET)

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

The ACBH WET unit are in the process of conducting a workforce needs assessment survey in quarter four of 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.

V. Capital Facilities and Technological Needs (CFTN)

African American Wellness Hub Update

Recognizing through both qualitative and quantitative data analysis that Alameda County African American community members are disproportionately diagnosed with mental illness, substance use and enter into both our mental health system and criminal justice system at higher rates County wide, ACBH has engaged in a planning and development process in order to identify how best to meet the needs of the African American population in an innovative and preventative way. As a first step, ACBH, in partnership with the Alameda County General Services Agency (GSA) department, is in the process of purchasing a property at 1912 MLK Way in Oakland for the development of the African American Wellness Hub Complex (HUB). The Hub will be designed to serve as a space where those in need of services may walk in and receive and benefit from consistent, reliable and welcoming services, in an effort to prevent crises, divert from more acute services and in order to collaborate with a team dedicated to equitable and culturally appropriate services. In preparation for the Wellness Hub services, the Office of Health Equity has conducted multiple listening sessions to better understand what types of services the community would like to see in the Hub once it' s open for operational services. Results from these listening sessions will be available later in the calendar year of 2024.

= in process = in development = about to be implemented

MHSA Technology Project (TN1) update under CFTN

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 legacy 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 workflow challenges and facilitate enhanced flexibility for data sharing. SmartCare was scheduled to go live on 07/01/2023, though has been somewhat delayed to early 2024.

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 2024. An informational update on this process will be shared in the FY 25/26 MHSA Plan Update.

VI. MHSA Community Investment Opportunity: Second Round

In FY 23/24 ACBHD developed a new, time-limited 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. This opportunity was highly successful in terms of increasing staff retention, creating comfortable, welcoming and safe facilities, increased technology capacity and increased access to services through expanded transportation.

Due to the success of the project and available MHSA and 2011 1x Realignment funding, ACBHD will offer a second round of capacity building grants for up to at total of $10,000,000 again.

Each contracted provider will be eligible to apply 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. More details will be provided in the RFPQ when it's released.

FY 2024/25 Mental Health Services Act Annual Update Funding Summary

County: Alameda Date: Date: 8/23/24

	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 2024/25 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	114,368,071	9,594,501	20,792,966	3,745,580	6,702,166	
2. Estimated New FY 2024/25 Funding	92,370,306	23,092,576	6,076,994			
3. Transfer in FY 2024/25[a/]	(19,500,000)			10,000,000	9,500,000	
4. Access Local Prudent Reserve in FY 2024/25						
5. Estimated Available Funding for FY 2024/25	187,238,377	32,687,078	26,869,960	13,745,580	16,202,166	
B. Estimated FY 2024/25 MHSA Expenditures	159,060,541	23,083,888	8,314,207	10,317,539	16,026,861	
G. Estimated FY 2024/25 Unspent Fund Balance	28,177,836	9,603,190	18,555,753	3,428,041	175,305	

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2024	14,593,038
2. Contributions to the Local Prudent Reserve in FY 2024/25	0
3. Distributions from the Local Prudent Reserve in FY 2024/25	0
4. Estimated Local Prudent Reserve Balance on June 30, 2025	14,593,038

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

FY 2024/25 Mental Health Services Act Annual Update
Community Services and Supports (CSS) Funding

County: Alameda

Date: 8/23/24

		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
FSP Programs							
FSP 3	Support Housing for TAY	3,332,950	2,393,391	939,559			-
FSP 4	Greater Hope Project	4,733,745	3,467,468	1,266,277			-
FSP 10	Housing Services	22,655,260	21,522,944	388,888			743,428
FSP 11	Community Conservatorship	780,614	780,614	-			-
FSP 12	Assisted Outpatient Treatment	845,666	845,666	-			-
FSP 13	CHANGES	3,863,220	2,683,006	1,180,214			-
FSP 14	STRIDES	3,860,338	2,782,146	1,078,192			-
FSP 16	Alameda Connections 0-8	1,121,109	832,311	288,798			-
FSP 17	East Bay Wrap 8-18	988,641	733,967	254,674			-
FSP 18	Homeless Engagement	5,134,784	3,616,942	1,517,842			-
FSP 19	North County Senior Homeless	3,882,817	2,882,603	1,000,214			-
FSP 20	Lasting Independence Forensic Team	3,532,544	2,618,322	914,222			-
FSP 21	Empowerment	1,766,267	1,215,015	551,252			-
FSP 22	Justice and Mental Health Recovery	5,244,536	4,577,332	523,945			143,260
FSP 23	Older Adult Service Team	14,303,756	8,658,410	5,645,346			-
FSP 24	TAY Forensic FSP	1,774,736	1,774,736	-			-
FSP 25	Care Court FSP	2,810,185	1,728,264	1,081,921			-
Non-FSP Programs							
OESD 4A	Mobile Integrated Assess Team for Seniors	1,173,998	630,202	543,796			-
OESD 5A	Crisis Response Program	15,271,563	11,962,469	2,819,489			489,605
OESD 7	Mental Health Court Specialist Program	1,095,881	909,747	128,830			57,304
OESD 8	Juvenile Justice Transformation of Guidance Clinic	192,745	121,622	48,186			22,937
OESD 9	Multisystemic Therapy	1,035,030	1,035,030	-			-
OESD 11	Crisis Stabilization Service	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 Disorders	4,458,491	4,458,491	-			-
OESD 18	Wellness Center	9,779,512	8,386,427	1,268,520			124,565
OESD 19	Medication Support Services	5,195,334	3,890,877	759,846			544,612
OESD 20	Individual Placement Services	6,954,964	4,755,037	1,659,453			540,474
OESD 23	Crisis Residential Services	1,926,866	1,537,226	373,854			15,786
OESD 24	Schreiber Center	423,999	267,543	106,000			50,456
OESD 25	Behavioral Health - Primary Care Integration Project	13,774,355	10,609,427	1,539,294			1,625,634
OESD 26AB	Culturally-Responsive Treatment Programs for African-American Community	807,587	784,458	23,129			-
OESD 27	In Home Outreach Team	5,480,718	4,249,177	1,231,541			-
OESD 28	SAGE Case & Care Management	2,968,615	2,809,380	159,235			-
OESD 30	Peer Respite	1,204,953	899,979	304,974			-
OESD 31	1st Onset	1,528,122	847,646	646,338			34,138
OESD 32	Suicide Prevention/Crisis Line	1,075,165	947,356	127,809			-
OESD 33	Deaf Community Counseling Services	328,153	301,482	26,671			-
OESD 34	School-Based Behavioral Health	368,050	368,050	-			-
OESD 35	Consultation	2,655,080	2,578,169	60,827			16,083
OESD 36	Presumptive Transfer Project	762,973	762,973	-			-
OESD 37	Re-entry Treatment Teams	5,665,377	3,306,740	2,337,843			20,794
OESD 38	SSI Advocacy & Support Services	2,513,823	1,280,477	228,649			1,004,696
OESD 39	Intensive Care Coordinaion Servcies	100,000	100,000	-			
OESD 40	Capacity Building Funds	651,139	651,139	-			-
CSS Administration		20,721,290	14,161,604	4,810,111			1,749,575
CSS MHSA Housing Program Assigned Funds		44,713	44,713	-			-
Total CSS Program Estimated Expenditures		205,367,979	159,060,541	39,124,090	-	-	7,183,347
FSP Programs as Percent of Total		50.69%					

FY 2024/25 Mental Health Services Act Annual Update
Prevention and Early Intervention (PEI) Funding

County: Alameda

Date: 8/23/24

		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	1,062,837	920,591	96,372			45,873
PEI 1B	School-Based Mental Health Access & Linkage in Elementary, Middle, & High Schools	1,095,156	1,095,156	-			-
PEI 1C	Early Childhood Mental Health Outreach & Consultation	1,040,319	1,000,000	25,236			15,083
PEI 1D	Unaccompanied Immigrant Youth Outreach	826,466	658,611	167,855			
PEI 4	Stigma & Discrimination Reduction Campaign	1,865,800	1,847,605	11,610			6,585
PEI 5	Outreach, Education & Consultation for Latino Community	1,886,931	1,155,368	731,563			-
PEI 6	Outreach, Education & Consultation for Asian Pacific Islander Community	3,130,088	2,516,464	535,484			78,140
PEI 7	Outreach, Education & Consultation for South Asian/Afghan Community	1,447,480	1,342,985	104,495			-
PEI 8	Outreach, Education & Consultation for Native American Community	353,500	223,942	96,152			33,406
PEI 9	Outreach, Education & Consultation for Middle Eastern Community	750,444	376,648	373,796			-
PEI 10	Outreach, Education & Consultation for African Community	353,381	288,536	64,845			-
PEI 12	Suicide Prevention/Crisis Text Line	2,134,994	1,982,775	152,219			
PEI 17AB	TAY Resource Centers	983,176	983,176	-			
PEI 19	Older Adult Peer Support	340,974	339,119	-			1,855
PEI 20A-G	Culturally Responsive PEI programs for the African American Community	2,666,722	2,517,472	140,543			8,707
PEI 22	LGBT Support Services	1,805,352	1,805,352	-			
PEI 24	Sobrante Park Comm Proj	350,000	350,000				
PEI 25	Trauma Informed Servcies	188,792	173,219	9,937			5,636
PEI 26	Mental Health Applications	308,999	308,999				
PEI 28	Community Prevention Programming	982,893	982,893				
PEI Programs - Early Intervention							
PEI 3	Mental Health for Older Adults, Geriatric Assessment & Response Team	1,374,881	874,837	343,720			156,324
PEI Administration		1,910,010	1,340,140	421,626			148,244
PEI Assigned Funds		-					
Total PEI Program Estimated Expenditures		26,859,196	23,083,888	3,275,455	-	-	499,853

FY 2024/25 Mental Health Services Act Annual Update
Innovations (INN) Funding

County: Alameda

Date: 8/23/24

		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	3,200,000	3,200,000	-			
INN 8	Forensic Alternatives: Peer Focused	2,524,649	2,524,649	-			
INN 10	Psychiatric Advance Directives	988,335	988,335	-			
		-					
		-					
		-					
		-					
		-					
		-					
		-					
		-					
		-					
		-					
		-					
		-					
		-					
INN Administration		336,999	237,441	69,970			29,588
Total INN Program Estimated Expenditures		8,413,765	8,314,207	69,970	-	-	29,588

FY 2024/25 Mental Health Services Act Annual Update
Workforce, Education and Training (WET) Component Worksheet

County: Alameda

Date: 8/23/24

		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 & Support	1,314,789	870,653	328,697			115,438
Action 2	Training/Technical Assistance	3,779,668	3,779,668	-			
Action 3	Mental Health Career Pathways	1,461,914	1,461,914	-			
Action 4	Residency/Internship	499,000	452,715	46,285			
Action 5	Financial Incentive	3,788,814	3,752,589	36,225			
WET Administration							
Total WET Program Estimated Expenditures		10,844,185	10,317,539	411,207	-	-	115,438

FY 2024/25 Mental Health Services Act Annual Update
Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: Alameda

Date: 8/23/24

		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
CFTN Program - Capital Facilities Projects							
CF2	Respite Bed Expansion	3,200,000	3,200,000				
CF5	AA Wellness Hub	5,000,000	5,000,000				
CF6	A Street Shelter Project	100,000	100,000				
		-					
		-					
		-					
		-					
		-					
CFTN Program - Technological Needs Projects							
TN1	Behavioral Health Management System	1,193,707	1,193,707				
TN3	County Equipment & Software Update	2,062,082	2,062,082				
TN4	Consulting Services	1,382,115	1,382,115				
TN5	Capacity Building Funds	1,220,997	1,220,997				
		-					
		-					
		-					
		-					
		-					
CFTN Administration		2,820,841	1,867,961	705,210			247,670
Total CFTN Program Estimated Expenditures		16,979,741	16,026,861	705,210	-	-	247,670

Demographics

The County of Alameda is diverse in its geography and its people. Alameda County comprises of urban cities, suburban communities, and rural areas. The diverse ethnic makeup of Alameda County is evident in each region, this diversity is reflected through people with different backgrounds and a variety of languages. The terrain varies considerably, ranging from swampy intertidal marshes and coastal plains along the western edge to dry, mountainous peaks and valleys along the rural eastern borders.

Occupying a large swath of San Francisco Bay's eastern shore, Alameda County is California's 7th largest county by population, and is the 21st-largest county in the United States. Within the Bay Area, it is the second-most populated county, second only to Santa Clara. Many industries and communities reside within its 739-square mile geography, including a large presence in the medical, technological, and travel logistics industries. The county boasts 14 cities, as well as 6 census-designated places and 16 unincorporated communities [1]. These communities vary greatly in their composition: the City of Oakland boasts a dense, urban environment, which contrasts starkly against the open and spacious fields surrounding Livermore. The terrain varies considerably as well, from swampy intertidal marshes and coastal plains along its western edge to dry, mountainous peaks and valleys along its rural eastern borders.

Alameda County also hosts a diverse group of people within its borders. Of its 1,628,997 residents, approximately half are under the age of 40 years old; roughly half are female (50.3%), and half are male (49.7%) [2], [3], [6]. No census-designated racial group forms a simple majority with respect to the population, and a significant number of folks identify as being of a multi-racial background, or of a background not indicated on simple Census data (*see Figure 1*) [4]. Approximately 30% of county residents identify as having Hispanic ethnicity [5]. While a majority (54.2%) of residents speak only English, a significant portion of the population (45.8%) primarily speaks another language, such as Spanish (15.8%) or an Asian-Pacific Islander (19.8%) (*see figure 2*) [7].

Figure 1.

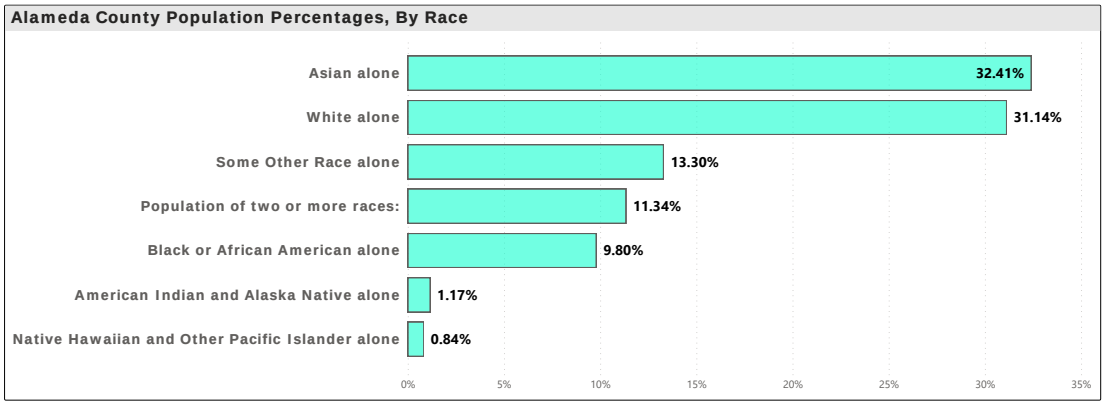
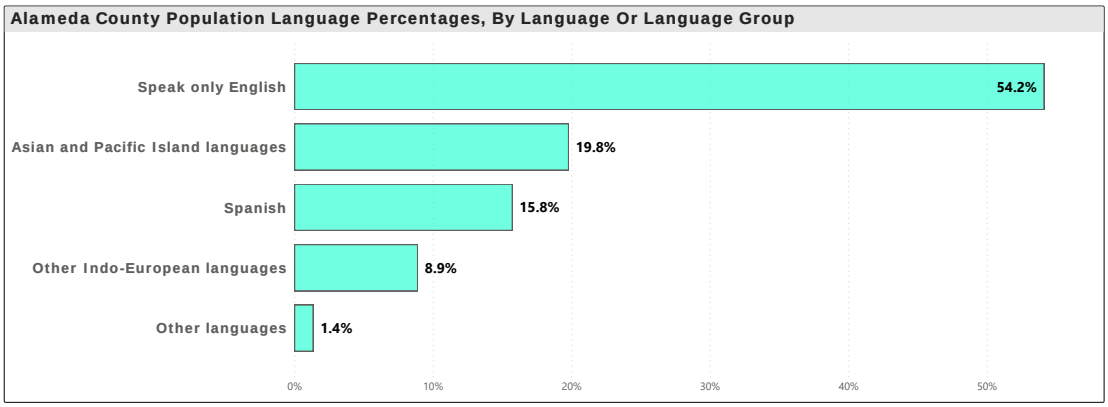


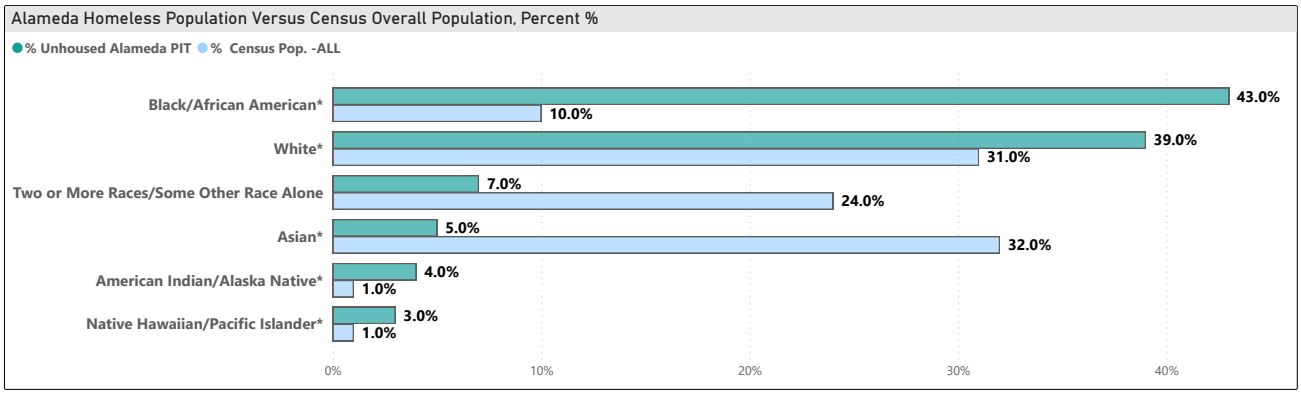
Figure 2.



Housing/Living Status

Alameda County is vast in geographical territory and population, hence there are areas of the county that have housing insecurities. Approximately 45% of the County lives in rented dwelling units; of those people renting, 48.9% pay more than 30% of their income to rent payments [8]. Additionally, 9.2 % of all individuals within the County live below the Federal poverty level, with 9.4 % of under the age of 18 living below this line [9]. Of the five core Bay Area counties[1], Alameda has the second highest poverty rate [9]. Almost 10,000 people have been identified as being homeless, in either an unsheltered (7,135) or sheltered (2,612) state [10]. According to the 2022 Point-In-Time Homelessness count, data indicates an over-representation amongst all races (meaning that these categories were found at higher populations relevant to the entire county Census population), with Asian people being the only racial group to differentiate from this trend (*see Figure 3*) [10].

Figure 3.



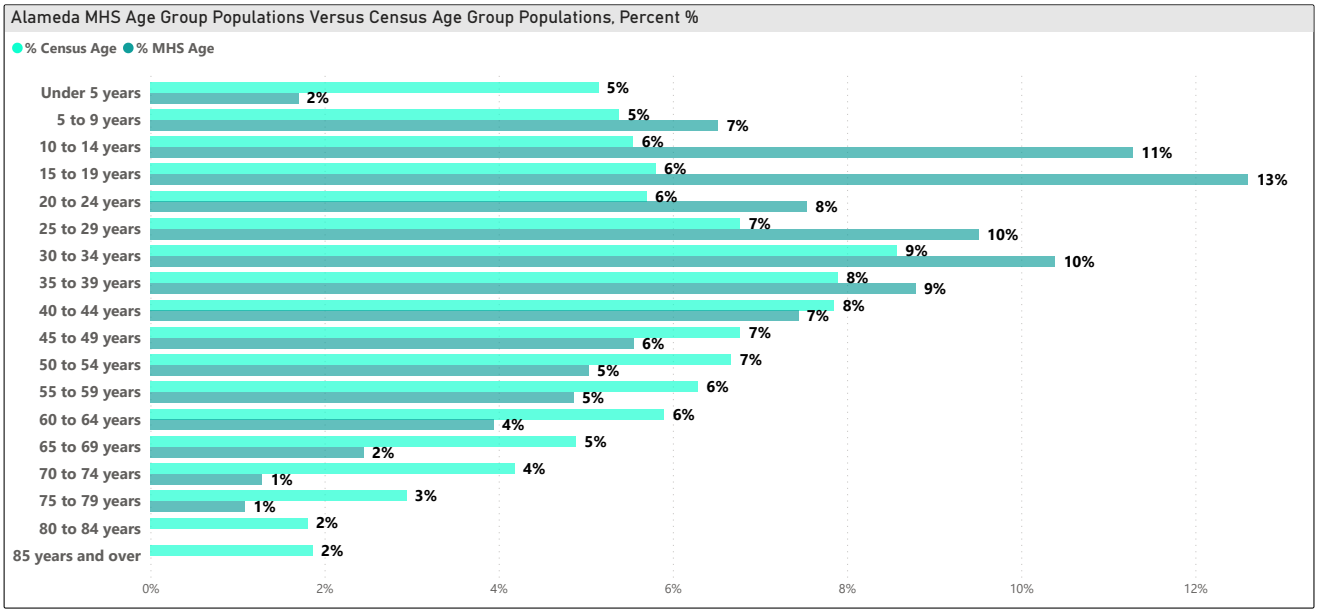
"*" *Denotes persons as identifying as one race only.*

1 Alameda, Contra Costa, Marin, San Francisco, and Santa Clara Counties.

Mental Health Challenges/Needs

In addition to these habitability issues, Alameda County residents also struggle with mental health challenges. Approximately 18.3 % of county households report some family impairment stemming from mental illness [11]. More than 1 in 5 Alameda residents (21.6%) state that they need mental health help, and almost 11% experience serious psychological distress [11]. The need for mental health services appears to be particularly acute for younger persons: person between the ages of 10 and 19 years old comprise 12% of the Alameda County Mental Health Services utilization population, but only roughly 6% of the Census-based population (*see figure 4*) [12].

Figure 4.



Additionally, data collected by both Alameda County and the California Department of Health Care Services (DHCS) suggest a clear need for mental health services, particularly amongst persons from diverse language and ethnic backgrounds, as well as persons under 21 years of age. Using DHCS-set prevalence rates as benchmarks, one can compare these against Alameda County Medi-Cal penetration rates to estimate whether mental health needs are being met with respect to given population groups[2]. For persons under 21 years old, the California prevalence rate for "serious emotional disturbances (SED)" is 7.00%; none of the identified Alameda County language groups surpass this threshold (*see figure 5*). Similarly, only two identified ethnic groups — persons identifying as either Alaskan Native/ American Indians or Black/African American— have Medi-Cal penetration rates that surpass the DHCS SED prevalence rates. In fact, the Medi-Cal penetration rates for the "under 21 years" age group as a whole fall below this benchmark (*see figure 6*) [12] [13]

Figure 5.

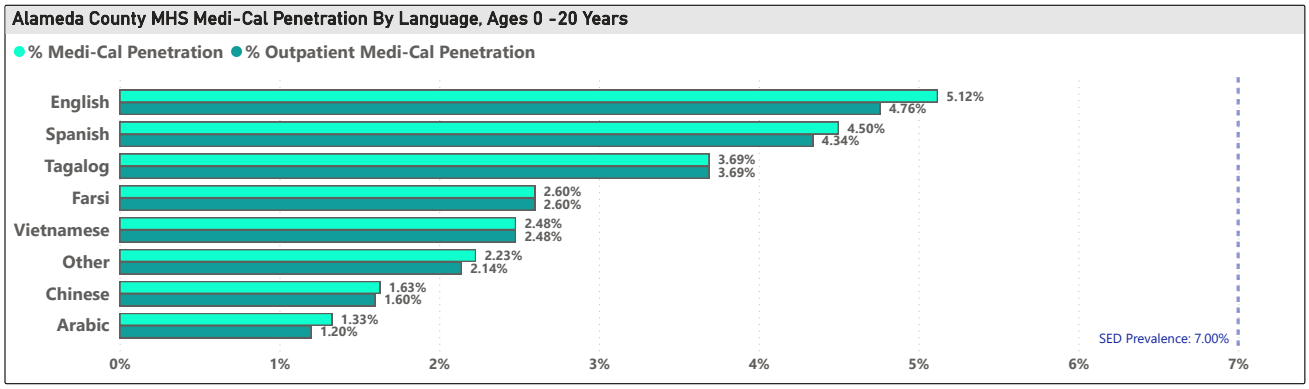
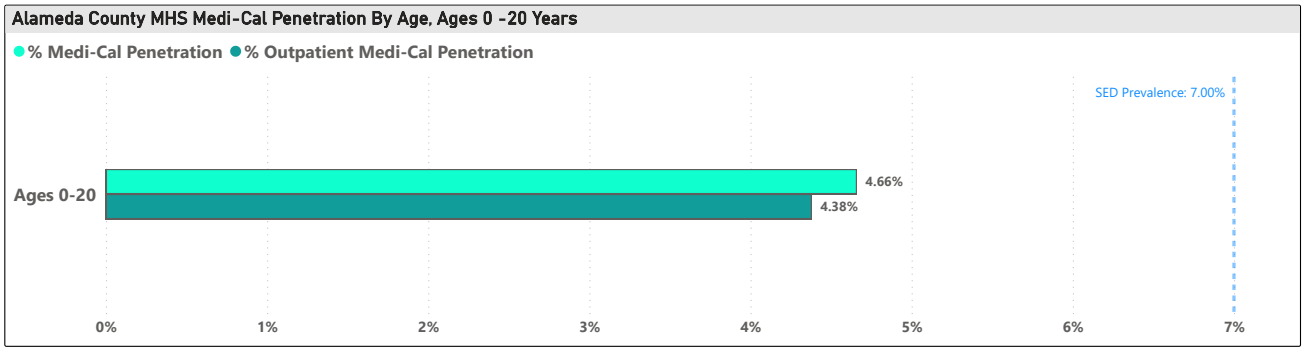


Figure 6.



2 California behavioral and public health professionals typically use county-level Medi-Cal penetration rates as a proxy value for behavioral and mental health illness prevalence levels with respect to their consumer populations.

Regarding persons 21 years of age and over, the data reflects a more nuanced reality. For language group Medi-Cal penetration rates, two languages (English and Farsi) exceed the "serious mental illness (SMI)" 4% prevalence threshold, although the rest of the identified group fall below this line (*see figure 7*). With respect to ethnic group Medi-Cal penetration rates, roughly half of the identified groups exceed the state SMI prevalence rate (*see figure 8*). Overall Medi-Care penetration rates for this age group approximately meet the SMI benchmark, although the outpatient Medi-Cal penetration rate (2.86%) is still below the 4% prevalence level. [12] [13]

Figure 7.

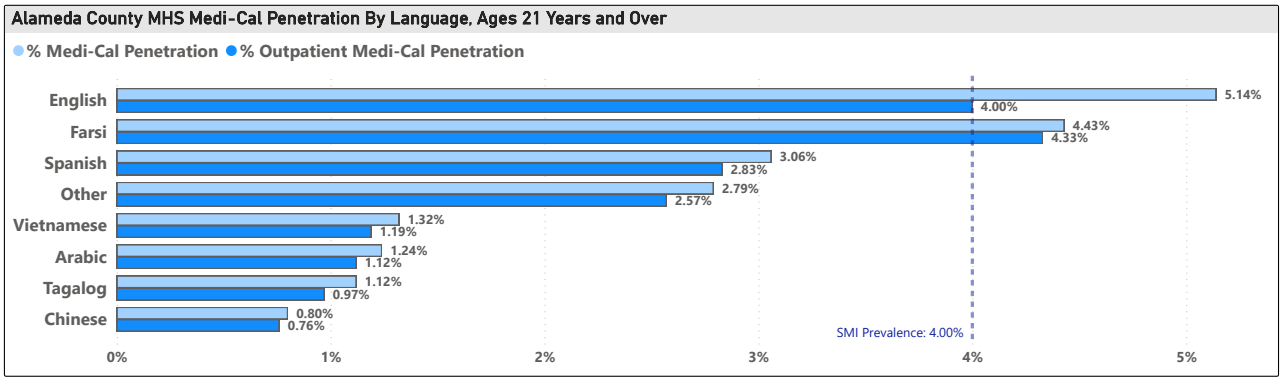
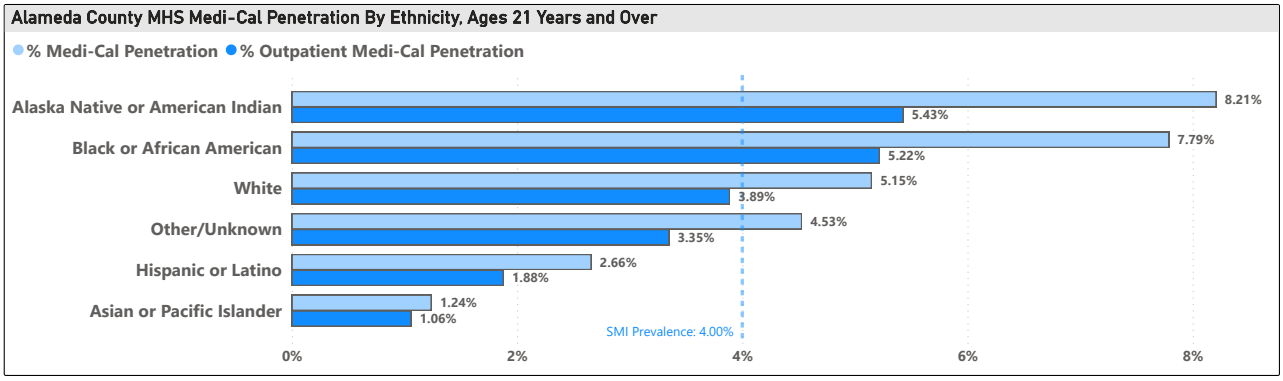


Figure 8.



Using data gathered from previous MHSA Plans and their associated updates, the Alameda County MHSA team has identified 11 areas of need related to the disparities noted above, and to other mental health challenges not discussed in this section. The Community Program Planning Process (CPPP), discussed in detail in the following sections, incorporates stakeholder input to align these needs with tangible, community-driven solutions to address these challenges. These strategies will be worked into existing MHSA programs in three different component areas: Community Supports and Services (CSS); Innovative Programs (INN); and Prevention and Early Intervention. The roughly 71 workplans articulated in these three program areas collectively serve approximately seventy thousand individuals, with robust budgets of nearly $150 million dollars (*see Table 1*) [14]. The promise of fresh, stakeholder-driven strategies to address mental health needs, coupled with practices implemented by MHSA-funded programs during the past years, will help ensure that Alameda County will meet its present and future mental health challenges with ever-increasing success.

Table 1.

MHSA Component	Clients Served (Estimate)	Work Plans	Budget
PEI	44,004	27	$20,826,170
CSS	22,253	43	$121,948,435
INN	1,898	1	$5,489,258
Total	**68,155**	**71**	**$148,263,863**

Above is information on clients served by component, number of workplans per component and the overall budget. Cost per client is listed in each of the program summaries within each particular component.

MHSA Community Program Planning Process (CPPP)

Senior Planner Noah Gallo engaging the Latino community during a toy giveaway in Oakland's Fruitvale neighborhood. Historically, this community has been underrepresented in outreach activities.

The MHSA Community Program Planning Process is an important component of the Mental Health Services Act. The CPPP focuses on acquiring community input to help shape Alameda County's mental health planning. The CPPP utilizes community engagement strategies to encourage the participation of community stakeholders from all regions of the county to ensure inclusion and diversity in identifying the community mental health needs and priorities.

The CPPP Process for the MHSA Update (FY24/25)

The Community Program Planning Process (CPPP) for the MHSA Update (FY24/25) was conducted October 28, 2023 - December 31, 2023. The yearly community input process guides MHSA to fund programs that are culturally responsive, accessible, and to ensure that services align with requests by consumers, families, and stakeholders. MHSA engages stakeholders in various marketing & outreach efforts: flyers, listening sessions, community survey, workgroups, social media, community events, street outreach, newsletters, email campaigns, and planning panels so that the MHSA Update (FY24/25) is inclusive of the community perspective. Clients, Staff, and family members involved in behavioral health treatment are essential to this process, Alameda County ensures we receive their feedback throughout the CPPP.

Communication Strategies	• ACBH & ACMSA website • Various Outreach channels • Inclusive feedback strategies
Advisory Committee	• Identify priorities • Monitor Implementation • Provide continous feedback
Program Planning	• Assess needs & develop service models • Review program proposals • Select qualified providers
Program Implementation	• Collaborate with participants to establish goals • Peer engagement in program governance • Stakeholders & consumers input for program planning/monitoring
Evaluation	• Peer & family engagement in evaluation efforts • Collect & analyze data on participant satisfaction • Data influencing decisions on programs and allocated funds

The CPPP Process for the MHSA Update (FY24/25)

August 2023 - September 2023

- Review regional strategies, evaluations, and reports
- Utilize MHSA Stakeholder Group and CPPP Committee to Plan and implement community input process

October 2023 - January 2024

- Listening Sessions
- Key Informant Interviews
- Community Input Surveys

February 2024 - June 2024

- 45-Day Public Comment
- Public Hearing at the Alameda County Mental Health Advisory Board
- Board of Supervisors Health Committee Presentation
- Board of Supervisors approval
- Departmental implementation

IDENTIFY NEEDS

The Community Program Planning Process (CPPP) for the MHSA Update (FY24/25) was conducted October 28, 2023 - December 31, 2023. The yearly community input process guides MHSA in funding programs that are culturally responsive, and accessible, ensuring that services align with requests from consumers, families, and stakeholders.MHSA engages stakeholders in various marketing & outreach efforts: flyers, listening sessions, community survey, workgroups, social media, community events, street outreach, newsletters, email campaigns, and planning panels so that the MHSA Update (FY24/25) is inclusive of the community perspective. Clients, Staff, and family members involved in behavioral health treatment are essential to this process, Alameda County ensures we receive their feedback throughout the CPPP.

The data analysis led to the MHSA team creating a list of 11 categorized areas of community needs. The MHSA team utilized the categorized needs to standardize conversations with community members, staff, stakeholders, and civic leaders. Participants were then asked to provide a ranking of the 11 categorized areas of community need and to offer *strategies and solutions* to improve MSHA gaps in community services. See Appendix B-4 for a list of data sources used by the MHSA team.

COMMUNITY FEEDBACK

The Community Feedback phase - MHSA CPPP applies an inclusive methodology of community engagement to utilize a range of strategies to gather diverse opinions. The MHSA team conducted a series of Listening Sessions, Key Informant Interviews, and a multilingual Community Input Survey. The MHSA Senior Planner also led community Listening Sessions and Key Informative Interviews in English and Spanish; this was done to provide a voice to diverse groups in different regions of the county. The purpose of the listening sessions and key informant interviews was not to provide service information, advice, or solve systems issues; rather, these open dialogues created a vehicle for participants to learn more about MHSA and partake in facilitated discussions to add more context to needs and to offer recommendations to gaps in services. To help standardize conversations and the survey, participants were provided definitions of the 11 categorized areas of community needs to vote on their top rankings and then to provide strategies and solutions to these areas of need.

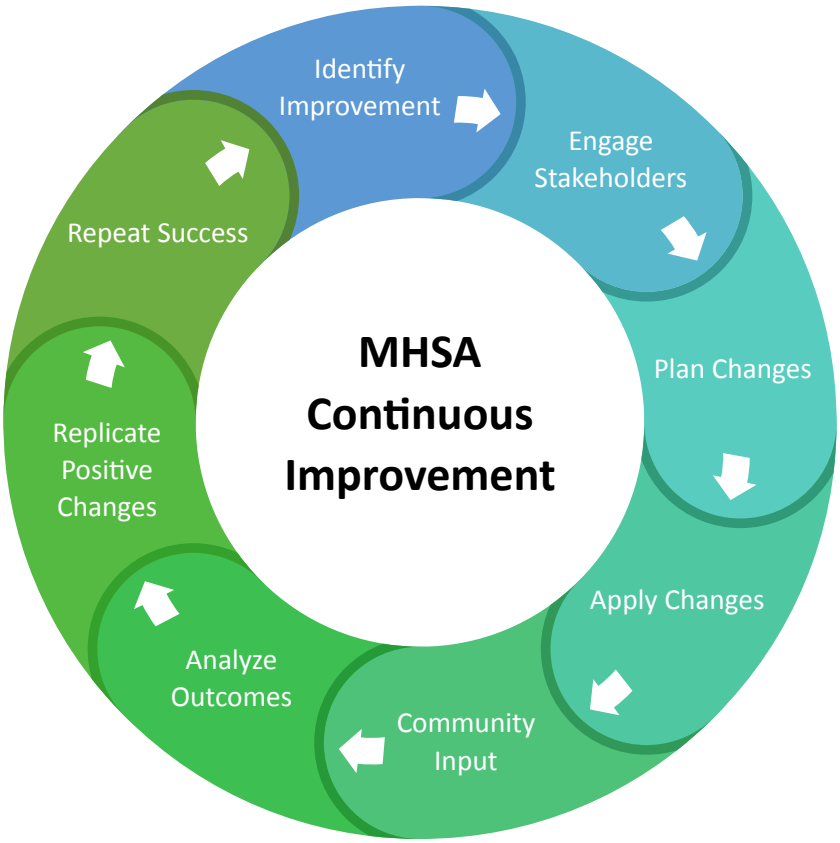
Below are the actions the MHSA team took to employ an inclusive CPPP:

1. Listening Sessions – The MHSA team conducted 23 Listening Sessions (LS). The MHSA team identified key community groups based on their strategic representation of our client base and community. Examples of the Listening Session groups: mental health groups, veterans' groups, senior citizens groups, family groups, Transitional Age Youth groups and other groups spanning the different demographic makeup of Alameda County. Additionally, a Demographic Survey was used to capture insights and demographic profiles from the Listening Session participants.

2. Key Informant Interviews – The MHSA team conducted 13 Key Informant Interviews (KII). The MHSA team utilized a new tactic to community engagement for the MHSA FY24/25 Update Plan and led interviews with leaders from city governments, clinics, agencies, and nonprofits. The objective was to have interviews with individuals in leadership positions that are knowledgeable of their community's needs. We strategically sought interviews with leaders from entities in different regions of the county to gain a better understanding of the demographics of their region of Alameda County. A full list can be seen below in **Table 4.**

3. **Community Input Survey** – the MHSA team conducted an 18-question survey that was available in digital format and paper format. The survey was shared with consumers, Alameda County residents, community leaders, nonprofits, clinics, mental health groups, advertised on social media and with Alameda County employees. The survey was offered in English, Spanish and Chinese. The Community Input Survey is available in Appendix B5.

MHSA FY24/25 UPDATE



The MHSA FY24/25 Update Phase - The MHSA Update (FY24/25) was created and written by the ACBH MHSA Division and the Finance team. The plan was approved by the ACBH Executive Leadership, planning, and fiscal staff in consultation with the ACBH MHSA Stakeholder Group. The ACBH MHSA method for the CPPP provides a variety of opportunities for consumers, peers, family members, providers, community members, and other stakeholders to participate in the development of our planning efforts. ACBH posted the plan on two websites: http://www.acbhcs.org/mhsa-doccenter/ and https://acmhsa.org/reports-data/#mhsa-plans on April 1, 2024 for forty five (45) days for public comments. The circulation of the MHSA Update (FY24/25) will be done numerous times beginning April 1, 2024, and listed in Alameda County Health Care Services Agency newsletter on April 13, 2024. To increase awareness and outreach about the plan, targeted emails were sent out to various Stakeholder Groups (Mental Health Advisory Board, Alameda County Consortium of Mental Health providers. **(please see Appendix B-1 Outreach Plan).**

These community engagement methods enabled Alameda County residents to express their opinions, needs, and requests of the mental health services Alameda County offers. The MHSA Team gathered community input with transparency, discretion, flexibility, and community focused solutions. The MHSA Team analyzed the data from the various community input strategies to provide insight to ACBH leadership and the public, the analysis can be seen below. Lastly, the MHSA Team directed the CPPP to access the community's input and encourage community support to improve the mental health programs and services that Alameda County offers. Below is a list of the 11 Categorized Areas of Community Need and definitions:

Categorized Areas of Community Need in Alameda County

1. Access, Coordination and Navigation to Services – this category captures the needs of diverse cultures and identities such as race/ethnicity, language, LGBTQIA+, veteran status and age related to accessing/finding/navigating to mental health and substance use services, including community knowledge and education, language capacity and culturally responsive approaches to engaging communities. There is also a need for successful connection to services after an emergency

2. Behavioral Health Workforce – this category captures the needs related to recruiting, developing, supporting and maintaining a sufficient clinical and peer/family member workforce to address the needs and the diversity of the community. This includes a workforce that looks like the community it serves and provides services in a communities languages so clients can be served in their native languages. This category also captures the Provider Support needs around training/core competencies burn out, high turnover and vicarious trauma.

3. Crisis Continuum – this category captures needs related to mental health and substance use crisis response and with an emphasis on non-law enforcement response, as well as appropriate community-based supports, early assessment of suicide risk, and stabilization during and after a crisis.

4. Housing Continuum – this category captures the housing needs for individuals living with behavioral health challenges ranging from prevention of becoming unhoused, housing navigation, and supports needed to maintain housing. This is particularly needed for those living with disabilities and older adults, who may be facing becoming unhoused for the first time.

5. Substance Use – this category captures the increasing need for substance use services and supports that are accessible, integrated and coordinated with mental health services.

6. Community Violence and Trauma – this category captures gun violence, domestic violence, human trafficking, gang violence, immigration trauma, poverty, pervasive racism and homophobia, family conflict and stress, school safety and bullying, and post-traumatic stress disorder (PTSD).

7. Child/Youth/Young Adult Needs – this category captures mental health and substance use challenges for school to transition-age youth ages 6-25, it also includes specific needs of children 0-5 and their families, respite services, ongoing increased suicide rates, youth runaways, juvenile justice involvement, human trafficking, gang violence, lack of support on how to access services, needs of LGBTQ+, pervasive racism, needs of bi-cultural children, lack of training on the part of schools for students with MH challenges.

8. Adult/Older Adult Needs – this category captures mental health and substance use challenges for adults and older adults including social isolation, depression, complex chronic health issues (including Alzheimer's and dementia), general poor mental health outcomes for those living with a severe mental illness, suicide rates, alternatives to incarceration, pervasive racism, LGBTQ+, immigration stress, gun violence, elder abuse, traumatic impact of social unrest-fear, in particular for Asian communities.

9. Needs of Family Members – this category captures the ongoing stress, frustration and isolation family members can feel in taking care of their loved ones in a healthcare system that is mainly a "fail first" system, especially for loved ones with severe mental illness and episodes of anosognosia. Numerous navigation issues, especially related to the criminal justice system. High need for 24/7 access to inpatient and outpatient psychiatry services. Suicide (and how this effects the family and entire communities) lack of understanding about Child Protective Services (CPS), intergenerational trauma, and immigration trauma.

10. Needs of Veterans – this category captures the mental health and housing needs of Veterans: OaklandBerkeley/Alameda County has the 4th highest number of homeless veterans, and second highest (78.8%) percentage of unsheltered homeless veterans in California. Veterans have a higher rate of poor mental health compared to nonveterans and women veterans have a poorer mental health compared to their male counterparts, in particular due to military sexual assault trauma. Additional needs include high suicide rates (1618/day), stigma, lack of navigation support, lack of focused veteran groups for non-VA (veterans association) connected individuals and the aging veteran population who are older, sicker and more isolated. There is also a misunderstanding that not all veterans are eligible for VA services. In addition to these needs for American veterans, veterans of other countries also have significant needs around problem solving and healthy coping mechanisms.

11. Needs of the Re-entry Community for both Adults and Youth – this category captures the mental health, substance use, housing and employment needs of this community. Difficult to navigate uncoordinated and complicated systems to receive both behavioral and physical health services. Stigma, a high need for services to be provided by people who reflect this community and have lived experience with being justice involved. Additional needs in the areas of: focused treatment for sex offenders (housing, prosocial rehab services etc.). Lack of MH supported recovery residences, cooccurring treatment and focused job training. Needs of specific communities (LGBTQ+, immigrant, communities of color). Housing assistance and support services for those with disabilities to live independently.

Summary of Areas:

Access, Coordination and Navigation to Services

Behavioral Health Workforce

Crisis Continuum

Housing Continuum

Substance Use

Community Violence and Trauma

Child/Youth/Young Adult Needs

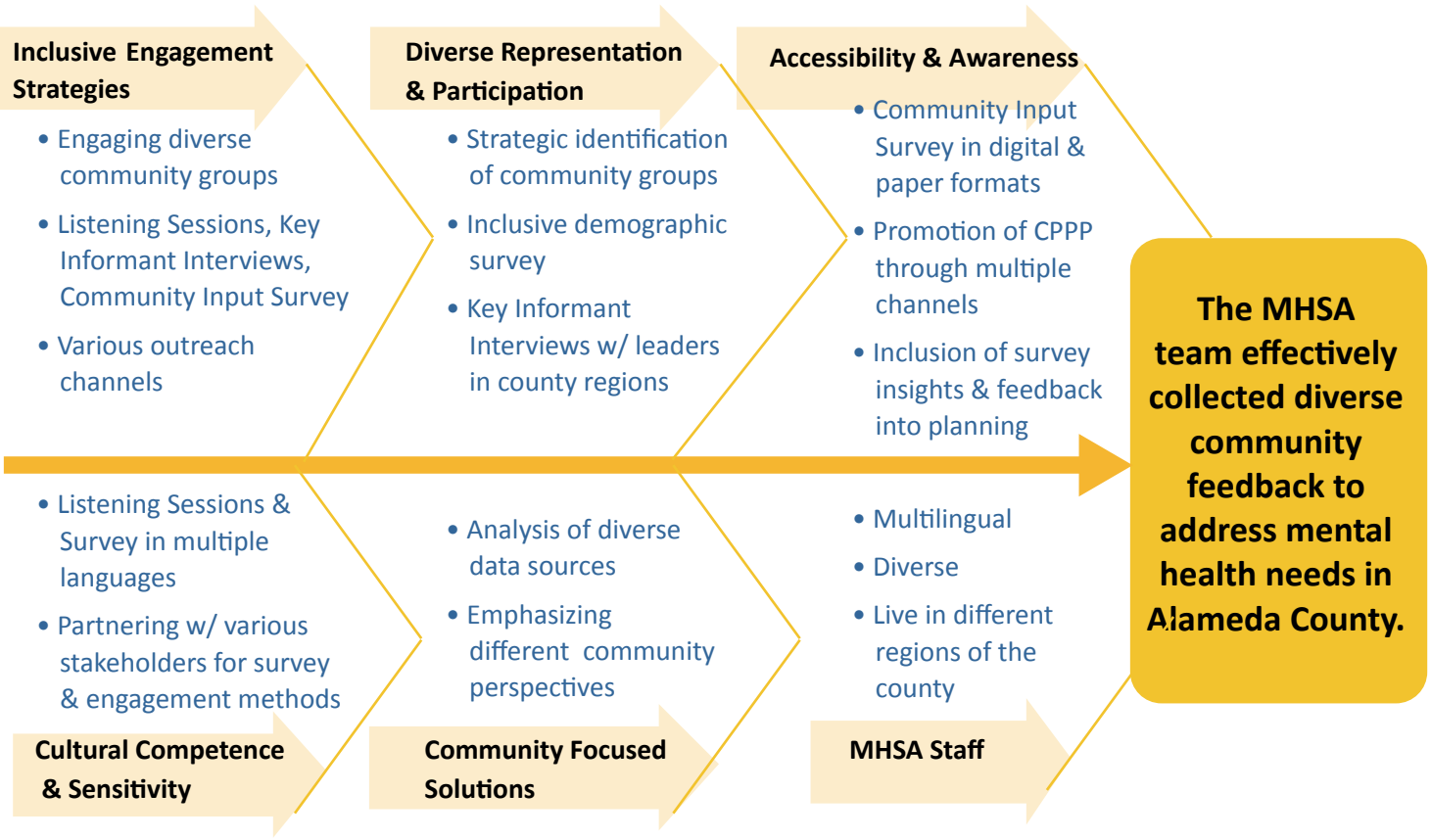
Adult/Older Adult Needs

Needs of Family Members

Needs of Veterans

Needs of the Re-entry Community for both Adults and Youth

CPPP Inclusive Strategies



Community Program Planning Process Planning Committee

The MHSA CPPP Planning Committee (MHSA CPPP-PC) consisted of 13 members of ACBH employees and Community Stakeholders that met regularly to guide and discuss CPPP activities. The MHSA CPPP-PC provided input, expertise, and their professional network to ensure the continuity of services and administrative transparency for all community outreach efforts, which included:

• Endorsing CPPP outreach plan.

• Participating in CPPP activities (such as listening sessions).

• Approving CPPP assessment instruments.

• Coordinating with mental health groups to increase CPPP stakeholder engagement. The CPPP-PC participated in a total of 6 biweekly planning meetings.

Table 2: MHSA FY24/25 Update Plan CPPP Committee Roster

(see Appendix A-2 for the MHSA Meeting Calendar)

Name	Organization/Program Unit	Seat/Role
Tracy Hazelton	MHSA, Division Director	Alameda County
Robert J. Williams	Health Human Resource Education Center (HHREC), MHSA Program Manager	Committee Support/Facilitator
Odessa Caton	MHAAC Family Education Resource Center (FERC), Director	CBO Provider, representing Family Members
Noah Gallo	MHSA, Senior Planner	Alameda County
Mona Shah (MSW)	Health Equity Policy and Systems Manager/ Interim Office of Ethnic Services, Administrator	Alameda County
Mark Walker	Swords to Plowshares, Deputy Director of East Bay Programs, MHSA Stakeholder Group Member	Veterans
Ingrid Chung (LCSW)	Asian Health Services, Clinical Program Manager	CBO Provider, representing Asian American Communities
Gina Lewis	MHSA Stakeholder, Family Member/Peer Advocate	Family Member/Peer Advocate
Gavin O'Neill	Superior Court of California, County of Alameda, Collaborative Courts, Principal Analyst	Collaborative Courts, Justice Involved Individuals
Eleni Spiru	Swords to Plowshares, Community Engagement Liaison	Veterans
Danielle Guerry (LMFT)	Telecare Alameda Court Collaborative Program, Clinical Director	Collaborative Courts, Justice Involved Individuals
Carole Wang	Mental Health Association for Chinese Communities (MHAACC), Sr. Deputy Director	CBO Provider, representing Asian American Communities
Brian Godwin	MHSA, Data Analyst	Alameda County

MHSA Stakeholder Group

ACBH recognizes the need to have the community involved in the planning process for MHSA related activities. ACBH is committed to being inclusive of all stakeholders, family members, and community members who wish to participate in the planning process and in stakeholder groups in accordance with WIC § 5848 and California Code of Regulations (CCR) § 330.

The MHSA Stakeholder Group is a group of 20 mental health peers with lived experience, family members, providers and other key constituencies. This group has met 7 times in 2023 with the goal of advancing the principles of the MHSA. During meetings the group provides recommendations to the transformation of the mental health system in Alameda County. The meetings are open to the public to attend and provide comments and discussion. 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.
- Communicating with relevant mental health constituencies.

Table 3: MHSA FY24/25 Update Plan MHSA SG Roster

(see Appendix A-1 for the MHSA Meeting Calendar)

Name	Seat/Role	Title/Affiliation
Aaron Chapman	ACBH – Agency Leadership	ACBH Medical Director
Annie Bailey	Provider	City of Fremont Youth & Family Services Division Administrator
Carissa Samuel	Provider-TAY Student	UC Berkeley Student/ Former Ohlone College Mental Health Ambassador
Carole Wang	Consumer/Family Member	Mental Health Association for Chinese Communities (MHACC)
Dr. Karyn Tribble	ACBH - Agency Leadership	Behavioral Health Director
Elaine Peng 彭一玲	Peer with lived experience/ Family Member	Mental Health Association for Chinese Communities (MHACC)
Gina Lewis	Family Member/MHAB Member	Peer Advocate
James Wagner	ACBH- Agency Leadership	Deputy Behavioral Health Director
Jeff Caiola	Peer with lived experience	Recovery Coach
Kate Jones	ACBH - Agency Leadership	Adult & Older Adult System of Care Director
Liz Rebensdorf	Family Member	President, National Alliance on Mental Illness (NAMI)- East Bay
Margot Dashiell	Family Member	Alameda County Family Coalition, African American Family Support Group
Mark Walker	Provider	Associate Director of East Bay Programs, Swords to Plowshares
Noah Gallo	ACBH- MHSA	MHSA Senior Planner
Shawn Walker-Smith	Family Member	Business Owner
Stephanie Montgomery	ACBH - Agency Leadership	Health Equity Division Director
Terry Land	Family Member/MHAB Member	Scientist
Tracy Hazelton	ACBH - Agency Leadership	MHSA Division Director
Viveca Bradley	Peer with lived experience	Mental Health Advocate

Table 4: Listening Sessions and Key Informant Interviews

(see Appendix B-4 for transcripts)

	Date	Region	Children	TAY	Adults	Older Adults	Additional Population Characteristics
ACBH Cultural Response Committee	11/21/2023	County			X	X	Providers
ACBH Pride County Coalition	12/6/2023	County			X	X	LGBTQ
African American Family Outreach Project	10/2/2023	Oakland			X	X	Adults, Older Adults
Alameda County Fatherhood Support Group	12/4/2023	County	X	X	X		Fathers
Alameda/Contra Costa Medical Association	1/4/2024	County					Providers
Ashland Cherryland Food and Basic Needs Coordination Meeting	1/9/2024	Castro Valley, Hayward, San Lorenzo	X	X	X	X	Providers, Education, Community
Asian Health Services TAY Group	11/29/2023	Oakland		X			TAY Group
Axis Community Health	11/20/2023	TriValley	X	X	X	X	Providers
Bay Area Community Services	12/8/2023	County	X	X	X	X	Community Services
CARES Alameda	12/21/2023	Alameda	X	X	X	X	Providers
Casa U English Speaking	10/24/2023	Oakland			X	X	Adults, Older Adults
Casa U Spanish Speaking	10/24/2023	Oakland			X	X	Adults, Older Adults
City of Alameda	11/30/2023	Alameda	X	X	X	X	City Leadership
City of Fremont	11/8/2023	Fremont	X	X	X	X	City Leadership
City of Livermore	11/17/2023	Livermore	X	X	X	X	City Leadership
City of Oakland	11/13/2023	Oakland	X	X	X	X	City Leadership
City of San Leandro	11/16/2023	San Leandro	X	X	X	X	City Leadership
CPPP Committee Members Listening Session		County			X	X	Consumers
Family Advocating for the Seriously Mentally Ill (FASMI)	1/12/2024	County	X	X	X	X	Consumers, Families
Family Education & Resource CenterEnglish	11/3/2023	County			X	X	Family Services
Family Education & Resource CenterSpanish	12/18/2023	County	X	X	X	X	Family Services
First 5 Alameda County	12/4/2023	County	X	X			Youth, TAY, Parents
Jay Mahler	12/7/2023	County		X	X	X	Consumers
Korean Health Center		Oakland	X	X	X	X	Providers
La Familia	12/6/2023	County	X	X	X	X	Providers
LGBTQIA Center	12/7/2023	Oakland		X	X	X	LGBTQ
Mental Health Association of Chinese Communities	1/4/2024	County	X	X	X	X	Chinese Community
MHSA Stakeholder Group	12/15/2023	County			X	X	Mental Health Board
Pacific Center	11/20/2023	Berkeley	X	X	X	X	LGBTQ
Peers TAY Group	12/6/2023	Oakland	X	X			TAY Group
PEERS	1/16/2024	County					Consumers

	Date	Region	Children	TAY	Adults	Older Adults	Additional Population Characteristics
PEI and UELP (ACBH Contracted Prevention Provider)	1/10/2024	County		X	X	X	Providers
POCC (Peers Organizing Community Change)	12/1/2023	County			X	X	Adults, Older Adults
Supportive Housing Community Land Alliance	11/29/2023	Oakland			X	X	Adults, Older Adults
Swords to Plowshares	11/2/2023	Oakland			X	X	Veterans
Partnerships for Trauma Recovery	12/8/2023	Oakland	X	X	X	X	Youth, TAY, Adults, Older Adults
Veterans Collab Court	10/27/2023	Oakland			X	X	Veterans

36 listening session focus groups were hosted by ACBH, the MHSA CPPP-SM, and community-based organizations. Approximately **394** community stakeholders participated in the FY23/24 MHSA CPPP (See Figure 1 and 2). Most listening session participants were community providers at 45% and peers, who made up 38% of participants. Of the total 36 listening sessions, 20 were conducted with providers, 11 sessions with peer groups and 5 sessions were conducted with city level representatives. There was also an effort to include groups that represented specific communities and subsets of the population. There were 3 listening sessions completed with groups that identified or specifically served LGBTQIA communities, 2 groups for veterans, 1 for families and 1 for transitional age youth (TAY).

Figure 1: Participants by Stakeholder Group (n=394)

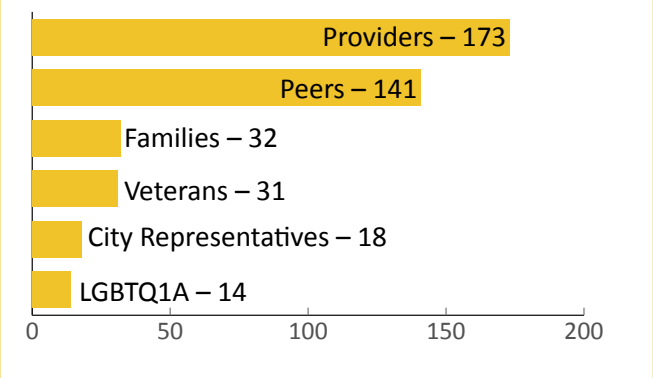
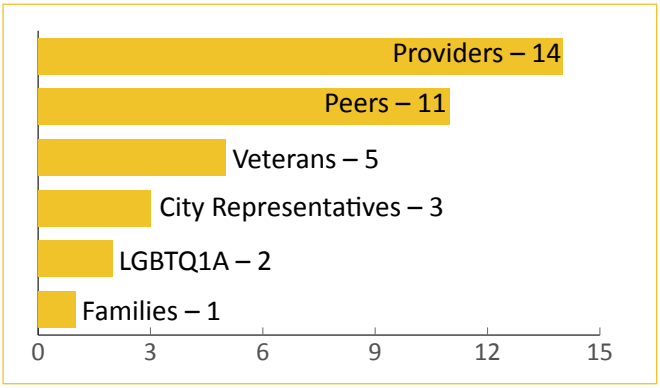


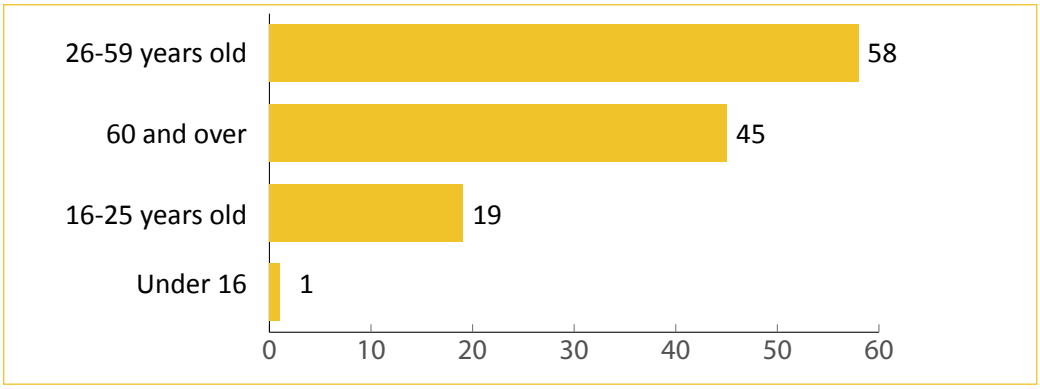
Figure 2: Sessions by Stakeholder Group (n=36)



Listening session participants were given the opportunity to fill out a demographic survey following the listening sessions to help gather additional data.

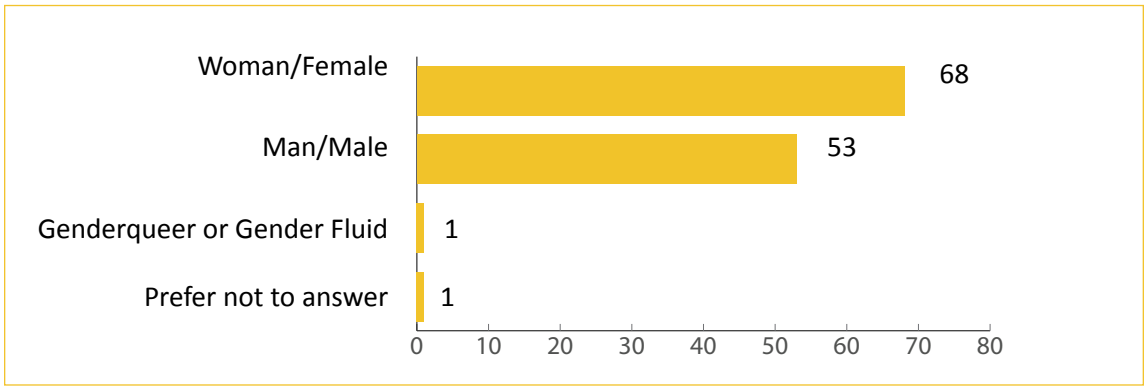
There were 123 participants who elected to fill out the demographics survey, 47% reported being between the ages of 26-59, 37% being 60 and over and 15% being 16-25 year olds. Refer to Figure 3.

Figure 3: Participant's Age Groups (n=123)



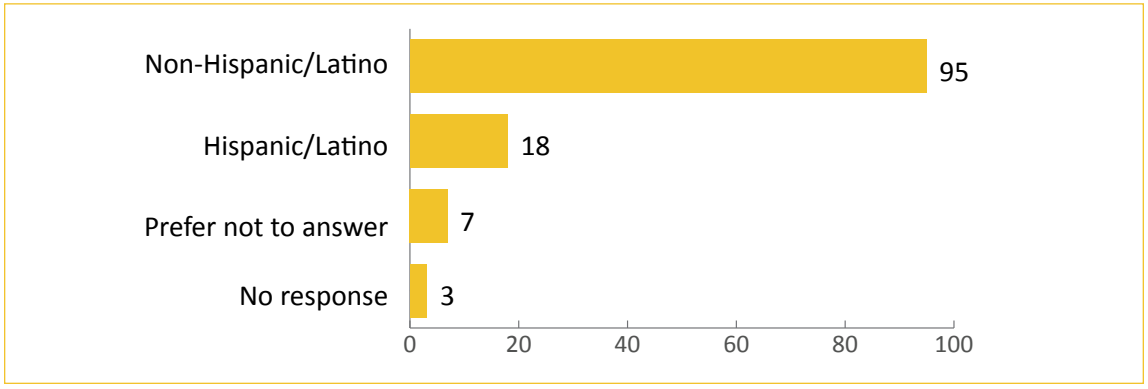
Most participants that elected to fill out the demographics survey identified as a woman/female (55%), followed by those who identified as a man/male at 43%. See Figure 4.

Figure 4: Participant's Gender Identity (n=123)



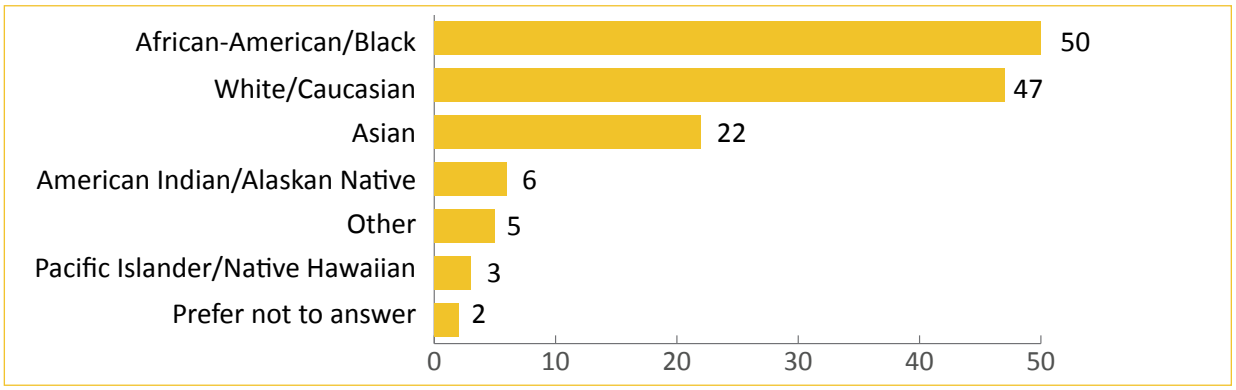
A high majority of the listening session participants who elected to fill out the demographics survey identified as Non-Hispanic/Latino (77%), while only 15% reported Hispanic/Latino as their ethnicity. Refer to Figure 5.

Figure 5: Ethnicity (n=123)



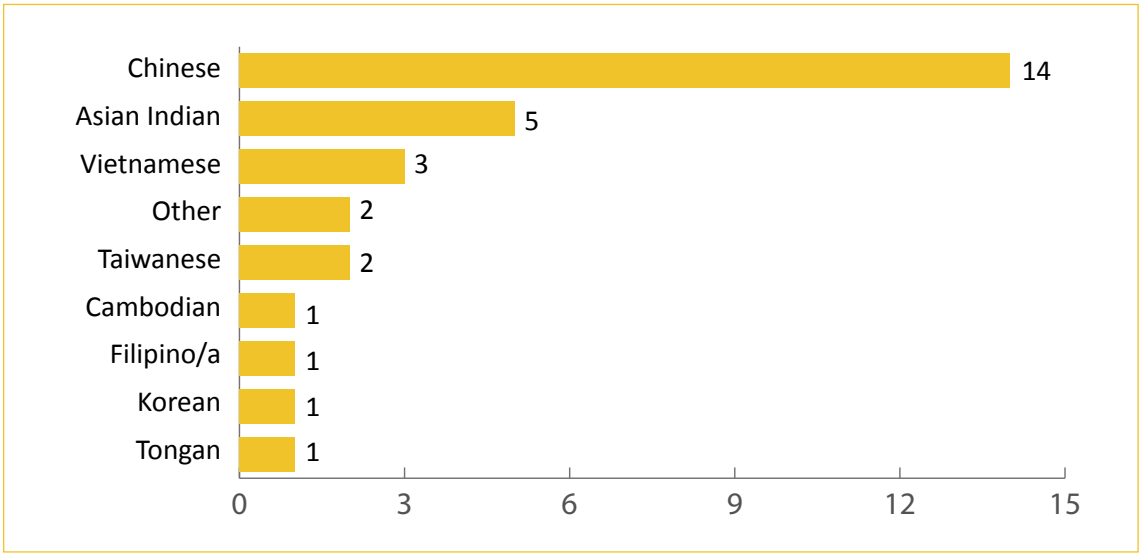
Of the 123 listening session participants who were elected to fill out the survey, the top 3 reported race identities were: 1. African American/Black (41%), 2. White/Caucasian (38%) and 3. Asian (18%). See Figure 6

Figure 6: Race (n=123)



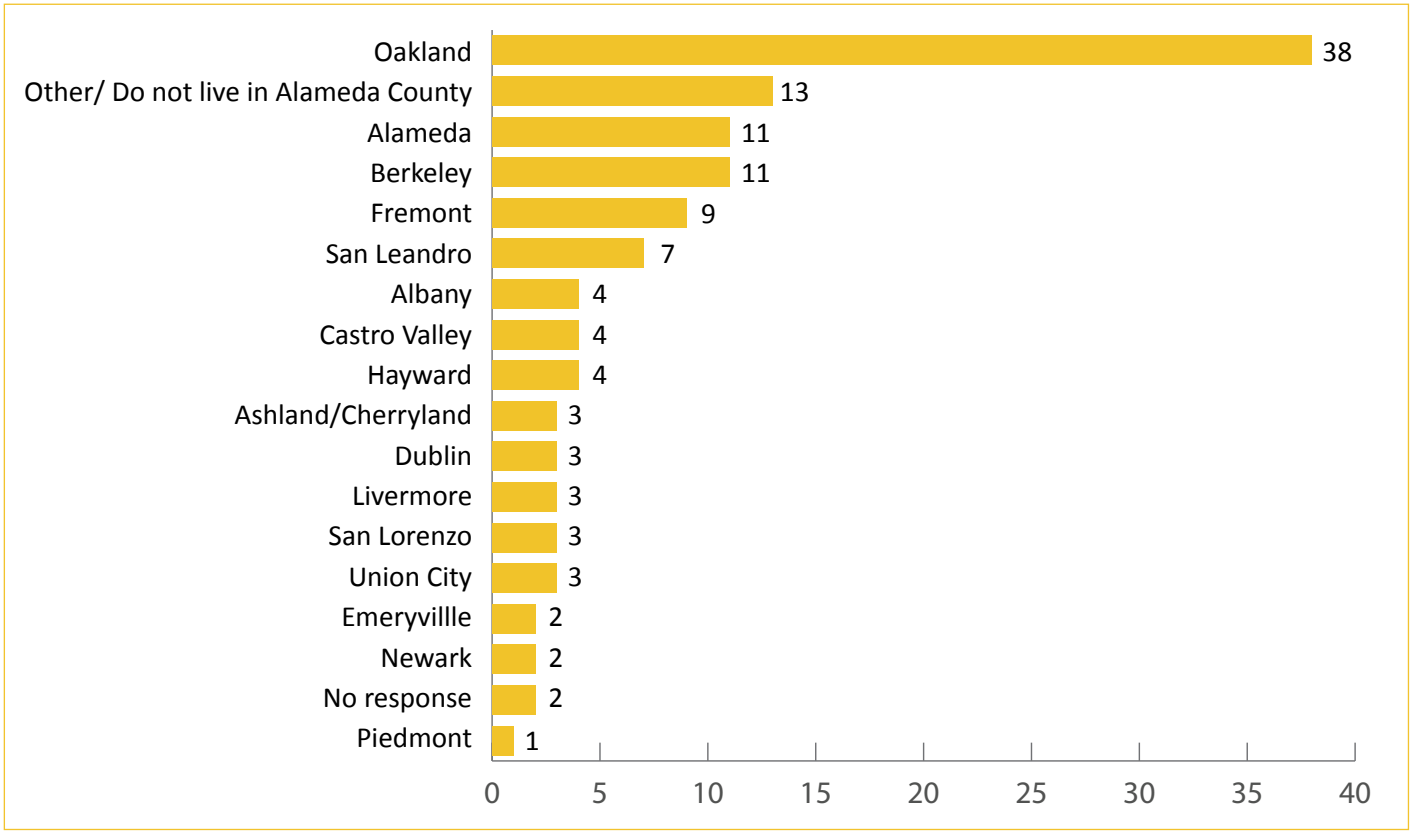
There were 25 respondents who identified as Asian (22) or Pacific Islander/Native Hawaiian (3) in the race question and 30 respondents who provided a response for the API ethnicity. The most common AAPI ethnicity was Chinese (56%), followed by Asian – Indian (20%) and Vietnamese (12%). See Figure 7.

Figure 7: Asian or Pacific Islander Participant's Ethnicity (n=30)



Oakland residents were represented the highest (31%) in the post-listening session demographic survey. This was followed by 11% reporting they did not live in Alameda County and the City of Alameda and Berkeley each making up 9%, respectively. Refer to Figure 8.

Figure 8: Participant's City of Residence (n=123)



During the listening sessions, stakeholders provided input on mental health services and various priority areas of need. The following reoccurring themes were identified across all listening sessions:

Access to Services:
Ensuring clear processes for accessing mental health services, including non-law enforcement solutions and 24/7 availability.

Peer Support:
Promoting the role of peer support specialists with lived experiences in aiding clients and providing immediate assistance.

Housing Interventions:
Addressing the housing needs of individuals with mental health challenges, including supportive housing and services.

Specialized Support for Vulnerable Populations:
Addressing specific needs of populations like LGBTQ individuals, veterans, re-entry citizens, and foster care children.

Youth Empowerment:
Supporting programs that incentivize young adults to seek mental health resources and empowering youth through education in schools and other community settings.

Stigma Reduction:
Addressing stigma related to mental health, especially for children and youth, and promoting acceptance of mental health care across different cultures.

Cultural Sensitivity:
Recognizing the need for culturally sensitive and appropriate services, including bilingual support and LGBTQ clinicians.

Workforce Support:
Emphasizing the importance of support systems for the workforce, including training, self-care, and incentives.

Trauma-Informed Work:
Emphasizing trauma-informed approaches, such as Crisis Intervention Team (CIT) training, to enable informed and culturally responsive services.

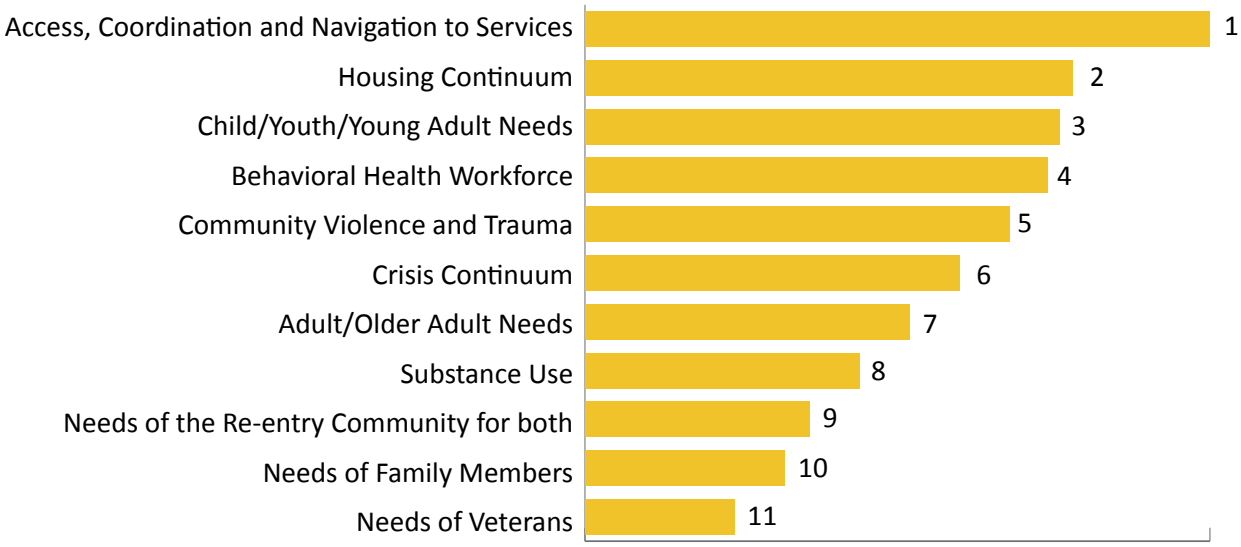
Data and Transparency:
Emphasizing the need for data analysis, transparency in decision-making, and advocacy for funding to support mental health services.

Community Safety Initiatives:
Addressing the need for initiatives and strategies to address community violence and enhance overall safety.

Collaboration with Law Enforcement:
Emphasizing the importance of collaboration between mental health services and law enforcement to ensure community safety and appropriate responses to crises.

Crisis Support Teams:
Advocating for the presence of mobile crisis support teams on the streets to respond in a timely manner to and prevent escalation of violence during crisis mental health situations.

Listening session participants **1)**. reviewed the provided 11 areas of need, **2).** ranked their top 3 areas of need and **3).** discussed their reasons for selecting each. Participants also provided possible strategies and solutions to address each of these needs. The results of that ranking show the following to be the top ranked areas of need (in rank order):



Area of Need	Strategies and Solutions
1. Access, Coordination and Navigation to Services	• Establish community navigation centers as one-stop shops to provide access, coordination, and navigation to various services. • Support, fund and increase programs that utilize community navigators, promoters, and peer support services to improve patient access and navigation of services. • Implement culturally sensitive and appropriate outreach strategies to effectively engage diverse communities. • Develop a comprehensive digital platform and master directory containing contact information, assessment details, and available resources for mental health services. • Prioritize bilingual services to support multiple languages in the growing client base and improve accessibility for diverse communities.

"There needs to be more promotion on the mental health stigma to inform people from different cultures it is acceptable to receive mental health care."

"There should be a clear process on where people can go for services or who they can talk to on a personal level that they can trust."

Area of Need	Strategies and Solutions
2. Housing Continuum	• Increase prevention and early intervention programs to avoid homeless-ness. • Provide safe/welcoming places with direct services and housing for those with mental health challenges, aiming to prevent additional trauma. • Provide emergency housing lasting a minimum of 6 months, followed by long-term supportive housing. • Support housing interventions with additional funding for operational support to meet the needs of the community that include comprehensive and wraparound services. • Establish accountability and check-and-balance mechanisms in housing pro-grams and services. • Ensure transparency in decision-making processes related to housing.

"People with serious mental illness have one of the highest needs for permanent and/or supportive housing."

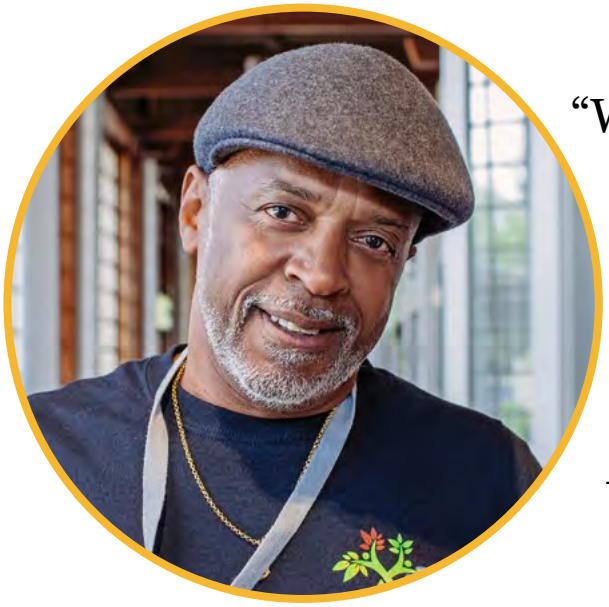
"There needs to be more service enriched housing programs, this is a greater need than just shelter. These housing programs can address the mental health needs of clients they house."

Area of Need	Strategies and Solutions
3. Child/Youth and Young Adult Needs	• Increase and improve engagement strategies for youth by incorporating creative and fun activities like art, music, and movement recognizing the therapeutic benefits of these. • Address the diverse needs of children, youth, and young adults from marginalized communities such as immigrant youth, unaccompanied minors, LGBTQ youth and those in the foster care system. • Strengthen support systems by educating family members and parents on mental health issues and providing spaces for dialogue and offering tools for parents to understand youth issues more comprehensively. • Advocate for programs in school and other community spaces that promote mental health awareness, seeking help and identifying mental health issues among youth. • Increase youth workshops, townhalls events such as youth leadership summits to discuss various mental health topics, healing and resources. • Provide tangible means to youth that can support their stabilization and encourage them to reach out to mental health resources while aiming to break the mental health stigma. Resources such as stipends, respite care and other practical needs etc.

"Healing the parents is important to heal the child, [so we need] more events to incorporate youth and family together."

"[We need to] engage with youth to empower them and for them to know how special they are. When people believe they're precious they will act precious."

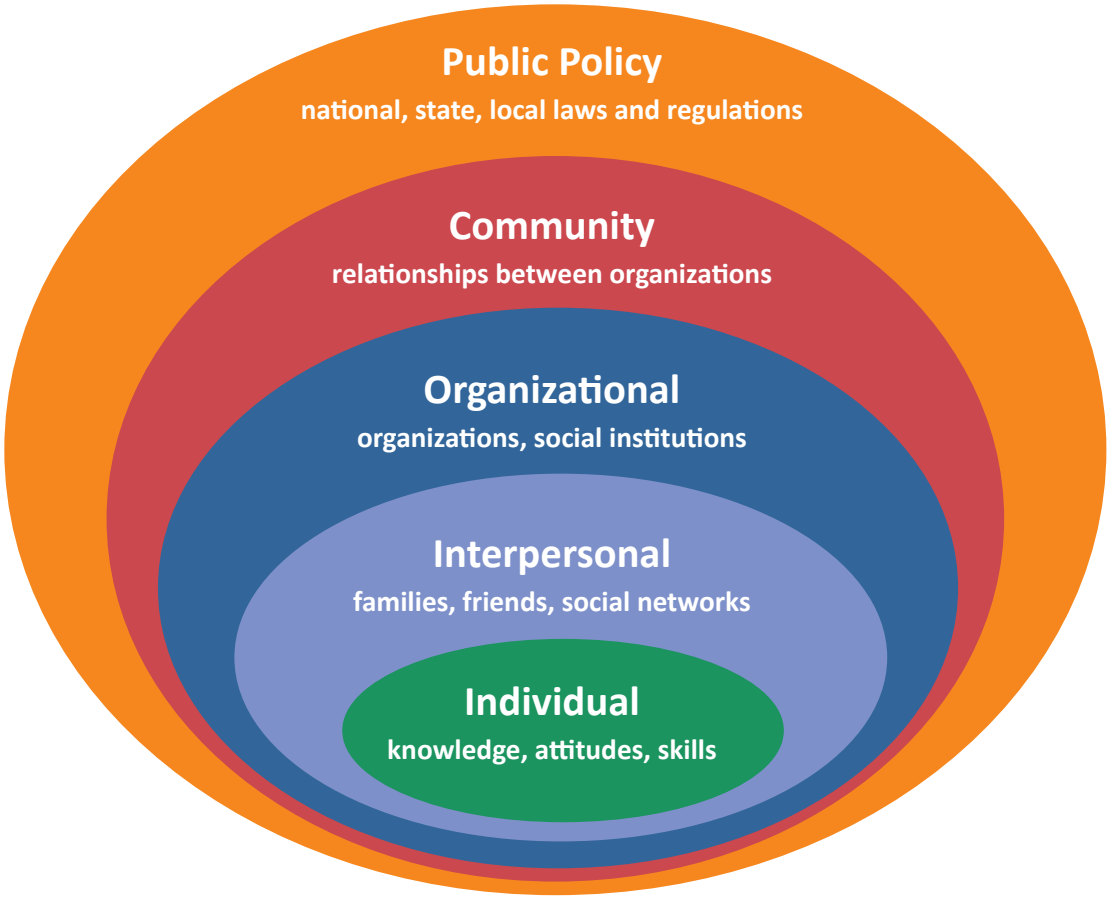
Area of Need	Strategies and Solutions
4. Behavioral Health Workforce	• Address workforce shortages by incentivizing the recruitment of individuals from diverse backgrounds that reflect the client population. • Develop partnerships and pipelines to work with schools and other non-traditional agencies to train, recruit and hire mental health workers (clinical and non-clinical) • Expand peer support programs and paid training opportunities and intern-ships to increase access to mental health jobs for people who have lived experiences and direct ties to the community. • Provide funding to aid in training programs that will equip staff with the necessary skills for their roles, especially around cultural competency. • Provide self-care opportunities for staff to enhance their ability to serve effectively and emphasize the need for a support system in the workforce to prevent burnout and ensure staff well-being. • Provide support services and resources for the workforce when staff members also experience crisis.



"Workforce shortages and challenges such as recruiting counselors that reflect the client diversity plus the scarcity of BIPOC psychiatrists are issues that limit hiring."

"We need more trauma informed training for providers, so people can continue to be informed, continue to examine their biases, can provide culturally responsive services."

All listening session feedback was documented, summarized, and analyzed to ensure that major themes, strategies, and solutions were captured. Using the socioecological model (see image below) participant responses were placed into 5 categories (1. Individual, 2. Interpersonal, 3. Organizational, 4. Community and 5. Public Policy) to demonstrate the various efforts that can be made to address the complex issues Alameda County faces with regard to mental health service delivery at various levels (see Appendix B-5).



The top 4 areas of need were reviewed and analyzed in more depth, as shown above. While most of the listening session feedback collected, focuses on addressing organizational and community needs at the programmatic level (which was expected since participants comprised mostly of providers from partnering agencies), there were a vast number of solutions and strategies provided that identified the need to bring families and social networks into play to increase interpersonal resilience. There is also a clear connection between how local and state policy affect service delivery at every level.

The following subsections describe the specific community feedback collected during CPPP Listening Sessions (LS) and Key Informant Interviews (KII) by unique stakeholder groups. A full listening session transcript of all reported needs and recommendations can be found in **Appendix B-4**.

Alameda Contra Costa Medical Association

The MHSA team met with the Alameda Contra Costa Medical Association to conduct a virtual listening session. The providers shared their top concerns for community needs as Community Violence and Trauma, Behavioral Health Workforce, and Access, Coordination and Navigation to Services. There was a theme in the discussion about strategies to ensure that the staffing for medical professionals is sufficient. The group discussed how non-licensed staff can be utilized through internships and as navigators for multilingual and multicultural needs diverse clients. The group also discussed the need for wraparound services at housing sites to ensure that clients' needs are being met. Lastly, the group is concerned by the potential changes to programs from Proposition 1 and they would like to write a letter advocating for mental health programs.

Alameda County - Culturally Responsive Committee

CRC Meeting was attended by different participants from different organizations within and outside the county and communities, with a total of 16 participants. The participants were from San Mateo County BHRS, Diversity in Health Training Inst., Sidra Team, Pacific Center for Human Growth, Pathways to Wellness, ALCO of Homelessness Care and Coordination, ALCO Tobacco Control Program, ACBHCS WET, CSS, Licensed SW, Supportive Housing Community Land Alliance, and others as anonymous.

The areas of needs were presented and elaborated to the participants for the main goal of getting their feedback and insights. A survey was launched, and the top three (3) topics were identified for discussion and input. Participants have voiced the need for stabilization inside their organization and concerns about workforce burnout, retention, housing needs and further support. The need for providing up to date resources that are available now regarding housing, SUD, training, and jobs available for families. Geriatrics system support is lacking and more support/resources/programs for vulnerable elders. Easier access of resources to the marginalized community. Resources, treatment, and support to boarding houses and expansion to other cities. Lastly, prevention programs and trauma supportive resources for the youth and older adults especially the immigrants.

African American Family Outreach Program Listening Session

MHSA cohosted a listening session with African American Family Outreach Program participants. Participants identified streamlining service access with a centralized system, consistent crisis response, and comprehensive aftercare plans. They also addressed urgent housing needs requiring longer emergency stays, increased supportive and affordable housing, and better oversight for program safety. The participants also addressed family and youth support gaps through education, peer support, expanded mental health programs, and respite care. Additionally, emphasizing community engagement and changing mental health and violence narratives.

Alameda County Fatherhood Support Group

The MHSA team spoke with leaders of the Fatherhood Summit with First 5 Alameda County to address the needs of fathers in the mental health landscape. Discussed were challenges fathers encounter when accessing low-cost mental health services and the need for support and understanding in their mental health wellness. They advocate for more mental health resources and programs designed for fathers, that seek to engage both involved and disengaged fathers without judgement or bias. The conversation highlighted the importance of changing the discussion around mental health resources for fathers, specifically the black and brown communities, by extending available and culturally aligned services.

Ashland/Cherryland Basic Needs Committee

The MHSA Team facilitated a session with members of the Ashland Cherryland Food and Basic Needs Coordination Committee. Participants identified Access/Coordination/Navigation, Housing and Child/Youth Needs as top areas of needs. Solutions included: Utilization of the promotora, peer to peer, model to bring MH to communities, more services/supports for parents, e.g. parent support groups/workshops, more school-linked services, increased language access and cultural representation, roving housing navigators, especially to help youth/young adults, a migrant shelter, and more transitional housing. Participants also suggested substance use education for youth and parents, particularly around

cannabis, there's a good deal of self-medicating post-covid, supporting the full family, screenings for abuse, providing fun and a sense of community in order to successfully engage with community members and overall meeting people where they're at.

Asian Health Services – Transitional Age Youth Group

MHSA cohosted a listening session with Asian Health Services for college-aged youth. The top mental health issues mentioned included Access, Coordination and Navigation to Services, Housing, Behavioral Health Workforce and Community Violence and Trauma. Participants identified solutions such as media projects to reduce stigma/discrimination regarding mental health services as well as stories and information on how effective or helpful mental health services can be. A variety of outreach strategies were mentioned including social media platforms such as Instagram and WeChat, event outreach, and phone banking. The group stressed linking outreach efforts to the various needs of specific communities. Other solutions included school-based training on boundary setting and healthy relationships- for the purpose of preventative approaches to domestic violence. Demographics included: Asian identified young adults ages 18-24.

Axis Community Health

MHSA conducted a key informant interview with Jennifer Penny, Chief Behavioral Officer at Axis Community Health. Axis Community Health has indicated that their top clients' needs are Crisis Continuum, Behavioral Health Workforce, Community Violence and Trauma, and Access, Coordination and Navigation to Services. Axis Community Health has been innovative and created successful programs such as Bridge Urgent Care Mental Health Program, however funding constraints limit further expansion into neighboring cities. They have persevered through workforce shortages, such as recruiting counselors that reflect client diversity, and the scarcity of psychiatrists. Trauma cases have risen due to the Covid pandemic, immigration issues and global conflicts. Axis has taken a proactive approach to create programming around non law enforcement response and these programs have yielded a decrease in 5150s. Overall, Axis has been responsive and innovative for effective mental health care delivery.

Bay Area Community Services (BACS)

MHSA conducted a key informant interview with Jovan Yglecias Chief Program Officer and Katherine Lutz Associate Director of Programs, Bay Area Community Services. The top needs highlighted were addressing the crisis in the behavioral health workforce, creating integrated systems to address substance abuse, minimizing gaps in crisis intervention services, and creating service enriched housing programs. BACS emphasized the need for culturally sensitive navigation services, support for the reentry community, difficulties faced by veterans and for Alameda County to continue to refine and seek community input on how resources are spent to enhance mental health services in the region.

Casa Ubuntu Listening Session - English

During the Casa Ubuntu English speaking listening Session, we presented information regarding the needs of the community that were based off collected data over prior years. These were the highlights for three key areas of concern: This group identified access to services with solutions that solves issues involving the challenge of finding appropriate services and the need for more non-profit support, peer support groups, and accessible resources. One of the main concerns was homelessness, with recommendations including simplifying housing applications, promoting tiny home programs, and ensuring affordability. Supportive services for those with disabilities are crucial. Another main concern was addressing community violence & trauma with the focus in this area which focuses on youth support, emphasizing early intervention, better housing conditions, and increased access to therapy services. Programs like the Housing Academy are suggested. In addition, addressing substance abuse is also a priority, with suggestions for non-spiritual 12-step programs, more sponsors, and improved access through peer support and transportation services.

Casa Ubuntu Listening Session - Spanish

MHSA cohosted a listening session with Casa Ubuntu's Spanish program participants. Participants identified addressing urgent community needs: Combat community violence & trauma by prioritizing faster police response, enhanced patrols, school-based support for families & youth, and secure transportation for both youth & elders. Additionally, cater to adult/

older adult needs by bolstering social services, aiding DACA/Undocumented individuals, hosting job fairs, facilitating literacy programs, offering transport aid, and ensuring accessible housing. Commitment extends to the re-entry community through education, online classes, tech access, housing, and benefits for undocumented individuals.

City of Alameda

The MHSA team conducted a key informative interview with the City of Alameda Social Services team. The city of Alameda identified the Housing Continuum, Crisis Continuum and Substance Abuse as the top 3 needs of Alameda. The conversation highlighted the difficulties recruiting and retaining qualified professionals, with diverse backgrounds and clinical training. The public's access to mental health services is a critical concern, with the need to overhaul a complex system to expedite access to ensure individuals can navigate resources more effectively. Housing remains a top concern with the need to provide mental health services in a residential setting. Substance abuse has increased due to the availability of drugs and the potency of them. They are also seeing a need to support individuals transitioning from the justice system to the workforce and the reintegration to society.

City of Fremont

MHSA conducted a key informative interview with the city of Fremont Human Services division. The listening session featured 4 participants that worked in youth, young adult, adult, and older adult services for the city of Fremont. The cultural diversity of the city of Fremont and the neighboring cities requires a diverse BH workforce to reduce community stigma. There is a continued need for bilingual staff to communicate with clients. In recent years staffing has become more difficult due to stated concerns about the increase in the cost of living, student loans expenses and the ability to purchase a local home on a provider salary. The city of Fremont has asked the county for assistance in helping create programs to attract new talent. The geographical location and size of the city of Fremont has limited timely non law enforcement response for substance abuse services. There are few residential treatment program opportunities for clients in the Fremont area and this has created a recurring loop for clients in need of residential treatment. There is an ongoing need to continue to educate clients about the services available to them. Fremont's geographical location limits client's accessibility to nearby mental health services.

City of Livermore

MHSA conducted a key informative interview with Mr. Josh Thurman, Human Services Programs Manager Housing and Human Services Division, Community Development Department, City of Livermore. Central themes from the interview included the need for services and support to be *physically located in the Tri Valley Area*. Having services in the Tri Valley area allows for relationship development and knowledge of residents and neighborhoods, which helps increase access, coordination, and navigation of services. This theme of local services includes crisis, SUD detox, cooccurring services, not simply weekly group meetings/low-level outpatient treatment. Additionally, youth and youth services were mentioned in response to the heavy academic pressure that children and youth are facing.

City of Oakland

MHSA met with the City of Oakland Human Services team. The participants discussed needs and challenges focusing on the diverse demographic groups. Community Violence and Trauma are a top priority to address escalating domestic violence and homeless violence threats. New approaches and strategies are being created from statistics with the goal of protecting youth from violence. Access, Coordination, and Navigation to services is an issue that requires timeliness service, and the absence of expert professionals makes the service wait times longer. There is an increased effort to offer peer support services to fill this void, to provide residents have guidance. Child, Youth, and Young Adult needs discussions are ongoing with the hopes of addressing trauma informed practices for foster care youth. Non-law enforcement strategies to approach mental health crises have been in the forefront of discussions and expansions to current programs are being reviewed. Oakland is making efforts to secure housing for the homeless and expand its reentry services. The meeting participants were knowledgeable about the needs of the Oakland residents and were willing to participate in feedback and potential ways to improve care.

City of San Leandro

The conversation was with Jessica Lobedan, Human Services Director. She indicated that the top needs are Crisis Continuum, Housing Continuum, Substance Use and Access, Coordination and Navigation to Services. Housing is a top need and the ability to help mental health clients at housing locations. The need for crisis intervention services is a recurring topic that they think will be needed in the future. They are looking for continued collaboration and assistance with accessing services for their residents. There has been an expressed interest in having a community center for de-escalation services.

CPPP Committee Members Listening Session

MHSA cohosted a listening session with the Community Planning & Processing Committee that had 12 participants identify community needs, and solutions. For Re-Entry, providing pre-transition support, simplifying system navigation, fostering collaboration among re-entry programs, improving mental health coordination, and ensuring incarcerated individuals receive mental health support. For Child/Youth/Young Adults, educating parents, integrating mental health into public schools, enhancing early intervention, and reducing stigma through peer counseling. For Access, Coordination and Navigation to Services, establishing a comprehensive online resource, creating a county-wide linkage system, and employing navigators from diverse communities to enhance accessibility. Additional funding and a centralized online platform for services are also vital community priorities.

Family Education & Resource Center - English

MHSA cohosted a listening session with 13 FERC program participants. These participants identified pressing concerns about violence, theft, and gun violence, advocating for changes in police priorities, safer spaces for youth, and improved aesthetics. They emphasized effective agency management, promoting healthy family communication, safe service access, and the vital link between a safe environment and mental health. Housing-related issues focused on income-based senior accommodation, transparent housing access, preventing evictions, and developing more accessible housing options. Recommendations included culturally aligned healing practices, stigma reduction, and accessible treatment, alongside peer-led groups, funding support, harm reduction education, and career development initiatives, shaping future community initiatives.

Family Education & Resource Center - Spanish

The MHSA team met with the Family Education & Resource Center (FERC) Spanish Group. The discussion focused on the mental health challenges and solutions to addressing the mental health needs of the Spanish speaking population. The group highlighted the barriers to language accessibility, the stigma around receiving mental health services, and the lack of accessible information. The group also spoke about how important housing is to mental health as well as culturally competent individual mental health professionals. The group discussed the need for preventative programs for youth and adults, trauma informed care, and family support services.

First 5 Alameda County

MHSA conducted a key informative interview with Laura Otero Administrator with First 5 – Help Me Grow. The Help Me Grow team works with children ages 0-5 and their families. First 5 – Help Me Grow indicated that they are seeing clients' top needs as: Access, Coordination and Navigation to Services, Behavioral Health Workforce, Community Violence and Trauma and the Housing Continuum. There is a continued need to help families seamlessly access and locate services. Recruiting and retaining credentialed providers and ensuring staff are multilingual and cultural remains a top priority. They continue to have to aid in supporting the youth and family clients as they recover and cope with domestic violence and trauma related incidents. Housing has continued to be a main issue with families needing temporary housing and they see an increase organizing with shelters.

Jay Mahler Recovery Center

The MHSA team held a listening session with 10 participants at Jay Mahler Recovery Center. The top needs of the group were the Housing Continuum, Substance Use, and the Needs of the Re-entry Community. The group expressed the need for more housing for the unhoused and detailed how housing is a barrier to mental health. They are looking for Alameda County to improve substance abuse services

that are repetitive and provide more intensive inpatient treatment programs. They were concerned that the needs of the re-entry community are not being adequately addressed and there needs to be more care navigators available to help with accessing community services. Overall, the group was knowledgeable on the resources that Alameda County offers, however they would like Alameda County to provide more resources and guides to help consumers connect with services more efficiently.

La Familia

MHSA conducted a key informant interview with Aaron Ortiz CEO of La Familia. The discussion reviewed the complexities of structuring mental health services in Alameda County. The discussion highlighted the essential need for increased access, efficient coordination, and successful navigation of the services available to mental health clients in Alameda County. The topics discussed varied from the significance of workforce development and crisis management strategies to the housing continuum and concentrated support for children, adults, and the reentry communities. There is a necessity for more tailored mental health services to address community members' needs across different demographic groups to make a greater impact on substance use, community violence, trauma, and family member support.

LGBTQ Center

The MHSA team spoke with the Executive team at the LGBTQ Center in Oakland and learned more about the needs of its clients and the LGBTQ Community. They are seeing a need for more programs to address social isolation in the elderly population. The housing being developed is not created with LGBTQ concerns in mind and accommodations for the LGBTQ community are leading to displacement from new developments. Also, needs for LGBTQ people in homeless encampments need to be addressed due to rising threats and violence. HIV is an ongoing problem that is receiving less resources but still needs to be addressed. Overall, the LGBTQ Center is looking to bring on a care navigator and would like to continue to participate in county programs.

MHACC

MHSA co-facilitated a listening session with community members from the agency, Mental Health Association for Chinese Communities (MHAAC) 美國華裔精神健康聯盟 资深副執行長 The top mental health needs included access/coordination/navigation of services, workforce and children/youth/young adult needs. Frustration with housing services was also brought up. Participants identified many solutions including the need for a resource directory of all behavioral health services, expanded loan forgiveness programming, more activities/events for youth and families to do together for joint learning (one participant said… Healing the parents is important to heal the child). Other solutions included activities to reduce stigma, dedicated funding for their tri-lingual warm-line, youth leadership activities and advocacy at the state level for California to opt into Psychology Interjurisdictional Compact (PSYPACT®), an interstate compact designed to facilitate therapeutic services across state boundaries. A memorable quote from the session was, "I think if you really want to improve mental health, try to convince people that they are not worthless, insignificant, invisible, or powerless. You can brainstorm as to how to convince people that they are worthy, significant, visible, and capable". Demographics included 12 individuals who identified as Chinese.

Pacific Center

MHSA conducted a key informant interview with Shanna Bowie, Director of Programs at the Pacific Center. The Pacific Center offers wide ranging programs, including support groups and mental health services. The Pacific Center indicated that they are seeing clients' top needs as: Access, Coordination and Navigation to Services, Behavioral Health Workforce, Child/Youth/Young Adult Needs, and the Crisis Continuum. There is a need for a more diverse and culturally competent behavioral health workforce. They suggest more training of clinicians to better serve LGBTQ groups. They also recommend addressing gaps in services and including funding specifically around the needs of children, youth, and young adults. The Pacific Center has increased services and resources for the crisis continuum and is focusing on non-law enforcement intervention to support individuals experiencing a mental health crisis.

Peers TAY Group

MHSA team conducted a Listening Session with 7 community members from the PEERS TAY group. The group is comprised of youth and young adults who were vocal about sharing their concerns and

recommendations for the MHSA services in Alameda County. The Peers TAY group highlighted their top concerns as: Access, Coordination and Navigation to Services, Housing Continuum, Child/Youth/Young Adult Needs and Substance Use. They addressed that there needs to be cultural destigmatization around mental health services and incentivization for youth to want to come forward to access mental health services. There are numerous members of the group who live in unsafe communities and believe their mental health issues stem from their environment. The group thinks there needs to be more mental health resources in schools to help youth address issues immediately, and not wait to access services after school or on the weekend. The group encourages MHSA to continue to conduct focus groups to listen to strategies and solutions to community members mental health needs.

POCC – Peers Organizing Community Change

The POCC Meeting was held via Zoom video conferencing that was attended by total of 30 attendees among them were 26 expected survey participants. A demographic survey was launched in the beginning. Then the areas of needs were presented and elaborated to the participants for the main goal of getting their feedback and insights. Afterward the participants cast their top three (3) votes of topic in the chat, then were tabulated and identified the most voted topic for discussion and input.

Participants have asserted that services and assistance are needed to meet people where they are literally (going to homeless camp) and in other avenues of their current situations. They've pointed out that there's a great need for after-hours and weekend services, especially for people with MH challenges, that's a safe and welcoming space or place, including temporary triage. They are advocating hiring more peer support specialists to team with clinicians and doctors as a whole component in providing complete care services. To have an analysis of data that can show which has effective results in reaching the needs of the community. To have a one-stop-shop for respite care continuum. To have a check and balance in housing and transparency in its decision-making. In the end part of the forum, it was added to create a group home for undocumented Latino community experiencing MH crisis. And final suggestion to hire a position and develop a comprehensive master directory that gets updated with different resources like hospitalization, housing, treatment etc.

Supportive Housing Community Land Alliance

The MHSA team presented at the Supportive Community Land Alliance board meeting to board members and community members. The top needs of the clients were the Housing Continuum, Behavioral Health Workforce, Crisis Continuum, Access, Coordination and Navigation to Services, and Substance Abuse. The group wanted to emphasize that more affordable housing needs to be made in different areas of the county. They also want there to be more wraparound services for mental health clients in residential buildings. The participants praised the Supportive Housing Community Land Trust model for providing them with the opportunity to be invested in their living situation as opposed to being homeless or a renter.

Swords to Plowshares - Veterans

MHSA cohosted a listening session with 17 Swords to Plowshares veterans program participants. Participants identified Veterans' Need are more Advocacy centers like Swords to Plowshares, emphasize more mental health training, addressing impacts of hospital closures, and call for ongoing support. To prevent community violence and trauma, the participants talked about pushing for more prevention crisis teams, reconciliation efforts, relocation aid, and faster crisis services, while addressing societal issues impacting safety.

Partnerships for Trauma Recovery

The MHSA team met with the African Program Manager at Partnerships for Trauma Recovery. The conversation highlighted their top needs as Access, Coordination and Navigation to Services, Community Violence and Trauma, Child/Youth/Young Adult Needs, and Adult/Older Adult Needs. The conversation discussed how many of their clients are new immigrants from 55 African countries speaking over 23 different languages. Their clients have experienced violence in their home country, violence on their immigration journeys to the United States and some have experienced violence here. They encourage the Alameda County services to be culturally sensitive, provide linguistic accessibility, and to be mobile in the community. They see the need to bring together the different age groups of the new

African immigrants so they can better understand each other with the goal of African youth, adults and elders improving the family dynamics and alleviating the elders needs of social isolation and caretaking duties.

Veterans Collaborative Courts

MHSA cohosted a listening session with the Office of Collaborative Courts participants and graduates of the program. Participants identified enhancing veteran services: local facilities, better transport, support for younger veterans, veteran workforce, and peer groups, citing Swords to Plowshares' impact. Some housing solutions vouchers, affordable housing, repurposed military bases for homeless veterans. Lastly, the participants addressed needs around improved training, community programs, aiding access to housing/ services, fostering community, and engaging VA providers.

ACBH Pride Coalition

The ACBH Pride Coalition meeting was attended by ACBH Health Equity Division, Family Behavioral Health Care & Ethnic Services, and other CBOs like Quality Assurance Dept & Co-Chair Pride Grp., Restorative Justice for Oakland Youth, Horizon Treatment Services, Intake & Quality Assurance, Pacific Center for Human Growth, and Pathways to Wellness Clinics. Participants suggested the need to provide funds for substance use education, prevention, and treatment at all school levels. Participants voiced the need for: youth housing services, the re-design of the ACBH website for LGBTQIA information services/program, emphasis on prevention, education, additional support for Trauma, expansion and replication of the CATT program, and a physical location where clients can find resources and link to the services they need.

Figure 1: MHSA Community Input Website

https://acmhsa.org/community-input

CPPP & 30-Day Public Comment Outreach Period: April 1, 2024 – May 20, 2024

Figure 2: MHSA Community CPPP E-Flyers

(see Appendices B-2)

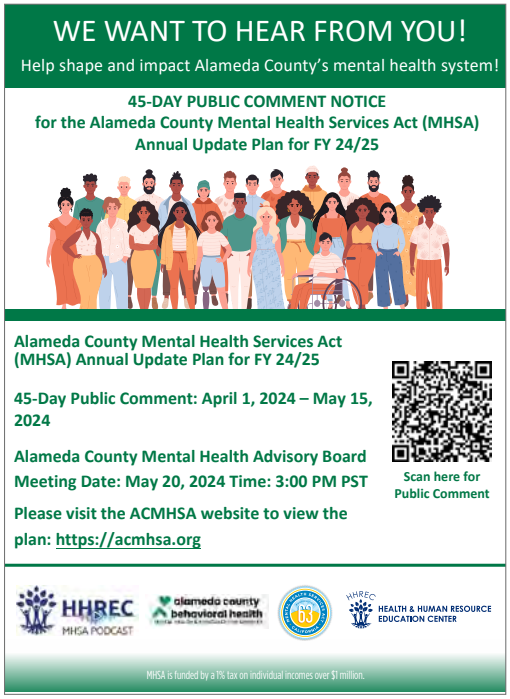
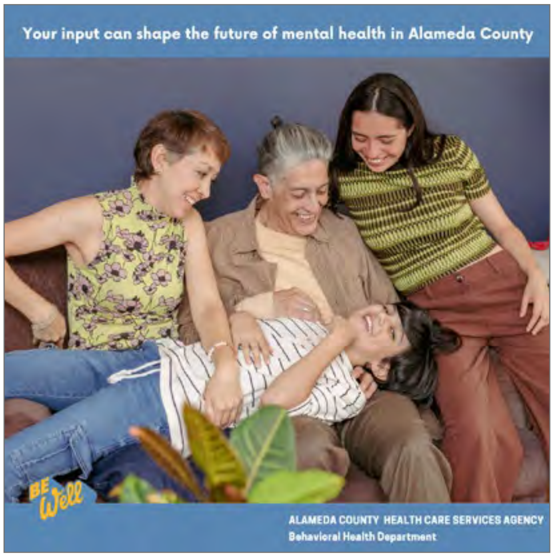


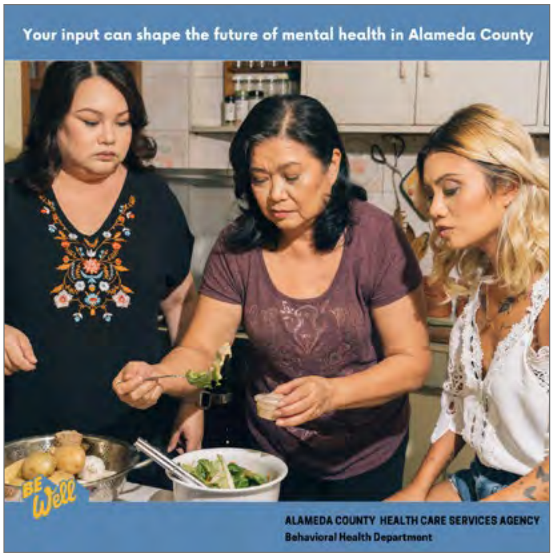
Figure 2: MHSA Community CPPP E-Flyers (cont.)

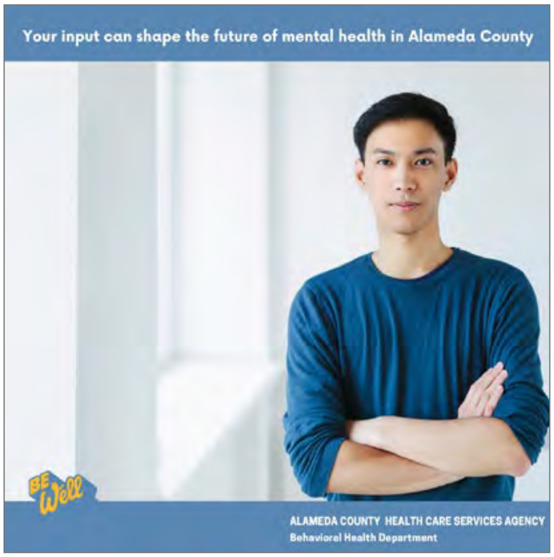
(see Appendices B-2)

Figure 3: Media Announcements

(see Appendices B-2)







The 18 question Community Input Survey is a tool that MHSA used to facilitate identifying key areas of interest and concerns about mental health in Alameda County. The Community Input Survey is a robust and important part of the Community Planning Process for the MHSA Update FY24/25. The survey was available on the www.acbhcs.org website and in paper format from October 28, 2023 – December 31, 2023. In previous years, participants have had an impact by contributing recommendations that have led to new MHSA funded programs, such as the CATT (Community Assessment Transport Team), the Supportive Community Land Alliance, new programming for early childhood, new programming for the LGBTQI community, and capacity building grants for ACBH contracted CBOs, etc. The survey was available in English, Spanish, and Chinese. To create the survey questions the MHSA team partnered with ACBH stakeholders and community stakeholders. The survey questions focused on gathering community feedback on program effectiveness, cultural competence, consumer satisfaction and recommendations for service improvement. One section of the community input survey allowed participants to rank the 11 categorized community needs in order of importance and provide strategies and solutions. Below are the top ranked community needs and their most common identified strategies and solutions:

Rank #1

Access, Coordination and Navigation to Services

The mental health system continues to face complex and multi-faceted challenges that often affect access, coordination, and navigation of services. Survey respondents identified potential strategies and solutions to improve our current system.

Strategies and Solutions

- Develop clear and transparent referral processes to ensure individuals are directed to the most appropriate services.
- Centralized care coordination teams: Establish dedicated teams to navigate patients through the system, coordinate appointments, and advocate for their needs.
- Continue to increase outreach and awareness of mental health services in the community.
- Increase the number of programs and resources available that accept insurances like Medi-Cal and Medicare and can offer mental health services.
- Address language barriers to ensure that services can be provided directly to non-English speaking residents.

Participants reflected these concerns in the free response portion of the survey and shared the following:

- "Access is important for individuals seeking help, especially to those historically marginalized communities who may need a nudge to trust services in the community. There should be constant outreach to let them know what's available and the power of accepting assistance with mental/ behavioral health needs."
- "People should prioritize the most vulnerable in our society who go through these things because they are also the least well-equipped to deal with a challenge like a mental health crisis. Getting the word out about conditions that can happen to people in their formative years is very important, so there are fewer sad situations out there."
- "Just having access and guidance to navigate the hurdles for services and programs can be overwhelming and providing clear and open access would help many seeking help."
- "Community health navigators are vastly important, along with health promoters that are representative of folks' backgrounds, to do outreach, educate about resources, and support with referrals into the system as otherwise many folks are unable to access the programs that do exist."

Rank #2

Housing Continuum

Housing continues to be at the forefront of addressing the needs of residents overall, but especially those experiencing or at risk of mental health issues. Providers and residents, alike, can see the direct connection between meeting this basic need and the ability to access, receive and maintain mental health services in the county. Survey respondents identified potential strategies and solutions to improve access to housing.

Strategies and Solutions

- Provide more funding allotted to provide no-cost housing for the unhoused with mental health issues and expand housing subsidies to support very low-income individuals.
- Support programs to identify those with risk of becoming unhoused and providing mental health services prior to homelessness.
- Collaborate with city and other public entities to negotiate the use of vacant land for housing.
- Form safe housing communities with specific supports, resources and services to meet the need of unhoused residents with mental health issues.
- All housing efforts should include supportive service systems that keep people housed.

Participants reflected these concerns in the free response portion of the survey and shared the following:

- "By addressing housing first, other important needs can be addressed more quickly and effectively."
- "There is too much attention being paid to 'affordable housing'; people who are homeless are so far away from being able to afford affordable housing as they do not have nearly enough income."
- Providing dignified housing is healing and allows a person to think of other needs if their shelter, hygiene and food needs are met. When temporary housing leads to subsidized permanent housing with services [this] could end homelessness for that individual.
- "There needs to be 'housing villages' established with simple, safe living quarters, full support staff educated in severe mental illness challenges, structured activities on site, housekeeping, volunteer force that would accompany people on appts and help keep them organized, and in good health. Partner with institutions to intern social workers, even horticultural and architectural planning students for developing functioning social space. Structured environments with full blown calendar of work-based day programs. Provide "serenity rooms" and yoga, art therapy to help people feel stimulated and useful.

Rank #3

Crisis Continuum

There is a need for immediate support for crisis intervention and an improvement in the delivery of crisis services. As the county becomes more familiar with the needs of residents that require crisis mental health services, there is a drive to increase crisis intervention services and to create a more intentional and comprehensive crisis continuum that responds to immediate needs but also addresses the long-term well-being of individuals experiencing a crisis. Survey respondents identified potential strategies and solutions to improve services to residents experiencing a mental health crisis.

Strategies and Solutions

- Prioritize community driven crisis mental health services that can reach residents faster and partner with law enforcement, only if necessary.
- Expand after-hour and weekend crisis mental health services, such as 24/7 hotlines or mobile programs with trained providers that can provide immediate assistance.
- Provide crisis stabilization beds for anyone who does not meet 5150 criteria but is still in crisis and requires immediate care.
- Crisis mental health workers need to be able to case manage and coordinate linkages to follow-up care.

Participants reflected these concerns in the free response portion of the survey. Selected quotes are below:

- "Addressing people in crisis is very important. Key to this is to have a non-police response. Keeping people out of jail and treating them in the community is very important."
- "[We need] volunteers to take on crisis hotlines to have people readily available for those in need of assistance. Also provide them with sufficient training to prepare for any arising issues."
- "[We need to] Invest in specialized mobile crisis teams composed of mental health professionals, peer support workers, and crisis counselors who can respond to crisis situations directly in the community.
- "Establishing Mobile Crisis Outreach Teams in every region, consisting of specially trained mental health specialists partnered with plain-clothes law enforcement and/or EMTs without lethal weapons. The goal is balancing compassionate care with safety by having the right responders available 24/7 to meet mental health crises where and when they arise."

Rank #4

Behavioral Health Workforce

Addressing workforce challenges in mental health services continues to be of critical importance. While other areas of need were ranked higher, this area was tied and connected to all other areas of need presented to ensure the efforts to improve mental health delivery are successful and sustainable. Survey respondents identified potential strategies and solutions to create a stronger more stable behavioral health workforce.

Strategies and Solutions

- Increase overall pay scales for the mental health workforce to reflect the cost of living in their service area. Salaries should be competitive and sufficient to attract strong candidates and retain staff.
- Consider different types of providers beyond clinical degrees and equate value and compensation for lived experience held by staff.
- Explore alternative provision of services, such as telehealth, mobile visits, home visits, and more.
- Increase opportunities for community residents and youth to receive certifications in non-emergency/crisis response, community safety, care navigation and referral linkages.
- Collaborate with local schools to develop employment pipelines via volunteer opportunities, internships and other educational programs that can create a path to mental health careers.
- Develop more standardized, extensive, and continued training that is accessible to providers.

Participants reflected these concerns in the free response portion of the survey. Selected quotes are below:

- "Mental Health positions need to be plentiful and pay a sustainable wage. No one should be making under 80k to hold these jobs. If there is not adequate staffing, who are properly trained and well paid, it will make everything else fall through."
- "Better paying jobs and ongoing support for folks entering the workforce that may not have all the work/professional skills and may also have mental health challenges. Ongoing mentoring for folks at the workplace that may also involve on-site therapy or mentoring check-ins."
- "Support career pathways for wellness and health in schools from high school, college, post-graduate degrees. Give school incentives for people to enter these fields and give peer mentoring counseling experiences."
- "This is the most important area because without a competent and effective workforce of compassionate, culturally educated people, we cannot accomplish any behavioral health goals. I feel like training more older adults in this area and offering peers specialist training in residential/housing developments will expand the workforce exponentially and allow older adults to grow in this field, ultimately contributing to their own well-being and lessening the effects of elder abuse and dis-ease."

Most survey respondents were made up of adults aged 26-59 (67%), older adults aged 60 and over (23%) and transitional age youth ages 16-25 (3%), while 71% identified as woman/female, 18% identified as man/male, and 4% identified as transgender, gender queer/gender fluid or non-binary. See Figure 1 & 2.

Figure 1: Participant's Age Groups (n=611)

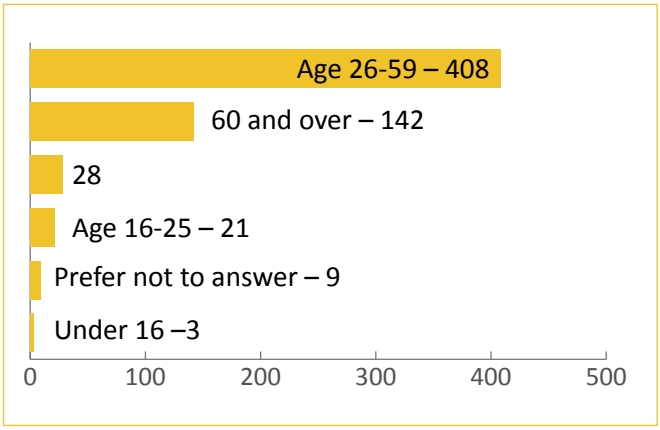
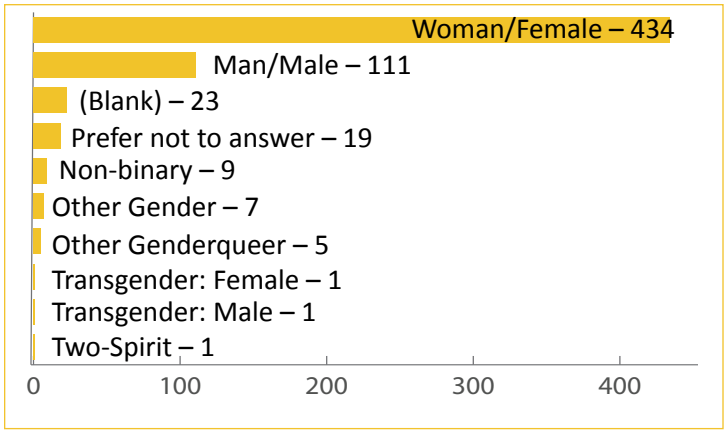
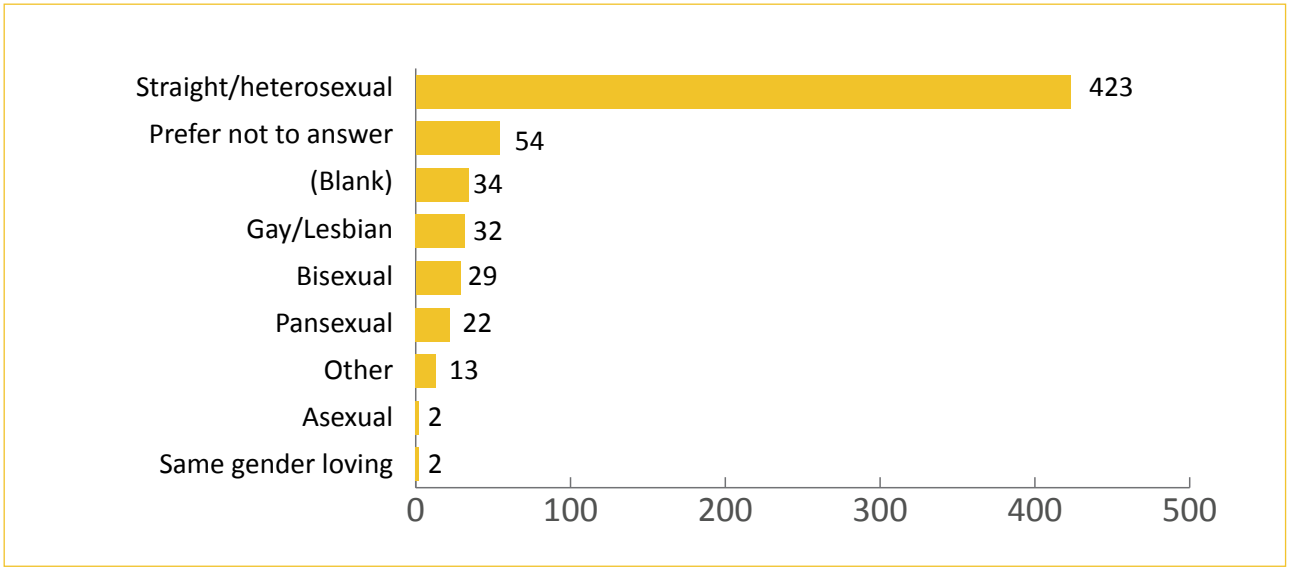


Figure 2: Participant's Gender Identity (n=611)



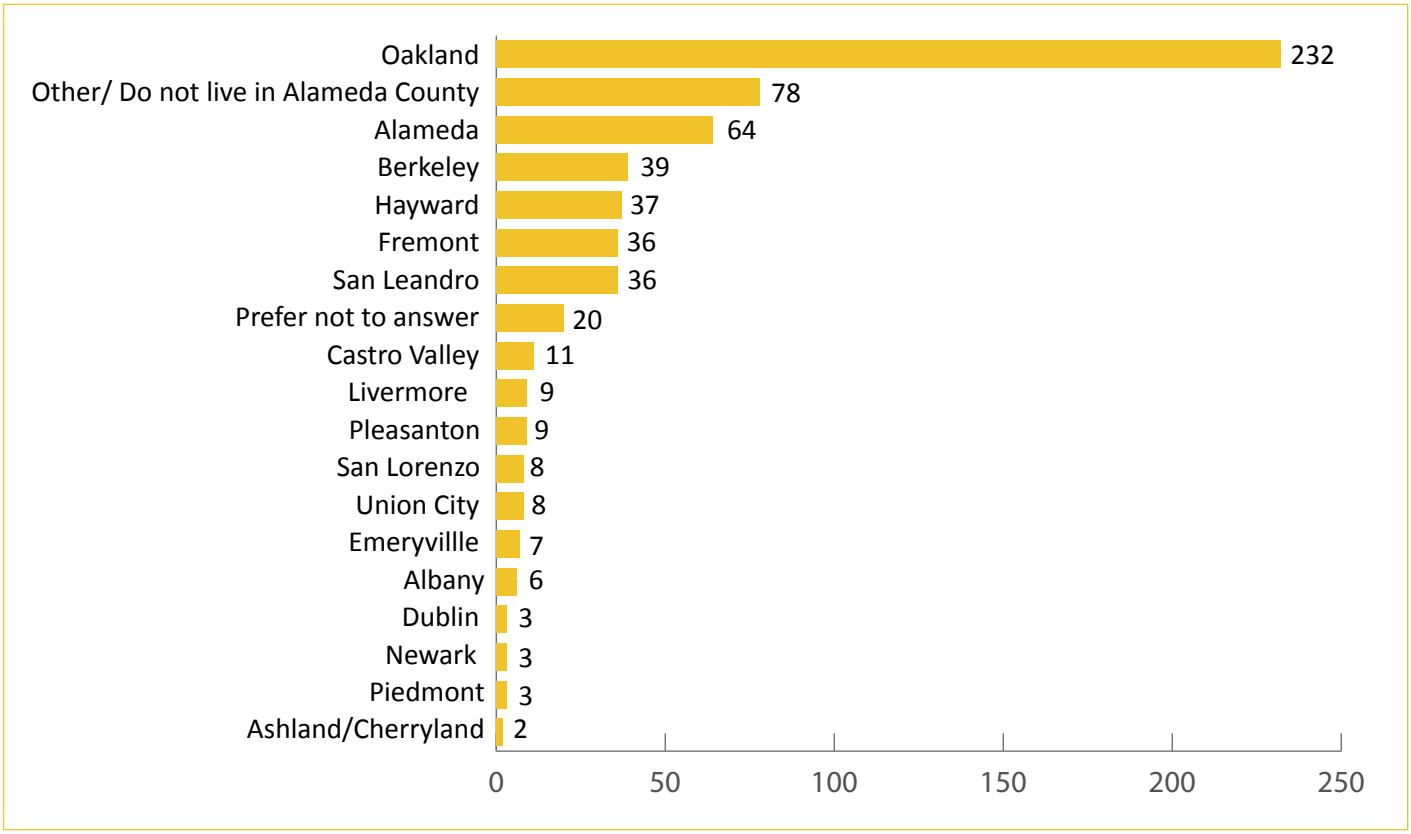
Survey participants were asked to optionally provide information about their sexual identity. Most survey respondents (69%) identified as straight/heterosexual, (16%) identified under one of the LGBTIQA+ identities and (14%) preferred not to answer or provided a blank answer to this question. See Figure 3.

Figure 3: Participant's Sexual Identity (n=611)



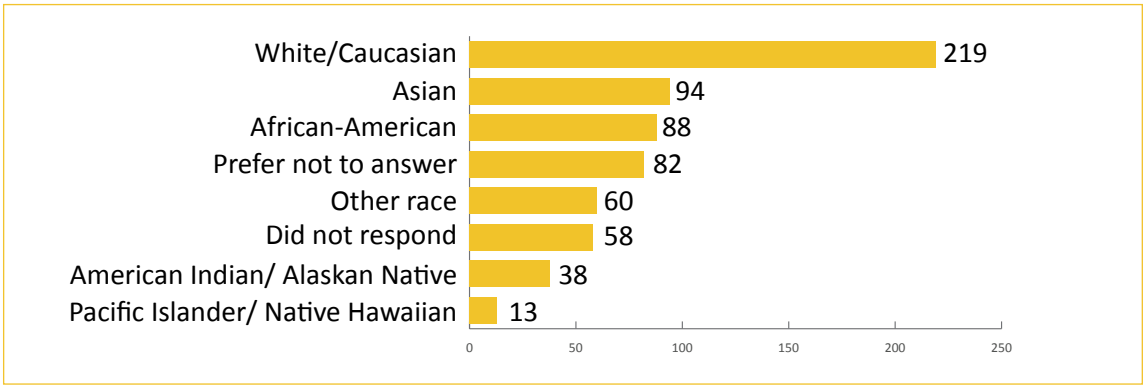
Outreach covered multiple cities within Alameda County. 38% of survey respondents reported Oakland as their city of resident residence, while 13% of respondents stated living outside of Alameda County. Other participant residence locations included Alameda (10%), San Leandro, Fremont, Hayward and Berkeley (each representing 6% of responses respectively). See Figure 4.

Figure 4: Participant's City of Residence (n=611)



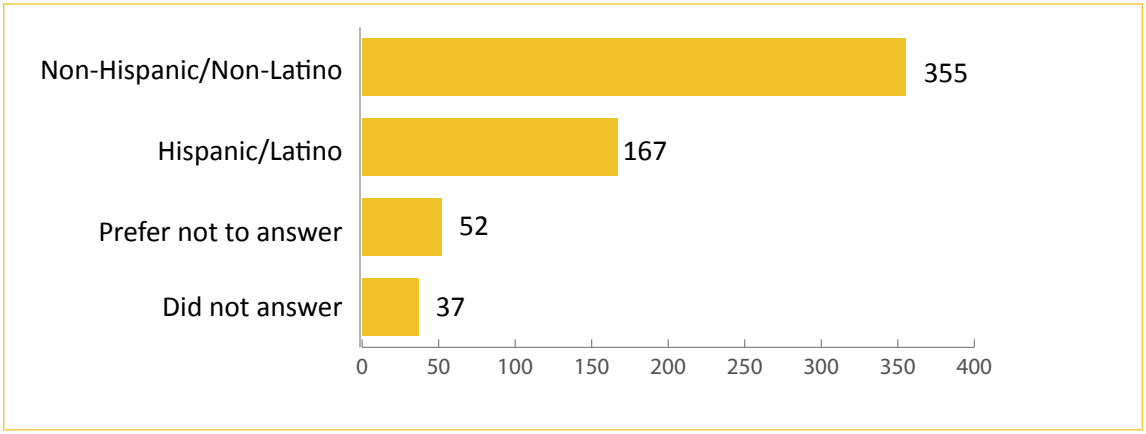
Survey respondents were asked to specify their race and the most frequently chosen racial identification was White/Caucasian (36%), followed by Asian/Pacific Islander or Native Hawaiian (18%), African American/Black (14%), and American Indian/Alaskan Native (6%). While 10% of respondents selected 'other race,' 23% of respondents opted not to answer this question. See Figure 5.

Figure 5: Race (n=611)



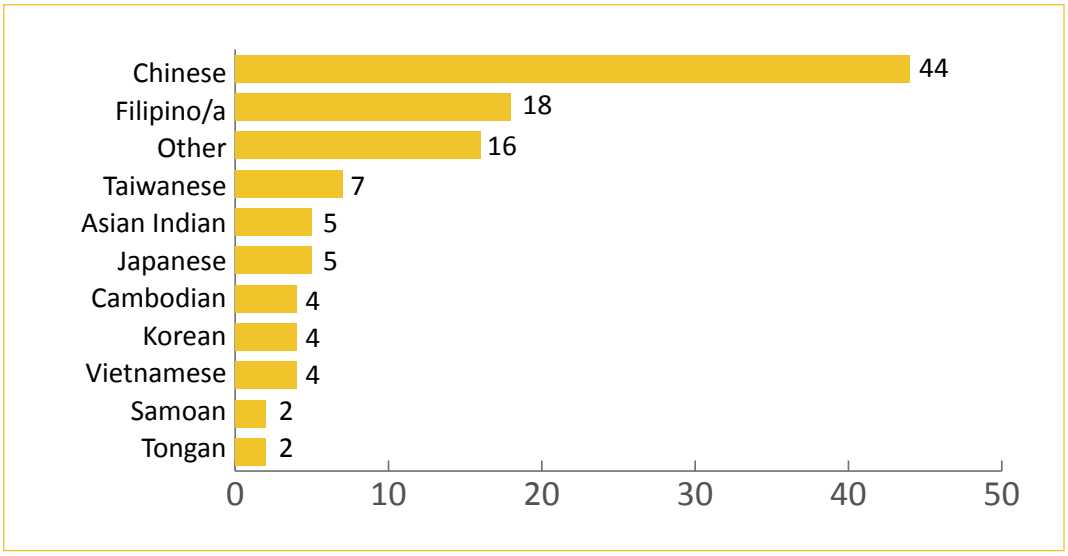
Regarding ethnicity, the survey found that 58% of respondents identified as Non-Hispanic/Latinx, while 27% identified as being Hispanic/Latinx. See Figure 6.

Figure 6: Ethnicity (n =611)



Out of the 103 participants who selected an Asian or Pacific Islander nationality or country of origin, the top specified groups included Chinese (43%), followed by Filipino/a (17%) and Taiwanese (7%). Refer to Figure 7.

Figure 7: Asian or Pacific Islander Participant's Nationality or Country of Origin (n=103)



Participants were asked what stakeholder group they represented and most identified as a community member (36%), family member (31%), followed by provider of mental health or substance use disorder programming (27%). See Figure 8.

Figure 8: Participant's Stakeholder Group (n=611)

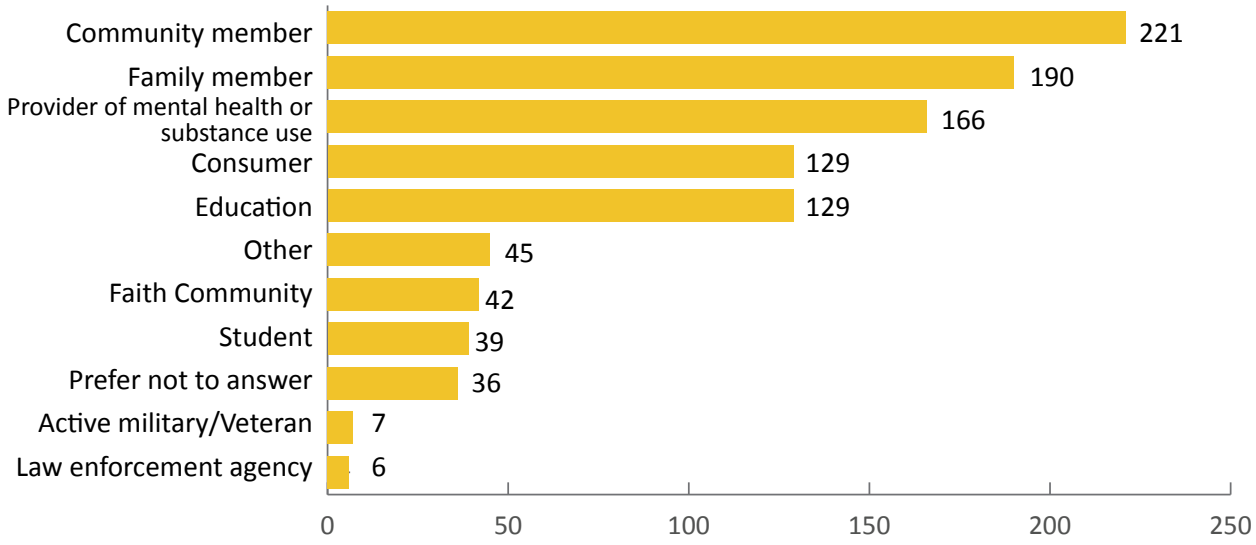
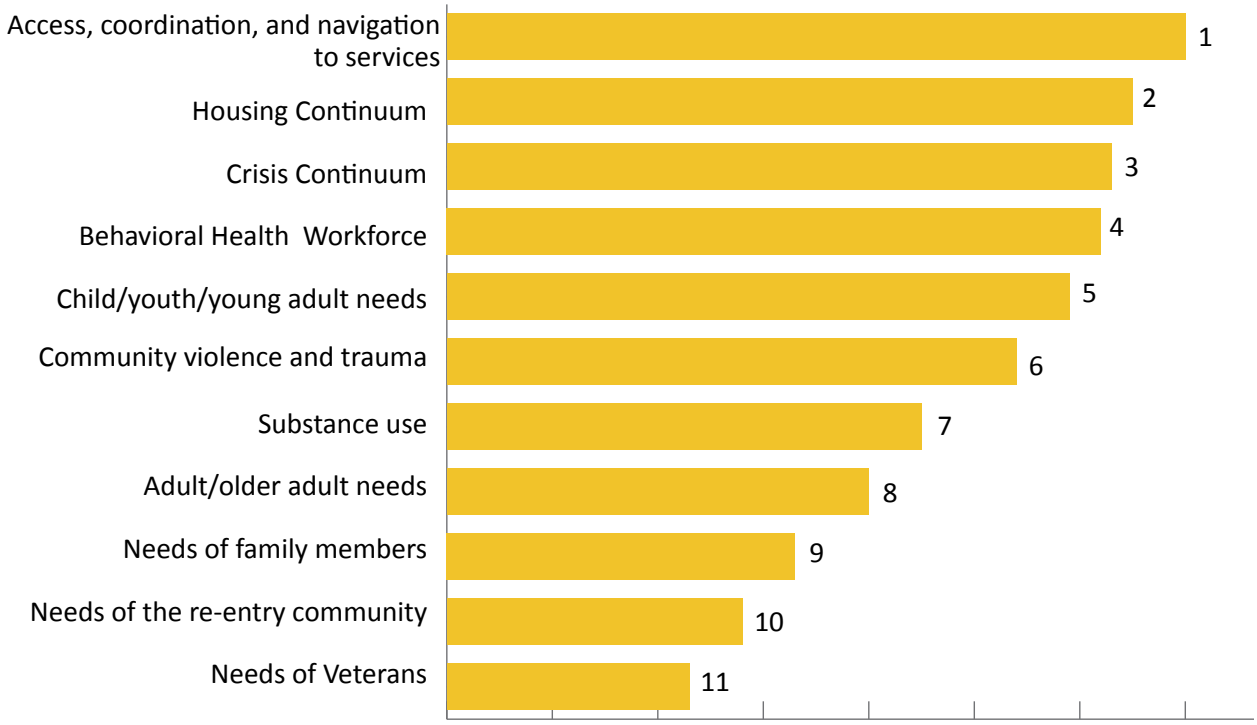


Figure 9: Areas of Need Ranking: Greatest to Least (n=611)



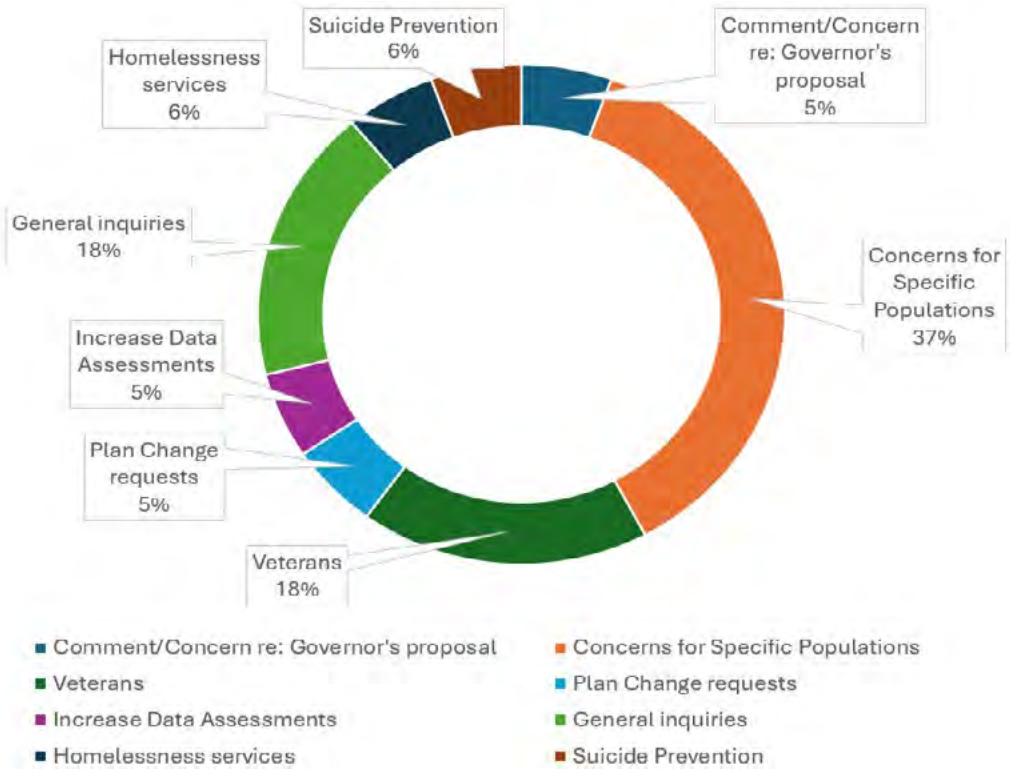
LOCAL REVIEW PROCESS

The Annual Plan Update FY24/25 was written and developed by the ACBHD MHSA Division in collaboration with the Finance Division. It was approved by the ACBHD Executive Leadership Team, planning staff and fiscal staff in consultation with the ACBHD MHSA Stakeholder Group. The draft Plan was made available on two websites: http://www.acbhcs.org/mhsa-doccenter/ and https://acmhsa.org/reports-data/#mhsa-plans on April 1, 2024 for forty-five (45) days for public comments. Notifications about the Public Comment period was distributed multiple times throughout ACBHD and the greater Alameda County community beginning April 1, 2024. It was also publicized weekly in the ACBHD webmaster email notification system starting on April 1, 2024. A targeted specialized marketing campaign was conducted to various Stakeholder Groups (Mental Health Advisory Board, Alameda County Consortium of Mental Health providers, Alameda County MHSA Stakeholder Group, etc.) to enhance awareness and engagement with the draft Annual Plan Update (please see Appendix B-1 Marketing & Outreach Plan). On Monday May 20, 2024, the Mental Health Advisory Board hosted a public hearing regarding the Annual Plan Update and provided a final opportunity for public comment. To read the complete list of public comments and responses please see Appendix H. The MHSA Annual Plan Update FY 24/25 was presented to the Alameda County Board of Supervisors Health Committee on June 10, 2024, and approved by the Alameda County Board of Supervisors on October 1, 2024.

FY 24/25 MHSA 45-DAY PUBLIC COMMENT RESULTS

The 45-day public comment period began on April 1,2024 and ended May 15,2024, with submission of 19 comments. Public comments typically fell into six broad categories: (1) concerns for specific populations, (2) veterans, (3) general inquiries, (4) homelessness services, and (5) suicide prevention. These comments were presented and discussed at the MHSA Public Hearing on 4/20/24.

MHSA Public Comment Summary (MHSA Annual Plan Update FY24/25)



CHANGES TO THE DRAFT MHSA Annual Plan Update FY 24-25 and PUBLIC COMMENT HIGHLIGHTS

Upon review of public comments, as well as community input data, the ACBHD Leadership Team has made the following modest changes to the draft Annual Plan Update:

- **The MHSA Division has implemented additional navigation tools for readers to locate information.** The Annual Plan Update incorporates tabs and hyperlinks throughout the MHSA Annual Plan Update to help the reader identify and navigate information. The reader has the option to click on links to find information without reading the entire report. These additions have made the report easier to use, easier to read, and easier to understand.

- **Connecting with homeless outreach services**. The MHSA team has been in collaboration with the Alameda County Office of Homeless Care and Coordination to improve services and understand the needs of homeless people in Alameda County. This inter-agency partnership will only increase due to the passing of Proposition 1 SB326. ACBHD will be required to help house individuals and expand services to include individuals with a substance use disorder.

- **The MHSA highlights the Crisis phoneline and ACESSS hotline in the plan as well as during outreach to stakeholders.** These funds will be utilized for additional staffing for weekend and evening/overnight hours on the crisis line and bringing the text line onboard 24/7. 988 is the three-digit, nationwide phone number to connect directly to the 988 Suicide and Crisis Lifeline. Individuals can also contact the ACCESS hotline for information, screening and referrals for mental health and substance use services and treatment. The ACCESS program is the first step in enrolling in Alameda County mental health services. Operators of the ACCESS hotline are fluent in multiple languages. The ACCESS hotline is open 8:30am-5pm Monday-Friday, the phone number is: 1-800-491-9099. The other option is the crisis number: 988.

- **Veterans' groups are looking for representation and inclusion**. The public comment states that Veterans' groups are thankful that BHSA will include additional venues for substance use treatment and housing options for veterans with mental health needs. However, it appears that Proposition 1 provides no improvements in funding for veteran *services*, and therefore supportive service dollars will be even more difficult to secure. Veterans' groups are concerned that veterans continue to be extremely underfunded in county MHSA plans and will not be adequately addressed in the Alameda County mental health BHSA funding formula.

- **Minority groups highlight the need for representation and inclusion in MHSA funding.** The Latinx Steering Committee voiced the need to have the MHSA Division create programs and allocate resources to address the disparities in mental health services. The Latinx Steering Committee is creating mechanisms to help Alameda County to continue advancing equity and dismantle language barriers, cultural stigmatization, and limited access to culturally competent care for members of the community. Another public comment advocated that more substance use services for the LGBTQIA+ population be made available. The comment also mentioned how vital youth and young adult drop-in centers would be for LGBTQIA+ communities and suggested Alameda County initiate funding.

INTEGRATING FEEDBACK INTO MHSA

Alameda County Behavioral Health Care Services Department (ACBH) and the MHSA team encourages feedback from people with lived experience, Alameda County residents, service providers, ACBH staff, and other community stakeholders. After obtaining feedback the MHSA team analyzes the community's needs and requests to determine how to direct available funding. We welcome the community participation and encourage community feedback!

The final opportunity for the public to comment on the MHSA FY24/25 Update is the public comment period. The county evaluates public comment presented during the 45-day Public Comment period from April 1, 2024 – May 15, 2024. The Mental Health Advisory Board (MHAB) public hearing review date is May 20,2024 at 3pm. The MHSA team reviews the public comment and makes recommendations to leadership. Then the ACBH Director makes final decisions on program partnerships and program funding allocation, as funding is available. The diagram below shows the process we use to integrate feedback into decisions.

Community Services & Supports (CSS) Program Summaries

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).

Community Services and Supports | 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 23/24, Alameda's CSS component funds 14 Full Service Partnerships (FSP) programs (1,095 slots), including our Community Conservatorship and Assisted Outpatient Treatment (AOT) programs; all using the Assertive Community Treatment (ACT) and Forensic Assertive Community Treatment (FACT) evidenced-based treatment model.

Additional FSP slots will also become available as the ACBH Service Teams (case management/ medication support) are transformed into FSPs. These service teams have slowly been transitioning into the FSP model as funding has been available with the goal of completion being in late FY 24/25 or the beginning of FY 25/26.

The CSS component also funds 28 Outreach Engagement/System Development (OESD) *workplans*. Key service areas within these workplans include: crisis services, wellness centers, Integrated health programming, homeless outreach, early psychosis programming, medication support, suicide prevention and forensic services as well as other outpatient treatment programs.

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

I. The Crisis System of Care;

II. Forensic, Diversion, and Re-entry System of Care, and

III. The two ongoing age-based Systems of Care which serve 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 as FSP 10.

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.

Who does FSP serve?

FSPs support individuals of all ages with serious mental illness who are unserved or underserved and who may be experiencing, or at risk of experiencing, homelessness, justice involvement, and/or frequent utilization of psychiatric emergency services.

What are FSP services?

FSPs apply a "whatever it takes" approach to partnering with individuals on their path to wellness and recovery, providing a comprehensive set of services including: mental health, housing, medication support and employment support among other services as merited by the individual's treatment needs.

What is the relationship between FSP and ACT programs?

In California, Full Service Partnership (FSP) programs are intended to be the most intensive level of publicly-funded outpatient treatment programs (in addition to Laura's Law, or Assisted Outpatient Treatment/AOT programs). Some counties, like Alameda, base their FSP service models on the ACT evidence-based model that operates nationally; this model is the highest intensity service level for outpatient services. FSP ACT model programs are team structured with a staff to partner ratio of 10:1 and provide coordinated comprehensive services that support and promote recovery.

ACT Fidelity Review Trend Data

Alameda County Behavioral Health performs annual fidelity reviews for the Adult and Transition Aged Youth (TAY) FSP teams for the goal of ensuring high quality services based upon the implementation of the ACT model. With regards to team performance metrics, our findings show a gradual improvement in all of the listed areas below, see the next page for averages across all teams for 2021 and 2022.

Total face to face contacts

Community engagements

Natural support contacts

Average face to face contacts

Average number of minutes per face to face contact per week

% of cases that had more than one staff member visit within a two week period. This metric captures if the FSP team is operating like a hospital without walls. A team approach to mental health service.

	High Fidelity Metric	2021	2022
Total number of Face to Face contacts [S4] & [S1]	120	53.5	70.6
Total number of Face to Face contacts in the community [S1]	72	43.1	61.5
Average number of Natural Support contacts [S6]	2.0 contacts	1.4	1.53
Average number of weekly face to face contacts [S5]	3	1.354	1.75
Average number of minutes per week face to face contacts [S4]	85	41.98	48.1
Percentage of cases that had face to face visits with multiple staff in a 2 week period [H2]	60%	73%	83%%

For more information on the ACT Fidelity process, see the Appendix D-1 section for the ACT Fidelity Review Manual.

Full Service Partnership (FSP) service data for FY 22/23 and budget data for FY 23/24

State ID#	Population	Organization/ Program Name	Referral Guidelines	Capacity	Budget/Cost per Client FY 23/24	Clients Served FY 22/23
FSP 16	**Child/ Youth**	Seneca: Alameda Connections 0-8	Serves birth to 8-year-old consumers county wide	20	$831,724/ $41,586	22
FSP 17	**Child/ Youth**	Fred Finch Youth Center (FFYC): East Bay Wrap 8-18	Serves 8 to 18-year-old consumers county wide	20	$832,738/ $41,636	25
FSP 3	**TAY**	FFYC: STAY	Serves 18-24-year-old consumers in North & Central County	100	$3,370,283/ $33,702	76
FSP 21	**TAY**	BACS: PAIGE (Prevention, Accountability, Innovation, Growth, Empowerment)	Serves 18-24-year-old consumers in South & East County	50	$1,684,943/ $33,698	59
FSP 24	**TAY**	pending	Serves 18-24-year-old consumers county wide with a history of chronic justice involvement.	50	1,220,021/ $24,400	N/A

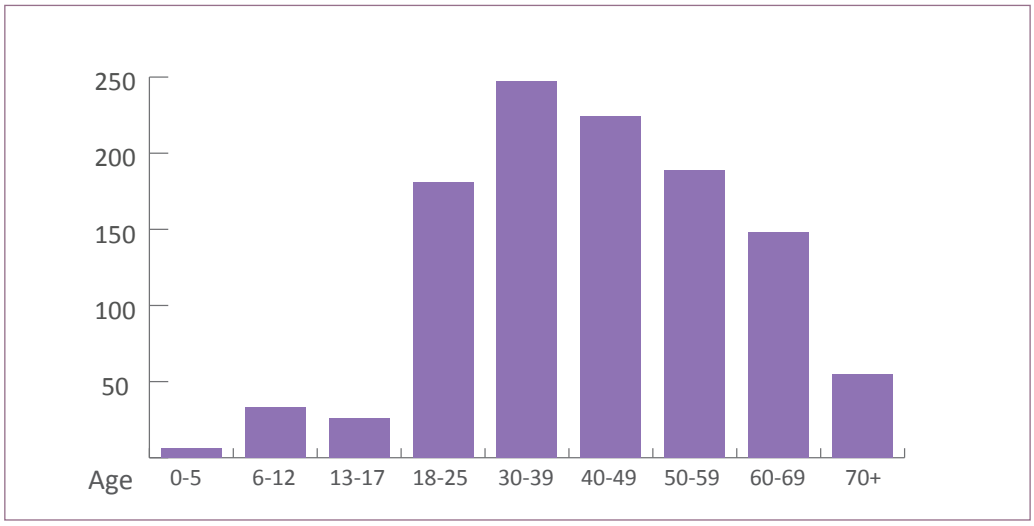
– continued next page

State ID#	Population	Organization/ Program Name	Referral Guidelines	Capacity	Budget/Cost per Client FY 23/24	Clients Served FY 22/23
FSP 13	**Adult**	Telecare: CHANGES	Serves 18+ year old consumers county Wide	100	$3,374,043/ $33,740	113
FSP 14	**Adult**	Telecare: STRIDES	Serves 18+ year old consumers county Wide	100	$3,860,338/ $38,603	102
FSP 4	**Adult Homeless**	Abode: Greater Hope	Serve 18+ year old consumers county wide who meet HUD homelessness Criteria	150	4,992,872/ $33,285	108
FSP 18	**Adult Homeless**	BACS: HEAT (Homeless Engagement Action Team)	Serve 18+ year old consumers county wide who meet HUD homelessness Criteria	150	$4,993,861/ $33,292	142
FSP 20	**Adult Forensic**	BACS: LIFT (Living Independent Forensic Team)	Serve 18+ year old consumers county wide with a history of chronic justice involvement.	100	$3,369,896/ $33,698	107
FSP 22	**Adult Forensic**	Telecare: Justice and Mental Health Recovery (JAMHR)	Serve 18+ year old consumers county wide with a history of chronic justice involvement.	100	$4,698,581/ $46,985	105
FSP 19	**Older Adult**	BACS: Circa 60	Serves 60+ year old consumers county wide with co-morbid healthcare support needs.	100	$3,296,823/ $32,968	84
FSP 12	**Adult**	Telecare: Assisted Outpatient Treatment (AOT)	Serves 18+ year old consumers county wide in need of court assisted support in addition to FSP services	30	$805,396/ $26,846.53	54
FSP 11	**Adult**	Telecare: Community Conservator-ship (CC)	Serves 18+ year old consumers county wide in need of a community conservatorship in addition to FSP services	25	$743,442/ $29,737	24
TOTAL				**1,095**	**37,588,666**	**1,021**

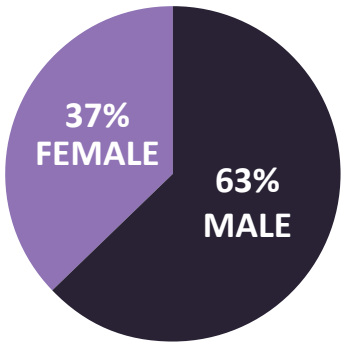
FY 22/23 FSP Demographic Data

During FY 22/23, 1,212 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, 2022 and June 30, 2023.

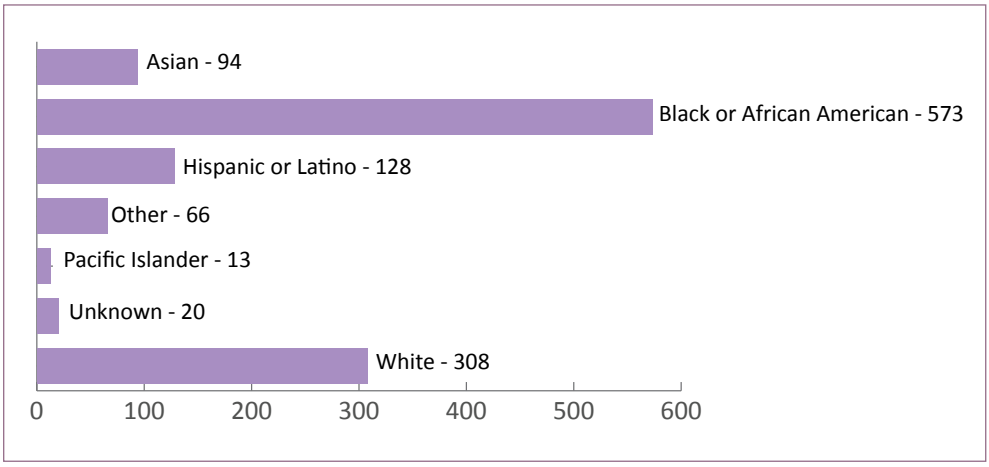
AGE



GENDER

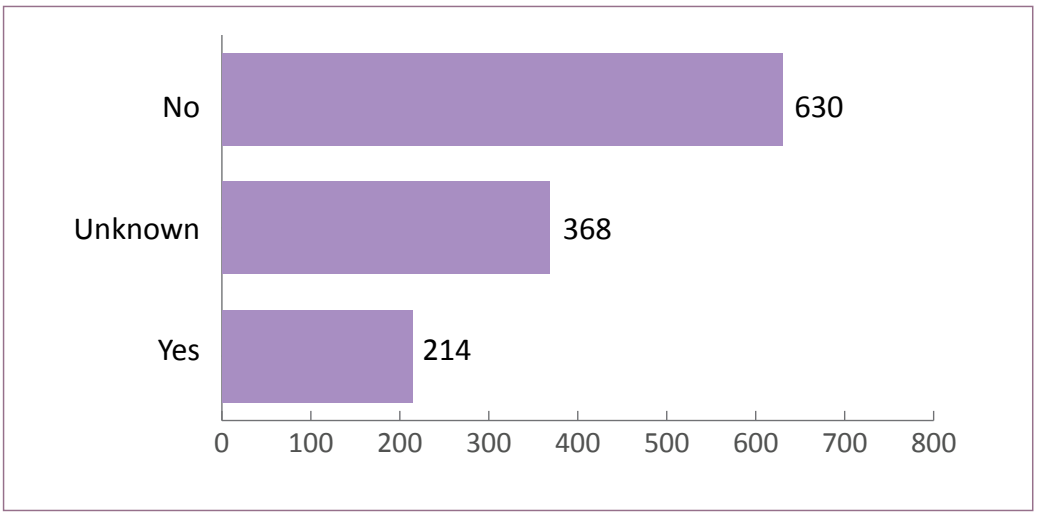


RACE/ETHNICITY

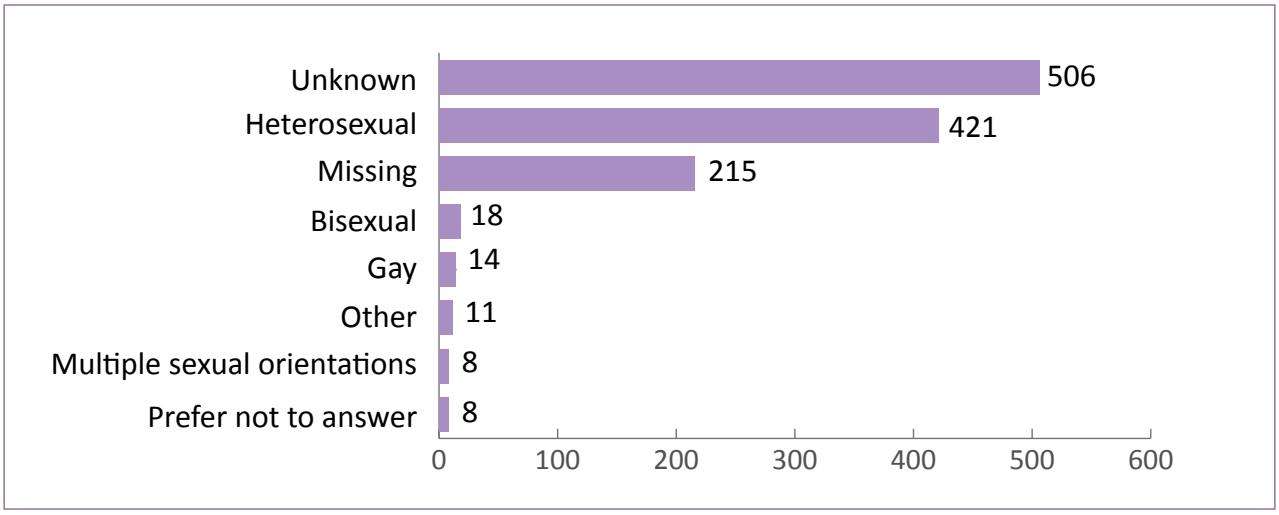


1 All data is derived from the ACBH billing and tracking system called INSYST unless otherwise noted.

DISABILITY STATUS



SEXUAL ORIENTATION



FY 22/23 Performance Indicators

FSP providers are continually working with ACBH to develop and/or refine performance indicators to document and highlight the impact of FSP services. Below are several indicators ACBH is tracking for the FSP partners. This is data from clients served from July 1, 2022 to June 30, 2023.

A. Reductions in Hospital Admissions:

Do hospital admits decrease in the years that a partner was active in an FSP, when compared to the year prior to program admission?

All FSP Episodes*	Pre Year: FSP Episodes with At Least 1 Hospital Admit	Year 1: Eligible Episodes**	Year 1: Episodes with Decrease in Hospital Admits	Year 1: Percent with Decrease	Year 2: Eligible Episodes	Year 2: Episodes with Decrease in Hospital Admits	Year 2: Percent with Decrease	Year 3+: Eligible Episodes***	Year 3+: Episodes with Decrease in Hospital Admits	Year 3+: Percent with Decrease
1,607	**667**	473	343	**73%**	350	274	**78%**	250	217	**87%**

*Total number of FSP episodes considered for the metric where there was a service in FY 22/23

**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.

B. 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 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
1,607	**667**	473	343	**73%**	350	274	**78%**	250	217	**87%**

*Total number of FSP episodes considered for the metric where there was a service in FY 22/23.

**Eligible Episodes – FSP episodes who had at least one hospital day in the 12 months prior to their Level 1 admission, and remained in the Level 1 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.

C. Primary Care visit within one year of service

The percent of active FSP partners who have completed at least six months of treatment who received at least one primary care visit within one year of their participation in the FSP. Metric excludes individuals with six or more months out of the community (in Subacute, MH hospital, and/or jail).

Fiscal Year	Eligible Clients	Clients with Primary Care Visit During this FY	% with Primary Care Visit During this FY
FY 2022-2023	685	541	79% (increase from 65% previous FY)

* Data Source: Anthem/Alliance/CHCN

D. 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
1,691	1,229	72% (similar to previous FY)

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

E. 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%.

Hospital/Crisis Episodes	Follow-Up in 5 Days	Success Rate
1,691	1,229	72% (similar to previous FY)

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

F. No Gaps in Service over 30 days

The percentage 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 2022-2023	32	32	100%

*Children's focused FSP metric only

G. Reduction in Jail Days – Overall

Of clients who completed six consecutive months during the 12- month fiscal year, percentage with a reduction in jail days, when comparing unduplicated days from the 12 months prior to the fiscal year to the current 12-month fiscal year.

Fiscal Year	Eligible Episodes	Episodes with Reductions	% Of Episodes with Reductions
FY 2022-2023	177	111	63%

Excludes clients if out of community (in hospital and/or subacute) for six or more months during the current fiscal year or the prior fiscal year.

This is a success story from the FSP called **Prevention, Advocacy, Innovation, Growth, and Empowerment (PAIGE)** that serves Alameda County Transition Age Youth (TAY)[2].

This story highlights the success of a young man who initially struggled to accept his mental health diagnosis and need for prescribed medications. He exhibited erratic behavior at his grandmother's home, where he lived, and this led to police involvement and an eventual stay away order from his grandmother's home. He was enrolled in Behavioral Health Court and attended weekly court dates for over 1 year. PAIGE staff supported him at each court hearing. He was provided psychoeducation around mental illness and medications, individual therapy, case management and supportive housing from the PAIGE team.

During this time, he was connected with vocational services through the Individual Placement & Support (IPS) evidence-based model and enrolled in Rising Sun, a training program that provides training in various trades and provides opportunities for people who complete the training to join Alameda County unions.

In December of 2022 this participant completed his training program and joined the Painters Union. In January of 2023 he graduated from Behavioral Health Court, his charges were expunged from his record and his grandmother attended his court graduation. He's still working with the PAIGE team, still taking all medications as prescribed, just turned 24, is still in the painter's union and is looking into enrolling in college.

2 The mural painting is from the MHSA funded Wellness Center called Casa Ubuntu at the Eastmont Town Center in East Oakland.

Full Service Partnership (FSP) Report Titles:

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 0-8) who are experiencing difficulties in school and/or may need intensive support services to stabilize.

FY 23/24 Budget: $805,396

How Much Did We Do?

I. FY 22/23: Number of Unique Clients Served: 25

How Well Did We Do?

II. Please Describe Ways that the Program Strives to 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.). We give families the control over who becomes a part of their Family Team and let their vision for their child and family drive the focus of team meetings. For some families, we provide a Family Partner who has personally experienced challenges with their own children (CPS, IEPs, etc.) in order to validate the caregivers' experiences and show them that receiving mental health support is valuable.

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 recently moved our offices to a new location which is more welcoming to families – including having a playground for necessary paperwork to obtain temporary guardianship, obtain social services funding, and add the

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Siblings, children, a Koi pond, ample outside areas, and comfortable offices. While we still meet with families +primarily in the community, some families have appreciated having a beautiful and quiet place to come to for appointments. 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. Over the past year, we have primarily provided services in-person; however, we are able to pivot and use telehealth when illness arises, or a family can't meet in person.

III. Language Capacity for this Program:

We provide services in the families' preferred language (English and/or Spanish). This year, we served 23 English-speaking families and 2 Spanish-speaking families.

IV. FY 22/23 Challenges:

Although COVID's impact has lessened over the past year, our clients continued to struggle with the impact. Many clients exhibited significant school avoidance and a greater dependance on screens for self-regulation. Many of the schools that we partnered with continued to have a backlog of IEP assessments to complete and significant staffing shortages which impacted on our clients. Our program had difficulty connecting clients to outpatient therapy and other resources due to long waiting lists and staffing shortages, which made it challenging to close cases as we always want to ensure that clients and families are connected to necessary support before termination.

Is Anyone Better Off?

V. FY 22/23 Client Impact:

Here is a case story submitted by one of our Care Coordinators that highlights some of the interventions provided by Connections 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.)**
Our wrap team has been working with an eight-year-old boy, Jason, and his family since January of 2022. Jason was referred to the program due to significant concerns regarding family safety, exposure to violence, parental drug use, and risk of homelessness. The school had filed multiple CPS reports and Jason's mother presented as stressed by his behaviors in the home. Additionally, Jason had behavioral challenges at school, a speech and language impairment, and concerns about the need for psychiatric mediation to address ADHD symptoms. Jason was living in a transitional housing program with his mother and older brother. Although the family had support from Jason's maternal grandparents, the relationship between grandfather, grandmother, and Jason's mother was very strained and frequently volatile.
Our Care Coordinator immediately began to collaborate and build relationships with Jason's mother, school staff, grandfather, grandmother, and the transitional housing program staff. She worked to support mom with financial and transportation resources to ensure that Jason and his sibling could get to school consistently. However, within a few months of opening WRAP services, Jason's mother was briefly arrested and kicked out of her transitional housing program. When grandfather agreed to step-in to take care of Jason and his two older brothers (one of whom was already living with him), our Care Coordinator shifted to supporting grandfather with all the resources that he needed. She worked with him to

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complete the to his Section-8 to ensure stable housing. She connected him with Legal Assistance for Seniors, Homeless Action Center, and Kinship Support Services. She continued to communicate with Jason's mother, working to include her in decisions and support healthy communication between family members.

Both our Care Coordinator and Support Counselor worked to support the social and emotional well-being of Jason (and often his siblings) by providing safe spaces to communicate their feelings. They also offered consistent support at the school and home, collaboration with Jason's pediatrician & psychiatrist regarding ADHD medication, and worked to promote positive routines in the home (chores, responsibilities, routines, etc.). In addition to supporting Jason's grandfather with his many financial and resource needs, our Care Coordinator provided the emotional support and reflection to help grandfather consider how he wanted to communicate with his daughter and care for his grandchildren more intentionally. When Jason's mother became pregnant, our Care Coordinator continued to link her to services and support her search for housing and stability.

As Jason's circumstances have become more stable and predictable, Jason's behaviors have also stabilized. He is doing well in school and has consistent medication support for his ADHD symptoms. He recently made the honor roll at his school for 2 semesters in a row and often helps students in his class with math after his teacher noticed that he excels in this subject area! Although his grandfather still experiences stress, his finances have become more robust and both grandfather and mother are able to meet together to discuss how to care for Jason and his siblings both independently and in regularly held Family Team Meetings. Jason's mother has recently moved into an apartment with Jason's new half-sister and the family continues to consider how to work together to meet the needs of Jason and all of his siblings as they prepare to transition back to Mom's care in the future.

VI. FY 22/23 Additional Information: None

VII. Projections of Clients to be Served:

FY 23/24	20
FY 24/25	20

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FULL SERVICE PARTNERSHIP (FSP) REPORT

FSP #: FSP 17

PROVIDER NAME: Fred Finch Youth and Family Services

PROGRAM NAME: East Bay Wrap

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

Target Population: East Bay Wrap-FSP serves youth aged 8-18. The entry criteria include having repeated or recent hospitalizations; or having at least 2 of the following: Failed multiple appointments with past providers; School absenteeism; Risk of homelessness; High score for trauma on CANS or Lack of significant progress in Therapeutic Behavioral Services (TBS).

FY 23/24 Budget: $3,344,938

How Much Did We Do?

I. FY 22/23: Number of Unique Clients Served: 30

How Well Did We Do?

II. Please Describe Ways that the Program Strives to Reduce Mental Health Stigma:

There are many ways in which the East Bay Wrap (EBW) program is striving to reduce mental health stigma. The team is staffed with youth and parent partners who have lived experience. Families have reported that having a staff team member who has navigated similar struggles helps them to feel less judged and "able to be themselves" thus creating a more therapeutic environment for permanent change to occur. EBW also provides advocacy and psychosocial education about the 3 stigmas of mental health (public, self and systemic) to families, participants and natural supports in an effort to reduce stigma and shame around accessing mental health services. EBW staff are encouraged to use each participant's preferred language of people first vs identity first language in reference to their mental health challenges and disabilities. Using a participant's preferred identity language actively empowers EBW participants and their families to realize that their mental health challenges and disabilities are important parts of their identity that should be held without shame while also acknowledging the intersectionality of their many identities.

III. Language Capacity for this Program:

While most of EBW staff are English speakers, we have the capacity to provide services in most languages through the use of translation services, including ASL. All participants and their families have the option of video, telephone and/or in-person translation. EBW continues to actively recruit staff who are fluent in the languages of the populations of the program.

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IV. FY 22/23 Challenges:

Throughout fiscal year 22/23, staffing the program continued to be a barrier to providing more access to services to the families that we serve. The demand for mental health services continued to rise while the supply of providers, especially clinicians, continued to decline. The Youth Partner is also a difficult position to fill and maintain constant staffing. Unfortunately, this resulted in high turnover. At one point, the Program Director had a full caseload in addition to the clinican asigned to the program to ensure that families were able to access services.

Is Anyone Better Off?

V. FY 22/23 Client Impact:

EBW has made a significant impact on the participants of the program. Most participants have reported at least a 50% reduction in symptoms at discharge. Families have also verbalized having stronger connections with each other and the communities that they reside in. School attendance continues to improve for the youth in the program. Most participants and families have successfully transitioned to lower levels of care and benefited from aftercare resources provided at discharge.

VI. FY 22/23 Additional Information: N/A

VII. Projections of Clients to be Served:

FY 23/24	40
FY 24/25	45-50

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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.

FY 23/24 Budget: $721,429

How Much Did We Do?

I. FY 22/23: Number of Unique Clients Served: 80

How Well Did We Do?

II. Please Describe Ways that the Program Strives to Reduce Mental Health Stigma:

STAY offers family partner services to all participants in the program, and should they choose to participate in this service, there is intentionality in discussing and addressing stigma with loved ones of participants so that those natural and primary supports are equipped to understand and support participants with mental health conditions.

STAY provides periodic events and activities which increase community for the participants in the program. Participants are invited to help choose, plan, and execute the activities. Through this initiative, mental health experiences are normalized and validated amongst peers within the program.

III. Language Capacity for this Program:

All program staff have access to the county language interpretation resources. In addition, one Clinical Supervisor, one Mental Health Counselor, and one Care Facilitator/Family Partner are bilingual and able to provide services in both English and Spanish.

IV. FY 22/23 Challenges:

When already experiencing a staffing shortage, STAY experienced additional turnover from July – October 2022, losing 2 clinicians, an employment specialist, and a peer mentor. All employment and education services were provided by one staff, the Employment Supervisor, from estimated October 2022 to February

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2023. At times in the year, STAY asked Alameda County to pause referrals. Once adequate staffing was achieved in late Spring 2023, county ACCESS have been slow to increase referrals to STAY, additionally impacting the programs' capacity to grow in census.

Is Anyone Better Off?

V. FY 22/23 Client Impact: Employment and education services have been enhanced in the last year through care coordination with employment and training programs. At least 3 participants have graduated from a dual high school and employment skills program, and 2 participants are actively engaged in a baking training program. It is expected that through ongoing engagement and collaboration with these programs, participants will have increased skills to effectively join the work force in the area of interest they prefer. One participant in particular, who initially came to the STAY program while particicpating in a residential substance use treatment program, was the Valedictorian of their class.

VI. FY 22/23 Additional Information:

VII. Projections of Clients to be Served:

FY 23/24	75
FY 24/25	75

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FULL SERVICE PARTNERSHIP (FSP) REPORT

FSP #: FSP 21

PROVIDER NAME: Bay Area Community Services

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

Program Description: The program 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.

FY 23/24 Budget: $360,712

How Much Did We Do?

I. FY 22/23: Number of Unique Clients Served: 62

How Well Did We Do?

II. Please Describe Ways that the Program Strives to Reduce Mental Health Stigma:

PAIGE team builds our services around the goals that participants have for themselves, and we view participants as experts on how their mental illness effects their lives and how mental health symptoms show up for them. We use recovery-centered language and meet participants where they are at, provide psychoeducation as necessary, and normalize their struggles. We see ourselves as partners in our participants recovery journey and provide safe, judgement free spaces for our participants to process their feelings. We provide psychoeducation to families and other natural supports so that participants can be better supported in ways that do not reinforce societal stigmas around mental health. We also connect participant's family members and supports to groups like NAMI so that they can receive support for themselves, as well as resources and information. We organize events where participants from the team can meet each other, be around peers and build friendships in the community. We also link participants to community groups/resources where they can join groups and participate in activities with peers. Our peer support staff share their lived experience which can build trust and normalize mental health struggles, substance use struggles and experiencing homelessness. Working with peer supports on PAIGE might be the first opportunity that our participants have to receive mental health services from someone who knows firsthand the barriers and paths to recovery.

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

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IV. FY 22/23 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 22/23 Client Impact:

The PAIGE team has been able to witness and celebrate multiple successes with our participants in the past year. We were able to provide financial support for 2 participants to complete a veterinary assistant program and both have since found competitive employment in that field. 7 participants graduated to a lower level of care. The mother of a participant who graduated to a lower level of care, and is currently in college, told me that the support and services offered by the PAIGE team had saved her son's life and allowed their family to rebuild positive relationships. We have been able to engage and serve participants who have not previously engaged with outpatient mental health services, and we've been able to reduce, overall, psychiatric hospitalizations. Many of our participants met with our psychiatric prescribers this year and we have been able to offer a combination of face to face and telehealth visits, depending on which would be the most beneficial for individuals. Multiple participants received IPS services and were connected to educational and employment opportunities. We celebrated 2 participants earning their high school diplomas this year. We were able to increase the number of participants who were linked to and had appointments with their PCP, which reduces their contact with medical emergency rooms and supports them in receiving preventative medical care. We have held social events and support groups which has led to friendships among participants that have extended outside of PAIGE team events. We have been able to provide financial support to multiple participants while they wait to hear if they'll be approved for SSI which has allowed them to live in supportive housing, utilize public transportation, and have access to basic necessities that would be difficult for them to access otherwise.

I'd like to highlight the success story of a young man who initially struggled to accept his mental health diagnosis and need for prescribed medications. He exhibited erratic behavior at his grandmother's home, where he lived, and this led to police involvement and an eventual stay away order from his grandmother's home. He was enrolled in Behavioral Health Court and attended weekly court dates for over 1 year. PAIGE staff supported him at each court hearing. He was provided psychoeducation around

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mental illness and medications, individual therapy, case management and supportive housing from PAIGE team.

During this time, he was connected with IPS services and enrolled in Rising Sun, a training program that provides training in various trades and provides opportunities for people who complete the training to join Alameda County unions. In December of 2022 this participant completed his training program and joined the Painters Union. In January of 2023 he graduated from Behavioral Health Court, his charges were expunged from his record and his grandmother attended his court graduation. He is still working with the PAIGE team, still taking all medications as prescribed, just turned 24, is still in the painter's union and is looking into enrolling in college.

VI. Additional Information:

Paige team plans on implementing initial TDMs (team decision meetings) when participants join our program, and have them as often as needed, but at least yearly ongoing. We would like to increase the number of psychoeducation and process groups we provide to participants. We would also like to incorporate a parent/natural support group to link parents and natural supports with each other to reduce the feelings of isolation and loneliness that caregivers, supports and family members have reported to us while attempting to support their loved ones. PAIGE team will continue to schedule group outings and social gatherings to provide a sense of community to our participants. We plan to find creative, solution-focused and innovative ways to support our participants in ways that can support long lasting change, in reaching their goals.

VII. Projections of Clients to be Served:

FY 23/24	72
FY 24/25	72

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FULL SERVICE PARTNERSHIP (FSP) REPORT

FSP #: FSP 4

PROVIDER NAME: Abode Services

PROGRAM NAME: Greater HOPE FSP

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

Target Population: Chronically homeless adults

FY 23/24 Budget: $ 4,829,962

How Much Did We Do?

I. FY 22/23

a. **Number of clients served:** 131

How Well Did We Do?

II. Please describe ways that the program strives to:

a. **Reduce Mental Health Stigma**

Staff strive to continually reduce mental health stigma in the community through a variety of avenues. Our program works with several partners for housing and have to provide ongoing education about how participants will present in housing and some challenges they might have as a result of their symptoms. Staff work to provide strategies and support so that participants can successfully maintain in the community.

This year we also had support from an Employment Specialist who has been able to successfully engage with employers to link participants to jobs. Our Employment Specialist spent several hours in the field weekly speaking to employers about the benefits of hiring participants from our program as well as education on how to successfully manage and continue to engage participants ongoing. Our Employment Specialist was able to match at least five participants to jobs and engaged with over 20 employers in our community.

Our staff strive to be present in the community and show partnership in addressing Mental Health. One way that we do this is by attending community meetings to hear concerns of business and residents and address these concerns by providing education and insight into what mental health looks like and strategies for engagement with those who live with it.

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b. Create a welcoming environment:

Our front lobby was reopened this past fiscal year post COVID. From our lobby we provide participants with food, water, coffee, hygiene supplies, clothing, and a staff to greet them daily from their FSP Program. We also continued to gather feedback from our Consumer Advisory Board regarding their experience coming to our offices and incorporated their feedback around what they liked (warm food, coffee etc.) and what could be better (a main line with hours of operation, training new hires on how to quickly help them connect with their Case Manager and helping them more quickly access their mail/checks).

III. Language Capacity for this program:

We use the Alameda County language line for interpreter services as well as our internal application Boost lingo as needed.

IV. FY22/23 Challenges:

Hiring has continued to be a significant challenge during the past year. There has continued to be a reduction in applicants for Management and Clinical positions in particular. During the last quarter we hired a behavioral health recruiter specifically for clinical positions and have been able to hire a new clinician and two Program Managers with her support since that time.

Is Anyone Better Off?

V. FY 22/23 Client Impact:

The team continues to see an increase in graduating participants to lower levels of care. Four participants stepped down in the last year, three of these participants had been with the program for over 5 years. One participant who is preparing to graduate has been in the Greater HOPE FSP Program for over 10 years. He has been stably housed, navigates the community independently, has resumed playing guitar after 20+ years of fear of playing due to mental health symptoms, he manages his medication, and finances independently and has been a part of our Consumer Advisory Board for the past year. He takes day trips independently and will be stepping down to a lower level of care.

VI. FY 22/23 Additional Information: None

VII. Projections of Clients to be Served:

FY 23/24	150
FY 24/25	150

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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 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 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.

FY 23/24 Budget: $3,870,411

How Much Did We Do?

I. FY 22/23:

a. **Number of Unique Clients Served:** 855

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

a. **Reduce Mental Health Stigma:** The program supports participants with their goals of living independently. As housing challenges arise due to someone's mental health, Abode quickly assesses the need to support their mental health and links them to their case manager/TSS provider for support.
b. **Create a Welcoming Environment:** Abode provides housing choice when possible, and support. The housing team is diverse and connects with the participants by meeting them where they are at.

III. Language Capacity for this Program:

Abode utilizes a language line that is available for all staff.

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IV. FY 22/23 Challenges:

- Property Managers sometimes feel confused about who to contact when tenant issues arise. Property Managers don't always respond in a timely manner to emergency maintenance issues that have arisen.
- Some participants do not have the skills to engage in their housing retention plans and sometime lack insight into behavior causing lease violations. Housing and Services need to continue to rebuild communication amongst each other so that staff splitting is not occurring.
- Staying within Fair Market Rate (FMR) and/or rent reasonableness (RR) within Alameda County is extremely challenging with the rental market as it is today. There is an increasing need for 1st floor and ADA units for our aging population who is becoming more disabled. These units are very difficult to secure and can delay a participant from moving in or relocating.

Is Anyone Better Off?

V. FY 22/23 Client Impact:

The vast majority of participants that we serve have remained housed and when challenges have come up, we have provided the support to move into a suitable location. Over 90% of RALE participants remained stably housed in FY 22/23.

VI. FY 22/23 Additional Information:

- Abode has increased landlord relationships and increased retention due to Abodes dedication in ensuring that the participants and Landlords needs are met, and that housing staff are responsive.
- Abode housing staff collectively works together to resolve issues when the solution is unclear and have shown the ability to continue working under changing and sometime sometimes challenging circumstances.

VII. Projections of Clients to be Served:

FY 23/24	990
FY 24/25	990

VIII. FY 23/24 Programs or Service Changes:

The RALE program has fully adopted the PRHT housing/rehousing model where the Real Estate Team and Unit Matcher locate units and support participants through the application process, and the Housing staff to focus on tenant housing stability along with continuously improving relationships with Property Managers. Abode staff will participate in a day-long RALE Summit to review program policies and guidelines, share best practices and challenges and receive trainings on landlord and partner engagement. This Summit will be provided by Alameda County's Office of Homeless Care and Coordination's / Housing Services RALE Program Lead

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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.

FY 23/24 Budget: $ 413,945

How Much Did We Do?

I. FY 22/23:

a. **Number of Unique Clients Served:** 343 individuals received outreach support for the FY 22/23

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

a. **Reduce Mental Health Stigma:** Project HOPE serves a diverse group of houseless individuals in the Tri-Valley, Mid and East County areas of Alameda County. HOPE staff use a trauma informed approach and communicate with and about a person using person first language. Staff receive ongoing training around Unconscious Bias, LBGTQIA, Knowing Your Privilege and Diversity and Inclusion training. This informed the person centered, strength-based approach with engaging individuals who are hard reach.
b. **Create a Welcoming Environment:** HOPE staff met individuals in areas that were comfortable for them. Staff approach individuals in a friendly manner and pay close attention to the boundaries individual display including approaching their identified area, use their preferred name and pronouns. Upon connecting with individuals, HOPE staff build a connection and keep a supply of hygiene kits, water, clothes, blankets, tents, transportation vouchers and community resources in case individuals request those items. HOPE staff can complete assessments for individuals who indicate they want emergency, interim and permanent housing. The agency also provides links to housing resources and navigation centers.

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.

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IV. FY 22/23 Challenges:

The HOPE program experienced work force recruitment and retention challenges. Homeless Management Information System (HMIS) not properly capturing information leading to automatic exits. New guidelines on how to access Homestretch funds made it difficult to support people in a timely manner. Extreme weather conditions (Winter storms and summer heatwaves) impacted the community efforts to engage the houseless communities.

Is Anyone Better Off?

V. FY 22/23 Client Impact:

HOPE strengthen relationship with emergency shelters, navigation centers and City-Serv for more navigation support. Of the 343 outreached, 29 adults, 16 families accepted emergency shelter, 2 individuals who were outreached went from the streets to their own subsidized place (tenant and subsidy), 3 accepted short-term motel stays, 6 were reunited with family and 43 increased income including 7 with earned income. As the workforce stabilized, the HOPE project was able to build a trusting relationship in the community served so they can better meet the needs.

VI. FY 22/23 Additional Information: N/A

VII. Projections of Clients to be Served:

FY 24/25	N/A
FY 25/26	N/A

VIII. FY 23/24 Programs or Service Changes:

HOPE no longer operates a mobile van clinic, but the agency uses a van to connect with the unhoused community which allows for more flexibility to move between targeted communities.

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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.

FY 23/24 Budget: $540,687

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;
   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;
5) 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;

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6) Referrals, coordination, clinical consultation, training, and oversight of a network of more than 450 licensed board and care and permanent support housing slots countywide;
7) Housing education and counseling sessions at ACBH-funded Wellness Centers and other community locations;
8) Rental Assistance and Landlord Engagement (RALE) 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;
9) Staff involvement and financial support toward countywide efforts focused on addressing homelessness;
10) MHSA affordable housing project application preparation in partnership with nonprofit affordable housing developers.

Coordinated Entry System:
The County's Coordinated Entry System (CES) for addressing homelessness, formalized in 2017, underwent significant changes that started rolling out in FY '22 and were fully implemented in FY '23. Coordinated Entry ensures coordinated and equitable access to the resources managed by the Housing Crisis Response system. One change includes ensuring that everyone has access to housing problem solving services, that flexible funding is available to support creative housing solutions and that there is increased transparency so that housing resolution plans can be successful, and people are able to take informed next steps. Ongoing 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):
During FY2223, OHCC worked collaboratively with cities, other county departments, and affordable housing developers towards bringing state funded No Place Like Home (NPLH) Program efforts of creating more supportive housing for homeless individuals with a serious mental illness, online. Counties must commit to providing supportive services to NPLH tenants for a minimum of 20 years. NPLH set aside units will be restricted as affordable to the NPLH target population for a minimum of 55 years; referrals will be facilitated through the Coordinated Entry System. In total, 562 NPLH units will be brought online within Alameda County and will support expansion of units dedicated to those experiencing homelessness and SMI. During FY2223, a total of 75 NPLH units within four sites came online.

Housing Assistance Fund:
The HCSA Housing Assistance Fund provides one time, or short-term financial assistance for housing costs for applicants who are receiving specialty mental health services from Alameda County Behavioral Health Care Services (ACBH) or one of its contracted service providers. Applicants must be either homeless or at risk of losing their housing and working with an ACBH-approved provider aiding in stabilization of housing situation as well as prepare the Housing Assistance Fund application. Funds may be used for: Back rent/arrears that a client owes and must be paid to avoid an eviction; Security deposit on a new place to live and/or first month's rent, or short-term/temporary housing payments while permanent housing or stable income is being secured. All payments are made to third parties (landlords, property managers or hotel/motel operators). During FY2223, a total of 95 unique clients were supported within the Housing Assistance Fund.

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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 Community 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 support as approved/included in their Exhibit A-Scope of Work (SOW). The program offers a range of services 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.

FY 23/24 Budget: $ 5,551,208

How Much Did We Do?

I. FY 22/23:

a. **Number of Unique Clients Served:** 341
b. HSP remains increased its portfolio adding three Adult Residential Facilities (ARFs) that included a 42-bed new home and two Residential Facilities for the Elderly (RCFEs) in locations with limited supported housing.

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

a. **Reduce Mental Health Stigma:** HSP provides 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

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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 promotes client preference by working with referring agencies and applicants to find the best match fit within the agency portfolio. Applicants are offered in person and a 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 the 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 Globo Multilingual Line. Signage and flyers are in Alameda County threshold languages.

IV. FY 22/23 challenges:

Licensed Residential Care homes are continuing to close at a high rate. One operator that had served clients for over two decades closed; this resulted in a loss of 10 beds. Individuals were supported in relocating to other sites. HSP providers report difficulties in recruiting and retaining adequate staff levels as the population present high level of needs and acuity. Referring agencies and community partners experienced high turnovers which impacted care coordination leading to increase psychiatric and medical crises. HSP providers also highlight the increased expense with standard costs such as food, utilities, etc impacts their bottom line. In addition, limited business insurance options. One of the long-term insurance agents passed away during this fiscal year. He helps insurance 90% of the HSP homes.

Is Anyone Better Off?

HSP experienced a higher volume of referrals for FY 22/23. Of the 17 congregate facilities with shared rooms, only four homes experienced a COVID 19 outbreak. Flexibility within HSP allows for transfers when a home cannot meet the need of residents. 42% of the Clients, have benefited from HSP services for over a decade, and there are 12% with over 2 decades stay.

One of the new HSP 42 bed facilities was at capacity within a year. The home's location, size of the lot and rooms and the staff's capacity to support with Activities of Daily Living made it a preferred site for referring parties and applicants.

HSP providers rallied around a long-term provider who closed their business of twenty years at the end of the fiscal year. Six of the eight displaced residents were housed within a short period of time in other HSP homes due to strong network of support and collaborative spirit amongst the board and care owners.

HSP providers with the support of their county assigned liaison, systemize admission, housing stability and discharges from the home. Homes dug deep into evaluating and admitting residents. Homes worked closely with service teams to address challenging behaviors from these same residents.

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In addition, some operators reported higher housing retention rates due to increased collaboration with community partners, planned care coordination and access to crisis support programs. Through those established network and system coordination homes were able to admit residents who hard to place due to their complex medical needs as well as those individuals stepping down from State hospitals.

V. FY 22/23 Client Impact:

HSP consists of owners and operators who have been in business on average over 10 years. Their dedication and commitment 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.

Before and after admission to HSP data shows psychiatric hospitalizations decreased, outpatient services, medication support services and client contact increased. Post admission to HSP, crisis intervention and crisis stabilization increased.

98 of 341 of the clients have benefited from HSP services for 10+ years. 29 residents in HSP have lived at their current housing for over 2 decades. This shows the dedication of the homes and the satisfaction of the clients served.

VI. FY 22/23 Additional Information:

HSP solicits Request for Proposal (RFP) bi-annually; potential HSP providers are offered an Informational meeting to increase HSP portfolio. Supportive Housing Community Alliance Land Trust (SCHLA) held listening sessions and administer survey to determine to identify gaps and opportunities with board and care. Highlights indicate hiring and maintaining staff was a challenge, along with the high cost of living and operations of a licensed facility as well as acute needs of formerly unhoused individuals with mental health diagnoses and substance use disorder. The findings of the report will shape the technical assistance HSP providers need for long-term planning and sustainability. Alameda County applied and was awarded Community Care Expansion Preservation funding to assist with some of the areas highlighted in the SCHLA board and care report.

VII. Projections of Clients to be Served:

FY 23/24	275-320
FY 24/25	

VIII. FY 23/24 Programs or Service Changes:

Additional recruitment efforts and a twice-per-year Request for Proposal (RFP) have resulted in expansion of operators. One new operator, representing three new sites, are currently in contract negotiations to come online during FY 23/24.

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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 support 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.

FY 23/24 Budget: $ 788,716

How Much Did We Do?

I. FY 22/23:

a. **Number of Unique Clients Served:** 105 unique clients served.

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

a. **Reduce Mental Health Stigma:**
BACS OPC is committed to being low barrier and quick access for unhoused populations. OPC staff meet enrollees where they are and make sure their basic needs are met and offer person centered services and referrals.

Standard staff trainings to address stigma and biases are:
1. Working Effectively with LGBTQI population
2. Cultural Competence Training
3. Critical Time Intervention (CTI)

b. **Create a Welcoming Environment:**
BACS OPC staff are community based. Part of the engagement and outreach process include offering hygiene kits, access to food and other hierarchy of needs. BACS office space is a home-like environment where visitors can use kitchen space to heat up food and or make coffee and tea. There is a staff or ambassador to great members visitors to their sites. There are private offices and conference room for confidential meetings.

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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 22/23 Challenges:

Enrollees with acute psychiatric needs and substance use disorder (SUD) has been an engagement challenge. The threshold for psychiatric holds are high and individuals are too acute to consent to voluntary services. Alameda County SUD system to care has been difficult for unhoused and transient applicants to access and complete all the steps required to access SUD care. Alameda County saw a rise in fentanyl overdose. Unusual bad weather during the Winter made it difficult to locate unhoused individuals.

Staffing: OPC experienced a high turnover and transition in the dept that also impacted enrollee engagement and care. Alameda County is experiencing workforce development challenges due to high cost of living and competitive recruitment from Counties with more affordable housing.
Housing: There is limited low-income housing or transitional housing for individuals with SSI or less income.

Is Anyone Better Off?

BACS OPC exceeded contract deliverables serving over 105 unique individuals with 55% increasing income at discharge, 85% obtaining health insurance, 85% decreasing crisis system of care contacts and 60% discharged to permanent supportive housing or rapid re-housing.

V. FY 22/23 Client Impact:

BACS OPC identified Critical Tine Intervention as critical tool used to successfully move enrollees through the program. This led to decrease incarceration and crisis services and increased success with transitions to more independent living. BACS OPC reported enrollees during this time period showed increased interest in employment and education with a handful obtaining competitive employment and enrolling in educational programs. BACS OPC identified community resources such as benefits representative programs, social services agencies, housing resource centers and navigation centers, employment agencies, credit repair programs, discounted membership programs from gyms, DMV and other enrichment agencies as essential to enhancing the lives of individuals served in their program.

VI. FY 22/23 Additional Information:

BACS OPC staff is field based and worked throughout the pandemic and winter weather challenges to serve vulnerable unhoused populations.

VII. Projections of Clients to be Served:

FY 24/25	50-75
FY 25/26	50-75

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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 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.

FY 23/24 Budget: $3,870,411

How Much Did We Do?

I. FY 22/23:

a. **Number of Unique Clients Served:** 160

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

a. **Reduce Mental Health Stigma:**
BACS recognizes that landlords participating in RALE are joining the effort to address the homeless crisis in the county and that the clients being housed are vulnerable and have high needs. BACS upholds a client centered and trauma informed approach which meets client's where they are in their journey to live and thrive with hope. The RALE Team understands that symptoms do not define the person and a housing first approach is necessary as the foundation to address other health needs. The RALE Team is part of the county's Supported Housing Learning Collaborative which is guided by a curriculum of training founded in the REAL BASIC framework. This framework promotes partner engagement and empowerment through respectful relationships, cultural and experiential understanding, and validation. In addition, BACS works with landlords to ensure them that partners are being provided with wrap around support services to meet their mental health needs whenever possible.

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b. Create a Welcoming Environment:

BACS strives to create office sites staffed by those with lived experiences and that reflect the diversity of the community. BACS and staff regularly meet with partners and landlords to discuss how to respectfully engage partners and resolve issues that affect housing. These interactions uphold the self-determination and dignity of partners and the development of self as a resource while also holding up the rights and program expectations of landlords. The BACS team meets regularly with the county's RALE program lead, a clinician and trainer, who creates brave space to discuss authenticity, self-awareness of power and privilege and lift-up cultural affirming practices to help build effective engagement and trusting relationships with program partners. BACS RALE Program Manager is available to speak with both partners and Landlords when issues arise. BACS conducts visits at the sites to ensure that the environment is safe and welcoming to the diverse partners served. On March 16th, BACS held a Landlord Appreciation Day at one of its' sites to pay tribute to our participating landlords and to provide a great opportunity to meet and great our community partners. The event was a huge success.

III. Language Capacity for this Program:

Fortunately, all RALE partners speak English, and the BACS is able to easily communicate with each of them. If needed, BACS has access to GLOBO Language Solutions, who will provide over the phone multilingual interpretation services to individuals who are non-English speaking or limited English proficient.

IV. FY 22/23 Challenges:

Issues related to partners' non-compliance can be very challenging. Housing Locators have expressed the need for more case management support and feel that they must take on case management duties in order to manage the landlord relationship. And staff feel that they have no recourse to address when partners are being verbally abusive, threatening, or using racial slurs and behaving inappropriately towards them.

Before the lifting of the Eviction Moratorium, the RALE team has expressed concern that our program does not truly have in place ways to terminate a partner from the program when necessary. The Project Manager is working with the staff to ensure that they are properly documenting issues and issuing Non-Compliance and Notices of Termination of Subsidy letters after all measures have been taken. Policies and guidelines are not consistently used by staff. The staff feel that their interpretation of the program's rules and policies have not always been accurate. It would be helpful for our partners to participate in housing workshops specifically designed to explain program rules and develop reasonable expectations. This is especially important when it comes to holding our partners accountable for their behaviors, actions and non-engagement.

Is Anyone Better Off?

V. FY 22/23 Client Impact:

160 partners have maintained their housing through long term tendency or rehousing efforts.

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VI. FY 22/23 Additional Information:

VII. Projections of Clients to be Served:

FY 23/24	175
FY 24/25	175

VIII. FY 23/24 Programs or Service Changes:

The RALE program has plans to hire an additional Housing Locator and will be able to enroll additional individuals into our program. BACS staff will participate in a day-long RALE Summit to review program policies and guidelines, share best practices and challenges and receive trainings on landlord and partner engagement. This Summit will be provided by Alameda County's Office of Homeless Care and Coordination's/Housing Services RALE Program Lead.

Success Stories

BACS team had several success stories to share:

"*Rina keeps her apartment in ship-shape and has a garage she has converted to a play area for her children. She says Bacs changed her life and gets tears thinking about how she lived before. She says she can never be grateful enough for the services and support she has received since being housed in 2017 at this location.*"

"*Client, Beverley Rollins, resided at Pacifica Senior Living in Oakland. She engaged in nuisance behavior and received multiple lease violations. I worked with her and her family around addressing the behavior. The nuisance behavior continued, and she was ultimately issued a 30- Day Notice to Terminate. At the time, she also struggled with alcohol use which impacted her behavior and jeopardized her housing.*

I collaborated with her family to transition her from Pacifica Senior Living (avoided the eviction) and she entered medical detox. Afterwards, she transitioned to a treatment facility in Oakland then to Fremont.

*Once she completed the 90- day treatment program, she successfully transitioned to a 1 BD unit in Alameda where she was in close proximity to support groups and family members. Since moving to Alameda in May 2023, she has received ***zero** lease violations and continues to access AA meetings in the community for added support*."

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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 ten designated beds for guests 18+, who are literally unhoused and eligible for Alameda County Behavioral Health (ACBH) services.

FY 23/24 Budget: $ 302,761

How Much Did We Do?

I. FY 22/23: Number of Unique Clients Served: 82

How Well Did We Do?

II. Please Describe Ways that the Program Strives to Reduce Mental Health Stigma:

Screening/admission tailored environment for individuals to reduce triggers and trauma responses. 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 inform the service delivery throughout an individual's stay. Training on cultural competency, boundaries, trauma-informed care and implicit biases are standard onboarding trainings.

III. Language Capacity for this Program:

Staff on site speak English. Within the agency, staff also speak Spanish. Interpretation and Language Line is available for guests and staff. Signages are in Alameda County threshold languages.

IV. FY 22/23 Challenges:

USV/Harrison experienced significant staff changes for FY 22/23. The cook position has been vacant for over a year due to limited interest. There were limited housing options for individuals with no income or General Assistance/Cal Fresh income, and there was an uptick of individuals with high needs and limited support, leading to quick exits from the program. The Bay Area experienced significant flooding during the Winter, and the shelter experienced weather-impacted building issues. Significant substance use led to early exits for residents, mostly under 40.

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Is Anyone Better Off?

USV/Harrison House team created a system where shelter residents were assessed through Coordinated Entry within three mos shelter of admission, residents were doc-ready within six months of admission, and decreased length of stay for the average shelter admits. Eleven leavers engaged in housing problem solving by moving in with friends and/or family.

V. FY 22/23 Client Impact:

The USV/Harrison House team created a schedule of groups to promote life skills and community living. Staff also provided enrichment activities, such as celebrating major holidays and birthdays as a community. USV/Harrison House staff also provided space for residents and staff to discuss grief and loss after the current and former community passed away. Staff also provided job readiness groups for shelter residents. A long stayer finally secured income after three years of refusing to share her identity of record. Shelter staff and her outpatient provider worked closely to build trust and set goals at this person's comfort level. She is in the process of securing SSI benefits. Another long stayer with a history of substance use disorder (SUD) began working on her sobriety by attending groups thrice a week. Her sobriety led to her applying for housing and a guard card independently. She eventually moved into her own apt after a year at Harrison House. She is one of the 53% of leavers who left the shelter with increased income and/or benefits. The shelter lead stated, "The participant is an example of how progress can take time, but when it happens it is a beautiful thing for the participant and everyone else involved."

VI. FY 22/23 Additional Information:

BOSS also maintained a partnership with Samuel Merritt's Nursing Program. Due to Winter floods and under the guidance of the City of Berkeley Public Health dept, Harrison House resumed its ten-bed capacity for ACBH participants before the end of the COVID-19 moratorium. BOSS QA dept set up tracking to ensure all staff are SOAR certified.

VII. Projections of Clients to be Served:

FY 24/25:	60-80
FY 25/26:	60-80

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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.

FY 23/24 Budget: $ 358,971

How Much Did We Do?

I. FY 22/23:

a. **Number of Unique Clients Served:** 41

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 is honored. Since COVID protocol restrictions were lessened and eventually expired, Casa Maria has existing residences that offer tours and answer questions about the program.

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III. Language Capacity for this Program:

Staff primary language spoken is English. BOSS as an agency has a Spanish speaker on staff and uses Alameda County Globo Multi-Lingual Line.

IV. FY 22/23 Challenges:

Moving toward a post-COVID program, it has been difficult to engage isolative and non-responsive residents, so the agency experienced delays in getting individuals the documentation needed for housing opportunities. Casa Maria has maintained staff for the FY 22/23, but community partners who provide housing navigation and care coordination experience high turnover with staff, which impacted workflow and response time to alerts. Length of stay (LOS) increased for some residents due to lease-up delays with new housing projects.

Is Anyone Better Off?

Casa Maria met contract deliverables, with 63% of residents moving to permanent supportive housing and 89% exiting with insurance and GA income.

V. FY 22/23 Client Impact:

Casa Maria continues developing a community with short-term residents. Staff instituted a system of submitting work orders to host community forums to give the agency feedback on the state of the building, which led to a new process of annual building inspection. The community forums also launched monthly birthdays, life skills groups, and invitations to community partners to share resources and network with residents. Casa Maria welcomed their first couple to the building.

VI. FY 22/23 Additional Information:

Casa Maria increased access by accepting residents after business hours and on weekends if needed. Casa Maria expanded staffing with two program aides per shift supporting expansion work.

VII. Projections of Clients to be Served:

FY 24/25	17-30
FY 25/26	17-30

VIII. FY 23/24 Programs or Service Changes:

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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 shelter for adults experiencing homelessness and meet eligiblity requirements for speciality mental health serivces and receive housing navigation, benefits eligibility, employment, health, wellness, and peer support services. There are 24 set-aside ACBH shelter beds.

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.

FY 23/24 Budget: $ 766,372

How Much Did We Do?

I. FY 22/23: Number of Unique Clients Served: 35 individuals.

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

Reduce Mental Health Stigma:

The South County Homeless Project (SCHP) follows Alameda County Shelter Standard's as a guide for intake, service coordination and discharges while being person-centered. BOSS staff receive annual training on privacy and confidentiality regulations. BOSS uses the 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.

III. Language Capacity for this Program:

SCHP staff speak English. Staff have access to colleagues within the agency who speak Spanish. Staff also have access to the Interpreter and Language Line. Signages and flyers are posted in Alameda County threshold languages Spanish, Chinese and Farsi.

IV. FY 22/23 Challenges:

SCHP is a 24-bed facility and the agency had been operating at a decompression level of 12 beds in 2022.

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The moratorium expired in May 2023 and the agency completed the fiscal year at full capacity. The agency experience a change with shelter leadership which impacted work flow. Due to limited housing opportunities for individuals with GA income or less there are limited housing opportunities, delays with new housing projects lease up, and shelter residents with legal statuses that prevent access to affordable housing and residents with uresolved immigration status lead to an increased length of stay at the shelter. SCHP reported shelter residents presented with more acute and SUD issues which led to increase self discharges. One of those self exit ended in an accidental death which impacted the SCHP community. Staff participated in trainings for Suicide Awareness/prevention and substance use training that was age and community specific.

Is Anyone Better Off?

V. FY 22/23 Client Impact:

SCHP met its contract deliverables of serving at least 35 unduplicated guests for the FY 22/23. Of the 35 served, 3 of the SCHP guests obtained employment. 34 of the Clients served, were able to secure public benefits.

VI. FY 22/23 Additional Information:

SCHP reported one longer stayer (over 2 years at the shelter) was able to find permanent housing. 1 of the long stayers obtained employment and secured market rate room to rent.

VII. Projections of Clients to be Served:

FY 24/25:	24-48
FY 25/26:	24-48

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FULL SERVICE PARTNERSHIP (FSP) REPORT

FSP #: FSP 10

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

PROGRAM NAME: Supported Independent Living (SIL)

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.

FY 23/24 Budget: $ 336,557

How Much Did We Do?

I. FY 22/23:

a. **Number of Unique Clients Served:** 29

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

a. **Reduce Mental Health Stigma:**
BOSS upholds the Housing First Model with low barriers to permanent supportive housing. Staff are provided with Mental Health First Aid and Harm Reduction training to increase awareness of stigmatizing behavior, language, and response, reinforce client-centered practice, and respect residents' self-determination in reaching their goals. Treatment and Substance Use Disorder services are voluntary and offered as needed. BOSS staff utilizes evidence-based practices such as guiding principles of Trauma-Informed Care and Motivation Interviewing to build upon the strength of tenants. TAY residents have formed relationships with local businesses and neighbors. One tenant painted several murals for two businesses to promote outreach and engagement. SIL team has been promoting wellness care through groups like art photography, targeting residents' interest.

b. **Create a Welcoming Environment:**
BOSS SIL program has implemented a process where potential residents can meet existing tenants and learn more about the program. The SIL team also greets applicants together so they can learn about the menu of services available. SIL furnishes units with shared common areas.

III. Language Capacity for this Program:

English, BOSS has a Spanish-speaking staff. Staff also have access to Alameda County Globo Multilingual line.

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IV. FY 22/23 Challenges:

The 15-bed TAY SIL project experienced a fire in Aug. 2022, which took four units offline, displacing four residents who secured short-term and long-term housing post-fire. The four units have not been restored, impacting unhoused young adults. The 11-bed project has a 1-bedroom unit open for over one year due to squatters taking over the unit, pest outbreak in the building, and finding a candidate that meets the criteria for the project, which serve adults with SMI, HOPWA, and literally unhoused. Limited affordable housing resources are available so people can continue their housing journey. Community partners have experienced high staff turnovers, and it has impacted collaborative care. Some SIL projects have experienced environmental stress due to increased property crimes and theft in the area.

Is Anyone Better Off?

Four residents at the TAY project obtained Section 8 vouchers. Two graduated from supported housing to independent housing using their Section 8 vouchers. Two residents are still in housing search. Two residents in the SIL projects are currently enrolled in school, four residents are employed.

V. FY 22/23 Client Impact:

BOSS has strong community partners. A local sorority hosted a Housing Warming Party for the TAY project and brought new housewares for the tenants. OHCC Housing Services hosted a debriefing and healing circle with tenants, BOSS staff, and community partners after the fire at Meekland. BOSS employment program hosts job fairs and job readiness groups and SIL residents are invited to participate. A resident at the family SIL project received custody of her children. She said having a safe home and the stability to complete required parenting courses led to reconciliation with minor children.

VI. FY 22/23 Additional Information:

BOSS SIL projects have moved to in-person support and resumed monthly Town Hall meetings with tenants.

VII. VII. Projections of Clients to be Served:

FY 24/25	32-38
FY 25/26	32-38

VIII. FY 23/24 Programs or Service Changes: N/A

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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.

FY 23/24 Budget: $ 378,679

How Much Did We Do?

I. FY 22/23:

a. **Number of Unique Clients Served:** 25 Unique Clients were served.

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 underserved 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 monthly training 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 mealtimes 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 contacts information and a calendar of events are given to new enrollees. Community meetings are weekly, and the agency is working to reinstitute the buddy system was in place for new residents

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now that the COVID 19 moratorium expired. EOCP strive to make space welcoming for all community members. A young trans woman felt targeted by staff and other residents. EOCP leadership held a debriefing with staff on creating safe space for all guests. A community meeting was held with shelter guests to discuss shelter expectations and need for healthy and safe space for all. Staff participated in a 3-day Alameda County sponsored training, "Intersectionality within LGBTQIA" and supplemental trainings from the Supported Housing Learning Collaborative (SHLC) Affirming LGBTQ+ Tenants in Supportive Housing and the Peer to Peer LGBTQ+ training. EOCP program uses Alameda County's Shelter Standard Equal Access In Accordance with One's Gender Identity to promote inclusion and remain accessible for all.

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 22/23 Challenges:

COVID-19 continues to pose a barrier to serving more individuals at EOCP shelter. EOCP remained at decompression level until the COVID-19 Moratorium expired at the end of April 2023. EOCP experience several COVID outbreaks during that period that triggered a significant amount of self-discharges due to quarantine restrictions. EOCP long term founder and CEO, Wendy Jackson died in 2023 and the loss impacted staff and shelter residents alike. Her commitment to East Oakland community and vulnerable community members inspired the team to continue the unwavering commitment to fight for people who are houseless. Housing opportunities are limited for individuals with low incomes. It is more challenging for individuals with income less than SSI, and individuals who are undocumented individuals or have legal statuses that bar their entry into subsidized housing. EOCP experienced an uptick in residents with high psychiatric and medical acuity, which increased crisis episodes and contributed to high number of discharges from the facility. Access to quality and affordable housing was scarce. The length of stay increased as new developments experienced delays with lease ups.

Is Anyone Better Off?

V. FY 22/23 Client Impact:

EOCP serves many individuals and families needing urgent spaces of safety and accommodation. Many guests are fleeing violence, have physical and mental health diagnoses, former foster care youth, individuals discharged from an institution (e.g., hospital, jail) with no resources to obtain housing. Despite these barriers, the agency has built connections and relationships within Alameda County to connect EOCP guests with the proper support when needed. Of the 25 served, 19 left with income, including non-cash benefits, and 15 individuals obtained employment. 1 exited with health insurance. The most common exit from the program was with family/friends, temporary situations, and transitional housing. There were 2 individuals fleeing domestic violence who were able to secure permanent housing.

VI. FY 22/23 Additional Information:

EOCP staff were able to help an individual with a long history of being unhoused secure his first apartment.

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He obtained a voucher but was struggling to find a place that met his needs. The process was long and required patience and advocacy. Staff used Motivational Interviewing and remained person centered, to keep the person focused after almost an entire year and multiple extensions from the local public housing authority, this long stayer found the right place. This is an example of the work it takes to build trust, listen to the person's needs and provide voice and choice.

VII. Projections of Clients to be Served:

FY 24/25	25-40
FY 25/26	

VIII. FY 23/24 Programs or Service Changes:

Historically EOCP has used a behavioral health clinician as a consultant. That contract was not renewed for the 22/23 and the agency brought that position in-house.

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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. 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. 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 team consumers living in 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.

FY 23/24 Budget: $ 1,000,000

How Much Did We Do?

I. FY 22/23

a. **Number of Unique Clients Served:** 33

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.

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III. Language Capacity for this Program:

English and use of County Language/translation services, if needed.

IV. FY 22/23 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 22/23 Client Impact:

Number of unduplicated individuals-served, who have retained housing: 32

VI. FY 22/23 Additional Information: N/A

VII. Projections of Clients to be Served:

FY 24/25	30-50
FY 25/26	30-50

VIII. FY 23/24 Programs or Service Changes:

During FY22/23, a lottery was 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. OHCC staff continue to support households in transitioning to the housing choice vouchers.

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FULL SERVICE PARTNERSHIP (FSP) REPORT

FSP #: FSP 11

PROVIDER NAME: Telecare Corporation

PROGRAM NAME: Community Conservatorship (CC) Program

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

Target Population: Adults (Age 18 +) diagnosed with severe mental illness, many of whom would otherwise require extended care in institutional settings. This includes individuals who are high utilizers of mental health services and who are considered to be at great risk for psychiatric hospitalization.

FY 23/24 Budget: 743,442

How Much Did We Do?

I. FY 22/23: Number of Unique Clients Served: 24

How Well Did We Do?

II. Please Describe Ways that the Program Strives to Reduce Mental Health Stigma:

The question of experience of stigma is embedded in our initial assessments and on-going exploration of how our partners are engaging in the community. We discuss and identify any barriers in the community as far as access and advocate, link and fight for our partners rights.

In response to internalized stigma, we work with individuals, families and community by providing psychoeducation, support groups, and resources to help our partners and their support network understand and develop empathy around mental illness symptoms and behaviors. This has improved familial and community relationships, relationships within housing environments and improved outcomes around medication adherence for our partners.

We approach our interventions and client support from a partner-center perspective, using a power-with, non-judgmental, and welcoming approach. This is an effort to create and provide a space that is both safe and allows for partners to articulate and process their experiences of stigma or discrimination.

III. Language Capacity for this Program:

Telecare utilizes LanguageLine Solutions for any phone interpretive services. We have bilingual staff – Spanish/English. We are able to serve partners with any language needs.

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IV. FY 22/23 Challenges:
Community challenges FY22/23: pandemic, housing insecurity, increased risk of substance use, increase of hate crimes directed towards vulnerable populations, increased cost of living, especially for housing and food, increased isolation due to day program/group closure as a result of the pandemic, and access to dental services. While all these factors impacted our clients, the most challenging of the past year for the CC program were increased cost of living due to inflation, the dangerous risk of overdose and death due to the easy accessibility of fentanyl and other street drugs, and the increased isolation due to community groups/programs still being reduced from COVID. Although our partners are eligible for Medi-Cal services and therefore access to primary care; there is very little opportunity or resource for dental services for individuals on Medi-cal which increases risks for illness, poor nutrition, engagement in substance use due to pain as well as the potential for infections and death. This is a gap in the system. We are also limited in support groups, community activities for our partners in person which leads to isolation and increased symptoms.

Is Anyone Better Off?

V. FY 22/23 Client Impact:
CC program would like to share the story of "Anne". Anne came into the CC program after 6 months stay in a subacute hospital. She had been in and out of custody since 2016 including participation in Behavioral Health Court program. She had limited support outside of her immediate family and relied heavily on her father.

Over the last year, Anne lost her father to COVID and due to the pandemic, she had minimal contact with other members of her family. Anne struggled with increased substance use and depression and anxiety resulting from her isolation. With consistent assessment and engagement from the CC team, Anne was able to identify these concerns and developed some goals for herself. She started engaging for counseling sessions with CC clinician, started exploring substance recovery groups and agreed to a medication adjustment. Anne is now participating in therapy weekly and substance support groups 3 times a week and has reconnected with her family.

Anne is doing so well that she is being evaluated for graduation from her conservatorship and graduation from the CC program. Anne's participation and determination in her recovery and the progress she has made over the last year are inspirational.

VI. FY 22/23 Additional Information:
93% 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. 100% of CC partners who engaged in the program were connected with a PCP appointment within 90 days of admission.

VII. Projections of Clients to be Served:
CC program currently has 19 unique partners open to service, 3 referrals in outreach status, and 3 being evaluated by PGO for eligibility. We are also anticipating 2 graduations from the conservatorship program in the next few months.

FY 23/24	
FY 24/25	

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FULL SERVICE PARTNERSHIP (FSP) REPORT

FSP #: FSP 12

PROVIDER NAME: Telecare Corporation

PROGRAM NAME: Assisted Outpatient Treatment (AOT) Program

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

Target Population: Adults (Age 18 +) who are diagnosed with a severe mental illness, considered to be resistant or reluctant to mental health treatment, who meet the Welfare and Institution Code Criteria as outlined by AB1421.

FY 23/24 Budget: $805,396

How Much Did We Do?

I. FY 22/23: Number of Unique Clients Served: 54

How Well Did We Do?

II. Please Describe Ways that the Program Strives to Reduce Mental Health Stigma:

The question of experience of stigma is embedded in our initial assessments and on-going exploration of how our partners are engaging in the community. We discuss and identify any barriers in the community as far as access and advocate, link and fight for our partners rights.

In response to internalized stigma, we work with individuals, families, and community by providing psychoeducation, support groups, and resources to help our partners and their support network understand and develop empathy around mental illness symptoms and behaviors. This has improved familial and community relationships, relationships within housing environments and improved outcomes around medication adherence for our partners.

We approach our interventions and client support from a partner-center perspective, using a power-with, non-judgmental, and welcoming approach. This is an effort to create and provide a space that is both safe and allows for partners to articulate and process their experiences of stigma or discrimination.

III. Language Capacity for this Program:

Telecare utilizes LanguageLine Solutions for any phone interpretive services. We have bilingual staff – Spanish/English. We can serve partners with any language needs.

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IV. FY 22/23 Challenges:

Community challenges FY22/23: pandemic, housing insecurity, increased risk of substance use, increase of hate crimes directed towards vulnerable populations, increased cost of living, especially for housing and food, access/availability of support groups in the community, and access to dental services. While all these factors impacted our clients, the most challenging of the past year for AOT partners 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 accessibility of fentanyl and other street drugs.

Is Anyone Better Off?

V. FY 22/23 Client Impact:

AOT would like to share the story of "John" and his journey with the team. John was living at a hotel as a part of the Project Room Key during the pandemic for homeless individuals. He had been homeless and living on the streets for the past 10 years. John is 73 years old and has no family or social supports. He was initially very challenging to engage and determined to remain independent, refusing any assistance or support. His behaviors and beliefs got in the way of maintaining his room at Project Room Key and he returned to homelessness for a period of time. Over the course of many months, a lot of engagement, support from outreach officers and other community members, AOT was able to reengage with John and support him trying a board and care and a hotel setting to decrease his risks in the community and to explore shelter. He ultimately found a hotel that he was willing to stay in for a few months and during this time he became much more engaged with the team.

He began to share information about his life and experiences. He was able to develop relationships with our case managers, nurse and psychiatrist. The team was able to help him get connected with benefits, health insurance, and ultimately a licensed board and care home where he can get the support and care he deserves. He was able to get a CA ID, open a bank account, connect with a primary care doctor and started medications to manage his thoughts and mood challenges. John continues to struggle somewhat with his mood and thoughts periodically but he has the support he needs to manage his challenges. John is building relationships with the other residents and house staff and reports feeling well supported at the home.

John is getting ready for graduation and is anticipated to graduation to a lower level of care next month. AOT is proud of our work with John and very proud of John's commitment to his care and continued journey of success.

VI. FY 22/23 Additional Information:

Settlement vs. Order: 60% of AOT partners accepted continued services with AOT for additional court terms by signing a settlement agreement versus requiring another court order for services. Graduations and discharges: 27 discharges FY22/23 from AOT program: 4 were hospitalized and moved to a higher level of care (15%), 4 moved out of county(15%), 2 went into custody(7%), and 17 graduated to a lower level of care(63%).

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VII. Projections of Clients to be Served:

AOT census is set at 30 partners, and we are able to maintain this target consistently.
Each AOT term is 6 months with a possibility of 18 months which makes significant increases to the number of partners served a challenge.

FY 23/24	55
FY 24/25	55

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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.

FY 23/24 Budget: 610,474

How Much Did We Do?

I. FY 22/23: Number of Unique Clients Served: 117

How Well Did We Do?

II. Please Describe Ways that the Program Strives to 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.

III. Language Capacity for this Program:

English, Spanish. We also have the capacity to serve Samoan speakers although we don't currently have any in among our members.

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IV. FY 22/23 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 22/23 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 22/23 Additional Information:

VII. Projections of Clients to be Served:

FY 23/24	120
FY 24/25	120

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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.

FY 23/24 Budget: $610,472

How Much Did We Do?

I. FY 22/23: Number of Unique Clients Served:

- 108 unique clients were served by STRIDES in FY22/23
- 10 new clients joined during this year.

How Well Did We Do?

II. Please Describe Ways that the Program Strives to 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 client's 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.

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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 22/23 Challenges:

FY22/23 was a time of great uncertainty due to the stressors of the global pandemic (increasing COVID outbreaks again), 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 dangerous risk of overdose and death due to fentanyl and other street drugs, as well as increasingly complex psychiatric / medical presentations with our clients and the shortage of appropriate, supportive housing resources available.

Is Anyone Better Off?

V. FY 22/23 Client Impact:

"Jason" is a 48-year-old male with a diagnosis of Bipolar Disorder II, who was referred to STRIDES for higher level of care in December 2020 shortly after he returned to California from living in the state of Washington. At the time, he was connected to a Level 1 Service Team, homeless in the community, not adherent to his psychiatric medication regimen, engaging in illicit drug use, and had repeated acute psychiatric hospitalizations for serious suicide attempts (i.e. poured gasoline on himself to light himself on fire). We supported him with a referral to Crisis Residential Treatment, where we began our engagement and rapport building with him.

Now, almost three years later, Jason has remained housed independently in an SRO near our office in downtown Oakland for 1.5 years. He has maintained full time employment for the past two years through support of STRIDES' Vocational Specialist. Additionally, he has had no psychiatric crises or hospitalizations for one year and has maintained his sobriety through active recovery interventions with our Substance

Use Specialist. Jason is regularly engaged with treatment services, adhering to his psychiatric medication regimen, advocates for himself appropriately to get his needs met, and has re-established a healthy relationship with his family. Most recently, he started taking classes to work towards completing his GED. The entire team is so excited to share his recovery story!

VI. FY 22/23 Additional Information:

For the second year in a row, STRIDES met **High Fidelity** on our Annual ACT Fidelity Review.

STRIDES met partial or full achievement on all performance metrics as required in our contract with Alameda County Behavioral Health.

- 88% of STRIDES Partners received a follow up visit within 7 days of discharge from a mental health hospitalization.

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- 83% of STRIDES partners experienced a reduction in jail days compared to the prior year.
- 81% of STRIDES partners had at least one visit with Primary Care Provider *After corrections are made based on STRIDES PCP Corrections submission.
- 74% of STRIDES partners received a minimum of four visits per month.
- 57% of STRIDES partners had a reduction in jail days compared to the 12 months prior.

VII. Projections of Clients to be Served:

STRIDES currently has 96 unique partners open to services with 1 referral in progress. We project that we will remain at or above full census of 100 partners throughout the FY'23/24 and FY'24/25 year. Projection that we will be able to inactive 5-8% of our client census from transitions, which would make room for 5-8 new client referrals and admissions.

FY 23/24	103
FY 24/25	108

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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.

FY 23/24 Budget: $1,082,143

How Much Did We Do?

I. FY 22/23:

a. **Number of Unique Clients Served:** 146

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 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.

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

IV. FY 22/23 Challenges:

One of the biggest challenges the HEAT team faced this year was low staffing, which impacted client engagement and the team's ability to meet with each client in-person four times a month. However, between the period of June 2022 and June 2023 the HEAT team grew exponentially, and for the first time since before the pandemic, the team is staffed near capacity. This includes positions that have been historically difficult to fill including two nurses, two employments coordinators, and an in-person psychiatric provider, which all contribute to a transdisciplinary approach to providing services to our clients. What began as a challenge quickly shifted into one of the team's greatest strengths throughout the year.

Is Anyone Better Off?

V. FY 22/23 Client Impact:

As the pandemic has waned in severity and the number of staff has increased, several barriers were lifted and the HEAT team was able to engage and provide services to our partners with greater frequency and diversity, reflecting the true ACT model. As a fully staffed team, HEAT has been able to implement a multidisciplinary approach to client care, providing different levels of skill and expertise so that care is catered to each individual client. Psychiatry, primary care, and medication management were also great accomplishments of the HEAT team this year. The team was able to provide in-person psychiatry services as pandemic restrictions decreased, and this in turn improved outcomes and client engagement with psychiatric services. The in-person aspect has greatly improved client attendance of appointments as they are able to connect with the provider in a more visceral way. The HEAT team was able to link almost 80% of our partners to primary care services within the last year, improving their overall well-being, decreasing pain and discomfort, and linking them to the care that they need and deserve.

HEAT had a truly monumental success story this year. This participant, who immigrated to the United States from India with his family when he was 8 years old, was originally linked to BACS Intensive Case Management team prior to his referral to HEAT in 2021. In 2021, the client began experiencing an increase in symptoms of mania, disorganization, and erratic behaviors, coupled with substance use, and all of these factors resulted in more frequent inpatient hospitalizations, which led to a referral to a higher-level of care – the HEAT team. Prior to his linkage to BACS, the client was a practicing physician, and his license was As the client began working with the HEAT team, he identified depression, familial pressure, and low motivation as major barriers to his recovery goals. With consistent engagement, rapport building, and linkage to wraparound services, the client began to improve. It was apparent that he had a high level of insight and wanted to work with the HEAT team to stabilize his mental health symptoms and achieve many future goals. The client was able to participate in substance use treatment, regularly meet with a psychiatric provider and take his medications as prescribed, obtain stable housing, and maintain relationships with his family members while working with the HEAT team. Earlier this year, this participant was accepted into Cal State East Bay's Master's Program in Counseling with the hopes of becoming a therapist to provide mental health services to others as a peer with lived experience.

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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 close with the wellness center staff to link participants and their families to the support resources they are interested in. HEAT has invested time and energy into improving the quality of life of our partners by accompanying them on outings and leisure activities, bolstering and involving natural supports in their care, supporting them in locating and maintaining stable housing, linking them to medical and psychiatric care to address distressing symptoms, and providing a space for them to make decisions about their own lives based on their needs and preferences.

VI. FY 22/23 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 the team 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 23/24 Projections of Clients to be Served: 150

VIII. FY 23/24 Programs or Service Changes:

Last year, HEAT's goal was to increase the frequency with which services were provided to each client throughout the month in order to achieve and maintain progress towards client's goals and aspirations (including housing preference, employment/education, and community building). With the increased number of staff, the team has been able to accomplish this goal, and the team now meets each partner more frequently than they were able to in the year prior. With the variety of experienced individuals and specialty roles on the team, the HEAT partners are receiving multidisciplinary services which maximize treatment outcomes and reflect the true ACT model. Future goals of the HEAT team include continuing to emphasize the importance of frequent client engagement by multiple staff to promote diversity of services, revoked due to behaviors associated with psychiatric decompensation, which was devastating to him. highlighting the importance of personal choice and overall well-being (including fostering/including natural supports in treatment and engaging in meaningful community activities), holding regular TDMs led by the clients, maintaining linkage to psychiatric and medical care to reduce hospitalizations, and locating and maintaining housing that fits each client's unique preferences and needs.

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FULL SERVICE PARTNERSHIP (FSP) REPORT

FSP #: FSP 20

PROVIDER NAME: Bay Area Community Services (BACS)

PROGRAM NAME: Lasting Independence Forensic Team (LIFT)

Program Description: LIFT 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.

FY 23/24 Budget: $721,429

How Much Did We Do?

I. FY 22/23: Number of Unique Clients Served: 115

How Well Did We Do?

II. Please Describe Ways that the Program Strives to Reduce Mental Health Stigma:

1. LIFT has centralized the structure of the "TDM" or "Team Decision Meeting" to actively involve our partners, their families, other natural supports, and direct support staff (housing, mental health, and medical) in order to optimize our client-centered approach to supporting our clients and helping them reach their goals. LIFT provides psychoeducation to families to support them in supporting their loved ones, provides brokerage services 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 year, we have expanded some of these outings to connect clients to regular events in the community. In addition to BBQ's, block parties, trips to San Francisco, museums, and other activities, LIFT has also developed DBT groups and onsite housing stability wrap around programs to empower clients to address their challenges with others and in the context of a relaxed and welcoming environment. We believe that it is crucial for our partners to understand that they are not alone in their struggles and that they can have the support of other people facing similar mental health challenges. This creates an empowering environment that helps to reduce the stigma around mental health.

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III. Language Capacity for this Program:

The language capacity for the program is English and Spanish with one clinician speaking Hindu fluently as well. We also provide services with assistance of the language line which has been used to facilitate services in multiple languages.

IV. FY 22/23 Challenges:

The number one challenge facing our participants is the rampant availability of substances (especially substances such as methamphetamines that promote an increased risk of psychotic symptoms) and the low availability to SLEs and SUD inpatient treatment programs. Many FSP level clients do not have the ability to make daily calls to CenterPoint to find a sober living placement, adding another barrier to treatment. For those that have overcome this barrier and obtained an SLE placement, many SLEs take weeks to procure placement and immediately prohibit re-entry upon a single relapse. The LIFT program coordinates extensively to support partners in maintaining daily follow ups in connecting partners to sober living environments and treatment programs. Nevertheless, this barrier to our partners remains a central barrier to the program.

Another significant challenge is a shortage of housing resources, including licensed board and cares and PSH housing, adding significant barriers to housing placement and prolonged housing stability for clients requiring FSP level support. A combined shortage of resources and onsite support is one of the reasons the LIFT program has begun to develop structured wrap around programs at a major SRO site in Alameda County and to increase coordination with county housing services to develop regular housing stability meetings in order to improve the sustainability and success of our partners in achieve housing stability.

Lastly, staff shortages continue to pose a significant challenge to our program. During a period of staff shortage during the first half of the fiscal year, LIFT staff did an excellent job coordinating to ensure a high level of care was achieved and maintained for our partners. As a program, we have strived to increase our staffing, and have successfully achieved a full roster and range of direct staff, including a substance use specialist, employment specialist, a nurse, a psychiatric nurse practitioner who significantly increases client accessibility to medication, clinicians, care coordinators, and peer specialists. Currently, achieving the same level of staffing for supervisors/management has remained a challenge and leadership for this program has remained understaffed for the duration of the year.

Is Anyone Better Off?

V. FY 22/23 Client Impact:

As so many of our partners struggle with severe and persistent mental health symptoms which significantly impair their ability to connect independently to resources such as housing, employment, education, legal resources, SSI/disability income and other benefits, the DMV, medical/primary care services, psychiatric services, and a whole range of other important resources, the LIFT program continues to make amazing strides in supporting our partners in connecting to these resources. Partners are supported every day in following up with legal advocates applying for SSI, social service for Cal Fresh, GA, and Medi-Cal documentation, housing services such as CES/Coordinated Entry, HSP referrals to licensed board and cares, independent living sites, SROs, emergency shelters, and an entire litany of uncountable resources that enrich the lives our of our partners as they struggle to meet the mental health challenges they face in their day-to-day lives. The impact for our partners is immense and cannot be

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understated, as without this ongoing support, the vast majority of our partners, if not all of our partners at various points throughout the year, would not have been able to follow through in connecting to these resources. Whether follow through involves connecting to a primary care physician, connecting to lab work, connecting to an SSI hearing, connecting to medications required to treat and manage their Mx symptoms, or connecting to housing or shelter, the necessity of FSP level support is profoundly evident.

As a forensic program, we have supported 4 of partners in graduating behavioral health court and diversion court programs in the last 6 months, which would not have been possible without the intensive support and coordination of a program rooted in the ACT and FSP models. We continue to support a significant number of partners through these programs that offer the opportunity to utilize treatment in place of incarceration. We have placed dozens of partners into independent living, board and care, SRO, and permanent housing locations over the course of the past year. We have created a new Wrap Around Program at an SRO site where it was observed that partners struggled to manage ADLs and prolonged housing stability. We successfully developed and completed multiple DBT groups that have provided clients the opportunity to work with their peers as they explore issues related to emotional and behavioral regulation in order to develop insight into these challenges and to develop new strategies for identifying and managing difficult experiences. We are also excited to announce a new trauma group that is currently under development that will be implemented during the next fiscal year.

In addition to achieving and maintaining census for the last several months and graduating 2 of our partners to a lower level of care, we have also seen some extraordinary improvements in some of our newest referrals. One of our partners had a history of hospitalization at PES 2-4 times per week over the course of the several months leading to referral to our program, as well as a long history of chronic homelessness, depression, severe disorganization, frequent suicidal ideation, and a lack of access to medication management. This partner has now been placed in a board and care, receives a monthly injection, and has not utilized PES services in over 4 months. He is organized and rarely reports symptoms of depression. (Just today he expressed excitement about a trip to the Oakland Zoo planned for the coming weekend). He is just one of so many success stories over the past year. As we shifted our focus to building relationships with residential sites with higher levels of onsite support, we have witnessed partners that have historically struggled to live alone and with others or have struggled in maintaining ADLs, improve ADL management and their quality of life dramatically. As we have onboarded a psychiatric nurse practitioner willing to meet our partners in the field, we have also seen a significant increase in our partners connecting to medications, improved medication management outcomes, and increased stabilization (especially through a higher utilization of injections). One of the referred clients we received in the last 6 months presented with severe symptoms of psychosis, auditory hallucination, and aggression. He was living in a section 8 housing placement with his mother who frequently locked herself in her bedroom out of fear, and she would reportedly climb out of the back window in order to escape to a family member's residence as the client would undergo episodes of anger and aggression. This referred client had refused psychiatric medication for well over a year, had exhibited behaviors that resulted in neighbors calling the police out of concern for their safety, and he had refused to meet with support staff or engage in treatment. Today he is on an injection thanks to the persistent coordination between our direct support staff, our psychiatric nurse practitioner, the client's family, and the client. He has been stable for approximately 3 months during which time, there have been no reports from the partner's mother regarding concerns of safety. He has now begun to meet with our employment coordinator.

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VI. FY 22/23 Additional Information:

LIFT is an extremely dynamic and collaborative team that truly embodies the spirit of the ACT model. Passionate and driven, the team's ACT meetings never feel rushed, as staff are eager to ensure that optimal support and coordination is achieved to meet the needs of our partners. In the last 6 months, LIFT has hired one new nurse, two new clinicians, a new direct service staff that serves additional peer support roles for the team and has introduced a new psychiatric nurse practitioner. Most of our staff have lived experience with homelessness, substance use, and the challenges posed by mental illness (as is characteristic of the LIFT team historically), and these new hires have not only embodied the strength-based, client-centered, and compassionate approach and practice our program aims to achieve, they have also breathed new life into the team and created new opportunities for growth.

VII. Projections of Clients to be Served:

FY 23/24	115-125
FY 24/25	115-125

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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.

FY 23/24 Budget: 1,037,390

How Much Did We Do?

I. FY 22/23: Number of Unique Clients Served: 112

How Well Did We Do?

II. Please Describe Ways that the Program Strives to Reduce Mental Health Stigma:

(a) 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 sense of control over their lives. We educate about ways that stigma from society may impact their own self-perceptions.

III. Language Capacity for this Program: English, Spanish

IV. FY 22/23 Challenges:

In FY 22/23, JAMHR continued to serve community members with great acuity exacerbated by the COVID-19, increased access to lethal substances, increased cost of living, and housing and food insecurity.

Is Anyone Better Off?

V. FY 22/23 Client Impact:

Moh Bara is a 29 yrs. old male, referred to JAMHR in 2019 by his TAY FSP Prog. When Moh entered the program on the heels of multiple hospitalizations at John George Psychiatric Pavilion.

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Shortly after joining JAMHRs program Moh went on to experience mental health symptoms with such acuity that he made several trips to Santa Rita Jail, and the psychiatric emergency room resulting in inpatient treatment and admission to sub-acute care. Some of the behaviors exhibited by Moh included violence and assaultive behavior toward his parents and siblings.

Since his admission into JAMHR, Moh has worked consistently with his outpatient treatment team. With JAMHRs support, Moh has been able to maintain housing with his parents and have allowed his parents to help him with medication adherence. Moh's last hospitalization occurred in 2020 and has had no arrest since 2020. Moh participates in activities that he believes keep him healthy and happy (walks in his neighborhood, exercising, playing video games, creating art). He also has an improved relationship with his mother and father who are his main social supports. Moh will graduate from JAMHR and be stepped down to Service Team level of care this summer.

VI. FY 22/23 Additional Information:

VII. Projections of Clients to be Served:

FY 23/24	108
FY 24/25	112

- JAMHR currently has 101 unique partners open to service and approximately 6 referrals in outreach status.
- We project that we will remain at or above full census of 100 partners throughout FY22-23.
- Projection that we will be able to inactivate up to approximately 6 – 7 % of our partner census due to graduation and moving out of county during the 23-24 year, making room for roughly 6-7 new partners to join and benefit from our services.

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FULL SERVICE PARTNERSHIP (FSP) REPORT

FSP #: FSP 23

PROVIDER NAME: Asian Health Services (AHS)

PROGRAM NAME: Service Team Program (In transition to an FSP)

Program Description: This program 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. (Formerly known as program number OESD 29)

Target Population: This program serves adults (18-59) who meet criteria for Speciality Mental Health Services typically due to their diagnosis and high utilization of emergency/urgent behavioral health systems. Clients must have Medi-Cal, Medicare, or be uninsured. Private insurance is not accepted.

FY 23/24 Budget: $2,946.714

How Much Did We Do?

I. FY 22/23: Number of Unique Clients Served: 261

How Well Did We Do?

II. Please Describe Ways that the Program Strives to Reduce Mental Health Stigma:

All of our providers are bilingual and bicultural. The advantage of bilingual and bicultural providers is their ability to navigate the cultural nuances that may impact the mental health of individuals from different backgrounds. They can recognize how cultural factors such as family dynamics, cultural beliefs, and societal expectations can influence a person's mental well-being. This understanding enables them to provide effective interventions that are respectful of the client's cultural context, ultimately improving the mental well-being of the client.

A key to reducing stigma in the AAPI community is to prioritize collective well-being over individual needs, which can result in individuals neglecting their mental health for the sake of maintaining harmonious relationships. Outreach programs focus on the individual and when culturally appropriate, involving family members. We offer groups for all age groups including parenting, youth, and adult groups focused on improving communication and self-confidence. We are also utilizing social media outlets such as WeChat, Facebook, etc. to share resources about mental health. In collaboration with Skylink TVUSA, we have short videos on YouTube that provide scenarios regarding depression in youth and a healthy parent-child relationship.

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III. Language Capacity for this Program:

Services are available in AAPI languages including, but not limited to Cantonese, Japanese, Khmer, Korean, Mandarin, Mien, Lao, Thai, Vietnamese, and English. Other AAPI languages require the use of language lines or external interpreters.

IV. FY 22/23 Challenges:

We had challenges sustaining our staffing levels throughout this fiscal year. Two of our senior staff retired and we had multiple staff on leave due to VISA and personal issues. This limited our ability to take on new case assignments throughout the year.

The staffing shortage and tight labor market continued to impact our recruitment and hiring practices. We weren't able to fill positions for over six months after posting.

Is Anyone Better Off?

V. FY 22/23 Client Impact:

Despite some of the challenges this fiscal year, we continued to provide effective services to clients. We met all the contract quality measures, including client engagement in care and successfully connecting clients to primary care services. We have several successful discharges as well as referrals to the Alameda county vocational rehab program that assisted our clients with jobs.

One of the success stories this year involved a long-time client that had been reluctant to transition to a higher level of care. The client is a monolingual-speaking adult male, that suffers from schizophrenia. The client has limited connection with family and struggling to maintain daily living and housing. Our staff have supported this client for many years until recently his age, symptoms, and health began to impact his care.

Our team worked for over a year to successfully connect this client to Full Service Partnership (FSP) to better support his needs. Although the client was resistant and reluctant to seek help, we were able to work with family members and convince him to try the services. After several warm handoffs with the new FSP provider, the client finally agreed to care.

VI. FY 22/23 Additional Information:

We have filled the two positions that retired as of March 2023. We also had our staff on leaves return in April and May 2023. This will help to increase capacity for care for the upcoming fiscal year.

VII. Projections of Clients to be Served:

FY 23/24	286
FY 24/25	286

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FULL SERVICE PARTNERSHIP (FSP) REPORT

FSP #: FSP 23

PROVIDER NAME: Bay Area Community Services (BACS)

PROGRAM NAME: Service Team Program (In transition to an FSP)

Program Description: This program 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. (Formerly known as program number OESD 29)

Target Population: This program serves adults (18-59) who meet criteria for Speciality Mental Health Services typically due to their diagnosis and high utilization of emergency/urgent behavioral health systems. Clients must have Medi-Cal, Medicare, or be uninsured. Private insurance is not accepted.

FY 23/24 Budget: $1,388,321

How Much Did We Do?

I. FY 22/23: Number of Unique Clients Served: 135

How Well Did We Do?

II. Please Describe Ways that the Program Strives to Reduce Mental Health Stigma:

Care Coordinators in the 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.

III. Language Capacity for this Program:

English, Spanish, Nigerian Pidgin, African English

IV. FY 22/23 Challenges:

Over the past year, the BACS Intensive Case Management Service Team (ICM) has been challenged by increased demand for substance use treatment programs with longer wait-times for program entry, and

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lack of integration with other systems of care. The same can be said for supply of emergency and transitional housing, which leads to increased frequency of decompensation and hospitalization for many participants. Service teams will also benefit from the addition of nursing staff to the workforce to support the complex medical needs of our consumer population, and the extensive use of injectable medications. We are challenged to lean on outside nursing resources to maintain medication compliance and places our particpants at higher risk for decompensation.

Is anyone better off?

V. FY 22/23 Client Impact:

In the past year, clients have benefitted from increased staffing and lower turnover. This has afforded long-standing client-provider relationships, retention of skilled staff and increased talent and competency available for services provided. As a result, we have enjoyed a lower rate of recitivism, hospitalization and crisis service utilization. Several participants have been stabilized and connected with resources that provide sustainability to their success and greatly increase the likelihood that they will be able to maintain a healthy living situation for the rest of their lives.

An estimated 20 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 22/23 Additional Information:

ICM saw significantly less staff turnover this year than compared to the previous year, having only turned over 2 staff for the year, and maintaining full staffing for most of the year. The program is currently seeking one staff and anticipates for that position to be filled promptly. Last year, the program aimed 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. We are proud to report that we have achieved that goal and the instituted structure has resulted in improved outcomes, such as prevention of hospitalization and incarceration. The program has also adopted increased use of wrap-informed interventions with a focus on stages of change, wrap principles, client centered care, implementation of the Team Decision Making process with team-based diversity of contact.

VII. Projections of Clients to be Served:

FY 23/24	30-50 new participants
FY 24/25	30-50 new participants

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FULL SERVICE PARTNERSHIP (FSP) REPORT

FSP #: FSP 23

PROVIDER NAME: Felton Institute

PROGRAM NAME: Older Adult Service Team (In transition to an FSP)

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. (Formerly known as program number OESD 29)

Target Population: This program 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.

FY 23/24 Budget: $1,271,539

How Much Did We Do?

I. FY 22/23: Number of Unique Clients Served: 80

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. We were able to surpass this goal: Regarding the 10 clients who had recent crisis and/or hospital contact during FY 22/23, OAST successfully met 80% of the clients in this group within seven days of discharge from hospitalization. Staff also were quick to partner with natural supports and hospital staff to promote stabilization following hospitalization.

Additionally, OAST met its goal of decreasing client incidents of CS, PHF, or psychiatric hospital admissions as 71% of clients (N=14 clients eligible) who have been in services for at least one year experienced a decrease in use of psychiatric emergency services and hospitalization. In total, review of clients who have been in the program for at least one year (N = 64) shows 93% maintained and improved stability, as 60 of our longer-term clients experienced either a decrease or no crisis contacts/hospitalizations.

Quality Measures	FY 22/23 Data Results	Contract Quality Objective Benchmark
Percent of clients who receive at least one face-to-face visit per month	46.8%	85%

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Percent of clients who had an appointment with a primary care provider during the reporting period (6 mos. in care at least)	70%	75%
Percent of discharges for which Contractor provided a face-to-face visit with the client and/or their caregiver within seven days of that discharge from a crisis stabilization service (CS), hospital for a mental health diagnosis, Institution for Mental Disease, and/or psychiatric health facility (PHF)	80%	65%
Percent of current clients who complete the Mental Health Statistics Improvement Program (MHSIP) form at each required administration	Data unavailable	50%
Percent of eligible clients who had a decrease in CS, PHF, or psychiatric hospital admissions in their most recent 12 months in the program as compared to the 12 months prior to their entry into the program	71%	70%

How Well Did We Do?

II. Please Describe Ways that the Program Strives to Reduce Mental Health Stigma:

OAST and Felton Institute highly value reducing stigma around mental health issues. As a team, both in team meetings and with our clients, we make an effort to talk openly about this subject in an effort to normalize accessing mental health services as part of overall wellness management. We talk to clients about how a psychiatric diagnosis is no different than another medical diagnosis (e.g., you take medication to control your diabetes, so 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. OAST has two Peer Specialists available to meet with clients. Our Peer Specialists use their lived experience with mental health to connect with clients; their ability to draw from their own experience helps to reduce stigma related to mental health.

III. Language Capacity for this Program:

During the FY22/23, language capacity for this program was limited to English. In May, we hired another case manager with some Spanish language capacity, which we have used to help communicate (albeit with some limitations) with monolingual Spanish speaking clients.

IV. FY 22/23 Challenges:

Consistent staffing was, unfortunately, a challenge during FY 22/23. Several staff experienced lengthy and sudden leaves, including medical staff, case managers, and leadership, resulting in not meeting program deliverables particularly medication support hours. In spite of staffing challenges, staffing is looking promising for FY 23/24. By the end of FY 22/23, OAST's direct service staff is almost fully staffed – as of the time of writing, we have a contract NP to replace the PA who left, and one of the CMs (who has been with OAST since early 2021) has been promoted to a Team Lead CM position to provide leadership support.

Is Anyone Better Off?

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V. FY 22/23 Client Impact:

Case Study:
Client PF is a 72-year-old AA male with a history of Schizoaffective Disorder, Depressive Type who has worked with Felton's Older Adult Service Team (OAST) since April 2021. This client was arrested in November 2021, a month after he was added to the Team Lead CM's caseload. OAST worked with the Public Defender's office to get PF released, and after several months of Telehealth appointments and monthly progress notes, OAST was able to get PF released pending supportive housing and mandated biweekly therapy. OAST was able to find PF housing and provide him with bi-weekly therapy through the OAST Clinical Case Management team. PF was released from Santa Rita on May 19, 2022. Per client's CM, following client's release, "PF has since been thriving in the community and has expressed interest in working part-time. OAST continued to provide monthly progress notes to the Judge and on August 7, 2023, we were informed that the judge determined that PF completed diversion successfully and dismissed the case." PF has a PCP at a clinic in the community and receives monthly psychiatric care from OAST's psychiatry team. He regularly meets with his team of providers on OAST and expresses optimism about the future.

VI. FY 22/23 Additional Information:

We continued to feel the impact of the pandemic in terms of program and clients.

VII. Projections of Clients to be Served:

FY 23/24	90
FY 24/25	90

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FULL SERVICE PARTNERSHIP (FSP) REPORT

FSP #: FSP 23

PROVIDER NAME: La Clinica de la Raza

PROGRAM NAME: Service Team Program (In transition to an FSP)

Program Description: This program 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. (Formerly known as program number OESD 29)

Target Population: This program serves adults (18-59) who meet criteria for Speciality Mental Health Services typically due to their diagnosis and high utilization of emergency/urgent behavioral health systems. Clients must have Medi-Cal, Medicare, or be uninsured. Private insurance is not accepted.

FY 23/24 Budget: $1,691,625

How Much Did We Do?

I. FY 22/23: Number of Unique Clients Served: 53 Unique clients.

How Well Did We Do?

II. Please Describe Ways that the Program Strives to 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.

III. Language Capacity for this Program:

English and Spanish

IV. FY 22/23 Challenges:

Casa del Sol lost two clinicians in May and are struggling to hire new staff.

Is anyone better off?

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V. FY 22/23 Client Impact:

Under the "Client Impact" section please provide a *brief* case study to highlight how your program is positively effecting client(s) so that the community can better understand your program.

Client is a 67 y/o monolingual Spanish speaking woman. She began to develop increased fragility and acute liver failure that was episodic over the course of the year. Her consistent inpatient stays in the physical care setting often led to her mental health being compromised. She also experienced a loss of mobility and independent functioning given the acuity of her physical health.

Over the year, we have successfully connected her to a consistent hepatic specialist, linked her to PCP for establishing a medical home, secured medical case management services and moved her from a less supportive independent living environment to a more support independent living home.
She has successfully been stable in both her physical and mental health and through therapy services has been able to reconnect with her family and repair fractured family dynamics.

VI. FY 22/23 Additional Information:

VII. Projections of Clients to be Served:

FY 23/24	Case Load 142 clients/month
FY 24/25	Case Load 142 clients/month

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FULL SERVICE PARTNERSHIP (FSP) REPORT

FSP #: FSP 23

PROVIDER NAME: La Familia Counseling Center

PROGRAM NAME: Service Team Program (In transition to an FSP)

Program Description: This program 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. (Formerly known as program number OESD 29)

Target Population: This program serves adults (18-59) who meet criteria for Speciality Mental Health Services typically due to their diagnosis and high utilization of emergency/urgent behavioral health systems. Clients must have Medi-Cal, Medicare, or be uninsured. Private insurance is not accepted.

FY 23/24 Budget: $1,321,485

How Much Did We Do?

I. FY 22/23: Number of Unique Clients Served:

One hundred and six (103) clients served. Unfortunately, one client passed away the last year.

How Well Did We Do?

During the reporting year, our case managers worked diligently to support clients in visiting their primary care providers, billing 264 hours for this code during this fiscal year. In June, we billed almost 20 hours for visiting clients' doctors, representing an improvement this year due to the staff's dedicated efforts to connect clients with their doctors.

We are incredibly proud of helping a client who had not seen her Primary Care Provider in over eight years finally receive the care she needed.
Moreover, we ensured that active clients registered in Alameda County received at least one service within 90 days, demonstrating our commitment to ongoing support and engagement with our clients.

II. Please Describe Ways that the Program Strives to Reduce Mental Health Stigma:

III. Language Capacity for this Program:

The majority of our clients are Spanish speaking. While we have a few clients who speak English but prefer Spanish-speaking services, we also have one client in our program who speaks Arabic. To communicate with this client effectively, we utilize the interpreter line.

IV. FY 22/23 Challenges:

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Is anyone better off?

Our program faced several challenges during the fiscal year:

- Staffing/Retention: We experienced a shortage of therapists throughout the year, despite receiving support from our program manager and human resources. We have been actively working on hiring a Spanish-speaking therapist to support our clients better. Additionally, one of our staff members was absent for the last four months, affecting our overall service capacity.
- New Employee Learning: We had two new employees who took more time to learn about billing and productivity. One of our staff members struggled with billing and productivity throughout the fiscal year. However, the supervisor and program manager's close support and assistance have improved this staff member's skills and billing performance.
- Monthly Productivity Goal: Unfortunately, we could not meet our monthly productivity goal for several reasons. Firstly, one of our case managers was on a leave, affecting our overall service capacity. Additionally, we currently need a therapist, which further influenced our ability to meet the needs of our clients. As a result, we fell short of our target of ensuring that 90% of our clients receive at least one in-person service monthly. However, we prioritized serving clients based on their needs and urgency.
- Service TEAM staff have billed 2,938 hours Year-to-Date (YTD) despite the challenges. However, being short-staffed, we could not meet the annual target of 3,673 hours last June.
- Challenges to Connect Clients with Their Primary Care Providers: Some clients with SMI still have concerns about receiving in-person services due to fear of Covid-19, leading them to postpone their doctor visits. We have tried various interventions, including motivational techniques, to help them connect with their doctors, and some clients have successfully visited their doctors.
- Additionally, some clients have not seen a physician in years due to fear, and we have encountered challenges securing appointments from clinics, leading to long service waiting periods. Some clients have also faced cancellations on the same day of their appointments.

V. FY 22/23 Client Impact:

Increased In-Person & Face-to-Face Services: Many clients verbalized access to their usual professional supports and community connections were increased by telehealth services. La Familia continue providing telehealth services. This has been a tremendous support for our clients and has increased relationships with their case managers, as they would support the linkage to their prescribers.

Support Families/Caregivers to Navigate Community Resources & Mental Health Care System: La Familia has provided education and information to family members and caregivers about the array of mental health resources that exist in the community, such as the Family Education & Resource Center (FERC). Staff dedicate time to explain to families of clients the continuum of care that exists in Alameda County (Level 1, Level 3,
Full Service Partnership, Assisted Outpatient Treatment), the eligibility criteria for each appropriate level of care, and the scope of such services. Service Team provides education about the process of contacting their Service Team support staff (included in their Safety Plan) prior to calling psychiatric hospitalization (51/50), such as criteria for 51/50, how to initiative 51/50 by calling the police, 51/50 hold, collaboration with staff at John George Psychiatric Hospital, discharge, and referral to community mental health resources. There are many inhouse resources such as Recovery and Wellness, as well as Community Outreach, and Sally's Place.

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Referral Linkage:
La Familia has successfully connected clients to specialty mental health services within Alameda County based on their level of care, such as Level 1, Level 3, and Full-Service Partnerships (FSP). Some clients required more support that Service Team could provide, and with the proper collaboration and links, we had connected a client to an FSP. We successfully linked three clients with an FSP.

Provision & Delivery of Basic Needs:
La Familia's commitment to providing basic needs support has been evident through the encouragement of client participation by offering incentives such as delivering food, clothes, and other necessities, as well as gift cards for various essentials. We have connected clients to economic resources like General Assistance, CalFresh, unemployment, and SSI benefits. Additionally, we have provided legal resources to clients concerning housing and immigration issues and helped them connect with the Vocational Program, leading to some clients finding jobs. Furthermore, we have assisted clients and their families in linking with IHSS.

It is essential to mention that many Service TEAM clients come to treatment with challenges related to housing, medication adherence, or Social Security Benefits. Therefore, TEAM staff often address these needs first.

Case Study:
La Familia had a client who is 65 years old, living with her daughter and husband. This patient was not responding to medications and treatment, making the situation difficult at home due to her aggressive behaviors toward her family at night. She also exhibited aggressive behaviors toward neighbors, and her inability to sleep worsened the situation. Due to their culture, the family was resistant to the team's recommendations of taking the client to a place where she and other family members could have a better quality of life. With patient and persistent work from the staff, the client's family gradually accepted trying other service options for this client. The team referred this client to an FSP program that could provide services directly from her home, and the client and her family have improved the quality of their lives.
Service Team provided a very compassionate approach, warm hand off and ongoing care to the client and family, up until they were supported, fully, by the FSP we had transferred them to. They are grateful for the connection and support that client and her family had received while they were with LF Service Team.

VI. FY 22/23 Additional Information:

VII. Projections of Clients to be Served:

FY 23/24	We project to serve between ninety or a hundred- ten clients, if we have the required staff. Otherwise, due to uncertainty and unpredictability about staff transition and recruiting challenges for qualified bilingual applicants, the same projections can be use for the coming year
FY 24/25	

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FULL SERVICE PARTNERSHIP (FSP) REPORT

FSP #: FSP 23

PROVIDER NAME: West Oakland Health Council

PROGRAM NAME: Service Team Program (In transition to an FSP)

Program Description: This program 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. (Formerly known as program number OESD 29)

Target Population: This program serves adults (18-59) who meet criteria for Speciality Mental Health Services typically due to their diagnosis and high utilization of emergency/urgent behavioral health systems. Clients must have Medi-Cal, Medicare, or be uninsured. Private insurance is not accepted.

FY 23/24 Budget: $1,593,289

How Much Did We Do?

I. FY 22/23: Number of Unique Clients Served: 132

How Well Did We Do?

II. Please Describe Ways that the Program Strives to Reduce Mental Health Stigma:

We create a warm and welcoming environment and provide psychoeducation around diagnoses as needed. We meet the client where they are in their journey and are supportive of their self-identified goals.

III. Language Capacity for this Program: English

IV. FY 22/23 Challenges:

We are severely understaffed. We currently have 2 open positions for our adult program and are unable to serve all who need mental health services in the community. Housing also continues to be an issue for many of our clients.

Is anyone better off?

V. FY 22/23 Client Impact:

We have been able to get some clients to become more consistent with their medication and some have been able to secure employment through our relationship with vocational rehab. Many of our clients feel connected to and supported by their case manager.

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VI. FY 22/23 Additional Information:

Again, our biggest issue is staffing. We would love to increase our capacity to serve more people in need but have not been able to fill the two positions that have been open since April.

VII. Projections of Clients to be Served:

FY 23/24	150
FY 24/25	150

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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.

FY 23/24 Budget: $10,745,759

How Much Did We Do?

I. FY 22/23: Number of Unique Clients Served: 85

How Well Did We Do?

II. Please Describe Ways that the Program Strives to 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.

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, Spanish, Korean - access to the county Language Line.

IV. FY 22/23 Challenges:
During this period, our team continues to struggle with the impact of low staffing both within our program

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but also, with community agencies that we partner with, creating significant barriers to providing the linkage/brokerage that our partners need. Also due to concerns of Covid (even after the lifting of legal restrictions) many housing placements were reluctant to house our clients due to their concerns about their medical vulnerability. Even outside of Covid restrictions, there is a chronic lack of beds at licensed facilities leaving our partners with few options for housing even when they are qualified.

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 22/23 Client Impact:

One of our partners was able to reunite with previously estranged family members, with staff support. The team was also able to support this client in becoming independent in managing his medication despite being un-housed at the time. As a result, the client was able to stabilize enough to be placed in permanent housing. Another success story involves a client who has been homeless for decades and due to being accustomed to this lifestyle has been unwilling to follow through on any residential placements, including important inpatient medical stays. In the last several months the client has followed through with several inpatient hospitalizations where she previously would have self-discharged AMA. The client is also now requesting support with finding housing which she has never been open to in the past.

VI. FY 22/23 Additional Information:
Circa60 worked hard to support clients by taking precautions against COVID-19 given their increased risk due to their age and medical concerns.

- **Programs or Service Changes:** This year we increased the number of clients receiving four or more visits a month from 46 – 93%. 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.

VII. Projections of Clients to be Served:

FY 23/24	100+
FY 24/25	100+

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Outreach Engagement System Development (OESD) 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:
The intent of the Senior Mobile Mental Health Program is to increase access for older adults in the tri-city areas + Hayward who are suffering from mental health challenges including those who are homebound. The program serves seniors 60 years or older who are isolated, unbale to access traditional mental health services and community resources., fearful of outside psychiatric intervention and maybe at risk of psychiatric hospitalization. The majority of services are provided in the home of the senior. Older adults could access range of outpatient mental health services including individual, family and group therapy, medication support and management. Case management and crisis intervention as assessed. As clients become more stable and not needing intensive mental health services and getting ready for discharge from the program, they can be referred to a step-down program (Recovery and Resiliency). The goal of the step-down program is to provide clients more supportive services for a smooth and successful transition to stable community placement and increase their ability to sustain independent living with emphasis on promoting successful community integration.

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 65% of clients having arthritis and other physical pain, 30% with diabetes and high cholesterol. Increased number of clients losing their mobility leading to increased falls as well.

FY 23/24 Program Budget: $1,173,998 **Cost per Client:** $16,535

How Much Did We Do?

I. FY 22/23: Number of Unique Clients Served: 71

How Well Did We Do?

Please Describe Ways that the Program Strives to:
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.

ACBHCS 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 ACBHCS mission, we implement the following:

- Senior Mobile Mental Health Program and all other City programs continues to see the need

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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 about mental illness to increase their awareness of their attitudes and behaviors towards clients suffering from mental illness.
- Educating our client and their families and the larger community 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 and their families to actively engage in various community networking, and community programs as this 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.

II. Language Capacity for this Program:

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

We also have other language capacities provided by our student interns. This year we have Vietnamese language capacity. We also utilize language line for other languages we don't have the capacity for.

III. FY 22/23 Challenges:

1. COVID-19 hit us all so unprepared. Mental health symptoms have worsened during the pandemic. Rate of anxiety, depressive symtoms and subtance use and abue have increased. Also noted that this time of crisis, there has been increased in our client's risk factors such as financial insecurioty, housing needs, food, fear of contracting COVID 19, increase in medical and physical symptoms while their protective factors including social connection and communiyt engagement, access to physical exercises, daily routine access to health and mental health services decreased. The impact of self-quaratine and social distancing almost created a second wave of mental health crisis for our seniors.

   Delivery of program services continues adapting to digital services. Switching service deivery to teleheath raised some questions to service providers. Ie: how acceptable it is from client's

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perspective, how effective are the services and how much digital literacy our clients have especially the older adult population. The program continued to provide services during this difficult time. As client's symptoms increase or new symptoms developed, the program also increased frequency of services. AS observed, clients who are already receiving treatment prior to the pandemic, were willing to move to telehealth or phone services.

We are currently delivering FTF service delivery. However, client still have the option to utilize telehealth services if they wish.

2. 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.

3. Losing some level of independence ie: decline in mobility, increase falls, decline in vision and hearing, losing family and friends and early cognitive decline .

Is Anyone Better Off?

IV. FY 22/23 Client Impact:

During the pandemic, we expanded and transformed our service delivery. Onset of COVID 19 has precipitated rapid uptake to digital services.

V. FY 22/23 Additional Information:

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

55 clients for the Senior Mobile Mental Health
We now have 24 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.

FY 23/24:	50
FY 24/25:	50

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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), Community Assessment and Transport Team (CATT), and Outreach & Engagement Teams

Program Description: The Crisis Services Program (CSP) is a fully mobile crisis service that responds to 5150 calls, engages with consumers who are in crisis,assesses consumer needs, and conducts follow-up post crisis . Currently, all clinical staff work primarily in the field, which increases community-based crisis prevention and early intervention services, thereby ensuring clients are referred to the appropriate type of mental health services.

ACBH clinical staff work on the Mobile Crisis Teams (MCT) for North County and South County as well as on the Mobile Evaluation Team (MET), a partnership with Oakland Police Department. Bonita House clinicians staff the third mobile crisis team, the Community Assessment and Transport Team (CATT) along with Alameda County's Emergency Medical Services and Falck. Three post crisis follow up teams focus on telephonic follow up, field-based services for ACBH's high utilizers, and field-based services focused on the county's population that are not securely housed.

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.

FY 23/24 Program Budget: $9,755,626 **Cost per client:** $4,038

How Much Did We Do?

I. FY 22/23: Number of Unique Clients Served: 2,416

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

a) **Reduce Mental Health Stigma:** The mobile crisis teams provide ongoing outreach, engagement, and psychoeducation to individuals living with mental health challenges, their loved ones, law enforcement, and the general community. Crisis Services Outreach and Engagement teams are also 80% staffed by peers with lived experience. Many Crisis Services staff have been involved with the Peers Organizing Community Change (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 feedback, and assistance from the Health Equity Division in staff recruitment, retention, and diversity training and community resources to provide culturally relevant 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 our teams can transport consumers to a variety of settings whenever appropriate and safe to do so. We only involve law enforcement when necessary. All of these efforts help to reduce stigma.

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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. All teams can transport individuals to appropriate care and encourage involvement of family and care givers whenever possible and appropriate. Crisis staff are trained to meet community members where they are and to provide information and guidance with consideration of cultural / linguistic needs and preferences for specific services.

Regarding our work environment, Crisis Services has developed a comprehensive training and on-boarding program including a manual and at least four to six weeks of shadowing and training with more experienced staff. Although not funded via MHSA, we continued our practice of holding 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 and prevent burnout. In 2023, our system management team led a three-month process creating a community agreement to help in building team cohesion, supportive, affirming, friendly, and empowering work culture.

We worked with our Human Resource department to address recruitment challenges. We created a more flexible entry into our clinical positions and continued to actively recruit peer staff members. Our internship program has also helped in developing our future workforce.

III. Language Capacity for this Program: Currently, Crisis Services language capacity is English, Spanish, Vietnamese, Cantonese, American Sign Language, Tagalog, Japanese, and Mandarin. GLOBO Language Solutions is utilized for all other languages when translation is needed or requested. 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 22/23 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, has 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.

Is Anyone Better Off?

V. FY 22/23 Client Impact: Focused marketing of Crisis Services via presentations and participation in many community events have resulted in an average of 6007 direct calls to Crisis Services for the fiscal year. These calls include referrals to our mobile and outreach teams, information, care coordination and follow-up.

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Coordination between Crisis Services and voluntary crisis stabilization, crisis residential treatment, sobering and detox facilities has resulted in a reduction of involuntary psychiatric holds. All our teams can transport individuals directly to these services.

Staff are in the field more than 75% of their shift. This ensures that services are provided in settings that are most convenient to the community.

ACBH Crisis Services, in collaboration Crisis Support Services of 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 from our mobile crisis teams when needed. For the fiscal year, 91% of callers to CSS/988 were de-escalated over the phone without the use of mobile crisis or police intervention.

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 face-to-face contact has helped to develop a rapport with the community and increase the likelihood 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 enforcement by these homes. Mobile team staff discuss safety plans, and de-escalation / diversion strategies with board and care staff and provide care coordination 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 this training will better equip providers with the necessary tools to better serve those with mental health and SUD challenges.

VI. FY 22/23 Additional Information: N/A

VII. FY 23/24 Projections of Clients to be Served: We anticipate serving an additional 170 consumers, bring our unduplicated consumers served to 2,550.

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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 (BHC) is a 12-18 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.

FY 23/24 Program Budget: $463,212 (covers 4 mental health staff across BHC and the Court Advocacy Program (CAP) **Cost per Client**: (admitted clients for both BHC and CAP (139): $3,332.

How Much Did We Do?

I. FY 22/23:

a. Number of Unique Clients Served:

a. Behavioral Health Court received 259 referrals between July 1 2022 – June 30 2023, up from the previous FY referrals of 149. Of the 259 referred, 111 did not meet basic eligibility requirements, 57 were successfully admitted, and 6 continue to be evaluated for admission.

b. Approximately 187 clients were served through FY 22/23. Because the program typically lasts 12-18 months, the total number of clients served may include individuals referred prior to FY 22/23.

c. Approximately 24 individuals successfully graduated during the FY22/23 period, 1 fewer than the previous fiscal year – this number reflects individuals who were referred and admitted during prior fiscal years, including clients admitted during FY18/19 and FY 19/20.

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 BHC.

b. Create a welcoming environment: BHC is a collaborative effort between Alameda County Behavioral Health (ACBH) the Alameda County Superior Court, District Attorney, Public Defender,

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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 utilizes ACBH's contracted language service, GLOBO, for interpretation services via phone 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. GLOBO interpretation services contracted through ACBH are medically certified and confidential.

IV. FY 22/23 challenges:
Data tracking: Collecting, managing, and analyzing data has proven challenging for Behavioral Health Court. There are multiple stakeholders and agencies involved in data collection and no centralized agency or person identified to collect, manage and analyze this data. Each agency has a different focus on data collection, and utilizes a different system for collecting those data points. During FY 22/23 ACBH focused on increasing transparency for reporting outcomes and developed a "Data Dashboard – BHC Outcomes" which may be found on Forensic Services -Alameda Coungy Behavioral Healt webpage: www.acbhcs.org/forensic-services/. In the future we hope to work more collaboratively with partnering agencies to collect a broad range of data points and better analyze outcomes.

Staffing: ACBH currently has a vacant Behavioral Health Clinician position since May of 2023, which has been challenging as it impacts the number of assessments we are able to complete and the timeliness for outreaching to referrals. Staffing rotations and changes with our partner agencies continue to be a regular part of Behavioral Health Court, with attorneys rotating every 1-2 years. Although each agency (Public Defender, District Attorney, and Superior Court) historically only assigns one staff person, this year we saw an increase in dedication of resources from our court partners. For example, the Distric Attorney's office has committed two social workers, an attorney, and a Supervising Deputy District Attorney. Additionally, the Public Defender's office has a committed attorney as well as additional attorneys for active referrals, along with various court appointed council when the Public Defender has a conflict of interest. While the additional staffing has been a huge support, the BHC team is working to ensure that all attorneys understand the eligibility and operating agreements of BHC to continuously improve referrals and support clients.

Is anyone better off?

V. FY 21/22 Client Impact: As a result of Behavioral Health Court, clients had improved access to treatment, increased engagement with wellness and recovery activities, and reduced number of days in institutional settings.

BHC Outcome Stories:
It is not uncommon for clients to begin the process of BHC but continue to struggle with engagement, particularly in the beginning. In one example, ACBH worked with a transition age youth with co-occurring substance use, trauma, and severe mental illness. Being raised in the foster care system this individual struggled with interpersonal relationships and had few natural supports. After being referred to BHC, they were connected to a treatment team who engaged them in a stage matched level of care. The client however was not yet ready to engage with substance use treatment. In her role as court coordinator, our

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Mental Health Specialist, provided information to the BHC Judge to better understand the client's needs and motivations, and to highlight opportunities for the Judge to acknowledge the client's efforts and progress from a strengths-based perspective. As a result, the client was given a second chance to continue engaging in outpatient treatment and was subsequently linked to a substance use treatment provider. As a result of these services, the client has improved insight and is now able to reflect with Judge on their progress. With continued engagement they will hopefully have improved relationships and successfully complete BHC to have their charges waived and criminal record sealed.

Another example of BHC's success involves a father and husband who was referred to BHC after serious violent charges and a standoff with police. After receiving treatment in an acute setting, he was transferred to jail, assessed, referred to BHC, and linked with intensive case management. He initially did well with BHC and was close to graduating from the program but after experiencing a traumatic event, the client ceased mental health treatment and relapsed with substance use. The BHC Court Coordinator, who serves as a liaison between the court and the treatment provider, reached out to the treatment provider and discovered the impact the complex trauma had on the client. The BHC Court Coordinator was able to communicate the client's situation and needs to the BHC Judge to avoid the client being dropped from the program. BHC collaborated with the treatment provider to link the client to residential substance use treatment, intensive trauma therapy, and he is now future focused with plans to move to a sober living environment when he graduates. As a result, the client reports he is healing, and recently, teary eyed, thanked the court for saving his life. To quote the BHC Court Coordinator, examples such as this are court coordinator shared, "the reason we come to work". Additionally, this example is a reminder that recovery is not a linear process, and our clients need support throughout their recovery journey.

VI. FY 22/23 Additional Information:

Alameda County BHC is unique from many other behavioral health courts throughout California. For example, BHC admits individuals before they make a statement admitting guilt. This is significant because it allows individuals to participate in community treatment without the judgement of being guilty. It additionally means that if they decide BHC program is not for them, they continue to have an option to go to trial and argue their case, rather than having a judgement and sentencing as their only alternative. In Alameda County, Probation is not involved in program administration or funding. This means that there is no monitoring from Probation Officers, no use of ankle monitors, and no substance use testing at court appearances. and Finally, client's charges are waived or reduced or records sealed upon successful completion of the program. This is a growing trend in California, that has been ongoing in Alameda County since 2009. It allows individuals to be able to apply for jobs, secure housing, and fully re-integrate into society without the stigma of a criminal record holding them back.

Behavioral Health Court additionally accepts clients with strike charges (i.e., violent or serious felonies), in some cases they are admitted to BHC after making a statement admitting guilt but before being sentenced to jail. This allows individuals with more serious charges to still participate in BHC instead of being sentenced and spending more time in custody. 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.

In the past the charges permitted were typically negotiated between the defense council and district attorney of the originating court of referral. Current protocols allow for the referral to be sent to BHC for assessment prior to the charges being accepted with an understanding that each member of the BHC

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Team (ACBH, Judge, District Attorney, and Defense Council) must approve of the admission in order for the individual to participate.

It is important to note that the majority of BHC services are funded by ACBH with dedicated funding from Mental Health Services Act. ACBH provides the funding for the Clinicians, Peer Specialist, and Clinical Supervisor. MHSA also funds many of the community treatment teams that serve BHC clients. Funds for other court staff are provided by their respective agencies.

VII. FY 23/24 Projections of Clients to be Served: The BHC program was initially created 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 had a capacity to serve a total of 30 clients, all assigned to 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 programs facilitated by the Superior Court.
- 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 2023/2024, 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 23/24 Programs or Service Changes: A significant change for BHC for FY 23/24 is the retirement of the Judge assigned to the program, which is planned for early 2024. While this change should not impact referrals, it will require the BHC team to spend some time re-affirming operational agreements to maintain collaboration.

The current BHC interagency agreement between ACBH, The Superior Court, Alameda County Public Defender's Office and District Attorney's Office is under review for revisions to reflect recent changes in laws, agreed upon workflow practices, and to 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 ACBH's "True North Metrics", the implementation of CalAIM, and in response to other mandates such as CARE Court.

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

Target Population: Justice involved adults age 18 and older with serious mental illness and co-occurring substance use disorder. Individuals must be eligible for diversion or re-entry services to the community. Consumers include Transitional Age Youth, Adults and Older Adults.

Y 23/24 Program Budget: $463,212 (covers 4 mental health staff across BHC and the Court Advocacy Program (CAP) **Cost per Client**: (admitted clients for both BHC and CAP (139): $3,332.

How Much Did We Do?

I. FY 22/23: Number of Unique Clients Served: 82

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 (i.e., housing, benefits, medical issues, substance use) that may lead to recidivism; families and community treatment providers were better able to navigate the court system and advocate for their loved ones, and clients were linked to the right-matched level of behavioral health care support.

b. **Create a Welcoming Environment:** CAP clinicians 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

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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 Alameda County Behavioral Health's (ACBH) contracted GLOBO language services for interpreting services via phone 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. GLOBO interpreting services contracted through ACBH is medically certified and confidential.

IV. FY 22/23 Challenges: The Court Advocacy Project experienced a slight increase in referrals increase this year. Similar to staffing shortages experienced across California, we have a current vacant Behavioral Health Clinician II position.

Is Anyone Better Off?

V. FY 22/23 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

CAP Stories:
One client was referred to CAP after they were unsuccessful in Behavioral Health Court. The client was found Incompetent to Stand Trial, on a misdemeanor charge (MIST), and referred to the CAP program for support. The assigned Behavioral Health Clinician coordinated with a full-service partnership team to come to court and meet with her for additional assessment. The judge granted an order for the client to be released directly to the treatment team after she agreed to receive a long-acting antipsychotic Injection before leaving the jail. The treatment team then assisted the client in obtained housing with a board and care home, building greater rapport between the client and provider, and a place for them to meet with her more consistently. She has been succeeding ever since, attending court, and receiving medication at an outpatient and out of custody setting.

Another client was referred to CAP after a long history with mental health services, mostly in a crisis setting. He was primarily supported by his single parent who has been his landlord, advocate and at times, an informal case manager. Our CAP Behavioral Health Clinician completed a referral to ACBH ACCESS line for ongoing mental health support and intensive case management, and he was connected to a Forensic Assertive Community Treatment program (FACT) team. Through a slow process of engagement, the client became willing to connect with services. He attends court virtually and is manages his health, including medications prescribed through the FACT team. As a result of the CAP program his mother has also been able to take a step back from his care to be more of a natural support, encourage his engagement with treatment services, and focus on her own health. The court subsequently anticipates granting him misdemeanor diversion and may dismiss the criminal charges upon completing 6-12 months of community treatment.

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VI. FY 22/23 Additional Information: The Court Advocacy Project initially saw a steady increase in referrals during 2022, with a dramatic decline in ealry 2023. Below are possible factors.

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, several of the judges met with the alienists and the Alameda County Sherrif's Office 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 Schedule, which resulted inmany individuals being released from custody, or cited and released, 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) Changes from the legislature on the legal options and treatment options available for individuals who are found incompetent to stand trial may have also impacted the number of referrals
4) Conserved clients being arrested from hospital settings: At times we have seen referrals for clients under Lanterman-Petris-Short (LPS) conservatorship. LPS Conservatorship is a legal mechanism in which the civil court appoints a person to make certain legal decisions for a person. If a conserved client assaults a staff person while recieving inpatient services at an acute hosptial they may be arrested and taken to the jail despite their conservatorship. All mental health services at the jail are voluntary and once there, conserved clients 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 23/24 Programs or Service Changes: 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 since COVID-19 and we expect this to continue for the forseeable future. We additionally anticipate the implementation of "CARE Courts" throughout California, and the passage of AB 2275 in Sept 2022 (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.

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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.

FY 23/24 Program Budget: $1,035,030 **Cost per Client:** $31,364

How Much Did We Do?

I. FY 23/24: Number of Unique Clients Served: 33

How Well Did We Do?

II. Language Capacity for this Program:

We provide services in the families' preferred language (English and/or Spanish). This year, we served 28 English-speaking families and 5 Spanish-speaking families.

III. FY 23/24 Challenges:

During the beginning of FY 22/23 we had two MST clinicians leave the program and this had an impact on our ability to serve additional clients in the MST program. Additionally, the number of referrals to the MST program remained low, which had an impact on our ability to hire additional MST clinicians. The number of referrals has begun to increase which has allowed us to hire a new MST clinician with plans to hire another clinician in the near future.

Is Anyone Better Off?

IV. FY 23/24 Client Impact: Here is a case story submitted by one of our clinicians that highlights 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.)**

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Robert was referred to MST by his probation officer. The client presented externalized aggression towards property/mother, and his behavior impacted his academic performance and social interactions with teachers and peers. At the time of referral, the client also presented significant verbal aggression towards his mother, often blaming her for his father's long-term incarceration and never coming home from state prison.

Over the course of treatment, MST services aimed at improving the client's ability to understand the factors contributing to his strong moods and outbursts and utilize healthy coping skills. The family focused on improving interactions within the system by decreasing reactionary communication, addressing triangulation, and enhancing the caregivers' empathy and understanding of the client's feelings of abandonment issues. A milestone in treatment occurred when the client could communicate the impact that his father's lifetime prison sentence had on his daily functioning, feelings, thoughts, and behaviors. This allowed the family to discuss the unspoken driver of the client's angry and sad moods that triggered his disruptive behaviors.

By the end of services, the client's verbal aggression significantly decreased, he graduated high school, the family continued to improve at pro-social communication and problem-solving, and he refrained from engaging in disruptive behaviors that led to him being placed on probation as well as developed coping skill to decrease hyperarousal response to conflict with his family. Focus was placed on developing the caregiver's parenting skills and abilities to create a safe and positive structure to support the client dealing with losses. I provided the family with Solution-focused therapy that helped balance the client's short-term and long-term decisions. Throughout the MST program, the client was observed to meet overarching goals and comply with his probation terms. Due to these advances and sustainable support, the client was dismissed from the probation department at the end of the treatment plan and graduated from the MST program.

V. FY 23/24 Additional Information:

VI. FY 23/24 Projections of Clients to be Served:

FY 23/24	50
FY 24/25	50

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OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 11

PROVIDER NAME: Bay Area Community Services (BACS)

PROGRAM NAME: Crisis Stabilization Unit (CSU)/Crisis Resential Treatment (CRT): Amber House

Program Description: Amber House is a dual voluntary crisis stabilization unit (CSU) and voluntary crisis residential treatment (CRT) program. Amber House CSU is a 12-bed voluntary-only CSU whose purpose is to assess individuals who are having a mental health crisis and are in need of assessment, stabilization, and brief treatment. The service is available to individuals for up to 24-hours. Amber House CRT has up to 14-beds for individuals in crisis who do not meet medical necessity criteria for hospitalization and would benefit from treatment and supportive programming. Amber House crisis services are available to only clients who are 18 and over and residents of Alameda County who possess and/or eligible for Medi-Cal.

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

FY 23/24 Program Budget: $5,382,469 (CSU) / $2,540,813 (CRT)

Cost per Client: $11,236 (CSU) / $12,704 (CRT)

How Much Did We Do?

I. FY 21/22: Number of Unique Clients Served: 479 (CSU), 200 (CRT)

How Well Did We Do?

Quality Measures	FY 22/23 Data Results	Quality Objectives
Percent of clients admitted who choose to stay for at least three days and receive services.	86%	80% or greater
Percent of clients who agree or strongly agree to overall satisfaction statements (items 1, 2, and 3) on the Mental Health Statistics Improvement Program (MHSIP) consumer survey.	100%	80% or greater
Percent of clients who agree or strongly agree to the cultural/ethnic sensitivity statement (item 18) on the MHSIP.	100%	80% or greater

Additional Crisis Stabilization Unit (CSU) Specifications:

Quality Measures	FY 22/23 Data Results	Quality Objectives
The percent of clients who make a connection to outpatient behavioral health services within seven (7) days of discharge.	70%	64% or greater

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Quality Measures	FY 22/23 Data Results	Quality Objectives
The percent of clients make a connection to outpatient behavioral health services within 30 days of discharge.	88%	78% or greater
The percent of clients that are admitted to John George within seven (7) days of discharge.	30%	11% or less
The percent of clients that are admitted to John George within thirty (30) days of discharge.	45%	24% or less

III. Language Capacity for this Program:
Amber House (CRT/CSU) offers monolingual support through translation services through the Alameda County language line.

IV. FY 21/22 Challenges:
Some challenges experienced at Amber House, specifically at the CRT, include client's willingness to stay in the program, as well as their willingness to show up upon admission date. We have seen hospitals submit referrals for clients who share they are ready to receive services, but never arrive at Amber House post hospital discharge. In addition, the average daily census has decreased from Q3 (.064) to Q4 (.058). It appears the number of referrals are limited or clients will choose to not be present; however, we have seen referrals slowly rising due to reengaging crisis teams, local police, hospitals, etc. CSU and management have made concerted efforts to email and reports via reddinet bed availability each shift to meet this challenge.

Is anyone better off?

V. FY 21/22 Client Impact:

Impact Measures	FY 22/23 Data Results	Impact Objectives
Percent of clients who agree or strongly agree with the MHSIP statement: "I deal more effectively with daily problems"	63%	64% or greater

Additional Crisis Stabilization Unit (CSU) Specifications:

Impact Measures	FY 22/23 Data Results	Impact Objectives
The percent of clients who agree or strongly agree with the MHSIP statement: "I deal more effectively with daily problems"	100%	60% or less

VII. Projections of Clients to be Served:

FY 23/24	**1,570**
FY 24/25	**1,600**

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OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 11

PROVIDER NAME: STARS Behavioral Health Group (Due to new procurement process STARS stopped operating the CSU in November 2022; Provider changed to Telecare)

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 Stars Willow Rock CSU served medically stable youth ages 12 to 17 years experiencing a mental health crisis. The program served up to a maximum of ten clients at a time.

FY 23/24 Program Budget: $5,762,755 **Cost per Client:** $20,804

How Much Did We Do?

I. FY 22/23: Number of Unique Clients Served:

In Fiscal Year 22-23, Stars operated the CSU from July 2022 to November 2022. During this time, Stars served 248 unduplicated CSU youth across 278 enrollments with 5,620 combined CSU hours; and 13 unduplicated outpatient youth across 14 program enrollments and a combined total of 490 outpatient hours.

How Well Did We Do?

II. Language Capacity for this Program:

While operating, the program recruited staff to offer multi-lingual services that meet the county threshold languages. The CSU had Spanish speaking staff, Korean-speaking staff, and an available language line for other non-English speaking clients. Written materials were translated into the county threshold languages. Additionally, a language line was posted in every room and accessible to families at any time. SBHG also utilized a cloud-based neural machine translation service to translate consumer satisfaction surveys to English so leadership could apply all consumer feedback to inform programmatic improvements.

III. FY 22/23 Challenges:

Challenges addressed during the months of operation included: a) sustaining staffing at regulated levels in light of Bay Area healthcare labor shortages; b) clarifying and managing expectations with the county

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intake processes; and c) implementing post-discharge protocols to measure contract Key Performance Indicators and intervene with client well-being after they leave the CSU into the community.

Is Anyone Better Off?

IV. FY 22/23 Client Impact:

Stars CSU and Outpatient clinicians measured risk behaviors, symptoms, functioning and coping using the standardized Brief Psychiatric Rating Scale (BPRS-Child). The BPRS has 9 Likert scale items that measure undesirable symptoms from 0=Not Present to 6=Extremely Severe. During FY 22-23, there were N=229 BPRS matched pairs, or enrollments with an intake and discharge. A paired, one-tailed t-test showed a statistically significant desirable reduction ($p<0.00$) between the initial total score (7.5) and the latest total score (5.8). There were also desirable reductions on each individual item: 1) uncooperativeness, 2) hostility, 3) manipulativeness, 4) depressed mood, 5) feeling of inferiority, 6) hyperactivity, 7) distractibility, 8) tension, and 9) anxiety. Stars also measured client progress at discharge with a Discharge Status Form in our EMR, with a 92% completion rate across all program enrollments. According to this form, more than half (58%) of enrollments met some or most/all of their treatment goals and 92% of clients either had a written Wellness Recovery Action Plan or discussed one with staff. An internal census log also showed that 33% of tracked clients discharged to a lower level of care; 62% of discharged clients went to the Telecare PHF. In self-report satisfaction surveys, clients and caregivers were satisfied with the CSUs services: client respondents (n=174) agreed they were satisfied with the services (93%) and that the setting was safe, clean, and comfortable (93%). The majority of caregiver respondents (n=33) agreed that their family member was kept safe (93%) and that they were satisfied with the CSU's services (89%).

V. FY 22/23 Additional Information:

Stars stopped operating the CSU in November 2022; Telecare now operates the facility. A few highlights from the prior year's (FY 21-22) report: 97% of clients and 93% of caregivers were satisfied with the services they received; the program team capably launched and managed health and safety during the COVID pandemic; risk behavior incident rates were low (64 total with 3 involving injury); the 30-day hospitalization recidivism rate was 14% and, the partnership with the ambulance company was strong – they reported improved coordination, responsiveness and efficiencies compared to their experiences with other operators

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

FY 23/24	STARS will not operate this program in this FY
FY 24/25	STARS will not operate this program in this FY

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OESD #: OESD 11

PROVIDER NAME: Telecare Corporation (Due to new procurement process Telecare began operating the CSU in December 2022; STARS stopped operating the CSU in November 2022)

PROGRAM NAME: Willow Rock - Crisis Stabilization Unit (CSU): Telecare Alameda County Youth Crisis Stabilization Unit

Program Description: Telecare Alameda County Youth 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 Telecare Alameda County Youth 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: Telecare Alameda County Youth Crisis Stabilization Unit 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.

FY 23/24 Program Budget: $5,762,755 **Cost per Client:** $20,804

How Much Did We Do?

I. FY 22/23: Number of Unique Clients Served:

Twenty-nine youth received services by the Youth CSU between the two months of operations in FY 22/23, e.g., May'23 & June'23.

How Well Did We Do?

The Youth CSU opened for 24/7 operations in May'23. In May'23, the Youth CSU received referrals form the emergency departments for youth placed on psychiatric holds. In June'23, the Youth CSU received voluntary walks ups from youths in the community in addition to the youth referred from the emergency departments.

II. Language Capacity for this Program:

Telecare Alameda County Youth Crisis Stabilization Unit uses an interpreter service via the telephone when communicating with nonnative English-speaking youth and guardians. The Youth CSU has one bilingual Spanish clinician that supports monolingual Spanish speaking youth and guardians.

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In FY22/23, The Youth CSU is preparing to accept referrals from EMS in the field to divert youth from the emergency departments to the Youth CSU. The Youth CSU is establishing an aftercare program to support youth who are not service connected to the Behavioral Health outpatient system of care.

Is Anyone Better Off?

IV. FY 22/23 Client Impact:

The Youth CSU is developing youth and guardian satisfactions surveys to track and measured member satisfaction.

V. FY 22/23 Additional Information:

Between 10/22 to 4/23, Telecare's Start Up Team prepared the CSU to accept youth for crisis services. The Start Up Team worked on improvements to the physical plant, hiring, onboarding new staff members, developing policies and workflows, and preparing the program for implementation. The Start Up Team transitioned to Operations to manage daily service delivery in 5/23.

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

FY 23/24	**250**
FY 24/25	**250**

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OESD #: OESD 14

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

PROGRAM NAME: Language ACCESS Asian (AHS ACCESS)

Program Description: AHS ACCESS operates a designated Intake and Referral phone line to provide API language speaking/cultural screenings, evaluate medical necessity, and determine service levels for community members requesting mental health services. Community outreach, psychoeducation, and home/field visist are provided to promote mental health awareness, help seeking, and service participation amongst API populations. The Program also provides short-term crisis stabilization outpatient treatment and reduces utilization of higher levels of care via medication support, individual therapy, individual rehabilitation, group rehabilitation, collateral, and case management services.

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

FY 23/24 Program Budget: $1,741,027 **Cost per Client:** $1,153

How Much Did We Do?

I. FY 22/23: Number of Unique Clients Served:

- Screening/linkage – served 376 unduplicated intake clients with 1,476 service contacts.
- Crisis stabilization outpatient treatment - served unduplicated 33 clients.
- Outreach/psychoeducation – served 1,635 community members.
- MH awareness on social media platforms – served 7,587 viewers.

How Well Did We Do?

Reduce mental health stigma:

- Conducted tabling and screening at community events to foster trust building w/ community.
- Partnered with AAPI-focused CBOs to conduct community education to address MH stigma and promote help seeking behaviors.
- Developed audiovisual/infographic wellness materials for community members on social media.

II. Language Capacity for this Program:

- Services are provided in AAPI languages including but not limited to Cantonese, Mandarin, Vietnamese, Khmer, Korean, Japanese, Mien, Burmese, Thai, and other AAPI languages.

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- With the hybrid workplace model and responses to social instabilities and anti-Asian hate crimes, intake staff primarily provided mental health screening and service linkage on phone.
- The untimely service seeking pattern led to numerous API clients with S/I, H/I and severe psychiatric symptoms upon the receipt of referrals, it was difficult to make urgent arrangement of psychiatric services with the limited/allocated resources.
- Culturally responsive MH providers were inadequate, and challenges were encountered to fill openings for culturally responsive MH providers.

Is Anyone Better Off?

IV. FY 22/23 Client Impact:

- Provided screening and service linkage services to 376 intake clients with 1,476 contacts, connected with appropriate level of services, conducted safety planning for S/I and H/I.
- Delivered MH treatment to 33 clients with assessment, treatment planning, medication support, individual therapy/rehab, group rehab, collateral, and case management services.
- Outreached 1,635 community members via 17 ZOOM wellness sessions and community events and 7,587 viewers with audience-targeting wellness materials on social media platforms.
- Coordinated with AAPI-focused Prevention Programs to foster trust building/working partnership and promote 2-way referral processes.
- A case study "LH is a 45-year-old, who was born in Korean and immigrated to America with his family when he was in the fifth grade. Due to childhood medical conditions (e.g., meningitis), a car accident resulting in a coma, and additional hospitalizations for epilepticus and seizure, he not only suffers from severe memory loss but also exhibits severe symptoms of depression which has impaired several areas of LH's life functioning – daily, social, and vocational functioning. Due to language and cultural barriers, the family experienced difficulty in finding MH services until they reached out to AHS SMH for therapy and medication under AHS ACCESS program in 2022. LH has received therapeutic support with culturally sensitive services in his native Korean language and his mental health symptoms have stabilized significantly. Through close collaboration with LH's family and vocational program, he is currently seeking part-time employment and is working toward an independent, meaningful and healthy life."

V. FY 22/23 Additional Information:

- Post-event feedback from community members were collected, and clients and caregivers involved throughout treatment to improve outreach strategy and service quality.

VI. 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.

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bilingual applicants, the same projections are currently used for the coming two years.

FY 23/24	• Screening/linkage – 375 • Crisis stabilization outpatient -35 • Outreach/psychoeducation – served 1,600 community members.
FY 24/25	• Screening/linkage – 375 • Crisis stabilization outpatient -35 • Outreach/psychoeducation – served 1,600 community members.

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OESD #: OESD 14

PROVIDER NAME: Multi-Lingual Counseling Center

PROGRAM NAME: Staffing to Asian Population

Program Description: MH Svcs for Afghan Immigrant and Refugee

Target Population: Afghan Immigrants and Refugees

FY 23/24 Program Budget: $175,750 **Cost per Client:** $1,417

How Much Did We Do?

I. FY 22/23: Number of Unique Clients Served:

- Outreach and Engagement Program provided 1,040 hours and 124 unduplicated clients.

How Well Did We Do?

- Connected clients to programs providing ESL classes and Life Skills.
- Coordinated services with IRC, Afghan Coalition, and other agencies to inform them to programs such as cash aid, food programs, and medical services.
- Case Managers would provide assistance such as delivery of food and essential items to clients' temporary shelters.
- Assisted clients obtaining assistance with rent, low-cost utilities and internet. Also assisted in helping clients in transportation and mobility to be able to commute and actively engage within their community.
- Provided services and assistance in helping clients seek and obtain employment.
- Organized community events to allow clients to meet each other in order to help each other transition better within their new living environments by sharing their experiences upon arriving within the US.

II. Language Capacity for this Program:

Case Managers provide services to Afghan new arrivals in Alameda County in Farsi, Dari, & Pashto.

III. FY 22/23 Challenges:

Program was funded initially by Philanthropic Ventures Foundation for FY21-22. For FY22-23 all funding was provided by Alameda County which was fully utilized. With recently new increases in Case Managers salaries, program might need an increase in funding in order to maintain providing the same services in the future.

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Program is designed for recently arrived Afghan refugees into Alameda County. MLC assisted in providing services to more than 100 Farsi, Dari, & Pashto speaking Afghan newcomers in Alameda.

IV. FY 22/23 Client Impact:

- A 29-year-old Afghan woman, accompanied by her two children, sought our assistance after enduring the traumas of war and family violence. The Resettlement Agency provided temporary accommodation in a hotel upon their arrival, but they lacked access to essential necessities. Recognizing their urgent needs, we swiftly intervened.
- A 32-year-old Afghan woman reached out to our Case Management team during her pregnancy, seeking help and sharing her story. She had recently arrived from Afghanistan with her husband, two children, four brothers, and her sick mother. They were all living together in a cramped two-bedroom apartment, struggling to make ends meet without any source of income. Additionally, her mother's health was deteriorating, requiring specialized care. Understanding the urgency of their situation, we took immediate action.
- A 48-year-old man sought assistance from our Case Management team, sharing his journey to the USA and his working background in a high government position in Afghanistan but was compelled to flee to the United States due to security concerns. Currently, he is residing with his wife and, five children in a small two-bedroom apartment, facing challenges related to the lack of essential services and the inability to work due to the absence of a social security card and work authorization. Understanding the significance, the team assisted them in applying for a Social Security card and work permit, which allowed them to legally pursue employment opportunities.

V. FY 22/23 Additional Information:

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

FY 23/24	100+
FY 24/25	100+

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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.

FY 23/24 Program Budget: $975,499 **Cost per Client:** $17,736

How Much Did We Do?

I. FY 22/23: Number of Unique Clients Served: 55 with 760.88 units of services provided.

How Well Did We Do?

We served 55 individual clients with 760.88 units of services provided. We are short of the target goal. We experienced having no staff therapist in the program (both positions of Staff Therapist were vacant all year). We utilized the support of interns.

II. Language Capacity for this Program: Spanish and English.

III. FY 22/23 Challenges:

1. We continue to experience challenge in getting our therapist position filled due to agency wide and county wide shortage of Spanish speaking therapists since Covid. We have difficulty to find applicants despite efforts made. La Familia Multicultural Psychotherapy
Training Institute (MPTI) which is the internship program for La Familia has provided us yearly with interns, this past year we had 2.5 interns to serve clients.

2. This year, there was an increase of consumer seeking therapy due to trauma and towards the end of the year an increase in suicidal ideation as a presenting problem.

3. Other community providers are also impacted with low staffing resulting increase in high service demand for the program therapy services in Spanish.

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IV. FY 22/23 Client Impact:

1. Clients Served: For the clients served improvement in overall daily functioning and reduction and/or amelioration of symptoms via psychotherapy services. Clients are provided psychoeducation on their symptoms to help reduce mental health stigma and increase awareness of their mental health symptoms and increase self-care activities to help reduce their symptoms, which also reduces mental health stigma.

2. Create a Welcoming and Culturally Sensitive and Responsive Environment. Consumers and Clients were provided culturally sensitive & responsive services. A large number of consumers that are seeking our services within Alameda County are monolingual speak Spanish speakers. Consumers and Clients are able to be served throughout the process of requesting services and receiving services by bilingual Spanish and English-speaking Staff. Many of the staff and interns are bilingual and bicultural. Are staff and interns trained in cultural sensitivity and cultural humility.

V. FY 22/23 Additional Information:

1. We hired Staff Therapist on 6/15/2023
2. We created a position for and hired an Intake Coordinator in late April 2023.

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

FY 23/24	80
FY 24/25:	80

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OESD #: OESD 17

PROVIDER NAME: A&A Health Services

PROGRAM NAME: Residential treatment for Co-Occurring Disorders

Program Description: Adult Residential Treatment

Target Population: Adults 18 years or older (18-59 years)

FY 23/24 Program Budget: $604,440 **Cost per Client:** $86,348

How Much Did We Do?

I. FY 22/23: Number of Unique Clients Served: 7

How Well Did We Do? 5 of the 7 clients served were successful in program.

II. Language Capacity for this Program:

English
Spanish
Tagalog
Mandarin
Cantonese
Korean
Vietnamese
American Sign Language

III. FY 22/23 Challenges: Lack of referrals from Alameda County

Is Anyone Better Off? Yes, 5 clients placed in long term supportive environment without rehospitalization.

IV. FY 22/23 Client Impact:

V. FY 22/23 Additional Information:

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

FY 23/24	**10**
FY 24/25	**10**

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OESD #: OESD 17

PROVIDER NAME: Ever Well Health Systems, LLC

PROGRAM NAME: Residential Support Services - Enclave at The Delta, Delta at The Portside, Delta at The Sherwoods

Program Description: Modern treatment communities or Healing Community Enclaves have their roots in social welfare, psychiatry, psychology, sociology and, more recently, substance use disorder treatment. We provide an array of integrated services including primary care; residential treatment with after care support; mental health services and transitional housing with supportive services. Our Enclaves and professional providers set the most effective, mindful and dignified standard for integrated behavioral healthcare.

Target Population: Adults 18 years or older (18-59 years)

FY 23/24 Program Budget: $652,795 **Cost per Client:** $217,598

How Much Did We Do?

I. FY 22/23: Number of Unique Clients Served: 3

How Well Did We Do?

II. Language Capacity for this Program:

English and Spanish are the primary languages we have provided support for. We have the ability to provide other language translations, however they are not currently needed.

III. FY 22/23 Challenges:

We have not been negatively impacted by COVID, and had minimal outbreaks. Outside of staff hiring being a challenge everywhere, we have not had any major challenges.

Is Anyone Better Off?

IV. FY 22/23 Client Impact:

The residents are doing very well and staying on their daily meds and programming. We had one resident specifically who struggled with the initial transition to our level of care. Wth Ever Well support they have grown to love the program and are doing very well.

V. FY 22/23 Additional Information:

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

FY 23/24	(30) We have been limited due to our "as needed" agreement, however we have the capacity to provide more beds and would like to see an increase of up to 30 beds.
FY 24/25	(30)

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OESD #: OESD 18

PROVIDER NAME: Bay Area Community Services (BACS)

PROGRAM NAME: Wellness Centers: Fremont/South Co. Wellness

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

Target Population: The BACS Wellness Centers provide services to adults (ages 25+) experiencing mental health challenges. These individuals may or may not be currently enrolled in ACBH specialty mental health programs (such as Service Teams, Full Service Partnerships, etc.). * There is also a Wellness Center provided by BACS that provides services to TAY (ages 16-24). Additional Requirements for IPS Supported Employment:

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

FY 23/24 Program Budget: $687,955 **Cost per Client:** $427

How Much Did We Do?

I. FY 22/23: Number of Unique Clients Served: 1,611

How Well Did We Do?

Quality Measure	FY 22/23 Data Results	Quality Objective
Percent of clients reporting that they agree or strongly agree with the statement "I like the services that I received here" on the Mental Health Statistics Improvement Program (MHSIP) survey	89%	At least 85%

II. Language Capacity for this Program:

Clients visiting the Fremont Wellness Center are able to access services in English. All other language needs are supported by certified bilingual staff or the language line.

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During the fiscal year, the Center faced challenges due to client displacement and site repairs. Our team made resource connections to support clients with accessing much needed services.

Is Anyone Better Off?

IV. FY 22/23 Client Impact:

Impact Measure	FY 22/23 Data Results	Impact Objective
Percent of clients who answer that they "deal more effectively with daily problems" as a result of the services they receive[4]	73%	At least 50%

V. FY 22/23 Additional Information:

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

FY 23/24	1,800
FY 24/25	2,000

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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 or 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 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).

FY 23/24 Program Budget: $833,766 **Cost per Client:** $354

How Much Did We Do?

I. FY 22/23: Number of Unique Clients Served: 2,355

II. How Well Did We Do?

Quality Measure	FY 22/23 Data Results	Quality Objective
Percent of clients reporting that they agree or strongly agree with the statement "I like the services that I received here" on the Mental Health Statistics Improvement Program (MHSIP) survey	92%	At least 85%

III. Language Capacity for this Program:

Clients visiting the Hedco Wellness Center are able to access services in English and Spanish and Vietnamese. All other language needs are supported by our staff that are certified language team and the language line. All clients visiting the Center are able to access services based on their language needs and no one is turned due to their individual language needs.

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Many of our partners are experiencing homelessness or housing instability. It has been challenging to match individuals with transitional places since there are very few options to match and the overwhelming need in the area. Our team continues to explore alternative options to support our partners, and we are hopeful that things improve, and additional services are available soon.

Is Anyone Better Off?

V. FY 22/23 Client Impact:

Impact Measure	FY 22/23 Data Results	Impact Objective
Percent of clients who answer that they "deal more effectively with daily problems" as a result of the services they receive[4]	66%	At least 50%

VI. FY 22/23 Additional Information:

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

FY 23/24:	2,600
FY 24/25:	2,800

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OESD #: OESD 18

PROVIDER NAME: Bay Area Community Services (BACS)

PROGRAM NAME: Wellness Centers: Townhouse

Program Description: Wellness Centers provide a welcoming entry point for outpatient services for individuals who are unserved or underserved by the mental health system. They provide step-down service for individuals transitioning from ACBH specialty mental health services in an environment of inclusion and acceptance in facilities that are commonly managed and staffed by consumers who provide or arrange for peer support. Wellness Centers are contracted providers who perform outreach and engagement; offer outpatient services such as mental health services, case management/brokerage, crisis intervention, medication support/dispensing; provide peer support and wellness services; and Tenant Support Services (TSP) for those with housing insecurity. Wellness Center personnel are trained in Harm-Reduction and Trauma-Informed Care principles to meet the participant where they are at in a whole-person manner. Cultural responsivity is a core axiom of the care provided by the team as the program was designed with Culturally and Linguistically Appropriate Services (CLAS) standards in mind.

Target Population: 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.

FY 23/24 Program Budget: $1,113,609 Cost per Client: $241

How Much Did We Do?

I. FY 22/23: Number of Unique Clients Served: 4,616

How Well Did We Do?

Quality Measure	FY 22/23 Data Results	Quality Objective
Percent of clients reporting that they agree or strongly agree with the statement "I like the services that I received here" on the Mental Health Statistics Improvement Program (MHSIP) survey	89%	At least 85%

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Clients visiting the Towne House Wellness Center are able to access services in English and Spanish. All other language needs are supported by our staff that are certified language team and the language line. All clients visiting the Center are able to access services based on their language needs and no one is turned due to their individual language needs.

III. FY 22/23 Challenges:

Towne House experienced the passing of regular program clients. Our team created space for healing by holding memorials and gathering in the memorial garden. The year was challenging for clients and staff, but the Towne House Community came together to celebrate life and uplift each other.

Is Anyone Better Off?

IV. FY 22/23 Client Impact:

Impact Measure	FY 22/23 Data Results	Impact Objective
Percent of clients who answer that they "deal more effectively with daily problems" as a result of the services they receive[4]	62%	At least 50%

V. FY 22/23 Additional Information:

During the fiscal year our team-built partnerships with CSUEB nursing students and mental health programs in Alameda County to assist our clients with connections to treatment services.

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

FY 23/24	4,700 Unique Clients
FY 24/25	4,800 Unique Clients

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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.

FY 23/24 Program Budget: $631,188 **Cost per Client:** $6,311

How Much Did We Do?

I. FY 22/23: Number of Unique Clients Served: 100

How Well Did We Do?

Quality Measure	FY 22/23 Data Results	Quality Objective
Percent of clients reporting that they agree or strongly agree with the statement "I like the services that I received here" on the Mental Health Statistics Improvement Program (MHSIP) survey	87%	At least 85%

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Clients visiting the Valley Wellness Center are able to access services in English. All other language needs are supported by our staff and the language line. All clients visiting the Center are able to access services based on their language needs and no one is turned due to their individual language needs.

III. FY 22/23 Challenges:

Ensuring that accurate information about Covid's ever-changing regulations and extreme weather updates being communicated to the partners was a challenge during the fiscal year. Our team provided ongoing support for healthcare resources for clients and connections to weather resources available through FEMA.

Is Anyone Better Off?

IV. FY 22/23 Client Impact:

Impact Measure	FY 22/23 Data Results	Impact Objective
Percent of clients who answer that they "deal more effectively with daily problems" as a result of the services they receive[4]	83%	At least 50%

V. FY 22/23 Additional Information:

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

FY 23/24	200
FY 24/25	300

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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.

FY 23/24 Program Budget: $466,397 **Cost per Client:** $8,799

How Much Did We Do?

I. FY 22/23: Number of Unique Clients Served: 53

II. How Well Did We Do?

Quality Measure	FY 22/23 Data Results	Quality Objective
Percent of clients reporting that they agree or strongly agree with the statement "I like the services that I received here" on the Mental Health Statistics Improvement Program (MHSIP) survey	86%	At least 85%

III. Language Capacity for this Program: English and Spanish

IV. FY 22/23 Challenges:

The program struggled to bring in clients that needed outpatient services. The center is highly utilized for group programming and treatment but most individuals are connected to other outpatient providers.

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V. FY 22/23 Client Impact:

Impact Measure	FY 22/23 Data Results	Impact Objective
Percent of clients who answer that they "deal more effectively with daily problems" as a result of the services they receive[1]	76%	At least 50%

VI. FY 22/23 Additional Information:

This program experienced a change in leadership at the end of the fiscal year when the director left the agency. This change has had a minimal impact on clients and service delivery.

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

FY 23/24:	65
FY 24/25:	75

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2 Based on the MHSIP instrument

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.

FY 23/24 Program Budget: $939,041 **Cost per Client:** $7,452

How Much Did We Do?

I. FY 22/23: Number of Unique Clients Served: 126

II. How Well Did We Do?

Quality Measure	FY 22/23 Data Results	Quality Objective
Percent of clients reporting that they agree or strongly agree with the statement "I like the services that I received here" on the Mental Health Statistics Improvement Program (MHSIP) survey	95%	At least 85%

a. The Casa Ubuntu Creative Wellness Center is a supportive, strength-based program that strives to help members achieve wellness and self-sufficiency. We provide a community setting in which participants are empowered to create lives of personal meaning, in which they can develop and manage support to live, work and play in the greater community.
b. We create a welcoming environment where clients are encouraged to develop their own wellness.

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provide peer driven support, individual counseling, wellness groups 5 days a week, community field trips, social and recreational activities to assist clients develop the skills and to use resources they need for better life satisfaction.

III. Language Capacity for this Program: English and Spanish

IV. FY 22/23 Challenges:

In March 2023 one peer support specialist was terminated and in June 2023 another peer support specialist resigned. The team has rallied and we have continued to provide both group and individual services in-person and through telehealth.

Is Anyone Better Off?

V. FY 22/23 Client Impact:

Impact Measure	FY 22/23 Data Results	Impact Objective
Percent of clients who answer that they "deal more effectively with daily problems" as a result of the services they receive[2]	88%	At least 50%

VI. FY 22/23 Additional Information:

We have added four new afternoon groups to our schedule i.e., men and women's specific groups, stages of change, CBT, and fun in recovery. The Group Latino, a Spanish language peer support group went from meeting once a week and now meets twice weekly. We hired an administrative assistant and have three professional master's level students (interns) providing groups, assessments, and individual counseling services.

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

FY 23/24	30
FY 24/25	40

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2 Based on the MHSIP instrument

OESD #: OESD 18

PROVIDER NAME: National Alliance on Mental Illness (NAMI) for Chinese Communities – Mental Health Association for Chinese Communities (MHACC)

PROGRAM NAME: Capacity Building & Family Empowerment

Program Description: Our Family Caregiver Support Services assist family members who have loved ones suffering from mental illness. Support groups are offered once each month in both Cantonese and in Mandarin. This program also offers a Cantonese and Mandarin Mental Health Warmline, along with volunteer manned WeChat Support Groups in order to provide 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.

FY 23/24 Program Budget: $20,000.00 **Cost per Client:** Capacity building funds for each NAMI

NAMI Chinese

For the first half of 2023, our community struggled to recover from the negative impact of Covid-19 and anti-Asian hate crimes. The need for mental health services in our community remains persistently high. The Annual Alameda County NAMI Affiliate Stipend Fund of $20,000 has made a significant difference in growing our capacity to meet these demands.

Once again, we believe that the best use of the Alameda County NAMI Affiliate Stipend Fund is to enhance our capacity. We utilized this fund to provide mental health training to our staff and volunteers. Additionally, the fund partially covered the expenses of our mental health warm line, internet, Zoom, staff, and volunteer liability insurance costs. With the increased funding compared to last year, we were able to promote mental health awareness and our services through newspapers and radio stations in the community we serve.

By combining the Alameda County NAMI Affiliate Stipend Fund with other funds, MHACC expanded our 800 Warm Line program, Peer and Family support group programs, as well as Mental Health apps, online Zumba, Yoga, Tai Chi, singing, and dancing classes.

We answered a total of 3,111 calls, held 64 support groups, Taught and facilitated 133 courses, ultimately served over 4,700 individuals, and received coverage via 97 media reports in the past six months.

Thanks to the ongoing support of the Alameda County NAMI Affiliate Stipend Fund, we experienced substantial growth. In addition to securing the Stop the Hate grant from the state of California in 2022, we became part of the CalHOPE grant sponsored by CalMHSA for the entire calendar year 2023. We have excelled with these two major grants, leading to the approval of the renewal for the 6TH grant. We anticipate being very busy moving forward and eagerly look forward to reporting our accomplishments six months down the road.

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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.

FY 23/24 Program Budget: $20,000.00 **Cost per Client:** Capacity building funds for each NAMI

The ACBHCS $20,000 grant that NAMI East Bay receives is very much appreciated, from both a financial and motivational perspective. We know that we are often the very first introduction that an individual has to the challenging world of mental illness. Family members are referred to NAMI by friends and medical professionals and we serve to educate and support these families. That support generally persists for years. We see ourselves as part of the Team and the annual grant reaffirms that we are indeed team members.

The payment we receive has been spent most recently on our infrastructure, since, due to the pandemic, we have shied away from in-person events and relied heavily on the high-tech world to get our messages across. Thus, a large percentage of the grant has been used for our tech needs, including Zoom, website, online/internet presence, bulk e-mailing, and a technical specialist who keeps it all going. We also pay for a part-time office manager who handles mail, phone-calls, email, membership, mailing, etc. Office rent and utility costs account for part of our expenditure. When appropriate, we support board members' attendance at conferences, meetings, etc. Other than the two positions noted, we are an all-volunteer organization.

The sustainability of the affiliate depends in large part on our ability to meet the needs of our constituents. We host a weekly, robust family support group on zoom with the number of attendees sometimes necessitating a twice-weekly meeting. We host a monthly evening educational event on zoom, with recent topics being therapy options, legal issues, Patient's Rights Advocacy, Wellness Centers, Hearing Voices, etc. Our next such event will feature one of our support group members who has a PhD in neuroscience and who will talk about the brain. We also send out a twice-monthly e-bulletin with announcements and recaps of our educational meetings along with information about upcoming events and legislation. Then, for our families who are uncomfortable with the world of tech, we send out a monthly paper bulletin. Add to this our ongoing replies to email and phone-call requests for help and information.
We feel this level of responsiveness ensures our sustainability since we receive donations and membership payments from individuals, who oftentimes are donating in a match arrangement with an employer.

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OESD #: OESD 18

PROVIDER NAME: National Alliance on Mental Illness (NAMI) East 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 are in need of peer support.

FY 23/24 Program Budget: $20,000.00 **Cost per Client:** Capacity building funds for each NAMI

NAMI Tri-Valley

1. **Describe how each $20,000 payment is utilized.**
   The ACBH NAMI Grant has greatly helped our operations to keep our doors open. The funds enable us to:
   - **Operational costs:** Insurances, tax filing services, bookkeeping, storage facility, office rental, Zoom service, phone, internet, capital equipment, printing, and office supplies.
   - **Family Programs expenses**: Family-To-Family classes, Family Support Groups, Parent Resource and Support Group - parents who have children under 18 with emotional and/or mental health challenges, Suicide Prevention Workshop for Family Caregivers, Supplies, Zoom service.
   - **NAMI Connections Recovery Support Group**: Stipends for facilitators, Zoom service, materials and when needed, training new peer facilitators.
   - **Public Education**: Monthly General Meeting with guest presenters, educational outreach, presentations to groups.
   - **Conferences and ongoing training:**
   - **Marketing and publicity:**
   - **Partnerships: Keep Hope Alive Collaborative (KHAC)**

2. **How the grant contributes to long term sustainability of NAMI Tri-Valley**
   NAMI Tri-Valley is an all-volunteer 501(C) (3) nonprofit organization, and we provide all our services at no cost. The minimum membership dues do not cover the expenses of all the services we provide. The grant helps us to meet the needs of the community such as educational outreach, support, giving resources and advocacy. The funds enrich the work that we are already doing.

3. **What NAMI Tri-Valley is doing beyond the stipend to ensure sustainability (for example fundraising)**
   In our 15 years, NAMI Tri-Valley has held a variety of fundraisers, (i.e. NAMI Walks, Golf Tournaments, Vendor Faires, Wine Tasting Luncheon) to name a few. We have received grants, corporate donations as well as private donations. Through responsible financial management, all of our programs and services continue to serve the needs of our community.

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OESD #: OESD 18

PROVIDER NAME: Alameda County Network of Mental Health Clients (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.

FY 23/24 Program Budget: $1,095,423 **Cost per Client:** $337

How Much Did We Do?

I. FY 22/23: Number of Unique Clients Served: 3,245

How Well Did We Do?

Reduce Mental Health Stigma: PWC 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.

II. Language Capacity for this Program:

a. PWC primary language capacity is English
b. PWC BestNOW provides services in English, Spanish, and Farsi
c. PWC BDIC provides limited services in Spanish

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- We continue to struggle with increasing staffing capacity and retention. COVID has had an impact on direct services where we are competing with a limited candidate pool.

- We are experiencing a need to relocate our services. We want to stay in our respective spaces, however the increase in dangerous activities is of great concern.

Is Anyone Better Off?

We can only measure success when members return to share with us. This is the challenge of our direct services. We tend to serve people who are in some form of crisis. We respond and they move on.

IV. FY 22/23 Client Impact:

- increased access to BestNOW Peer Specialist training in line with the state certification. We have also increased access to organizations to increase their capacity to offer peer services.
- We are providing peer run respite response to community crisis.

V. FY 22/23 Additional Information: We were successful in offering Peer Respite services in North Alameda County. This decreased the engagement of 75 members with law enforcement during a crisis.

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

FY 23/24	**3,500**
FY 24/25	**3,500**

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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 clinic-based services determined by the client's acuity of needs. Our staffing consists of Psychiatrist, Psychiatric Nurse Practitioners, Clinical Pharmacists, RNs, Licensed Therapists, and Case Managers. Our services promote the successful transition of patients from moderate to severe services to primary care level of services.

Target Population: Pathways to Wellness provides services to adults (18-59 years old) and older adults (60-99) 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 the ACBHS specialty mental health criteria for moderate to severe with impairments in an important area of life functioning. All clients are referred by Alameda County Acute Crisis Care and Evaluations for System-Wide Services (ACCESS). Services are provided in North County, South County and East County, located in Oakland, Union City and Pleasanton.

FY 23/24 Program Budget: $2,344,999 **Cost per Client:** $842

How Much Did We Do?

I. FY 22/23: Number of Unique Clients Served: 2,782

How Well Did We Do?

Increasing Coordination of Health Care Services: We have continued to provide coordination of care to all clients. We connected 82% of our total clients connected with a Primary Care Physician. We continued to reduce the number of psychiatric hospitalizations of clients enrolled into Pathways by 80%+ this fiscal year. We reduced hospitalizations by providing immediate follow-up appointments with laser focused coordinated care to our Pathways clients who were hospitalized, more therapy, case management, and completed assessments for higher level of care when needed. This allowed Pathways to free up more appointment slots for clients who needed our level of care. As with the previous fiscal year, clients who are of a higher acuity are continuing to increase through the referral process.

Creation of Pilot VIP Care Team: We created a pilot team in FY22/23 that provided extra support to 85 clients who were identified as utilizing higher level of services in Alameda County's emergency care systems and were opened to Pathways. These clients were assigned to the caseload of our VIP Care Team. This year, we successfully worked on increasing their coping skills and resiliency through stress tolerance and regular follow-up. We also coordinated case consultations with their identified support systems or helped to create an outside support system when needed. When patients need additional resources, we identify those patients and refer them to additional services. These resources may be temporary or more long-term as determined by the care team. Of these 85 clients: 30% African American, 22% Caucasian, 22% Hispanic, 9% Asian, 1% Afghan and 1% Native American.

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to care. Clients discharged from the hospital are scheduled an appointment within 7 days of their release date and non-hospitalized referred clients are scheduled an appointment within 14 days of date of receipt of referral. Per the quarterly Quality Measure Reports for Fiscal Year 22/23, we averaged 12 days from referral to initial appointment date, which outperformed the goal of quality measure goal of 15 days. In addition, we scheduled 1038 new client appointments this fiscal year.

In addition to the high level of acuity patients, our pilot care team provided extra support to Pathways geriatric population. We identified and tracked 136 geriatric patient's current medical conditions, noted responses to psychiatric and non-psychiatric medications with the overall goal of improving coordination of care, health measures, mental health outcomes, and stressors such as isolation. As a result of our data, we created an over 60's group to support and encourage community and less isolation for Pathways mental health geriatric population. These 136 geriatric patients' age group ranged from 66 – 97 years old.

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 an increase resiliency. Assessments incorporates a review of medical necessity, mental status determination, analysis of the client's clinical history by gathering relevant cultural issues, analysis of behaviors and interpersonal skills, 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 symptom and we ensure that clients are diagnosed correctly. We account for the impact of how these qualifiers can drive diagnosis including African Americans being disproportionally diagnosed with schizophrenia and other psychotic disorders when instead they have a trauma disorder. We at Pathways to Wellness differentiate between cultural and functional paranoia in symptoms and encourage an accurate portrayal of client symptoms. By focusing on what the client is experiencing in the world as who they are, we can differentiate between what is 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.

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

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

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essential while working together as co-partners.

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. This training is 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.

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

III. FY 22/23 Challenges: Since the start of the pandemic, there has been a sharp increase in the amount of mental health needs with our clients as well as with new client referrals. We have been seeing more severe clients even as the pandemic COVID-19 has lessened impact. We have been seeing more crisis and isolation with our clients.

Is Anyone Better Off?

IV. FY 22/23 Client Impact: During 2022-2023, we impacted clients through serving them throughout the entire year utilizing a variety of services. We have improved service coordination for 136 of our highest utilizers of emergency care, as well as for provided additional service coordination and focus for 85 of identified geriatric mentally ill population, as a direct result of our Pathways internal implemented initiatives. In addition, we provided approximately 19,829 services despite the pandemic and have continued to reduce rates of no shows and timeliness with appointments. We have been able to accommodate all referrals with appointments within 7 days or under who are discharged from the hospital.

V. FY 22/23 Additional Information: We added an Intake Nurse to our intake model in June 2023 to work specifically with new referrals who may have more complex medical conditions. She will be conducting a nursing assessment and identifying all new client external care teams on day one to ensure efficient and effective coordinate of care for clients enrolling into Pathways system of care. We continue to be faced with challenges around discharging high volumes of clients to a lower level of care due to the lack of capacity and/or inability for PCPs to take our clients.

We will also be moving one of our main clinics to another location. We will begin to provide children's services again and increase our level of access to families who have children in need.

VII. Projections of clients to be served:

FY 23/24	2,800
FY 24/25	2,800

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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.

FY 23/24 Program Budget: $753,353 **Cost per Client:** $12,768

How Much Did We Do?

I. FY 22/23: Number of Unique Clients Served: 59

How Well Did We Do?

STEPS has been able to provide short-term housing funds for 11 partners in FY22/23 to facilitate partners with unstable housing or barriers to housing secure placement while waiting for county funds or social security benefits. STEPS program has provided short-term intensive case management to 20 individuals in the community as direct referrals from service teams in an effort to reduce the risk of long-term hospitalization by increasing the amount of services and support in the community.

II. Language Capacity for this Program:

Telecare utilizes Language Line Solutions for any phone interpretive services. We have bilingual staff – Spanish/English. We can serve partners with any language needs.

III. FY 22/23 Challenges:

Community challenges FY22/23: pandemic, housing insecurity, increased risk of substance use, increase of hate crimes directed towards vulnerable populations, increased cost of living, especially for housing and food, access/availability of support groups in the community, and access to dental services. While all these factors impacted our clients, the most challenging of the past year for STEPS partners were the shortage of safe, affordable housing, increased cost of living due to inflation, and the lack of support groups in the community which led to increased isolation and increased substance use.

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IV. FY 22/23 Client Impact:

STEPS program would like to share the story of "Jane". Jane was referred to STEPS from Asian Health Services (AHS) after Jane was hospitalized at John George Psychiatric Pavilion. Jane had worked with STEPS in 2021 and transitioned successfully without any hospitalizations for a year but began to struggle again in 2022 and was hospitalized. AHS reached out for support to reduce her risk of needing a subacute hospital stay and to reduce her risks in returning home to live independently.

Jane remembered working with STEPS team previously and welcomed the support again. She was able to work with STEPS case manager to reconnect with her IHSS provider to get help at home. She worked with the team to locate and start participating in community support groups and activities at a local community center and online with the Reaching Across program.

Jane has reconnected with her brother and has family support. She has been able to continue to live independently and improve her symptom management including making the decision to switch over to a long-acting injectable medication. Jane is getting ready to graduate from the STEPS program and is focused on her continued success.

V. FY 22/23 Additional Information:

STEPS has focused on increasing our support and engagement with Villa Fairmont by providing monthly collaborative meetings to review and identify partners who qualify for STEPS services and ways for STEPS to support Villa Fairmont Social workers around discharge planning and coordination of care.

STEPS continues to utilize our emergency housing budget to support partners coming out of long-term hospital stays find and maintain housing. This emergency housing budget is a temporary support targeting partners who are waiting for the benefits to be reinstated and are ready for discharge from hospital settings. The goal is to support the flow of partners out of hospital when ready and improve their transition to the community.

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

FY 23/24	65
FY 24/25	75

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OESD #: OESD 20

PROVIDER NAME: Bonita House

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

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

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

FY 23/24 Program Budget: $2,181,163 **Cost per Client:** $121,175

How Much Did We Do?

I. FY 22/23: Number of Unique Clients Served: 18 clients served.

How Well Did We Do?

Of the 18 clients served, 18 resumes were developed, 7 clients received job interviews, and 4 clients obtained and maintained full time employment.

II. Language Capacity for this Program: English

III. FY 22/23 Challenges:

Challenges include client engagement and helping clients move from their respective stage of change.

Is Anyone Better Off?

A client obtained part-time employment which led to full-time employment, and significantly improved his ability to live independently.

IV. FY 22/23 Client Impact: An increase in client motivation, encouragement, hope, and self-esteem.

V. FY 22/23 Additional Information: Clients were educated on benefits counseling and understanding the parameters surrounding working while receiving SSI benefits.

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

FY 23/24	20
FY 24/25	20

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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.

FY 23/24 Program Budget: $ 72,941 **Cost per Client:** $2,515

How Much Did We Do?

I. FY 22/23: Number of Unique Clients Served: 29

How Well Did We Do?

The clients who were served received high quality work incentive benefits counseling that educated them about their benefits and the work incentives that could be helpful to them. Employment specialists who either attended a presentation, sat with their client during a WIB appointment, or spoke with the WIB counselor separately, also increased their knowledge about work incentives. The number of clients served in FY 22/23 was lower than projected due to CIL's loss of our WIB counselor at the end of the 2nd quarter and to lingering effects of the pandemic.

II. Language Capacity for this Program:

Although all services were provided in English, CIL's Work Incentive Benefits counselor can always 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.

III. FY 22/23 Challenges:

Staff turnover was the main challenge.

In July 2022, after an extensive 3-month search, CIL hired a new Work Incentive Benefits counselor. Caolan Hyland filled the WIBC position that was previously held by Geoff Evans for 6.5 years. Caolan met with participants virtually and in-person, contacted ACBH wellness center staff and provided presentations about benefits. In December 2022, Caolan gave notice of resignation. CIL again began searching for a new benefits counselor to replace Caolan. There was a severe lack of qualified applicants for the WIBC position throughout the 3rd and 4th quarter of 22/23. Program manager Robin Earth provided benefits counseling to any participants who were referred to the CIL WIB program for benefits support by ACBH wellness center staff during the 3rd and 4th quarters. However, due to other CIL program manager responsibilities that limited her time, was not able to provide active outreach to the agency staff herself.

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participants and number of contacts made with ACBH wellness agency staff.

Is Anyone Better Off?

IV. FY 22/23 Client Impact:
Participants who met with a benefits counselor learned important information about Social Security work incentives that allow recipients to begin working without necessarily losing their SSI and/or SSDI benefit payment right away. They learned how to maintain their free Medi-Cal, even if their new earned income begins to exceed the standard Medi-Cal income eligibility limit, via 1619b Medi-Cal and the CA Working Disabled Programs. They also learned the importance of reporting earnings on time to SSA each month to avoid overpayments and learned options for reporting the earnings. They were provided virtual, in-person and phone appointments depending on their preference. They were also emailed details of the discussions to refer back to, with links to information.

An example of an outcome of WIBC:
A participant was referred to the CIL WIB counselor in February 2023 by an Employment Specialist from one of the wellness centers. He had been receiving Social Security Disability Insurance for a year, was now looking for work and needed to learn how his SSDI benefits would be affected when he started working. He also had other questions about his SSDI. I explained to him about SSDI work incentives: how these incentives were a 3-stage process that allowed recipients to begin working without necessarily losing their disability payment or their health insurance right away. I explained to him about the Trial Work Period, Extended Period of Eligibility and Expedited Reinstatement Period. I also informed him about the CA Working Disabled Medi-Cal Program, which could enable him to keep his free Medi-Cal if his earned money rose above the standard Medi-Cal income eligibility limit. I also talked to him about the importance of promptly reporting any changes in his income to SSA to avoid overpayments. After our appointment, I sent him an email detailing all the information we discussed as well.

4 months later, the participant successfully found a job and met with me again for a refresher on how his benefits would be affected, now that he was starting work, and about the options for reporting his earnings to SSA. I provided a refresher to him about SSDI work incentives, with an emphasis on how to timely report monthly income to SSA to avoid overpayments. Afterwards, I emailed both him and his employment specialist the details about everything we had discussed, so that he could refer to it, if needed. He also knew he could contact me anytime with questions.

V. FY 22/23 Additional Information:
We are in the process of training a new hire to fill the Work Incentive Benefits Counselor position.

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

FY 23/24	We expect the numbers to increase once a new staff person is trained to provide WIBC. We project to serve 60 -80 clients
FY 24/25	We project our numbers served will increase to 125 - 150

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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 for up to 12 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, and have been authorized for services by ACBH.

FY 23/24 Program Budget: $ 1,734,121 **Cost per Client:** $54,191

How Much Did We Do?

I. FY 22/23: Number of Clients Served: 32

How Well Did We Do?

II. Language Capacity for this Program: Spanish and English

III. FY 22/23 Challenges:

Over the last year we have faced challenges with keeping our female clients safe that have a history of prostitution. They responded well to the care and concern of staff but would engage in the activity when money got tight for them personally. Another challenge was needing more services for clients that became acute but were unwilling to go into CRT for stabilization.

Is Anyone Better Off?

IV. FY 22/23 Client Impact:

More clients were able to complete the program successfully and gain permanent housing. The collaboration between outside teams is strengthening. Hoping to continue this partnership.

V. FY 22/23 Additional Information:

Again, we appreciate the services that the outsider teams provide. It has proven priceless in coordination of care.

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VI. FY 22/23 Projections of Clients to be Served: We hope to serve 40 clients.

FY 23/24	40
FY 24/25	42

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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.

FY 23/24 Program Budget: 397,904 (ACBH contribution) **Cost per Client:** $7,234

How Much Did We Do?

I. FY 22/23: Number of Unique Clients Served: 55

How Well Did We Do?

The Schreiber Center continues to provide mental health assessments, psychotherapy services, and medication management for a vulnerable population that can often get overlooked in traditional mental health settings. The Schreiber Center works to reduce mental health stigma and increase accessibility to mental health services for individuals with co-occurring intellectual and developmental disabilities and serious mental illness by regularly partnering with other departments, providers, care staff, and family members to collaborate, consult, and provide education on mental health symptoms and presentations in the IDD population. We have increased our collaboration with county clinics, working together on treatment so clients with IDD are able to access appropriately matched care. 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. During this past FY the Schreiber Center has increased frequency of in person appointments for both therapy and psychiatry, but also continues to maintain telehealth appointments based on client preference and clinical benefit.

II. Language Capacity for this Program:
Schreiber Center utilizes translation services offered by ACBH via phone, telehealth, and/or in person office visits. The Schreiber Psychiatrist is bilingual in English and Spanish.

III. FY 22/23 Challenges:
The Schreiber Center has been largely impacted by staffing challenges, including inconsistent clerical support. These staffing challenges have resulted in a limitation of referral reviews and intake assessments.

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The Schreiber Center has been without a full time clinician since October 2022, after the existing clinician transitioned to a supervisory role overseeing the program. The newly prompted current clinical supervisor has maintained a small caseload of therapy clients and our part time psychiatrist has been consistent with regard to caseload capacity throughout the FY 22/23. The Schreiber Center's clerical staff has been filled with temporary staffing, causing some challenges with consistent administrative support.

Is Anyone Better Off?

IV. FY 22/23 Client Impact:
Schreiber Center clients are noted to benefit from services anecdotally as well as evidenced by improvements in measurable treatment results. A majority of our clients have experienced significant periods of stability with a decrease in hospitalizations and engagement with crisis services. Clients benefit from additional time allotted for medication management appointments and regular engagement with their care teams by our psychiatrist. Clients who engage in our mental health counseling are offered skills to help prevent future mental health distress and crises and they report wanting and 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 integrated approach to care benefits clients who may have an intellectual or developmental disability and are receiving services in other areas of our system.

Case Study:
33 year old male dually diagnosed with developmental disability of cerebral palsy and mental health diagnosis of unspecified bipolar disorder. History of lengthy periods in acute and sub-acute inpatient psychiatric facilities and long history of depression, irritability, impulsivity which effect ability to cope with daily stressors in the community. Client also has a long history of suicidal ideation and attempts, as well as substance abuse, trauma, legal issues and homelessness. Client's symptoms are currently well managed, receiving both medication management and therapy services at the Schreiber Center. Over the past FY, client has been able to gain employment with the support of Alameda County's vocational program, increased recreational activities and independence by improving his self-advocacy of his needs to his care team (a goal he worked on in therapy), and has decreased weekly psychotherapy sessions to biweekly. Client reports continuing to experience triggers and ups and downs in mood, but stated the difference is that he now can manage these symptoms by actively use healthy coping skills.

V. FY 22/23 Additional Information:
Despite staffing issues during FY 22/23, the Schreiber Center has been able to screen incoming phone inquiries regarding services, review referrals, triage and refer to other mental health providers within our system based on need and acuity, schedule medication management only intake assessments, and maintain a structured queue for referrals pending intake assessments.

VI. FY 22/23 Projections of Clients to be Served:
During this past FY we have been able to review, triage, and create a structed queue for new referrals depending on need, acuity, and availability. We anticipate being able to hire a full time clinician this FY in order to support increased referral reviews, therapy services capacity, and intake assessments. If fully staffed, we anticipate providing services to at least 60 clients during the next FY.

FY 23/24: If fully staffed, we anticipate providing services to at least 65 clients during future FY.
FY 24/25: If fully staffed, we anticipate providing services to at least 65 clients during future FY.

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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.

FY 23/24 Program Budget: $3,038,853 **Cost per Client (for MHSA funds):** $1,833

How Much Did We Do?

I. FY 22/23: Number of Unique Clients Served: 1,657

How Well Did We Do?

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 psychiatrists are available daily for both low barrier walk-in and scheduled care.

The Lifelong Trust Clinic reported a total of 17,395 visits in FY 2022-23, which entail a variety of clinical and supportive services provided to patients. 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.

II. 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.

III. FY 22/23 Challenges:

1. **Staff retention, hiring, and turnover.** Trust Clinic staff turnover and retention was a challenge in the previous FY and has remained problematic through FY 22-23. LifeLong Medical Care, as a non-profit community health center, has to compete for staff in the current competitive health care job market, which is still experiencing shortages for key positions system wide. LifeLong is

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constantly filling vacancies due to retirements, and staff leaving for other higher paying, less stressful positions.

2. **Community violence**. Identified as a challenge in the previous FY, levels of community violence in the downtown Oakland area remain high and have presented challenges for patients and staff of the Trust Clinic. Staff continue to receive threats, and cars are broken into frequently. These events occur frequently enough to create a high level of stress for everyone, patients and staff alike. LifeLong installed a bulletproof barrier around the perimeter of the clinic in 2022; still, violence outside of and in the waiting area for the Trust Clinic remains a consistent challenge to operations and service provision.

3. **Continued COVID-19 impacts.** Trust Clinic patients, once screened at the door for COVID-19, are now able to wait in the waiting room. Showers continue to be closed off, partially due to COVID-19 precautions but primarily due to hiring and retention challenges. During 2022-23, LifeLong began allowing more people into the clinic at one time, though there are still lines outside. ACHCH is working with LifeLong to support expanded capacity and expanded telehealth for behavioral health visits to see more patients.

Is Anyone Better Off?

IV. FY 22/23 Client Impact:

Clinic Services:

In FY22-23, the Trust Clinic served 1,657 patients, providing 17,395 visits including 8,678 enabling services. This represents a decrease in both total patients and total visits compared to the previous fiscal year, largely due to a reduction in services provided related to COVID-19. The Trust Clinic continues to prioritize expanded Medication Assisted Treatment (MAT) for substance use services onsite, utilizing a team of social workers to support patients with SUD services. In addition, the use of telehealth practices has improved access of patients to behavioral health services, in addition to the onsite service modality.

Patient Story:

The symbiotic relationship between behavorial health and primary care at the Trust Clinic is highlighted in the case of 50-year-old African American woman who was unhoused and presented to Trust Clinic staff with auditory hallucinations and a tangential thought process which were exacerbated by methamphetamine use. These symptoms coupled with the client's traumatic history significantly impaired her interpersonal relationships and daily functionality. Additionally, this client struggled with complications from gastric bypass surgery. Integration of behavioral health within primary care allowed the client to receive comprehensive health care that effectively addressed her gastric complications as well as her mental health. She has received a long acting injectable that manages her mood and auditory hallucinations. Currently the client's auditory hallucinations and methamphetamine use have subsided. The client is housed, works part time, and is reconnected with her children, which is indicative of the client's perseverance and the comprehensive care she received at Trust.

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V. FY 22/23 Additional Information:

Media Coverage:

Street Psychiatrists Build Trust, Offer Hope to Homeless Patients With SMI
https://psychnews.psychiatryonline.org/doi/full/10.1176/appi.pn.2023.04.4.30

Doctors strike at East Bay clinics serving low-income, homeless patients:
https://www.berkeleyside.org/2023/06/28/oakland-berkeley-lifelong-strike-homeless-patients

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

FY 23/24	1,700
FY 24/25	1,750

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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 FQHC's that are 0-18 yrs of age.

FY 23/24 Program Budget: $2,040,434 **Cost per Client:** $322

How Much Did We Do?

I. FY 22/23: Number of Unique Clients Served:

a. The number of unique young clients and families attempted to reach for establishing care and being enrolled in wrap-around preventive services: **6,330.**
b. Number of young clients receive universal Behavioral Health, trauma, and/or pediatric screenings: **3,455.**
c. The number of young clients who have experienced adverse childhood experiences (ACEs) referred to appropriate follow-up resources: **1,334.**

How Well Did We Do?

a. **Behavioral Health Care Navigation Support:** Our team of 11 Pediatric Care Coordinators (PCCs) are key members of their clinics integrated behavioral health teams. The PCCs are housed between pediatric and behavioral health departments, often working with both teams in navigating care and support for pediatric patients within their primary care clinics. In FY 22/23, AHC continued to connect the PCCs to training that would support them in addressing the behavioral health needs of their pediatric patients and patient family members. Examples include:

    i. Three-Part We are Resilient training series with Dovetail Learning
    ii. Alameda County Behavioral Health Crisis Services overview with ACBH representatives
    iii. Eating Disorder 101 with ACBH consultant, Helen Savin

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b. **Supporting Pediatric Providers:** Prior to the implementation of this program, pediatric providers within our network of 8 FQHCs expressed the need for more care coordination support. Many of these providers were navigating care, resources, and additional support for pediatric patients and their families in addition to meeting them for their scheduled appointments. Since the launch of the program, providers shared positive feedback through quarterly check-ins and a Biannual Provider Survey, which we launched in FY22-23. The majority of survey responses indicated that the PCCs have had high impact on the following:

   i. Alleviating the time, they would have otherwise spent on care coordination and navigation for pediatric patients and their families.

   Highlight: In FY 22-23, the Pediatric Care Coordinators spent over 168,000 minutes with their patients.

   ii. Reducing provider burnout
   iii. Connection with other departments within their respective clinics
   iv. Connection with services outside of their respective clinics
   v. General support to them as pediatricians

III. Language Capacity for this Program:

A majority of our PCCs speak multiple languages including Spanish, Cantonese, and Mandarin.

IV. FY 22/23 Challenges:

Limited resources and long waitlists for services were major challenges in FY22-23. The PCCs noticed an increasing need for their services, but were met with little to no availability for the resources or support they connected their patients to. To address these challenges, we convened the PCCs on a regular basis to have them share updates with one another regarding resource availability and best practices around supporting patient families while they wait to get connected to services. Additionally, we experienced some staff turnover within the cohort this fiscal year, which caused some delays in connecting patients to pediatric care coordination services.

Is Anyone Better Off?

V. FY 22/23 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 PCC supported the family of a 2.5-year-old boy who had recently moved from Stockton. The patient was denied speech therapy and specialized health care but needed support in navigating services in Alameda County. The PCC supported the patient's mother with advocacy and translation services, serving as a liaison between agencies. The PCC also linked the family to Pre-K Special Education services and food assistance, in addition to closing speech therapy care gaps by linking the patient to an independent county language provider. Additionally, the PCC

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presented and administered the ACES screening tool, which helped connect the parent and child to community resources and parenting support focused on Resiliency.

- A PCC supported a 13yo white female recently hospitalized for anxiety and depression and was currently receiving weekly therapy sessions. Her therapist requested a referral to a higher level of care due to escalating concerns around anxiety, dissociation, and suicidal ideation. The PCC reached out to several treatment centers that either did not take patient's insurance or did not have a program for an adolescent dealing with patient's diagnosis. After several attempts, the PCC was able to find an in-network, virtual program that accepted the patient's referral. The patient was able to start treatment immediately.

VI. FY 22/23 Additional Information:

The Pediatric Care Coordinator Pilot continued to be a success in FY22/23. In previous years, we experienced issues in data collection and reporting, which have since been resolved after working closely with the health centers. In FY22/23, we were also able to collect additional metrics (e.g., time spent with patients) to further capture the positive impact the PCCs were making on their clinics and patient populations.

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

We expect similar numbers in the coming years given the PCCs' existing workloads and capacity.

FY 23/24	6,000 to 7,000
FY 24/25	6,000 to 7,000

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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 adults ages 22 to older adults.

FY 23/24 Program Budget: $161,363 **Cost per Client:** $179

How Much Did We Do?

I. FY 22/23: Number of Unique Clients Served: 900

How Well Did We Do?

Quality Measures	FY 22/23 Data Results	Contract Quality Objective Benchmarks
Percent of clients who receive service referrals from the Care coordinator out of all clients who received care coordination services from the Care Coordinator.	94%	**At least 60%**

II. Language Capacity for this Program:

AHS'S care coordinator provides services fluently in English, Mandarin, and Cantonese. For encounters with patients who are monolingual speaking in another Asian language, AHS's care coordinator will utilize professionally trained interpreters from contracted platforms for effective communication.

III. FY 22/23 Challenges:

The Behavioral Health (BH) department at AHS received an average of 110 referrals for therapy services per month throughout FY 22/23 and majority of the referrals are estimated to have been for monolingual speaking adults of an Asian language. With less than 10 behavioral health clinicians internally at AHS primary care, majority of whom are bilingual and/or bicultural, the AHS care coordinator had to link patients awaiting therapy services to external resources for timely access to care. However, one of the major barriers to timely access to care were limited bilingual external therapists, therapists who accepted patients' insurance plans but could not provide language access and the limited amount of external therapists who had availability to receive new referrals or patients. Moreover,

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patients had trouble making contact with external providers and this heavily involved the care coordinator's intervention to ensure successful linkage. This led to stagnancy in care coordination efforts and a demand for ongoing monitoring and linkage efforts, which subsequently amplified the amount of workload for the care coordinator at any one time.

Multiple factors also delayed patients' connection to higher or more appropriate level of care when referring to external resources. For instance, recent changes involving CalAIM/Enhanced Care Management (ECM) and the requisition of Beacon services by Alameda Alliance for Health (AAH) required quick adaptation by the care coordinator for positive outcomes in patient care. AAH's launching of their acquired services involved multiple troubleshooting with the AAH representatives on the correct protocol and workflow to refer and connect patients to external therapy and psychiatric services. CalAIM and ECM also revised the eligibility criteria and screening tools for patients' entry into specialty mental health level of services. This resulted in rejection of referrals coordinated by the care coordinator for monolingual speaking patients with chronic mental health conditions and who would benefit from weekly therapy care. The care coordinator had to find other external resources for rejected patients or return to the primary care setting to coordinate with the AHS care team on helping manage patients' presenting problems while awaiting availability for more appropriate level of care.

In summary, the major challenges for FY 22/23 for care coordination efforts involved the increase of needs amongst our patient population for therapy services that are language-concordant and specialized care but limited community resources and/or stricter criteria for eligibility of programs.

Is Anyone Better Off?

IV. FY 22/23 Client Impact:

A 43-year-old Cantonese-speaking female patient with paranoid schizophrenia exhibit aggressive behaviors towards her family and neighbors. The police were informed multiple times about her behavior. The patient is also sensitive to sound and often misinterprets and references surrounding noise from her neighbors as directed towards her. The last time she received Specialty Mental Health services was in mid-2021.

After her discharge from Specialty Mental Health (SMH), the patient returned to her PCP for ongoing medication management of psychotropics. She also started meeting with a male Behavioral Health (BH) clinician in the primary care setting. However, in August of 2022, both the patient and her mother informed AHS's front desk staff that they would prefer to transfer to a female clinician. The AHS care coordinator reached out to the patient to gather more information and understand the situation leading to the request for case transfer better.

The patient and her mother informed AHS care coordinator that the patient felt anxious the day before her appointment with the male clinician. Her anxiety was expressed as irritability. The patient expressed a preference for a female therapist with whom she would feel more comfortable discussing her concerns and topics. The patient's mother also shared that the patient's irritability and outbursts towards family and neighbors increased when she lacked adequate sleep. Simultaneously, mother's caregiver stress increased, and she felt more overwhelmed with patient's increased anger outbursts.

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The care coordinator suggested that the mother talk to her Kaiser PCP and request a counseling referral for herself, which the mother agreed to consider, to ease family tension and dynamics.
AHS's care coordinator advocated within the BH Department to reassign the case to a female BH clinician and submitted a new SMH referral for appropriate level of care. Meanwhile, AHS's care coordinator connected the patient to see an internal psychiatric nurse practitioner (NP). AHS's care coordinator coordinated the case with the SMH intake team, primary care team providers, the patient, and her family to ensure successful completion of intake screening by patient with SMH and ongoing engagement with BH provider and psychiatric NP while awaiting more appropriate level of care.
In the latter part of the month, SMH informed the care coordinator that they successfully assigned the case to one of their SMH clinicians. The transfer from BH to Specialty Mental Health was completed successfully.

V. FY 22/23 Additional Information:

AHS's care coordinator actively participated in monthly CHCN meetings and engaged in peer group spaces to exchange resources and insights with fellow care coordinators. Additionally, the care coordinator attended PEARLS training in June of 2023. Furthermore, the care coordinator(s) attended Mental Health/Alameda Alliance for Health open office hours to explore extended insurance resources and ensure seamless patient connection to appropriate services that alleviate mental health symptoms and/or psychosocial stressors.

Notably, the care coordinator(s)recently delivered a presentation during the Specialty Mental Health Direct Services Meeting. This presentation detailed their roles, daily responsibilities, coordination of Specialty Mental Health referrals, discharge procedures, and general linkages. Since the presentation, there has been more effective collaboration with Specialty Mental Health clinicians for patient care, which has resulted in enhanced outcomes.

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

We remain dedicated to providing mental health services to the AAPI community and ensuring prompt access through effective patient referral triage. AHS's behavioral health workflow has seen enhancements, with the AHS care coordinator engaging in daily meetings with BH managers to meticulously review new BH referrals for timely case assignments and maintaining contact with patients who are more complex to connect to appropriate services.

FY 23/24: In the FY23/24 projection, we anticipate a continued commitment to serving the APPI community with essential mental health services. We have taken a conservative approach and estimated a 30% increase in new patient intake, which is expected to translate to approximately 1170 unique patients. This projection is based on the estimated average growth recorded in the last two fiscal years.

FY 24/25: Looking ahead to FY 24/25, AHS's projection entails sustaining our dedication to providing essential mental health services to the APPI community. We've conservatively estimated a 30% rise in new patient intake, which is poised to yield an estimated total of 1521 patients. This forecast is grounded in the growth observed in the preceding fiscal year.

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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.

FY 23/24 Program Budget: $2,388,695 **Cost per Client:** $2,952

How Much Did We Do?

I. FY 22/23: Number of Unique Clients Served: 809

How Well Did We Do?

**All impact reflects utilization of all funding, with county funds representing approximately 1/3rd total funding.

- Expanded staffing – an additional care coordinator was added for a total of 2.0 FTE.
- Stable tele-psychiatry and increased utilization of psychiatry
- The program saw 246 more patients over yr. 1 with the same amount of therapist staffing at 1.4 FTE.
- Effectively stabilized patients in crisis – In year 1 & 2, rates of 5150 or psychiatric hospitalization following referral to our program remained below 1%.
- Provided stabilization and crisis intervention in an average of 5 sessions.
- Provided in-person and telehealth services.
- Prescribed and administered long-acting anti-psychotic injectable medications.
- Referred callers to local resources for food, housing, etc. Assisted in completion of paperwork, connected to health insurance, etc.

II. Language Capacity for this Program:

English only at this point due to staffing. If we increase language capacity, we want to have staff who speak that language in all positions (therapist, care coordinator and psychiatry) given that nature of the program and that translation while in crisis would not be ideal.

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III. FY 22/23 Challenges:

- It was our hope to increase therapist staffing (increase from 1.4 to 2.0 FTE); however, due to the national crisis related to recruiting therapists we have yet to fill this position.
- Costs were higher than expected. Tele-psychiatry is utilizing more of the budget than initially anticipated.
- Program funding from the county was used for the beginning of the year before SAMHSA funding was available, and also at the end of the year when SAMHSA funding had been fully utilized. Consistent funding moving forward will need to be established and the budget will need to be increased.
- Due to lack of ability to hire another therapist, and also the higher cost of the program we were unable to expand services to Castro Valley. We hope to do so in the future should we be able to secure additional funding.

Is Anyone Better Off?

IV. FY 22/23 Client Impact:

- 58 y/o Filipina female presenting with sleep issues and agoraphobia. Connected with therapy and psychiatry, provided financial resources, and assisting transferring insurance to this county for pt and her family.
- 11 y/o white female with history of self-harm and suicidal ideation, prior hospitalization. Initial diagnosis MDD- severe (symptoms: sadness, guilt, hopelessness, low self-esteem, loss of interest, inattention, fatigue/no energy, irritable, lack of motivation, social isolation/withdrawal). During her time on bridge pt was able to develop coping skills, depressive symptoms were stabilized, and she was connected to external psychiatry.
- 33 y/o female of Mexican descent. Initial diagnosis of PTSD, symptoms of guilt, hopelessness, uneasiness, worry, intrusive thoughts, avoidance, questioning everything, intrusive memories, flashbacks, self-blame, angry behavior, highly suspicious. Pt was connecting to Axis Mindfulness group and external supportive groups for survivors, while also working on development of coping skills and accessing psychiatry services through Bridge.

V. FY 22/23 Additional Information:

VI. FY 22/23 Projections of Clients to be Served: 700 for total funding at current rate (county & SAMHSA)

FY 23/24	700
FY 24/25	700

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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

FY 23/24 Program Budget: $193,738 **Cost per Client:** $75

How Much Did We Do?

I. FY 22/23: Number of Unique Clients Served: 2,600

How Well Did We Do?

Quality Measures	FY 22/23 Data Results	Contract Quality Objective Benchmarks
Percent of clients who receive service referrals from the Care coordinator out of all clients who received care coordination services from the Care Coordinator.	**95%**	**At least 60%**

III. Language Capacity for this Program: We have behavioral health providers who can communicate in English, Mandarin, Hindi, Gujarati, and Spanish. Our BHCCs speak Spanish, Punjabi, and Tagalog. Additionally, we make use of translation services to offer therapy in other languages as well.

IV. FY 22/23 Challenges: Our challenges are with hiring in-person BH Providers who can speak the language of our patient population. We have many telehealth BH Providers, but some patients request in-person visits. We have placed significant emphasis on recruitment and staff retention.

Is Anyone Better Off?

V. FY 22/23 Client Impact:
In Q2, one of our BHCCs provided domestic violence info and resources to a patient experiencing a domestic violence situation. The resources included housing, which helped the patient remove herself from the DV situation during an ongoing court case.

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VI. FY 22/23 Additional Information:

As the Covid-19 Public health emergency came to an end, BACH started incorporating a combination of in-person and telemedicine services to meet the needs of our patient population and enhance access to behavioral health care.

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

FY 23/24	4,370
FY 24/25	5,713

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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.

FY 23/24 Budget: $141,908 **Cost per Client:** $510

How Much Did We Do?

I. FY 22/23: Number of Unique Clients Served: 278

How Well Did We Do?

II. Please Describe Ways that the Program Strives to:

Reduce Mental Health Stigma: We, at PATH, collaborate with all staff very effectively. Our communication allows for the patient to not have to restate facts about their behavioral health issues. Both the Primary Care and Psychiatric sides are aware of patient's situations and it allows for us to provide care and support without the patient having to repeatedly discuss their status.

III. Language Capacity for this Program: Spanish and English

IV. FY 22/23 challenges:

We continue to have difficulties in collecting vitals as patients are preferring to have phone appointments. We also are missing our peer advocate to assist with transportation and have not been able to provide group activities.

Is anyone better off?

V. FY 22/23 Client Impact:

We have been working closely with BACH Behavioral Health and have been able to get patients counseling services.

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VI. FY 22/23 Additional Information:

We have two full days of clinic (Tuesday and Thursday) every other week. Alternating week has clinic on Tuesday only.

VII. FY 23/24 Projections of Clients to be Served:

We continue to meet the requests for new patients being added to our panel. We have brought in a new patient this quarter that receives her psychiatric services at Valley in Pleasanton but lives in Newark. It is her desire to transfer her BH care to Tri-City Community Support and we are able to make her most comfortable starting her primary care in anticipation of the transfer.

FY 23/24	approximately 250
FY 24/25	approximately 250

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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.

FY 23/24 Program Budget: $97,020 **Cost per Client:** $571

How Much Did We Do?

I. FY 22/23: Number of Unique Clients Served: 170

How Well Did We Do?

Quality Measures	FY 22/23 Data Results	Contract Quality Objective Benchmarks
Percent of clients who receive service referrals from the Care Coordinator out of all clients who received care coordination services from the Care Coordinator.	100%	**At least 60%**

II. Language Capacity for this Program:

English and Spanish support provided by the IBH Care Coordinator. Other language capacity is provided via translation service.

III. FY 22/23 Challenges:

This past year, the greatest hurdles I experienced in my employment as a care coordinator were learning how to navigate my job role and figuring out how to communicate successfully with the demographic of patients that we serve. The majority of people who are referred to CC are older Spanish speakers who have trouble navigating the healthcare system and comprehending how important it is to receive preventative and follow-up care.

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Is Anyone Better Off?

IV. FY 22/23 Client Impact:

Members were having difficulty with managing follow-up care due to the language barrier and lack of transportation. CC began speaking with members on a bi-weekly basis to ensure appointments were adequately getting scheduled along with transportation. After working with care coordinator, member completed all preventative and follow up care but continues to check in with CC on a bi-monthly basis to ensure regular PCP follow ups. Member contacts CC anytime any needs arise and has established a good relationship between CC and member. Members feel confident to ask questions that pertain to a member's wellbeing.

V. FY 22/23 Additional Information:

The most significant impact that I have witnessed in the people who are a part of my group is that they are more comfortable interacting with others who are in a similar situation to them. I explain that I am the daughter of my parents, both of whom are bilingual in Spanish and English, and that I assist my parents in managing their own medical requirements. Because of this, I have been able to connect with them in a way that has made them more comfortable approaching me for aid. The majority of the time, they have a difficult time figuring out where the site of the specialist referrals is at, so having someone who can set up their healthcare appointment along with transportation for them is a huge assistance for them.

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

FY 23/24	150
FY 24/25	150

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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: The Silva Clinic provides mental health services (i.e., screening, assessment, collateral, individual and group therapy, family engagement, individual and group rehabilitation, and plan development), crisis intervention, and case management/brokerage. Treatment includes additional Family Partner services. Providing specialized early childhood mental health services within the context of children's families/caretakers in the Central and South Alameda County area. Services range from very brief assessment to short-term treatment lasting typically from nine to 12 months in duration. The Integrated Health Program works in close collaboration with the client's pediatrician and medical support staff and shall provide primarily on-site, short-term services. In addition, clients may, when approved as clinically appropriate, continue to be seen by the Early Childhood Mental Health (ECMH) Program for longer-term services that are primarily home-based.

Target Population: Children, age 0-8, and their families and or caregivers.

FY 23/24 Program Budget: $101,187 **Cost per Client:** $8,432

How Much Did We Do?

I. FY 22/23: Number of Unique Clients Served: 12

How Well Did We Do?

Over the course of the year Family Engagement as measured by collaterals with the caregivers and/or Family therapy for the ECMH program indicated a 64% positive engagement to support the child clients.

II. Language Capacity for this Program: Spanish and English

III. FY 22/23 Challenges:

Some challenges were the changes in medical staff at Tiburcio Vasquez Silva Pediatric clinic, with some pediatricians leaving that agency and difficulty resulting for collaboration with the young client's doctors. Another challenge is hiring for staff workforce openings in our program.

Is Anyone Better Off?

In the Silva Clinic program, we had 22 clients over the year, with 12 openings, and 5 closings. The Reasons for closing indicated 65% closing successfully as measured by treatment goals reached or partially reached; and 83% indication of improvement on closing CANS scores over the year.

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IV. FY 22/23 Client Impact:

The Silva Pediatric Clinic from Tiburcio Vasquez continues to send referrals to our program and the community continues to be served. Client's increase functioning in many areas due to our interventions including developmental progress, attachment with caregivers, processing trauma experiences, and growing stability in many immigrants and economically challenged families.

V. FY 22/23 Additional Information:

The Silva Clinic ECMH program is currently fully staffed and will continue to build collaborative relationships with new medical staff at Tiburcio Vazquez Silva Pediatric clinic. Staff continue to increase their experience and training in Complex trauma as many referrals show an increase in families with these experiences.

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

FY 23/24:	**Projected 22-30 clients per fiscal year.**
FY 24/25:	**Projected 24-35 clients per fiscal year.**

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OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 25

PROVIDER NAME: Oakland-PATH/LifeLong Medical Care

PROGRAM NAME: Behavioral Health - Primary Care Integration Project: Eastmont

Program Description: LifeLong Medical Care operates a Federally Qualified Health Center (FQHC) to provide co-located services at the Oakland Adult Community Support Center (OACSC) 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.

FY 23/24 Program Budget: $127,227 **Cost per Client:** $403

How Much Did We Do?

I. FY 22/23: Number of Unique Clients Served: 316

How Well Did We Do?

Reduce Mental Health Stigma:

Our patients are seen in a clinic with their peers, in an environment that they have become accustomed to. Our staff are compassionate and are thoughtful about language used in communication with our clients. Additionally, we work together with the Peer Health Educator to develop programs and groups were patients feel welcomed and safe to share their stories and be themselves without judgement.

II. Language Capacity for this Program:

We currently have two clinicians who speak Spanish. We use several interpretation services including those offered by insurance, Language Line Solutions, PrOpio One for ASL video visits and Purple Communication for in-person ASL interpretation.

III. FY 22/23 Challenges:

The usual and continued challenges around transportation and quality housing still exist for our patients. Additionally, we are currently recruiting for another clinician.

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Is Anyone Better Off?

IV. FY 22/23 Client Impact:

We were able to assist a Board and Care where one of our clients resides by providing them with a case of rapid Covid tests to contain the spread of Covid.

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

We expect at least a 10% increase of patients being served through our Eastmont PATH program.

FY 23/24	300
FY 24/25	300

VIII. FY 22/23 Programs or Service Changes:

We are actively recruiting for one more clinician to add to the Eastmont PATH team so that we will be able to add an additional clinic.

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OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 25

PROVIDER NAME: Oakland-PATH/LifeLong Medical Care

PROGRAM NAME: Behavioral Health - Primary Care Integration Project: Eden

Program Description: LifeLong Medical Care operates a Federally Qualified Health Center (FQHC) to provide co-located services at the Oakland Adult Community Support Center (OCSC) operated by ACBH. The project provides coordinated, integrated health care to adults with serious mental illness. The project is called "Promoting Access to Health" (PATH) and has a Wellness Program to provide group health education and encourage socialization.

Target Population: PATH services are offered to all adults (18-59) and older adults (60+) assigned to the service team at the support center.

FY 23/24 Program Budget: $187,357 **Cost per Client:** $610

How Much Did We Do?

I. FY 22/23: Number of Unique Clients Served: 307

How Well Did We Do?

II. Reduce Mental Health Stigma:

Our patients are seen in a clinic with their peers, in an environment that they have become accustomed to. Our staff are compassionate and are thoughtful about language used in communication with our clients.

III. Language Capacity for this Program:

We currently have two clinicians who speak Spanish. We use several interpretation services including those offered by insurance, Language Line Solutions, PrOpio One for ASL video visits and Purple Communication for in-person ASL interpretation.

IV. FY 22/23 Challenges:

Transportation continues to be a challenge. The Shuttle has recently resumed their services and we anticipate that this will increase enrollment and participation in PATH services. Hiring and retention for our nursing staff is a major challenge that we continue to face. We are actively recruiting for a nurse for PATH.

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Is Anyone Better Off?

We have a client who needs constant reassurance about her health after watching movies and or tv programs. We have been able to reassure her that she is not diagnosed or experiencing the issues that she is seeing. Additionally, we have been able to work with a client's insurance to get him the durable medical equipment and supplies he needed.

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

We expect at least a 10% increase of patients being served through our Eden PATH program.

FY 23/24	330
FY 24/25	330

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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. The program delivers care coordination services and connects behavioral health clients 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.

FY 23/24 Budget: $193,738 **Cost per Client:** $151

How Much Did We Do?

I. FY 22/23: Number of Unique Clients Served: 1,279

How Well Did We Do?

Quality Measures	FY 22/23 Data Results	Contract Quality Objective Benchmarks
Percent of clients who receive service referrals from the Care coordinator out of all clients who received care coordination services from the Care Coordinator.	77%: 981 out of 1,279 patients received service referrals	**At least 60%**

II. Language Capacity for this Program: Spanish and English

III. FY 22/23 Challenges:

La Clinica's case workers have continued to have challenges connecting their clients with mental health services. Patients face accessibility issues due to not having insurance that will cover these service or insurances not having enough providers for therapy. This includes immigrant patients with no insurance, and patients with Brown & Toland or Tricare insurance. Many patients have been turned away due to limited availability for in-person therapy. Many MH providers have language barriers; there is a need for Spanish and Cantonese speaking providers. Overall Case Managers are continuously experiencing difficulties in finding financial resources and resources for immigrant patients.

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An increase in community violence has also enlarged the need of linkages to Victim of Crime Compensation program (VoCC). Patients have been overwhelmed, and resistant, to the VoCC program due to police involvement. Immigrant, and uninsured patients, experience difficulties being linked to free Mental Health services when they are in distress due to crime/assault.

Finding affordable housing for low-income patients has been a challenge due to the halt of applications for community program that was supporting back pay rent. Other factors such as capacity, lack of availability, patients not meeting requirements, has made it difficult to link patients with housing assistance and resources.

Is Anyone Better Off?

IV. FY 22/23 Client Impact:

A 55-year-old female patient was referred to CM by PCP for connection to psychiatry services. Patient has schizophrenia and some substance use. Case Manager first connected with patient through her father, a 72-year-old male, who seems to be involved in patients care coordination. The Case Manager was able to talk to the patient privately and she consented to a psychiatry referral. The Case Manager scheduled a phone call appointment with the patient to call Access together the following day. The patient and Case Manager called Access together for intake. The Case Manager answered some questions that the patient could not answer on her own. Access clinician referred the patient to Pathways to Wellness and recommended getting a therapist, but the patient declined. During follow up, the patient told the Case Manager that she was being verbally abused by father, but father declined this, and stated patient is 'out of it'. However, the Case

The manager supported the patient and offered to find community support. The patient addressed that she needs more support from the Case Manager other than just mental health services and requested assistance finding housing and possibly substance use treatment. The Case Manager is still working with and following up with patient.

V. FY 22/23 Additional Information:

Integrated Behavior Health interns have supported the Case Managers with researching new resources and appropriate services that our clients may be able to connect with. Resource guides regarding providers who accept diverse types of insurance have been distributed and are available for the clients. Monthly newsletters have been compiled and shared with patients. Patients are also referred to the Food Farmacy every 2nd Monday of the month.

Undocumented adults over the age of 55 are eligible for Medi-Cal and receive case management services. With the increase of senior services, patients have been referred to Senior Housing in San Leandro and Casa Del Sol support groups. The Case Managers continue to provide support for senior and disabled patients who need IHSS services.

Undergraduate and graduate level students are paired with IBH Case Managers for care coordination and provide services to IBH patients under the Mentored Internship Program.

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VI. Projections of Clients to be Served:

FY 23/24	Deliver at least 100 care coordination services, per quarter, per IBHCC FTE, to eligible clients.
FY 24/25	Deliver at least 100 care coordination services, per quarter, per IBHCC FTE, to eligible clients.

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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.

FY 23/24 Program Budget: $161,363 **Cost per Client:** $41

How Much Did We Do?

I. FY 22/23: Number of Unique Clients Served:

Q1: 847; Q2: 942; Q3: 1035; Q4: 1152 (total all 4 quarters 3,976) During FY 22/23, IBHCCs provided a total of 15,413 services to patients.

How Well Did We Do?

Quality Measures	FY 22/23 Data Results	Contract Quality Objective Benchmarks
Percent of clients who receive service referrals from the Care coordinator out of all clients who received care coordination services from the Care Coordinator.	**89%**	**At least 60%**

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II. Language Capacity for this Program: Language line is used for all other languages.

III. FY 22/23 Challenges:

1. The transition from Beacon to AAH left pts confused, and with reduced access to services, AAH has also been overwhelmed with CM.
2. Pts are deterred by barriers to care and loopholes that healthcare plans makes them jump through (Mental health assessments by AAH/BC then provided referrals that are not accepting new pts or not contacting back); insurance companies have at times not been warm or compassionate to monolingual clients and left them lost in process of connecting to services.
3. CCs and PCPs have continued to have challenges with the ACCESS screening tool and having pts denied ACCESS referrals.
4. Also seen an increase in challenges with referrals from Blue Cross and Alameda Alliance with referral provided not being successful.
5. CC have noticed increased challenge for Spanish-speaking clients seeking services. There is no appropriate workflow, culturally responsive screening, and a lack of support in navigating insurance and unsuccessful referrals.
6. Medicare, Medi-Medi, and straight Medi-Cal pts without a managed care plan seem to fall through the cracks due to a lack of available resources. We have been hitting several barriers with care transitions and are doing our best to assist pts.
7. Lack of resources for Medicare patients.

Is Anyone Better Off?

IV. FY 22/23 Client Impact:

A patient (pt) was referred to IBHP in early March. Pt was referred to IBHP for assistance with a higher level of care referral for an eating disorder. The care coordinator (CC), the IBHP Director, and the pt's primary doctor (PCP), collaborated in consultation to provide pt with the appropriate linkage to services. This pt was referred due to her anorexia being out of control and her anxiety not being well managed. PCP and IBHP director determined this pt would need to be referred to ACCESS due to a higher level of care needed. CC worked with PCP to facilitate this referral process. CC completed the referral demographics sections; PCP was able to complete the referral PCP sections. CC obtained pt's consent for this referral.

When CC spoke to pt regarding the ACCESS referral, resources for additional support were provided. CC provided pt with resources for support with eating disorders, therapy services, and the county crisis support line. CC also offered Pt IBHP services for therapy, to which pt agreed and was placed on our waitlist. Pt was thankful for the resources.

The referral was sent to ACCESS, however, to better serve pt, ACCESS requested to obtain the most recent medical notes. CC informed PCP, and PCP agreed to share notes to assist in pt's linkage to appropriate services. CC sent notes to access and made sure they were received. The referral process wait time was about a week, and when the referral was processed, pt was referred to an eating disorder agency with Alameda County. The assessor for this program contacted CC to request to speak to referring PCP. CC was

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able to connect with PCP and inform them of the request from the assessor to speak to them, cc facilitated the contact with the assessor and PCP. The pt was connected to the appropriate services for an eating disorder specialist and for therapy services to help pt manage her anxiety. Successful linkage to services for pt was possible with the collaborative work from PCP, IBH director, CC, ACCESS, and the referring agency.

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

FY 23/24	3,000
FY 24/25	3,000

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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.

FY 23/24 Program Budget: $97,020 **Cost per Client:** $243

How Much Did We Do?

I. FY 22/23: Number of Unique Clients Served: 399

How Well Did We Do?

Quality Measures	FY 22/23 Data Results	Contract Quality Objective Benchmarks
Percent of clients who receive service referrals from the Care coordinator out of all clients who received care coordination services from the Care Coordinator.	**80%**	**At least 60%**

II. Language Capacity for this Program: English, Spanish

III. FY 22/23 Challenges:

- We continue to have a long waiting list.
- We've had 3 care coordinators.
- Getting two new therapists trained and up to speed.
- Many of the providers believe all their patients are urgent, regardless of how many times it's explained what it means to be urgent.
- Many of our clients fall in the moderate to severe category, but don't quite qualify for SMH services.

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Is Anyone Better Off?

IV. FY 22/23 Client Impact:

I had a patient who expressed food insecurity during SDOH screening. I was able to successfully connect her to our WOHC Community Health team who was able to provide her with food pantry services. Patient was able to come into the clinic and received a package with lots of healthy food options to help alleviate her situation.

V. FY 22/23 Additional Information:

Our newest care coordinator, LeQuan Woods, has proven to be a positive addition to the team. I believe he'll be able to get the waiting list down to a more manageable number.

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

FY 23/24	450
FY 24/25	600

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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 African American Training and Technical Assistance (AATA) programs

Program Description: Through the AATA team, they designed and deliver culturally responsive trainings and technical assistance to support psychiatric prescribers and other behavioral health professionals that support African-American adults (18 to 59) who are living with behavioral health issues. The culturally responsive curriculum was developed to address topics around mental health issues in the African-American community that can delay or create issues of early termination of treatment; the program goals are as follows: 1. to assist with providing an accurate diagnosis, treatment, and healing practices for African-American communities. 2. To recognize racial biases and their impact on diagnosis and treatment decisions for African Americans across the age span. 3. To assist providers in understanding the role of culture in symptom presentation expression and alternative healing practices. 4. To recognize and work with strength and protective factors often overlooked when treating the African-American population. 5. To understand differential medication prescribing practices for African-Americans across the age span. While focusing on these areas and highlighting community health disparities, the AATA team seeks to improve the care for African-American clients with moderate to severe behavioral health issues.

Target Population: Alameda County, psychiatric prescribers, and other behavioral health professionals serving moderate to severe mentally ill clients. Those providers are identified by ACBH and through the contractor's outreach and promotion activities.

FY 23/24 Program Budget: $381,647 **Cost per Client:** $405

How Much Did We Do?

I. FY 22/23:

We completed a total of eight full trainings, one technical assistance, and one listening session for a total of 943 participants from July 1, 2022, to June 30, 2023.

a. Number of Unique Clients Served: 943 (A total of 116 participants were issued CEUs)

How Well Did We Do?

Throughout this year's training, a number of the speakers focused on the issue of racial disparities and developed a clear understanding of how those disparities impact services for behavioral health clients. This information was particularly highlighted in one of our presentations related to emergency room services and how it impacts healthcare disparities among African Americans clients. The trainers also offered specific recommendations on the utilization of strength-based services.

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This increased understanding by clinical professionals related to improving their skills in identifying the cultural strengths of African American clients that are often overlooked by most providers.

FY 22/23. Additional information:

We offered was a listening session primarily focused on suicide among African American youth. This panel discussion included both Youth and Professionals. In this format, the youth were asked to discuss their view of issues and deficits that existed in the treatment arena. The youth discussed various issues and had recommendations for some of the deficits they felt existed in the behavioral health system. This was the second listening session provided by the AATA team, and we will continue to have this format in the 23/24 FY. During FY22/23, we exceeded our projection of 200 to 300 unduplicated participants for the year, we actually had 943 participants for this fiscal year. We will continue our increased marketing activities as we move into the new year.

II. Language Capacity for this Program: N/A

III. FY 22/23 Challenges:

The AATA team continues to encounter challenges, moving from virtual presentations to live presentations. This year we offered two hybrid trainings, and in those trainings, the participants had an opportunity to attend a live training, and they were able to interact with the speaker, and there was also an opportunity to interact with other behavioral health clinicians who attended the presentation. These sessions were also available via Zoom. We are utilizing multiple methods to get the information out regarding the training. However, we are still encountering some providers who do not have information regarding the educational series. To deal with this challenge, we have increased our presence in various social media formats, and we have improved the information on our website.

Is Anyone Better Off?

IV. FY 22/23 Client Impact:

While the program does not specifically offer clinical services, several of our presenters discuss the issue of healthcare disparities among the African American population. In their presentations, they offered evidence-based, culturally sensitive tools and methods that can be utilized by practitioners when servicing the African American population. In a number of our trainings, the speakers discussed the issue of differential medication prescribing that may be needed for the African American population. We believe that a number of Alameda County providers are learning more about this subject matter by continuing to attend our training. In addition, they often comment on our teaching techniques and how relevant our content and resources are to improving the service delivery to the African American community in Alameda County.

V. FY 22/23 Additional Information:

This fiscal year, the team continued to offer a listening session that focused on the issue of suicide in African American youth to the increase in numbers we are seeing locally and nationally. In developing a diverse panel for this session, AATA team requested African American youth currently attending college

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to give us their views and understanding related to African American suicide. This allowed us to improve our outreach efforts and participation of African American students.

The students were candid and shared with the professional panel members the areas they felt were deficits in the behavioral health system. They also discussed the significant stress that a number of college students are feeling related to both economics and maintaining their grade point average. The students also raise the issue of social media and how it impacts students' behavior. This session was informative and offered behavioral health professionals' areas the youth felt could improve service delivery.

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

We are projecting 300 to 400 unduplicated participants for the year, with an average of 40 to 50 in attendance at any training. We have noted that the number of participants will depend upon the offered topic.

FY 23/24	300-400 participants
FY 24/25	300-400 participants

VII. FY 23/24 Programs or Service:

In the upcoming fiscal year, we intend to offer an improved and newly designed website and increase the utilization of social media, podcasts, and listening sessions. We are also actively reaching out to appropriate agencies to offer technical assistance. This activity has proven successful, the team already has three requests for technical assistance in this new fiscal year.

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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.

FY 23/24 Program Budget: $425,940 **Cost per Client:** $7,888

How Much Did We Do?

I. FY 22/23: Number of Unique Clients Served: 54

II. How Well Did We Do?

Successes:
Our program exceeded the projected number of members served for the fiscal year with 54 active members. Additionally, the percentage of members who have a reduction in admissions to jail and John George Psychiatric Hospital remain far above 60% at 90.74% and 100% respectively. AfiyaCare Navigators and Clinicians continue to meet with established and new members. During the 2022/23 fiscal year, AfiyaCare staff connected members to extensive 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. Members are also able to access psychiatric services and in-person groups, including the Women's Support Group; Frustration Tolerance: How to Navigate Difficult Emotions; What Makes Us SAD - Stress, Anxiety, and Depression; Substance Use Disorder (SUD) Group; Life in Review (Group for age 55+). AfiyaCare program staff have refined the Clinical Quality Review process which is being implemented each month. Additionally, administrative staff are actively completing training for the new county billing system, SmartCare. AfiyaCare documentation templates have been updated to align with this system.

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

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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 22/23 Challenges:

A consistent challenge for the AfiyaCare program concerns managing clinical panels to prevent provider burnout. AfiyaCare clinicians work with a high intensity of diagnoses, impairment, and distress. Therefore, it is critical that we continue to check in with our clinical staff and encourage self-care when needed.

AfiyaCare staff continue to adjust to the new SmartCare system as well as CalAIM requirements. Staff members are able to attend training and Mental Health Brown Bag meetings for support as needed. Adapting to documentation and billing workflows in AdvancedMD remains ongoing.

AfiyaCare Clinicians and Navigators continue to document in the Roots electronic health record system, AdvancedMD, while billing information is transferred into the ACBH system.

Is Anyone Better Off?

V. FY 22/23 Client Impact:

Ms. B
Ms. B was initially referred to Roots Community Health Center through the Safe Landing Pilot Program. When Ms. B was enrolled in AfiyaCare she was experiencing significant impairments to her daily functioning, including severe anger outbursts.

Ms. B had a history of Bipolar Disorder and was rapidly cycling for the first few months of connecting with her therapist, Morgan. Morgan assisted Ms. B in working through her past traumas and provided psychoeducation on Bipolar Disorder as well as effective coping strategies.

When Ms. B first started in the program, she had just got fired from her job due to conflict with the supervisor. She worked with her Navigator to find other employment opportunities, as well as other housing options. Ms. B was supported with housing through her probation officer and was able to stay at her current housing assignment for a year.

Ms. B now has a stable job where she is thriving. She is currently saving her money to move into an apartment on her own by the end of this year. Ms. B has been working on her anger throughout her time in AfiyaCare and has made progress toward reaching her goals.

Mr. G
Mr. G was referred to Roots through the Alameda County Probation Department and originally enrolled in the NiaCare program. After getting to know Mr. G and gaining a better understanding of his symptom presentation it was determined that he was a better fit for our Afiya care program.

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Mr. G came to the Afiya care program with Bipolar Type 1 with psychotic features and PTSD. His symptom presentation was severe. Mr. G also had a long history of substance abuse, and his drug of choice was methamphetamine.

When AfiyaCare Clinician, Monika, first met Mr. G he stated that he had four months of sobriety under his belt. Since he was recently released from jail, he had been sobered for longer but wanted to mark his length of sobriety from his release.

Mr. G came to the program with stable housing because he was on probation. Probation had placed Mr. G in a group home setting, and he was in the process of transitioning from the group home to sober living and eventually independent living.

Mr. G was a former member of the Nortenoes. He stated that being a non-participatory member is not an option for a person like him and he is always hypervigilant about an active member noticing him on the street and taking action against him. Mr. G had made a firm decision to leave that life behind when he left prison so he could be present for his family and young son.
Mr. G's main concern when he entered AfiyaCare was his mental health. He had a history of visual and auditory hallucinations which were more pronounced with his substance use but remained during his sobriety. He began the program on the medication regime he received in prison. However, Mr. G was starting to experience breakthrough hallucinations and was requesting a new evaluation from psychiatry. His care team scheduled an evaluation with Roots' consulting psychiatrists, and he was provided with a new medication regimen.

Mr. G's other symptoms were sleeping impairment due to intrusive thoughts and hypervigilance in addition to never feeling safe in his environment. He began working with his Navigator, Perrie, who supported him in-between therapy sessions and worked on removing barriers to employment and other areas.

One of the biggest barriers for Mr. G to overcome was feeling paranoid about being retaliated against for leaving gang life. Perrie validated the client's thoughts and feelings about his decision to change his life and reminded him that his feelings of being unsafe in the community are grounded in reality. The client received praise and affirmation for his new life choices from a peer navigator who has had similar life experiences.

Mr. G has been consistent and forthcoming in therapy and his interaction with Navigation. He has made significant gains since beginning the program and graduated from the group living environment that he was placed in by the probation department. Mr. G was able to move to a sober living community and completed his substance abuse program.

Mr. G is currently working temporary assignment jobs for now and he is seeking permanent employment. He has graduated from the sober living program and is now living with a relative until he can get his own place. Mr. G continues therapy via telehealth and is able to arrange weekly check-ins around his work schedule. He will continue to work with Navigation around assistance with housing and any other barriers to independent living.

VI. FY 22/23 Additional Information: N/A

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VII. FY 23/24 Projections of Clients to be Served: 70

We project and strive to serve a minimum of 100 unduplicated clients per year. In addition, we aim to maintain a panel of 70 unique clients at any point in time throughout the year.

FY 23/24	Plan for improving underperforming measures. The Roots Behavioral Health department has worked to expand its intern on-boarding process in order to increase clinical capacity within the AfiyaCare program. This has included training interns on AfiyaCare documentation standards and enrolling them as providers in the Alameda County Behavioral Health (ACBH) billing system. Beginning in the 2023/24 fiscal year, two new Navigators will be assigned to AfiyaCare. This Navigational team will remain focused on supporting the AfiyaCare and NiaCare programs. Restructuring Navigational panels will allow for streamlined communication between Clinicians and Navigation, encourage the consistent outreach necessary to keep members engaged, and support the timely submission of client-supportive expenditure requests.
FY 24/25	100

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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.

FY 23/24 Program Budget/Cost per Client: $655,264 **Cost per Client:** $5,284

How Much Did We Do?

I. FY 22/23: Number of Unique Clients Served: 124

How Well Did We Do?

Quality Measures	FY 22/23 Data Results	Contract Quality Objective Benchmarks
Percent of clients who receive their first face-to-face visit from IHOT team members within three days of the team receiving the referral.	**80%**	**At least 80%**
Percent of clients who receive weekly face-to-face Services.	**90%**	**At least 90%**

II. Language Capacity for this Program:
The team currently houses staff that speak English, Spanish, and French fluently. Additionally, the team

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has access to the county language line, as well as an internal language program called Boost Lingo.

III. FY 22/23 Challenges:

As with previous years, the major challenges stem from lack of resources available across the county, including temporary and/or transitional housing, shelters, crisis residential, SLE, board and care facilities, and availability in higher levels of care such as an FSP or AOT. If the client is homeless, major challenges have been locating said client, or giving a referral from a source that has never met said client and cannot do a warm introduction or provide accurate whereabouts. Overall, given the short timeframe to introduce services and produce positive results can be unfeasible at times due to inadequate rapport building and clients' distrust in mental health resources and county systems, which often times stem from a history of involuntary hospitalization and/or incarceration. These factors can lead to the team struggling to find an ethical discharge plan and may result in clients being enrolled in the program outside of set timeframes.

Is Anyone Better Off?

IV. FY 22/23 Client Impact:

Impact Measures	FY 22/23 Data Results	Contract Impact Benchmarks
Percent of engaged clients who successfully link to outpatient mental health services or rehabilitation and recovery services within the first 90 days of referral	**50%**	**At least 50%**

V. FY 22/23 Additional Information:

Despite previously stated challenges, there has been notable success in client work, with linkages to mental health resources and public benefits. Additionally, there have been positive interactions with family and community members that continue even after client discharges.

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

FY 23/24	150
FY 24/25	150

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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.

FY 23/24 Program Budget/Cost per Client: $655,264 **Cost per Client:** $5,160

How Much Did We Do?

I. FY 22/23 Number of Unique Clients Served:

- Number of the clients served: **127** unduplicated clients served, which is more than twice as much as the contracted **50** unduplicated client target.

How Well Did We Do?

II. Please describe ways that the program strives to:

A. Reduce mental health stigma: Inclusive and non-judgmental, avoiding clinical language (jargon), linkages to community (e.g., homeless encampments, inpatient settings) and natural supports (e.g., family friends), staff cultural awareness and competency.
B. Create welcoming environment: Empathic strong use of Motivational Interviewing, collaboration with natural supports.

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III. Language Capacity for this Program:

- English explicit currently. Looking at the budget for bi-lingual staff, and or use of language line. To date, language needs have been satisfactorily addressed.

IV. FY 22/23 Challenges:

Biggest challenges of next year will be to:

- Acclamate the county's new EHR, (Smart Care) system to ensure documentation and billing proficency.
- Need for increase of fiscal budget for more staff to increase enrollment capacity and to expand services.

Is Anyone Better Off?

V. FY 22/23 Client Impact:

Impact Measures	FY 22/23 Data Results	Contract Impact Benchmarks
Percent of engaged clients who successfully link to outpatient mental health services or rehabilitation and recovery services within the first 90 days of referral	**55%**	**At least 50%**

- At least 55% of engaged client were successfully linked to outpatient mental health services or rehabilitation and recovery services within the first 12 months of referral (Target=>50%).

VI. FY 22/23 Additional Information:

- Staffing requirements have been met.

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

We expect to meet the following 2023/2024 contracted guidelines of:

- 3,525 hours of MAA billable outreached and engagement.
- 25-30 unduplicated clients served (point intime).
- At least 50 unduplicated clients served annually.
- One family or caregiver group per week.

VIII. FY 22/23 Program or service Changes:

- Added additional Peer Support.

Client Story:
IHOT success story:
Confidentiality of the patient's name is hidden to protect the client's identity.
H.M. is a 51-year-old African American male with a history of chronic hopelessness, depression, anger, paranoia due to years of substance abuse issues. Disengaged from mental health services with a long

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history of psychiatric encounters, several linkages to outpatient services that date as far back as 2003. H.M.'s mental health continued to decompensate. The client became addicted to drugs to self-medicate from mental health issues and chronic pain associated with an eye injury. M.H. suffered from complex needs surrounding mental health and substance abuse.

IHOT was able to engage and build rapport, identify the client's needs and to navigate Alameda County Behavioral Health Services to receive a referral to a Full –Service Partnership (FSP). IHOT continued to support H.M. until the client was successfully linked to care.

FY 23/24	**125**
FY 24/25	**125**

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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.

FY 23/24 Program Budget/Cost per Client: $655,264 **Cost per Client:** $8,191

How Much Did We Do?

I. FY 22/23: Number of Unique Clients Served: Eighty (80) unique clients served.

How Well Did We Do?

Quality Measures	FY 22/23 Data Results	Contract Quality Objective Benchmarks
Percent of clients who receive their first face-to-face visit from IHOT team members within three days of the team receiving the referral.	**79%**	**At least 80%**
Percent of clients who receive weekly face-to-face Services.	**86%**	**At least 90%**

II. Language Capacity for this Program: English, Spanish and the county Language Line

III. FY 22/23 Challenges:

Is Anyone Better Off?

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IV. FY 22/23 Consumer Impact:

Impact Measures	FY 22/23 Data Results	Contract Impact Benchmarks
Percent of engaged clients who successfully link to outpatient mental health services or rehabilitation and recovery services within the first 90 days of referral	**41%**	**At least 50%**

Client Story: IHOT Lead Case Manager supported a female program participant along with her newborn baby and the participant's extended family of six navigate various systems of support over the course of several months, including Alameda County Behavioral Health Care, Medi-Cal, Child Protective Services (CPS), John George Psychiatric Hospital Psychiatric Emergency Systems, Women, Infant, and Children (WIC), and the Criminal Justice Court System of Alameda County. The Lead Case Manager supported the participant to connect with Eden Community Support Services Level 1 and re-certify Medi-Cal for herself and newborn son. The program participant was dependent on chemical substances shortly after the birth of her newborn baby which partially contributed to involvement from CPS. IHOT Lead Case Manager assisted the participant's participation in CPS which granted her family visitation with her newborn son. The program participant has been referred to residential substance abuse services at Terra Firma if she chooses so. IHOT Lead Case Manager also explained to the program participant and her family the array of services available in Alameda County, including behavioral health services and supplemental services. IHOT Lead Case Manager provided psychoeducation to the family about the client's problematic behaviors and symptoms of mental health and substance abuse. The family of the participant was an immigrant family who is also monolingual Spanish-speaking. IHOT Lead Case Manager provided support to the family in Spanish as well as helped the family access various supplemental services by helping them make sense, culturally, of how such services operate and provide services and what they expect from the participant and the family. Although IHOT is not directly involved in the Criminal Justice Courts regarding the participant, IHOT Lead Case Manager helped the family make sense of how the courts operate and what they expect from the participant and the family.

V. FY 22/23 Additional Information:

A total number of two-hundred and seventy-one (271) incentives in the form of gift cards (All-Day AC Transit Bus Passes, Grocery Outlet, Target, Visa Gift Cards, Jack in the Box, Walmart, Walgreens, and McDonald's) were given to program participants during the 2022-2023 Fiscal Year. IHOT staff also assembled and distributed more than fifty-five (55) homeless kits to program participants. The homeless kits included body soap, toothbrush, toothpaste, deodorant, feminine hygiene products, some undergarments, warming gloves, and heat pads.

VI. FY 22/23 Projections of Consumers to be Served:

FY 23/24:	Seventy-five (75) consumers projected to be served in FY 23/24
FY 24/25:	Seventy-five (75) consumers projected to be served in FY 24/25

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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.

STARS TAY IHOT Program focuses on transitional age youth (TAY) ages 16-24 years old, throughout Alameda County.

FY 23/24 Program Budget/Cost per Client: $567,627 **Cost per Client:** $10,512

How Much Did We Do?

I. FY 22/23: Number of Unique Clients Served:

In Fiscal Year 22-23, Stars served 54 unduplicated individuals during 54 enrollments; 43 of these enrollments opened this Fiscal Year.

How Well Did We Do?

This year brought a new scope of work (SOW) and a new reporting request. The data provided in the report is an attempt to address both the program's contract SOW and the spirit of the program's purpose and mission.

By definition, the IHOT population is difficult to engage, and sometimes to even locate. The purpose of this dedicated outreach team is to reach those clients who are not readily accessible. Frequently, the referral contains instructions about the optimal timing of outreach to the potential client as well as

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suggestions regarding the best path or modality of contact. Factors considered include safety (e.g.: presence of weapons) and culture (eg: family / community involvement). The internal IHOT process is as follows: every referral receives outreach and engagement within 1-day of receipt. Our team has been successful with the implementation and execution of responses within one day on average.

In the new SOW, we seek clarification on definitions related to a few performance indicators. For example, regarding the definition for face-to-face visits – are telehealth/phone contacts considered face-to-face encounters? Does contact with the referring party or with the client's family qualify as an encounter as this is often a required initial step to lead to locating and connecting with the identified client?

At this juncture, we can report as follows:

Quality Measures	FY 22/23 Data Results	Contract Quality Objective Benchmarks
Percent of referrals who received their first outreach and engagement attempt within one day of referral.	100%	Determining benchmark
Percent of clients who receive their first face-to-face, *in person,* visit from IHOT team members within three days of referral.	16%	**80%**
Percent of clients who receive weekly outreach.	100%	Determining benchmark
Percent of clients who receive weekly face-to-face services.	Please see paragraph below	**90%**

This last year, IHOT billed 4,423 total Medical Administrative Activities (MAA) hours; on average, each client was billed 4.6 MAA hours per week. We look forward to clarifying data definitions with the county and implementing additional data collection as needed to report on all the above tabled measurements accurately. Stars submitted a request (Issue IID: #17454) to Alameda BHCS Data Service Team for help regarding the data and reports in Yellowfin.

II. Language Capacity for this Program:

While operating, the program recruited staff to offer multi-lingual services that meet the county threshold languages. IHOT has Spanish speaking staff and an available language line for other non-English speaking clients. All client-facing written materials were translated into the county threshold languages: Cantonese, Mandarin, Tagalog, Spanish and Vietnamese Additionally, a language line is accessible to families at any time. Of the 54 enrollments, 42 were served primarily in English, 12 received services in Spanish.

III. FY 22/23 Challenges:

The program received several AAPI referrals; with these referrals team members are directed to work with the family before directly contacting the client. While this is a practice of cultural attunement, it may impact timeliness of services. Clients often move between counties, e.g., utilizing homeless shelters in other counties, which impacts timeliness and continuity of service delivery. Stars also received referrals

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with little to no contact information, in these circumstances staff visit the client's last known location(s), including emergency service location, to try to contact the client.

Is Anyone Better Off?

IV. FY 22/23 Client Impact:

Impact Measures	FY 22/23 Data Results	Contract Impact Benchmarks
Percent of engaged clients who successfully link to outpatient mental health services or rehabilitation and recovery services within the first 90 days of referral	**63%**	**50%**

We note again, data discrepancies between our tracking statistics and the county's Yellowfin system: in the latter, 44% of clients were connected to another provider last fiscal year, including 33% who re-connected to their long-term provider after an average of 77 days with the IHOT team. We will continue to work with the county to clarify and reconcile data for accuracy.

Client Story:

The client was referred by FERC on behalf of their sister who called seeking IHOT's services. The sister shared client's diagnoses of Aspergers, OCD, and ADHD. Sister reported client displayed physical and verbal outbursts when feeling overwhelmed. IHOT began outreach with the client directly. Client disclosed to the team that they were encouraged to take a leave of absence from school. Conditions of returning to school were that the client be connected to a treatment team. The team worked with the client to ensure their Medi-Cal was active, and to collaborate with the school and client's mother for background information. The client was referred to Tri-City Health. The client expressed apprehension about being connected to Tri-City after having prior negative experiences. IHOT provided validation and peer support.

The Transition Facilitator connected with the client several times after the warm handoff to ensure a productive connection. The client was successfully connected and then closed to IHOT's services within 3.5 months of being opened.

V. FY 22/23 Additional Information: Additional Client Data

- 2 clients went to Villa Fairmont then connected to AOT.
- 7 moved out of county, state, or country.
- 15 continue with the process of engaging with IHOT.

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 assist clients 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.

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VI. FY 22/23 Projections of Clients to be Served: (Contingent on referrals provided by ACBH)

FY 23/24	60
FY 24/25	70

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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.

FY 23/24 Program Budget: $477,292 **Cost per Client:** $4,262

How Much Did We Do?

I. FY 22/23: Number of Unique Clients Served: 112

II. How Well Did We Do?

II. Language Capacity for this Program: English, Spanish

III. FY 22/23 Challenges:

ADROC has not been acting in full capacity as multiple staff have gone on extended leave of absences which diminishes the program's ability to serve more clients. ADROC has additional challanges of being unable to hire a peer support specialist and a new case manager II to replace an CMII who will transition from the program.

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Is Anyone Better Off?

IV. FY 22/23 Client Impact:

During the fiscal year of 22-23, ADROC has provided services to 112 clients from all walks of life. The services ADROC provides to clients ranges from connecting them to psychiatry and therapy to providing life skills training. For example after enrolling into the ADROC program, a homeless client was able to be connected to stable housing and linked for long term medical care at Eden medical Center.

V. FY 22/23 Additional Information:

ADROC will continue to work with community partners such as Alameda County ACCESS, John George hospital and BACS' Woodroe place to provide services to referred clients.

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

FY 23/24	130
FY 24/25	150

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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.

FY 23/24 Program Budget: $273,160 **Cost per Client:** $2,375

How Much Did We Do?

I. FY 22/23: Number of Unique Clients Served: 115

How Well Did We Do?

II. Language Capacity for this Program: English, Spanish

III. FY 22/23 Challenges:

TAYROC has had difficulties obtaining TAY referrals to meet contracted goals. TAYROC has had difficulties recruiting a Peer support specialist to assist with outreach and enrollment with clients, as well as outreaching to community partners to educate regarding the program.

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Is Anyone Better Off?

IV. FY 22/23 Client Impact:

TAYROC has engaged with partnership with Youth Spirit Artworks' Tiny homes village to provide case management, individual and group therapy. TAYROC case manager had engaged 18-year-old female resident at the tiny homes and helped connected the client to emplyment training, permanent housing mental health and substance abuse treatment.

V. FY 22/23 Additional Information:

TAYROC will continue to work with community partners such as Alameda County ACCESS, Youth Spirit Artworks' Tiny homes, etc. to provide case management services to referred clients.

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

FY 23/24	130
FY 24/25	140

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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.

FY 23/24 Program Budget: $3,569,040 **Cost per Client:** $20,994

How Much Did We Do?

I. FY 22/23: Number of Unique Clients Served: 170

How Well Did We Do?

The Sage team continues to see clients successfully connect to their Social Security Disability benefits as well as housing, Social Services for Cal Fresh, Medi-Cal renewal, primary care, behavioral health services, dental, other health care specialist, and preventative health services. All SAGE clients are connected within 14 days to their care team which consists of a Clinician and Care Coordinator, who supports them manage their mental health and other supportive services. We are an agency that does “Whatever it Takes” and this is carried out daily by our SAGE teams. The SAGE team provides formal socialization groups to achieve specific client center goals. The SAGE team provides a whole-person care approach which allows them to identify the client’s immediate needs. We have found that when we are able to identify client’s immediate needs, we are able to support them and connect them to appropriate resources. The SAGE team’s ability to provide the client with resources for their immediate needs has also been shown to reduce their mental health symptoms.

II. Language Capacity for this Program:

We utilize the language line as needed to provide communication with the following spoken languages.

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III. FY 22/23 Challenges:

There are various challenges that impact clients' ability to stay connected consistently, with rare instances where clients are discharged due to non-engagement despite attempts. The SAGE team will collaborate with Legal advocate and the client's support person(s) to identify solutions to connect back with the client to support them in being re-engaged to services.

Understanding the process of applying for and qualifying for Social Security Disability. The SAGE team is working with legal advocates HAC and BayLa to provide informational sessions on the Social Security Disability process to SAGE staff which benefits the client's ability to understand the importance of staying connected to SAGE services.

Staff Retention: SAGE team continues to recover from COVID as we return to in-person visits/meetings with our clients, and providers. Staff reporting burnout and passion fatigue which can occur in the line of providing services to a high volume of at-risk populations with mental health and other social disparity factors. The SAGE is working with staff to identify "how to manage workflow to reduce one's burnout and passion fatigue."

Initial Engagement: The Sage team are working on increasing their capacity of 400 censuses and has been working with HAC/BALA to obtain referrals and outreach to referrals in a timely manner.

Is Anyone Better Off?

IV. FY 22/23 Client Impact:

Clients benefit from SAGE Case management through referrals and in-person support to connect them with psychiatry, primary care physicians, and therapy, supporting their physical and mental health. To support client's personal and professional goals, SAGE identifies resources to connect clients to support their psychosocial and _ well-being. SAGE supports clients in being connected to housing resources, both short-term and long term, with the goal of long-term sustainability in the community. The benefit of having clients enrolled in SAGE is our support in keeping clients connected to services and engaged with case management and their legal advocate to be able to ultimately attend their court hearings. In addition to the documentation provided by outside providers, clients benefit from documentation that is provided by the SAGE team to their legal advocates to support their case to the approving Judge. The SAGE team has successfully supported clients in accessing housing resources, resulting in clients transitioning to Permanent Housing Opportunities. The SAGE team sees clients consistently getting awarded their SSI benefits, with many clients being approved due to them being impacted by their mental impairments. Many success stories come to mind but one in particular stick out. In July 2019 the SAGE team began supporting a client that was experiencing homelessness. The client was living in transitional housing funded by HDAP after living in a place for years that was not meant for heapability. The client worked with their care team to identify immediate needs such as long-term housing, PCP, therapy, psychiatry, and financial resources to sustain the community. As of March 2023, the client was awarded their social security benefits and they successfully graduated from the SAGE program. The client while in the SAGE program was able to connect to therapy, psychiatry, PCP, dental, and additional case management through BACS Community Mental Health Re-Entry and ECM services, and as of 3/30/23 the client is successfully housed.

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V. FY 22/23 Additional Information:

VI. FY 22/23 Projections of Clients to be Served: 400

FY 23/24	400
FY 24/25	No anticipated changes.

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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- Pool of Consumer Champions (POCC) and the Alameda County Accelerated Peer Specialist Program (ACAPS). Guests receive support from compassionate peer staff and can stay for up to 14 days. Sally's Place Peer Respite is a voluntary, short-term program that provides non-clinical crisis support to help people find new understanding and ways to move forward with their recovery. It operates 24 hours per day in a homelike environment.

Target Population: Sally's Place serves adults, 18 years of age or older, who are experiencing mental health concerns or distress, have an identified place to stay in Alameda County at the time of intake (which could include a shelter), are able to manage medical needs independently and who voluntarily agree to engage in services.

FY 23/24 Program Budget: $1,204,953 **Cost per Client:** $12,956

How Much Did We Do?

I. FY 22/23: Number of Unique Clients Served:

Sally's Place has provided Peer support Services to 93 unduplicated new guests and re-admitted 37 guests that had returned who required more support either with referrals or respite services.

How Well Did We Do?

a. During FY2022-2023 Sally's Place impacted: 62 African Americans, 30 Caucasian, 22 Mexican/Mexican Americans, 99 Non-Hispanic or Non –Latino, 0 Vietnamese, 6 Asian, 3 American Indian or Alaska Native, 3 Another Race not listed, 0 Unknown, 1 Native Hawaiian or Other Pacific Islander, 27 Other Non –Caucasian community members. Having only 37 guests return for services at Sally's Place may mean that they were feeling better also connected to helpful supportive services.
b. Data shows that Sally's Place have served and supported 48 Females, 76 males and 6 unknown/unclassified.
c. 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 the duration of their 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

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be supported on creating a list of supporters or local sponsors. This is intended to let guests know they're not alone. The Sally's Place team collaborates on alternatives needed for challenging situations and on Phase #4 day 10-14 is the Preparation phase by where the staff and the Peer Advocate will continue to encourage the guest with tools of hope and motivating words. Also reminds the guest that Sally's place staff are here to support her/him/them with information and resources even after exiting Sally's Place. By creating the four Phases chart we will be able to ensure that we give complete care and support to each guest that Sally's Place comes in contact with, and that it's well documented.

II. Language Capacity for this Program:

We strive to keep our staff as diverse as possible and 30% of staff is bilingual (Spanish/English). When a guest arrives to Sally's Place and there is a language barrier we connect the guest to the Language Line, staff can access interpreters speaking many languages via phone – and most languages are available on-demand at 1 -855- 938-0124.

III. FY 22/23 Challenges:

a. Despite the growing number of referrals, we are still facing difficulties in meeting our target of clients served per fiscal year. One noticeable trend is that a significant portion of these referrals originate from the unhoused population, rendering them ineligible for the program. We have supported our clients with alternative housing programs and support them by advocating for them remotely. We also have encountered that referred clients often do not have a stable way of contact and we rely on them reaching out to us to check on their referral status, making our waitlist longer.
b. Another challenge we have faced is reaching out to follow up with our clients after they have completed their stay. Again, the lack of stable contact information such as a phone number or a lack of internet accessibility can make our follow-up outreach calls difficult to achieve.

Is Anyone Better Off?

IV. FY 22/23 Client Impact:

In the fiscal year 2022-2023, our records indicate that there were total of 10 pre-program hospital nights and 1 post-program night. These figures demonstrate our successful efforts in assisting our clients to avoid hospitalizations effectively. Furthermore, feedback from our clients during follow-ups has been positive, with them expressing improved mental well-being and satisfaction with the Peer Support services over clinical-based alternatives.

V. FY 22/23 Additional Information:

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

FY 23/24	144
FY 24/25	144

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OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 31

PROVIDER NAME: Felton Institute

PROGRAM NAME: Felton Early Psychosis Programs - (re)MIND® and BEAM

Program Description: The Felton Early Psychosis Programs - (re)MIND® and BEAM - 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.

Additional requirements for IPS Supported Employment:

Felton (re)MIND® and BEAM IPS providers 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.

FY 23/24 Program Budget: $1,528.122 **Cost per Client:** $16,257

How Much Did We Do?

I. FY 22/23: Number of Unique Consumer/Clients Served:

The Felton (re)MIND® and BEAM programs are contracted to serve 100 unduplicated clients per year. To date, the programs have served a total of 47 unduplicated program participants from July 1, 2022, to June 30, 2023. The programs have served 29 individuals in (re)MIND® and 18 individuals in BEAM.

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How Well Did We Do?

Quality Measures	FY 22/23 Data Results	Contract Quality Objective Benchmarks
Percent of clients who receive two or more visits within 30 days of episode opening date	100%	85%
Percent of clients who receive four or more visits within 60 days of episode opening date	100%	85%
Percent of clients who receive services in their sixth month in the program	90.9%	75%
Percent of direct services provided in community-based locations, outside of clinic offices, which are convenient for clients	85.4%	75%
Percent of clients who have a current primary care provider/ physician	80.9%	50%
Percent of clients on medication who receive at least one medication visit each 90 days	84.2%	75%

Felton (re)MIND® and BEAM programs have consistently met with 100% of the youth at least twice in their first 30 days of services and at least four times in their first 60 days of services for the past 2 years. At their sixty-month mark, 90.9% of youth remained engaged in services, exceeding the quality objective benchmark (75% of clients receiving services at their sixth month in the program). The Felton (re)MIND® and BEAM programs also exceeded the quality objective of having at least 75% of Felton services convenient and accessible to our youth; the percentage was 85.4% of services were in locations convenient for the programs' participants, such as in the home, in their school, or via telehealth or phone. Only 850 (14.6%) contacts out of Felton 5,819 services were conducted in our office. The programs continued to increase the percentage of youth who currently have a primary care provider (80.9% in FY 22/23). This increase was due to (re)MIND/BEAM adding a certified medical assistant to the team and an increased focus on integrated care coordination for our TAY population. Finally, the programs continued to exceed the quality benchmark of ensuring that at least 75% of engaged youth receive at least one medication visit every 90 days (84.2% in FY 22/23).

Despite persistent staffing challenges that contributed to the lower census, the programs exceeded expected quality outcomes benchmarks in FY 22-23.

II. Language Capacity for this Program:

Currently, Felton's staffing language capacity includes English and Spanish. Overall, the programs served 43 participants in English and 4 participants in Spanish in FY 22/23. In addition, Felton staff have prompt access to interpreter services as needed for other threshold languages.

FY 22/23 Challenges:

Felton staff faced two primary challenges that impacted service delivery: lengthy staff vacancies including

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a bilingual care manager, a clinical care manager, a peer support specialist, and a supported employment and educational specialist), and further adaptations required due to COVID-19.

During FY 22/23, the Felton (re)MIND® and BEAM programs were very short-staffed. The programs had the bilingual clinical care manager resign in August 2022, and a clinical care manager resign in November 2022 and another in January 2023. The Peer Support Specialist passed away in early 2022 and the program was unable to hire a replacement peer support specialist, leaving the position vacant. One of the two supported employment and education specialists resigned in 2022 and the position was not filled through the end of the fiscal year. The clinical team was reduced to the clinical team leader and the program manager for much of early 2023. In order to fill staff vacancies, Felton HR/Recruiting department has continued to utilize a recruiting service called ICIMS; in addition, the Felton HR department has been in contact with recruiting agencies for the more difficult to fill positions. The programs were able to hire a clinical care manager and a non-licensure-eligible care manager in March 2023, as clinicians' positions continued to be hard to fill. The program is in the process of hiring and onboarding a bilingual care manager and a peer support specialist in July 2023. At the beginning of the new fiscal year, the Felton (re)MIND® and BEAM programs are close to being fully staffed; Felton staff remain hopeful to be able to continue to provide the full scope of early psychosis coordinated specialty care and grow the programs' census to capacity.

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 recommended 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, and this was extended to new referrals. 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. With the lifting of COVID restrictions earlier this year, it is expected that Felton staff will be able to increase face-to-face interventions with the clients, enhancing engagement.

Is Anyone Better Off?

IV. FY 22/23 Client Impact:

Outcome Measures	FY 22/23 Data Results	Contract Outcome Objective Benchmarks
Percent of eligible clients who had a decrease in CS, PHF, or psychiatric hospital admissions in their most recent 12 months in the program as compared to the 12 months prior to their entry into the program	62.5%	80%

For FY 22/23, the (re)MIND® and BEAM Impact Objective was to have an 80% decrease in CS, PHF, and psychiatric hospital admissions for the youth served for 12 months who also have had at least two crisis stabilization (CS), psychiatric health facility (PHF), or psychiatric hospitalization admissions in the 12 months prior to their entry into the program.

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- During this reporting period, there were 35 youth who had received services for 12 months or more. Of these 35 youth, 16 individuals had at least two admissions to CS, PHF, or psychiatric hospital in the previous 12 months before enrollment. Ten out of these 16 youth (62.5%) showed a reduction in the total number of crisis stabilization or inpatient services episodes.
- It should also be noted that (re)MIND/BEAM Alameda was successful in preventing several clients from entering the inpatient system. Seven out of ten participants with no prior CS, PHF or psychiatric hospital admission 12 months prior to enrollment in early psychosis services continued to have ZERO CS, PHF, or psychiatric hospital admissions in the 12 month-period since enrollment in services. The Felton (re)MIND/BEAM programs were successful in helping prevent these youth experiencing early psychosis symptoms from increasing their use of the inpatient system.

V. FY 22/23 Additional Information:

- IPS Services:
  For FY 22/23, the programs' Impact Objective was to have a 30% competitive employment placement rate, with an average of at least one job placement per month. During this period, 37 individuals chose to receive supported employment and education services. 26 out of 37 individuals successfully engaged in competitive employment, resulting in a job placement of 70.3%; this surpassed the programs' Impact Objective for IPS services. In addition, the IPS staff maintained an average of one placement per month. Furthermore, 28 of these 37 participants (75.7 %) also received educational services; many returned to high school and college. Overall, the Felton IPS services were highly successful in assisting the clients in obtaining and maintaining employment as well as assisting the clients in pursuing their educational goals; the Felton staff were relentless in keeping the youth engaged in their employment and educational goals during a time of business closures, alarming unemployment rates and remote schooling.
- Personal Client/Success Story:
  For FY 22/23, the Felton (re)MIND® and BEAM programs had a number of success stories. One such story includes a client who has been struggling with psychotic symptoms for almost 2 years. The client was referred to the program from a transitional housing program because the client was hospitalized several times for being hostile and paranoid; the client was on the verge of eviction because the client was unable to care for themselves. With the support of the (re)MIND/BEAM Alameda team, which included the client's clinical care manager, psychiatrist, and supported employment and education specialist, the client was able to stabilize and avoid eviction. Soon after the client's admission to the program, the care team supported them in returning to college, where they studied business. The (re)MIND/BEAM Alameda team also supported their goal of gaining employment; the client was able to obtain and maintain employment as a care provider for children over the past 7 months. Recently, the client applied for a position as a youth advocate with a local TAY program; this has been the client's dream job for several years. The client was accepted and started the position on July 7th, 2023; all the staff are exceptionally proud of the client's progress over the past year.

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

FY 23/24	100
FY 24/25	100

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OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 32

PROVIDER NAME: Crisis Support Services of Alameda County

PROGRAM NAME: Suicide Prevention Crisis Line

Program Description: The Suicide Prevention Crisis Line is a 24-Hour Crisis line provided by Alameda County Crisis Support Services to provide: Crisis counseling in order to reduce the incidence of suicidal acts; lessen the number of psychiatric hospitalizations needed by individuals with suicidal thoughts; resolve crises; decrease self-destructive behavior; and increase awareness of suicide risk factors.

Target Population: The Suicide Prevention Crisis line provides a 24-Hour phone line for assistance to people of all ages and backgrounds during times of crisis, or their families, to work to prevent the suicide. Translation is available in more than 140 languages. We also offer teletype (TDD) services for deaf and hearing-impaired individuals. Age data is not disaggregated as the focus is on the crisis and de-escalation process.

FY 23/24 Program Budget: $689,402 **Cost per Client:** $17

How Much Did We Do?

I. FY 22/23: Number of Unique Clients Served: 39,476 (crisis line, 988, access after-hours, SUD after hours)

How Well Did We Do?

Collectively we responded to 39,136 calls. 797 duplicated callers (91.0%) of medium-high risk calls were deescalated over the phone without the use of police intervention. Emergency procedures calls make up 0.4% of our total call volume. This is made possible in part with follow-up calls made by staff to check in on client safety and review safety plans. The number of follow ups calls to medium-high suicide risk callers increased by 144.7% from 1,037 calls in FY22 to 2,538 calls in FY23. The time spent on the phone through outreach and follow up calls increased 210% from 8,579 minutes in FY22 to 26,595 minutes in FY23. The number of suicide-related calls increased by 11.6% from 7,871 calls in FY22 to 8,783 calls in FY23. We are reaching more consumers and adding additional and a robust follow up program in order to decrease reliance on hospitalization and law enforcement.

II. Language Capacity for this Program:

Our program offers language services from bilingual counselors staffing the lines. In addition, we use GLOBO to offer translation services to anyone needing services in another language.

III. FY 22/23 Challenges:

Is Anyone Better Off?

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The number of suicide-related calls increased by 11.6% from 7,871 calls in FY22 to 8,783 calls in FY23.

IV. FY 22/23 Client Impact:

Our impact during this year is that we have reached more callers and have been able to de-escalate more callers with less reliance on emergency services. Here is a client impact story.

(Name and details have been changed to protect the confidence *of the caller)*

Janelle called into the crisis line after she experienced intimate partner violence from her husband. She has two young children and described feeling very stressed, overwhelmed and hopeless. When she rated her suicide rate as a 4, the counselor asked her if she would be interested in learning more about the Follow Up Program. Janelle consented and the counselor made the referral.

The Follow Up Supervisor began reaching out to Janelle and they spoke regularly for six weeks. It took time to build trust, but once they did, Janelle was open to reaching out to different community supports that were suggested by the supervisor. These supports focused specifically on IPV and family support. The Follow Up Supervisor would check in with Janelle weekly to see how she was coping, what her safety was like, and check in with the progress of connecting with the referrals. With the support of the Follow Up Program, Janelle was able to connect and receive services with long term supports and the hope for herself and family increased.

By the end of her sessions in the Follow Up Program, Janelle stated that she was much more stable, had multiple community support systems and began therapy. Janelle reported that she is very likely to reach out to the crisis line in the future if she needed.

V. FY 22/23 Additional Information:

VI. FY 22/23 Projections of Clients to be Served: 39,476

FY 23/24	40,000
FY 24/25	40,000

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OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 32

PROVIDER NAME: Crisis Support Services of Alameda County

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.

FY 23/24 Program Budget: $275,165 **Cost per Client:** $389

How Much Did We Do?

I. FY 22/23: Number of Unique Clients Served: 707

How Well Did We Do?

Zero Suicide in Correctional Settings: This past year, we provided 10 suicide prevention trainings to Santa Rita civilian staff - nearly 1-2x a month per their training schedule. We also provided 2 trainings for the Santa Rita Jail mental health staff. In addition, we provided a training on Youth Suicide Assessment to mental health staff at the Guidance Clinic - Juvenile Justice Center

Zero Suicide Primary Care: We provide 15 workshops to healthcare providers. Five trainings were virtually hosted by CSS; in addition, we provided workshops for the following organizations: Lifelong TRUST Clinic, Stanford Valley Care - Newark and Livermore campuses, Samuel Merritt Professional College. A youth suicide assessment training was also provided to integrated behavioral Mental Health Staff from Children's Hospital.

Zero Suicide Hospital Follow Up: 100 individuals were served through this program. This is twice the number of people the program had set out to reach and a testament to relationships that have developed over the last few years of providing this service. The post-discharge follow-up contacts targets individuals admitted to the John George Psychiatric Hospital and/or Emergency Department following a suicide attempt and/or who are assessed by John George staff to be at medium to high risk for a suicide attempt or re-attempt. Staff begin outreach to referred individuals within 24-48 hours after discharge from JGPP and provide a series of up to six follow-up phone calls and five follow-up mailings (e.g., letters or postcards) depending on client availability and need. During the phone calls, the staff assessed suicide risk; assisted in developing/refining a safety plan; supported connection to mental health and supportive services to promote continuity of care; provided encouragement to engage in self-care activities; and provided unconditional positive regard and emotional support, among other activities. Supportive mailings were sent periodically after the follow-up phone calls were completed or if clients were unavailable for phone calls.

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II. Language Capacity for this Program:

English for Primary Care and Correctional Settings, English and Spanish for Hospital Follow up.

III. FY 22/23 Challenges:

Is Anyone Better Off?

Health Care Settings:
While there was success with our monthly CSS hosted workshops, where attendance ranged from approximately 30%-65% depending on the presentation, there seemed to be more attendance when the workshops were first rolled out and less attendance for repeated workshops (Suicide Safety Planning: An Introduction and Healthcare Professional Wellness: Managing and Preventing Burnout). Additional challenges included:

- Outreach and consistent connection with new contacts (for example: Kaiser Oakland wanting agency info but being unable to engage in other workshops)
- Time: Our suicide prevention workshops are comprehensive and take approximately two hours to deliver, which is difficult for medical professionals to commit to. \
- Despite initial enthusiasm of inviting CSS to provide multiple trainings for organizations, there was little re-invitation.

Correctional Settings:
In Fall 2022, we were notified by Santa Rita Jail that they were shifting their training to an online and self-paced model for their staff. Upon hearing about this we reached out to the mental health staff at Santa Rita jail and connected with the ACBH Guidance Clinic (Juvenile Justice Center) to discuss training needs. This spring we provided 2 suicide assessment trainings for the Santa Rita Jail mental health unit and a youth suicide assessment training for the Guidance Clinic staff. Since the notification, we've also continued to provide our regular monthly training for civilian staff at Santa Rita Jail.

IV. FY 22/23 Client Impact:

Based on surveys gathered for both Santa Rita Jail and for primary care providers, the results show a shift in a couple of major goals: 1) recognition of suicide warning signs and 2) Increased comfort in communicating with someone who is suicidal.

For example: Among 30 health care providers surveyed - 7% strongly agreed that they could recognize suicide warning signs before the presentation. After the presentation, 50% strongly agreed that they could recognize suicide warning signs.

Among Santa Rita Jail civilian staff surveyed, in response to the question: What would you do differently as a result of the training?" most responded that they would "listen more and approach with empathy".
For Hospital Follow up, a recent success was the coordinator's engagement with a 22-year-old Latina childhood sexual-abuse survivor who was navigating houselessness and job security, while also being undocumented. At the onset of services with Zero Suicide, the client was experiencing PTSD flashbacks of her former sexual abusers in the form of tactile hallucinations and parasomnia night terrors. These signs were noticed by the treatment team at John George, and she was provided with a 2-week residential

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Telecare referral for escalated care. However, the client did not comply with the Telecare referral due to fear of being without her phone for 2 weeks. However, after 3 weeks of processing with the Zero Suicide coordinator, the client was able to accept the severity of her signs and symptoms, and finally agreed to comply with the escalated Telecare referral. The coordinator immediately reached out to Telecare and advocated that the referral be reopened for the client. It was determined that a bed was still available but the window for intake was short. The coordinator collaborated with Telecare to create a warm hand-off and arranged a preliminary phone screening and secondary in-person meeting between the client and Telecare. The client successfully completed their rehabilitative stay at Telecare, and after discharge continued their services with the Zero Suicide coordinator. Upon completing the Telecare stay and returning to Zero Suicide, the client self-reported that not having total access to her phone for 2-weeks was "relaxing" and "better" for her mental health. The additional care received at Telecare decreased her experiences of the hallucinations and night terrors, and also served to connect her to supportive housing and educational resources through the department of rehabilitation that will cover all tuition costs for a bachelors or vocational degree.

V. FY 22/23 Additional Information:

VI. FY 22/23 Projections of Clients to be Served: 707

FY 23/24	We hope to continue to be part of Santra Rita Jail's training cycle and provide at least 12 trainings with an avg # of 20-25 people per training. For healthcare providers, outreach has always been a challenge. However, we aim to provide at least 20 trainings to health care providers during the year. In total, between the 2 settings we're aiming to reach at least 400 individuals. Hospital follow up would like to serve another hundred individuals for a total of **700-750**
FY 24/25	700-750 individuals

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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.

FY 23/24 Program Budget: $328,153 **Cost per Client:** $9,944

How Much Did We Do?

I. FY 22/23: Number of Unique Clients Served: 33 Clients being served currently.

How Well Did We Do?

a. DCCS has provided more than 8 outreach in the past year to satisfy our client and program outcomes. We have developed numerous partnerships with local and states services to ensure the needs of our clients are being met. Agencies that we have collaborated with: DCCS continues to collaborate with: DeafHope,
b. DCARA (Deaf Counseling, Advocacy and Referral Agency), Children and Family Services, California School for the Deaf of Fremont (CSD), and DeafLEAD and Peralta colleges of East Bay. Including consistently coordinating support for with Toolworks, and Deaf Plus Adult Community (DPAC) for clients.
c. We have increased our engagement with the Deaf/Hard-of-Hearing community by increasing our presence on social media for client and staff recruitment. The communication team involved in our program is dedicated to highlighting our program and spreading awareness about the Deaf/Hard-of-hearing community and deaf culture to a widespread audience.
d. DCCS hopes to expand our program with staffing to serve a wide number of clients in Alameda and San Francisco County, and other northern region counties.
e. Staff have been committed to increasing their knowledge by attending local and state required trainings aimed to help serve unique populations especially within the Deaf/Hard-of-Hearing community to be able to provide counseling to clients through multiple social work frameworks.

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II. Language Capacity for this Program:

a. Languages spoken/used: Majority of the client served used American Sign Language. Other unique languages used are English, Spanish (Spoken, and signed) (3. Number is set to increase), and Farsi (2).

III. FY 22/23 Challenges:

a. There is a statewide need for services to be culturally and linguistically accommodating for deaf and hard of hearing individuals seeking support from social services. Agencies that serve populations within the mental health field would stand to benefit of having a throughout understanding of ADA compliance, increased awareness about deaf culture and learning about appropriate resources for receiving language accommodations. Clients often reported struggling with receiving reasonable accommodations from other neighboring resources and face additional barriers with being able to fully participate in other local or state programs. These programs include Drug & Alcohol based programs, support groups, and Homeless services etc.
b. Written materials or resources remain fully inaccessible to clients whose first language is not English. The admission paperwork for mental health counseling given by the county is lengthy in detail and requires more than reasonable amount of time for translation to provide the deaf client with throughout understanding for the process for being admitted to services and resources available. The client would benefit from the information given if the language of the paperwork was simplified and/ or pre-interpreted in ASL.
c. With limited services that offers deaf based therapy programs, DCCS receive numerous of referrals requesting specifically for our services given that we have staff who are fluent in ASL, however, some referrals do not meet the criteria for our services because DCCS is not within the referral's insurance provider network.

Is Anyone Better Off?

IV. FY 22/23 Client Impact:

a. There have been several successes among our clientele. A few of our clients were able to achieve their counseling goals through our program. With the services that we offer, clients reported improvements in the following functions: Life, Social, Education, employment and community supports. DCCS has provided several outreaches that focuses on achieving client's goals and providing sessions to assist the client in getting they need whether it may be crisis intervention, case management and therapy on a consistent and flexible basis.
    i. One clinician reported behavioral improvement with a deaf youth since serving the client since November. He is now thriving with foster family whom he can communicate in ASL and continuing to make progress with his education and social life.
    ii. One case manager shared that her client who is deaf domestic violence survivor and struggled with independence will now be attending college in the fall. The decision can to be when after the client has been meeting with her case manager regularly for sessions related to skill building and being able to achieve counseling goals established by herself with the help of her case manager.

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V. FY 22/23 Additional Information: None at the moment.

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

FY 23/24	50
FY 24/25	65

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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.

FY 23/24 Program Budget: $145,441 **Cost per Client:** $93

How Much Did We Do?

I. FY 22/23: Number of Unique Clients Served: 1,557

How Well Did We Do?

During the 2022-2023 school year, AFS School-Based Behavioral Health helped reduce mental health stigma and promoted emotional wellness at 3 different high schools in Alameda Unified. Our School-Based Health Center (SBHC) staff, in coordination with our Youth Advisory Board Members organized and facilitated classroom presentations and school-wide tabling events focused on suicide awareness and prevention, healthy relationships, and mental health awareness. Outreach also included workshops, social media campaigns, flyers/signage around campus, fishbowl discussions with clinical staff, and other various activities and events to promote awareness around critical mental health issues for youth. All of our outreach efforts were focused on reducing mental health stigma by facilitating open dialogs, where serious topics could be brought to light while also acknowledging and normalizing challenges. Throughout the three campaigns, as well as on-going outreach and mental health services, the SBHC staff are able to provide youth with relevant and factual information, how to identify mental health concerns in themselves and community, and how to address these concerns utilizing the larger support network around them. The SBHC also provides all youth who participate with resources and further information on how to seek support at the SBHC, at their school, and within their community. Outreach encourages students to self-refer to therapeutic services, case management, and other SBHC services as well.

II. Language Capacity for this Program: Services were offered in English and Spanish.

III. FY 22/23 Challenges:

Though there continue to be improvements in how mental health support is perceived in the community, we still encounter situations where students and/or families are not open to receiving mental health

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information or support. This year we heard from repeatedly from youth around their hesitancy to engage caregivers in treatment due to their guardians' cultural and/or spiritual lens and mental health. We serve an incredibly diverse population which shines light into more outreach needed to address mental health stigma. For reference, between July 1, 2022, and January 1 (2023), out of 153 students who completed a Mental Health screener across all three SBHCs, 118 were students of color (Asian, Black, Latinx, Native American, Mixed Race) and 35 were white.

Although this continues to be a challenge to reduce stigma and barriers for youth to access mental health, it is one that validates the importance of continuing to increase outreach efforts to expand to a wider audience.

Some additional external challenges this year included unpredicted staffing changes and inconsistent youth attendance (ex. COVID, academic priorities, spring/summer schedules).

Is Anyone Better Off?

IV. FY 22/23 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 (@SBHC_AFS) receive information about a variety of relevant mental health topics (identified by SBHC staff and students). We provide students with local and accessible resources both on campus and in the community. Almost half of the students that we serve at the SBHCs are self-referred, highlighting that students are going to the SBHC on their own with the knowledge they can obtain mental health support.

One example of how powerful our outreach and services can be highlighted with a 12th grade student who sought support at the School-Based Health Centers after learning about our mental health services from a flyer at our Suicide Awareness Prevention Month campaign at her high school. The student was unhoused as well as experiencing suicidal ideation and trauma related symptoms. This student had been in a foster program prior but has turned 18 and currently has no guardian or reliable supportive adult. Students also struggled with maintaining healthy relationships and continued to be drawn into unhealthy and abusive peer relationships. Clinician supported the client with crisis intervention and in safety planning, including obtaining basic resources, such as with food security and getting a cellphone. At the SBHC, students were also able to receive information regarding safe relationships and reducing mental health stigma. Clinician advocated and supported students in facilitating transition into TAY (Transitional Age Youth) case management and psychiatric program to address her needs. Clinician supported students with accessing needed medical services at the SBHC. Students reported reduced suicidal ideation, risk behaviors, and increased sense of connection/support at school. Students expressed deep gratitude that no one in their life has ever helped them in these ways prior.

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. For example, the students were determined to start the school

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year off with focusing our outreach on educating their peers about the 988 emergency services. They facilitated presentations, organized tabling events, and created original outreach materials about 9-8-8.

Throughout the school year, 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.

V. FY 22/23 Additional Information: No additional Information to add at this time.

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

FY 23/24	1,650
FY 24/25	1,750

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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.

FY 23/24 Program Budget: Program Closed

How Much Did We Do?

I. FY 22/23: Number of Unique Clients Served:

EBAC provided a total of 2,063 unduplicated services to 19 clients (students enrolled) throughout the 22-23 school year within our Castlemont High and Roosevelt Middle school CEC sites. At Castlemont and Roosevelt, EBAC provided services to those who identified themselves as female or male predominantly, other gender orientations were not provided by students. The total unduplicated services are within the following categories: Family and Caregiver Supports, School Culture and Climate, and Direct client related services and supports.

How Well Did We Do?

II. Please Describe Ways that the Program Strives to 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 have time and space for consultation and relationship building amongst team members as 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 2,063 services, our services were predominantly provided in English. Staff spoke with students, caregivers, and site staff in English when conducting services.

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IV. FY 22/23 Challenges:

22-23 continued to be a challenging year as we continue to navigate in-person services, stigma related to counseling enriched classes and therapeutic services, and staffing inconsistencies. 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 post- pandemic challenges, several families shared feeling stressed and/or overwhelmed while juggling home life and work.

Is Anyone Better Off?

IV. FY 22/23 Client Impact:

Over the course of the year, students were impacted at various times of the year. Despite the staffing challenges at Castlemont and Roosevelt, having a smaller caseload/number of students allowed for the mental health clinician to support both sites multiple days a week and students leaning on the BHCs more frequently for milieu support.

V. FY 22/23 Additional Information:

No additional information as this time.

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

Due to changes in partnership from OUSD, EBAC will not be the primary therapeutic provider at this time for CE- Castlemont and CE- Roosevelt. Therefore, we do not have projections on clients to be served for the next school year.

FY 23/24	**NA**
FY 24/25	**NA**

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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.

FY 23/24 Program Budget: Program Closed

How Much Did We Do?

I. FY 22/23: Number of Unique Clients Served: 27

How Well Did We Do?

We served fewer participants throughout this year due to low enrollment in the programs. Having a smaller population allowed us to provide more focused services to the participants who were enrolled. We had great collaboration with the teachers and administration at Life Academy and Skyline High School. However, we struggled to maintain clear consistent communication and coordination with the Montera Middle School administration and teacher. Another challenge at Montera was difficulty with staffing. We did not have a full time Mental Health Therapist on site until November, and there was a vacancy in our Mental Health Counselor position from November through the beginning of April. Skyline High School had the most challenges in maintaining class size. During the past year, three students left the program due to feeling concerned about safety on school grounds. Additionally, our Lead Clinician who had been at Skyline for several years, was on maternity leave for several months, which impacted consistency and engagement for a few participants and families who felt particularly appreciative of her work. Life Academy had consistent staffing and engagement throughout the school year.

II. Language Capacity for this Program: English and Spanish

Is Anyone Better Off?

Fred Finch tracked measures looking at areas of improvement in Child And Adolescent Needs and Strengths (CANS) scores in several areas including Improvement in 1 Domain, Life Domain, Behavioral Domain, Strengths Domain, and School Items with targets based on historic data. We documented the following results: 74% of participants improved in 1 domain (target 70%); 59% of participants showed

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Improvement in Life Domain (target 25%), 51% of participants showed improvement in Behavioral Domain (target 40%), 38% of participants showed improvement in Strengths Domain (target 35%), and 59% of participants showed improvement in School Items (target 50%).

IV. FY 22/23 Client Impact:

Case study: A participant at Montera struggled with impulsivity and explosiveness when triggered. He was involved in a several of fights with peers both in the class and in transitional spaces. He was also quick to yell at teachers and other adults, especially when he felt like a situation was not fair or he was being the target of unequal treatment. He initially demonstrated difficulty in trusting providers and would call providers a "snitch" or tell peers that they should not trust providers because they were likely to lie or change their story when in front of teachers or school administrators. He struggled particularly with transitions in providers and named this struggle with themes of questioning why he should open up to providers if they were just going to leave. He experienced several home stressors including deaths in the family and had increased irritability and impulsivity around the time of those losses. These resulted in participants getting into physical altercations with peers, yelling at school staff and teachers, and class avoidance. He had begun to develop a trusting relationship with the Mental Health Counselor and was starting to open up to her about his struggles when she unexpectedly decided to leave Fred Finch due to needing to support a family member with medical needs. This created a setback in his willingness to open up with the Mental Health Therapist who started just before the Mental Health Counselor left in November. Our Mental Health Therapist worked slowly and consistently to build trust in the milieu setting, in Individual Therapy setting, and in small groups. Over the course of a few months, the participant began to open up in individual and group therapy regarding his grief and struggles to control his anger. He developed insight regarding his triggers and was able to name ways that he attempted to manage his triggers (such as leaving the room, taking deep breaths, and ignoring triggering behaviors of peers). He was also able to identify the limitations of those management techniques, especially in the mainstream classroom setting. He was able to voice frustrations with adults who did not understand his challenges and accept help from our team members when he was triggered. During the end of year picnic, he was triggered by a parent volunteer. This parent wanted participant to apologize to her and was talking to participant using a loud voice and critical language. Participant successfully walked away from the triggering situation and talked with our Mental Health Therapist to process his frustration and limitation regarding the request for an apology due to his emotional state. He successfully walked away from the volunteer parent and was able to manage his anger and explosive tendencies throughout the rest of the event. He did not calm down enough to apologize to the parent; however, he was able to maintain safe behaviors and process his emotional response to the situation with the Mental Health Therapist.

V. FY 22/23 Additional Information:

We had a vacancy in the leadership role of Clinical Manager, which impacted on our ability to provide the level of hands-on collaboration and coaching intended for this program. We enlisted support from other. Fred Finch programs to supplement service provision and training. These efforts, while helpful, were not sufficient to meet all the needs of the team. This was most palpable at Montera Middle School.

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

FY 23/24	35
FY 24/25	45

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OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 34

PROVIDER NAME: Lincoln Child Center

PROGRAM NAME: School-based Behavioral Health: MLK, McClymonds, Skyline and Howard

Program Description: MHSA Braided funding for Expansion of School-Based Behavioral Health in the Oakland Unified School District (OUSD). MHSA funding is being braided with Educationally Related Mental Health Services (ERMHS) and Early Periodic Screening Diagnosis and Treatment (EPSDT) funds to provide enhanced (non Medi-Cal billable) mental health services and supports to children in Counseling-Enriched Special Day Classes (CESDC) and two of its School Based Behavioral Health (SBBH) programs in OUSD in order to assist these children and their families in becoming successful in school and at home.

Target Population: Youth attending Counseling-Enriched Special Day Classes (CESDC) and/or two of its School Based Behavioral Health (SBBH) programs in OUSD.

FY 23/24 Program Budget: Program Closed

How Much Did We Do?

I. FY 22/23: Number of Unique Clients Served:

We provided services to 27 students between Skyline CE/SDC, McClymonds CE/SDC, and Oakland Academy of Knowledge I-CE/SDC for the 2022/2023 school year.

How Well Did We Do?

II. Language Capacity for this Program:

All students and families spoke English as a primary language; however, our Case Manager at Skyline and McClymonds is bilingual in English/Spanish if students and families who needed or requested translation support were referred to our programs.

III. FY 22/23 Challenges:

The imminent threat of school violence was a major theme of the school year on our high school campuses and was a major factor in the students' inconsistent attendance and engagement. At both high school campuses, multiple acts of violence made local news headlines which significanly impacted our families who often voiced their concerns about a lack of communication between school and families. More importantly, our students who are in therapuetic classroom environments experienced repeated school lock downs, witnessed violence first hand, and even heard violent acts being committed from their classrooms where signficantly triggered and required support to manage and cope with their increased feelings of anxiety and fear at school.

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At our elementary school site, the most significant challenge was low student enrollment. Enrollment at OAK was between one student and 3 students all school year with no referrals after the first quarter.

Lastly, the transition from Medi-Cal based funding to district funding created a great sense of uneasiness during the bidding process which occured during the last few months of school. Balancing student needs while holding the unknowns of the school year to come was challenging for direct service providers.

Is Anyone Better Off?

IV. FY 22/23 Client Impact:

Three seniors graduated from Skyline in May and two will be attending 4 year college programs for the 2023/2024 school year.

V. FY 22/23 Additional Information:

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

FY 23/24: : Lincoln was selected by OUSD to provide ERMHS services to the Counseling Enriched and the Intensive Counseling classrooms at Skyline High School. We are projected to start the year off with seven (7) in the counseling enriched program and four (4) in the intensive counseling enriched program.

FY 24/25: Lincoln will continue to provide mental health services for Skyline's Counseling Enriched and Intensive Counseling enriched programs for the 2024/2025 school under the current contract. Exact numbers of students served should be similar to the 2023/2024 school year.

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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 and Sequoia Elementary

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.

FY 23/24 Program Budget: $309,590 **Cost per Client:** $224

How Much Did We Do?

I. FY 22/23: Number of Unique Clients Served: 1383

- **SBBH at ASCEND:** 444
- **Oakland Academy of Knowledge:** 346
- **Sequoia Elementary:** 593

How Well Did We Do?

II. Language Capacity for this Program:

- UE Coaches at CESDC/ICESDC programs OAK and Sequoia 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 22/23.
- 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 22/23.

III. FY 22/23 Challenges:

Similar to schools across the nation, the CESDC/ICESDC programs and SBBH/ASCEND have experienced

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leadership transitions and school staffing shortages in the post-pandemic era. Across all three partnerships school staffing shortages impacted the team's ability to implement effective and consistent initiatives at school wide levels. Additionally, the transitions in key school leadership positions, some at the beginning of the year and some at the end, created significant barriers to alignment of practice and communication throughout the year. The Unconditional Education (UE) Clinicians and Coaches worked hard to ground the new staff and leadership in established practices carrying over from previous year to best support alignment in communication as well as strategically choosing key areas of focus to build understanding and practice incrementally through the year. Staffing shortages increased pressure on everyone's available time which then impacted their ability to schedule, participate or buy into various initiatives aimed at impacting school culture and climate. To address this, UE Clinicians and Coaches worked to be as flexible and creative as possible to find times and places to meet or reschedule meetings when staff and admin were available individually as needed. The staffing shortages also increased levels of teacher stress and burnout which impacted implementation of supports across all three tiers of support at the school and put focus and need back on Tier 3 individual supports for students. As UE Clinicians and Coaches were pulled to support Tier 3 student needs, they continued to be mindful of ways to support teacher and staff skill building and capacity to address behavior needs themselves while also tending to staff wellness and support needs to allow for this. Lastly, at the end of the year, the OUSD teacher strike had a significant impact on the CESDC/ICESDC programs which were not able to conclude the year with complete Culture and Climate surveys or review data or planning to prioritize focus areas for the following year.

Is Anyone Better Off?

IV. FY 22/23 Client Impact:

Similar to schools across the nation, the CESDC/ICESDC programs and SBBH/ASCEND have experienced leadership transitions and school staffing shortages in the post-pandemic era. Across all three partnerships school staffing shortages impacted the team's ability to implement effective and consistent initiatives at school wide levels. Additionally, the transitions in key school leadership positions, some at the beginning of the year and some at the end, created significant barriers to alignment of practice and communication throughout the year. The Unconditional Education (UE) Clinicians and Coaches worked hard to ground the new staff and leadership in established practices carrying over from previous year to best support alignment in communication as well as strategically choosing key areas of focus to build understanding and practice incrementally through the year. Staffing shortages increased pressure on everyone's available time which then impacted their ability to schedule, participate or buy into various initiatives aimed at impacting school culture and climate. To address this, UE Clinicians and Coaches worked to be as flexible and creative as possible to find times and places to meet or reschedule meetings when staff and admin were available individually as needed. The staffing shortages also increased levels of teacher stress and burnout which impacted implementation of supports across all three tiers of support at the school and put focus and need back on Tier 3 individual supports for students. As UE Clinicians and Coaches were pulled to support Tier 3 student needs, they continued to be mindful of ways to support teacher and staff skill building and capacity to address behavior needs themselves while also tending to staff wellness and support needs to allow for this. Lastly, at the end of the year, the OUSD teacher strike had a significant impact on the CESDC/ICESDC programs which were not able to conclude the year with complete Culture and Climate surveys or review data or planning to prioritize focus areas for the following year.

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Oakland Academy of Knowledge Deliverable: Contractor shall provide staff wellness activities ongoing through the development of initiatives that build camaraderie, promote self-care, and help staff to feel recognized, valued, and effective.

Case Study: The Unconditional Education (UE) Coach started the year with the intention of putting a greater emphasis on wellness and using the 'Wellness Wednesday' emails to tackle various themes centering on different aspects of wellness for educators. The emails have been well received as evidenced by positive feedback received from teachers in person or via email. Here is some of the feedback that the UE coach has received in response to the emails since the start of the school year:

"I really appreciate the Wellness Wednesday emails. The weekly encouragements, affirmations, and reminders always feel like they come at the right time in the week. I appreciate that they are usually brief enough to read when I first see them in my inbox. The reminders to take care of myself come right when I need them, in the middle of the week when I'm so focused on students that I'm often starting to forget to take care of myself. They also remind me that the people I work with are experiencing similar challenges or may also need the same reminders and encouragement that I do. It's fun when there's a reply-all prompts and many people engage. I don't always implement everything, and some weeks I read the emails a little less carefully (depending on when I open the email or how much text is in the email), but they always remind me that we are all valued as OAK staff. I also love reading through the monthly self-care calendars, even if I just choose a few of the activities to do whenever."

"Thank you for this reminder. I know that sometimes I tend to forget to stop and make sure that I'm all good because I want to get done with the millions of things that teachers have to get done with. These emails help remind us that it's okay to take a step back and do some self-care, or even decide to drop what you're doing to do something that makes you happy."

"I just want to take the opportunity to say that I really appreciate getting your wellness emails every Wednesday. For me it is a weekly reminder of how important it is to take care of ourselves in order to serve our students and their families. I have shared with my colleagues how I enjoy reading your messages and how I like implementing some of your self-care activities in my daily life. Once again GRACIAS for making sure that we feel appreciated, that we matter, and that it is essential to take care of ourselves."

"Your Wednesday wellness emails have personally made me feel seen in this work that I sometimes feel overlooked and could become taxing at times. It provides essential reminders to be gentle with myself and to take care of myself so that I am better able to care for others. The consistent reminders are helpful in creating a toolbox for myself and students in self-care. I really do appreciate the wellness Wednesday emails."

"I always like your Wednesday emails! I like that you make them interactive and remind us all that we are human and need to take a break/time for ourselves!"

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.

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Case Study:

There is a 3rd grade female student who was exhibiting several behavior challenges this school year. She had a negative rapport with her teacher and had trouble making friends because they were scared of her behavior. The teacher was initially unfamiliar and unwilling to follow the behavior intervention plan that was created for the student therefore this led to many office referrals and escalated incidents in the classroom. The student expressed feelings of not wanting to attend school. The Unconditional Education (UE) Coach started Check-In, Check-Out with her as well as provided monthly one-to-one coaching with her classroom teacher on classroom management strategies and de-escalation strategies as outlined in her behavior intervention plan. This student's treatment team (that was identified through COST) aided the student to receive counseling services as well. The team met this March with parents to discuss progress and she is doing very well. She is participating in all academic subjects and is using the break space within the classroom setting to self-regulate then return to work. She graduated from the Check-In, Check-Out program and only requires small check-ins when she is upset. There has been a significant decrease in her behaviors in class which has led her to finally build positive relationships/friendship with her teacher and peers. Her mom expressed great gratitude to the team for "not giving up on her" and teaching her the skills she needed to be successful at school this year. The students now expressed how sad she was to go on spring break because she loves being at school and will miss it.

V. FY 22/23 Additional Information:

During our Mid and End of Year Partner Surveys, we asked for feedback about what impact our Seneca staff and partnerships have had on the school communities. Responses from staff at our partner programs indicate an appreciation for ongoing efforts to support the diverse needs of students and families, support staff wellness and increase school culture, climate, and engagement:

ASCEND:

"More students are receiving therapy, and the clinicians have good relationships with them. Students who receive services seem better able to focus on things in class, and to self-regulate."

"Students are excited to see the providers that pull them out of class- the Seneca staff does a great job of creating trust between them and the students."

"I feel like our students are very fortunate to have such wonderful clinicians that are trying hard to meet the diverse needs of our students. They do home visits, attend meetings/events that are not required of their position, and are always willing to collaborate with adults in the building."

Oakland Academy of Knowledge:

"The students have access to multiple mental health services which allows for targeting their specific needs to help them stay engaged at school."

"Staff feel more supported and valued and students are better equipped to navigate social interactions."

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Sequoia:

"The Team has provided a wraparound system of support to make the climate here at Sequoia warm."

"Seneca has been an incredibly important and crucial element to our school community. I am grateful for the support they have provided our school and students."

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

FY 23/24	We project the number of students, parents/caregivers and school staff served to decrease by approximately 65%. This decrease reflects a reduction in partner schools since we will not be continuing in our two CESDC/ICESDC partnership programs.
FY 24/25	We are unable to determine at this time not knowing how many partnership sites we will be supporting.

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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.

FY 23/24 Program Budget: $96,474 **Cost per Client:** $437

How Much Did We Do?

I. FY 22/23: Number of Unique Clients Served: 221

How Well Did We Do?

II. Language Capacity for this Program:

Of the youth served, a large portion are bilingual (English/Spanish speaking). Our agency was short staffed at East Oakland Pride, losing our bilingual clinician at the start of the school year. We were not able to provide services exclusively in Spanish throughout the school year as we were unable to fill our bilingual clinician position during the 22-23 school year.

III. FY 22/23 Challenges:

Staffing provided a challenge throughout the school year. Our bilingual clinician left at the start of the school year and our other full time staff left in the spring of 2023. We ended the school year with only one part time staff member and were thus not able to take on many referrals at that time. In addition, there was an increased need for MHSA level support (for instance frequent requests for ongoing classroom and recess support) that we were not always able to meet.
Additionally, school administration expressed throughout the school year, that there were some caregivers who (due to distrust in systems) did not want their children engaged in any type of therapeutic support on site. This effectively limited the amount of MHSA support we could provide to certain students, despite their need, due to caregivers objections.

Is Anyone Better Off?

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IV. FY 22/23 Client Impact:

Case Study: We provided support to a sibling pair who had recently relocated to the Bay Area. The siblings, aged 9 and 10, needed support due to significant stressors impacting client and family, including caregiver's recent health crisis, and exposure to domestic violence. Presenting problems for the youth included externalizing behaviors (verbal and physical aggression at home and school). While in services, the family suffered loss of their family home due to fire, displacement, and financial hardships. As a result, the caregiver struggled to meet basic needs while managing her health challenges and was faced with housing instability, incidents of homelessness requiring hotel vouchers and risk of eviction once the family did find permanent housing. The caregiver received parent support and coaching, case management support services for accessing community resources and financial assistance during a period which the caregiver was unable to work due to medical condition. With support from Stars' staff the caregiver was able to navigate systems, and linkage to needed resources preventing eviction and exhibited improved parenting skills. Services enabled caregiver to develop natural/community supports reducing risk factors and increasing protective factors within the family unit.

Brief Overview of client impact: MHSA services have created the opportunity for providing direct services to students offering individual student support, group support, and crisis interventions to facilitate risk and safety assessments. Additionally, the impact of trauma and at-risk factors due to growing rates of gang-related activity and occurrence of community violence continues to have a direct impact on students and their immediate households. MHSA support has allowed for grief support on campus including support to school staff to address vicarious trauma, and parent support.

V. FY 22/23 Additional Information:

Over the course of next school year, we hope to increase our outreach to families and ideally establish a parenting support group. We have recently hired a bilingual Spanish speaking clinician which should aid in our increased outreach efforts.

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

FY 23/24:	During the current academic year (22/23) we have been able to offer support schoolwide to students (roughly offering support to 221 students, teachers, and caregivers) and expect the same level of service provision for the 23/24 school year.
FY 24/25:	During the current academic year (22/23) we have been able to offer support schoolwide to students (roughly offering support to 221 students, teachers, and caregivers) and expect the same level of service provision for the 24/25 school year.

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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.

FY 23/24 Program Budget: $91,974 **Cost per Client:** $50

How Much Did We Do?

I. FY 22/23: Number of Unique Clients Served: 1,855

How Well Did We Do?

- Our program's long-standing presence in the community helped to build trust with newcomers Staff were able to give clients hope and offered ways to increase their well-being. Staff educated clients about mental health challenges and shared stress-reducing activities such as taking walks, breathing in deeply, stepping away from conflict, playing with children, and visiting local parks. Provided furniture and clothing for many Afghan refugees due to the integrated nature of EBAC's programs and services.
- Clients were able to independently go to their therapy appointment and put into practice some of the strategies we offered that led to behavior changes.
- Our program coordinator actively participated as a member of the Fremont Family Resource Center Leadership Team, and our Fremont Healthy Start staff continued as members of the Tri-City Afghan Support Team. These two groups are made up of community service leaders who provide feedback on service improvements and needs. Because of this collaborative work, Parse Equality (an immigration service) is now available to refugees in Fremont. This service is making access to immigration assistance easier and more efficient.
- EBAC partnered with Sparkpoint, a financial independence program, to host a financial class in Dari to provide budgeting and saving education to Afghan clients.
- Because of EBAC's and our program staff's long-standing relationships with city, district, county and community resources and communities, we were able to provide prompt services to clients through mutual referral and collaboration. Further, these partnerships have afforded strategic opportunities to increase visibility and awareness of our programs. For example, our contact information is included in the Fremont Unified School District's website and the Kaiser Permanente website.

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- FHS staff participated in community partner trainings, such as “Mental Health and Wellness of Afghan School-Aged Youth" and “Compassion Fatigue”.

II. Language Capacity for this Program:

Cantonese, English, Farsi, Hindi, Korean, Mam, Mandarin, Pashto, Punjabi, Spanish, Vietnamese, and Urdu

III. FY 22/23 Challenges:

- A continued lack of counseling services available in Dari, Pashto, Urdu, and Punjabi resulted in long delays for people seeking mental health services. Common challenges included long waiting periods, lack of therapists who speak the client’s language, and costs associated with receiving services.
- Staff also were challenged with clients not following up with referrals due to other issues that clients were prioritizing, such as shelter and employment. Other families simply felt too overwhelmed by their challenges and responsibilities to even consider services or self-care.
- Working families are ineligible for services such as rental assistance, which exacerbates serious mental health issues.
- Encounters with Afghan refugees were time-consuming because of the issues and needs that they have and the complexity of the low-income housing application process. This added stress on staff as they are part-time. Staff also experienced vicarious trauma.
- Addressing wellness and/or mental health issues among diverse cultural groups was challenging at times. Cultural judgements, perspectives and misconceptions about mental health can influence how people receive the educational information we provide. Because of this, our program places great importance on establishing a bond with each client during the first encounter so as to establish good rapport.
- Another challenge was the 14-month Medi-Cal unwinding period and the millions of people who were expected to lose their coverage across the country. Starting April 1, the state started checking eligibility for the program, including household income and size. These checks were routine prior to COVID-19 but were paused during the pandemic. We discussed concerns with our county partners as it seemed that the community was unaware that this was coming despite the PSA campaigns that were happening. We additionally were concerned about our capacity to offer support if there was a huge influx of people that would lose their coverage (first group was in June). While there was a larger county-wide approach to this issue developing with SSA and HCSA, our county liaison was working to make the connection between strategy and coordinated action. As EBAC also is a current grantee of Alameda County’s Medi-Cal and CalFresh Outreach, Enrollment and Renewal Assistance Project, we were able to provide outreach, enrollment, and renewal support, but staff already were operating at enrollment/renewal capacity and thus had very limited time to provide outreach. Our FHS staff reminded their clients to update their contact information if it had changed and to look out for their renewal packet. Furthermore, all EBAC departments have been reminded about this change.

Is Anyone Better Off?

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IV. FY 22/23 Client Impact:

- Served 658 unduplicated individuals at-risk of developing a mental health problem or serious mental illness.
- Served 154 unduplicated individuals who showed early signs of forming a more severe mental illness.
- Served indirectly 1,043 unduplicated individual family members.
- Provided over 7,005 contacts with clients needing services such as assistance with health insurance, food, clothing, public benefits, domestic violence, etc.
- Provided contacts with 912 refugees who needed support with housing, ESL classes, driving lessons, school registration and immigration services.
- Worked with clients to create a family goal plan to identify the most helpful services. Offered warm hand-offs to ensure clients felt comfortable in following up with a referral.

Below is a client success story from this program year:
"Mr. Omar" arrived recently from Afghanistan with 4 children ages 3-12 and his wife. As our Family Resource Specialist 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 to review 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.

V. FY 22/23 Additional Information:
Lessons learned:

- It is important to remember that not all individuals are receptive to change or understand mental health in the way that our staff do. Persistence, patience, kindness, and cultural sensitivity are key in helping clients with traumatic experiences so that staff can start to build trust with the client. Once trust is established, clients tend to be more open to hearing about mental health resources or discussing mental health issues that they or their family members are experiencing. Staff is committed to creating a safe space so that when the client is ready, they will know where to go or know that they can talk to their Family Resource Specialist.
- Our clients have an expectation to receive something tangible from their encounter with our staff. 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.

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- Clients who are newcomers have a whole set of different challenges than those who have immigrated and have already adjusted to the lifestyle in America.

- Going to places where people gather may be intrusive so cultural sensitivity is a must.

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

FY 23/24:	1,000
FY 24/25	1,000

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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

FY 23/24 Program Budget: $2,094,840 **Cost per Client:** $899

How Much Did We Do?

I. FY 22/23: Number of Unique Clients Served: 2,331

How Well Did We Do?

CIT Deliverables: Quality Measure #1: 99% of CIT Officers responded, "strongly agree"/"agree" to the statement: "I expect to use some of the information learned today." Impact Measure #2: 91% of CIT Officers responded, "strongly agree"/"agree" to the statement: "This information will improve my effectiveness in interacting with consumers and family members." Measure #3: 95% of CIT Officers responded "Highly Satisfied"/"satisfied" with the CIT training.

Deliverable: 5,756 hours of Outreach and Engagement, supports and training to families: FERC delivered 15, 582 hours of these services.

Deliverable: 500 Outreach Contacts; 400 Outreach follow up contacts: FERC made 571 Outreach Contacts and over 500 follow up contacts in the Fiscal Year.

Deliverable: FERC collaborates with 2 organizations in Outreach Events: FERC collaborated with 6 Organizations in Outreach Events.

Deliverable: FERC holds 6 Outreach and Activities in the County: FERC held 19 Outreach and Activities in the County.

Deliverable: FERC holds a minimum of 10 Peer & Social Support Groups in the County: FERC held 53 peer and social groups in the County: 15 Parent Cafes and 38 Friday Bingo Groups. Both social groups are peer lead and build community through strengthening social support networks.

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Deliverable: 900 New Warmline Contacts: FERC received 1,222 Warmline calls.

Deliverable: FERC recruits/trains 2 – 4 Volunteers on subject areas: FERC continued to coach and developed 6 Spanish speaking volunteers in the Parent Café (Café Para Padres) Program model. These Parent Leaders hosted 15 Parent Cafes in Spanish.

Deliverable: At least 800 AB 1424 Consultations: FERC provided 983 AB 1424 consultations.

Deliverable: Full Day provider education training with modified version of the training provided quarterly: FERC delivered 6 trainings on Mental Health and self-care to providers in the county.

Deliverable: Monthly Family Support Groups in all areas of the county with attendance of 10 – 20 participants: FERC provided 102 support groups across the county.

Deliverable: 5-7 Family Leaders will be coached and developed to participate in county commissions and task forces: Throughout FY 2022-23 FERC coached and developed 7 Family Leaders to participate in county commissions, task forces, and focus groups, and to engage in community building activities.

III. Language Capacity for this Program:

FERC staff was 39% bilingual bicultural Spanish/English and 7% of staff was bilingual bicultural Tagalog/English. 29% of FERC Leadership was bilingual bicultural Spanish/English.

IV. FY 22/23 Challenges:

Is Anyone Better Off? To respond to needs expressed by the Latinx community during our Parent Café programming in FY 2022-23, FERC coached 6 FERC Family Leaders to develop a culturally syntonic Family Caregiver Wellness and Self-Care workshop series based in mental wellbeing through self-care, the Five Protective Factors, wellness and recovery precepts. The workshop series is titled: Construyendo Mi Cuidado Personal Efectivamente (CCPE) (Building My Personal Care Effectively). The program will be provided to Spanish speaking FERC clients and community starting August 2023.

Is Anyone Better Off?

V. FY 22/23 Client Impact:

Family Advocate (FA) supported Client A (CA) to build stronger boundaries with her son who lives with a dual diagnosis of SUD and Schizoaffective disorder. FA and CA met consistently every week for 16 months, and now CA's son is in a residential treatment program for the first time in his life. CA has stated several times that she would not have been able to endure the chaos of the last year and a half without FA's undying support. Client B's (CB) daughter lives with suicidality and schizophrenia. CB reported that her daughter entered treatment after just 3 months of receiving Family Advocacy work from FERC. By practicing the skills taught by her FA, CB was able to hold non-combative discourses with her daughter resulting in her daughter being more open to treatment. CB also received support from FA during a 5150 crisis with her daughter. FERC FA has supported Client C (CC) over a period of several years: to recognize the harmful impact the DV she was experiencing had on herself and her 10- year-old son who lives with

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ADHD, Anxiety and was later diagnosed with PTSD. FA helped CC and her son to escape the situation, file for divorce, enroll in a new school district and advocate for her Son's IEP accommodations. FA continues to advocate for this family in a school district where CC's son is being labeled as a "troublemaker" instead of being respected as a child in need of support. FA is currently supporting CC to file for sole custody of her child and supporting her to develop a robust self-care plan as she lives with multiple heath conditions.

VI. FY 22/23 Additional Information:

In FY 2023-24 FERC bicultural/bilingual staffing will increase to 56% resulting from vacated positions. Our Leadership team will increase to a 43% bicultural/bilingual team.

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

FY 23/24	**2,400 clients**
FY 24/25	**2,500 clients**

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OUTREACH / ENGAGEMENT & SYSTEMS DEVELOPMENT (OESD) REPORT

OESD #: OESD 36

PROVIDER NAME: CalMHSA

PROGRAM NAME: CALMHSA Presumptive Transfer Project

Program Description: Funding to be transferred for the support of providing services to Alameda County foster youth being served outside of Alameda County.

Target Population: Foster youth receiving mental health services outside of Alameda County This is a current mandate for all California Counties.

FY 23/24 Program Budget: $762,973 **Cost per Client:** $6,521 (for the 117)

How Much Did We Do?

I. FY 22/23: Number of Unique Clients Served:

Alameda County has received 183 youth from other counties through the Presumptive Transfer process. Alameda County has placed 117 youth in out of County placements through the Presumptive Transfer process.

II. FY 23/24 Programs or Service Changes: No Service Changes expected.

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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).

FY 23/24 Program Budget: $1,826,672 **Cost per Client:** $7,108

How Much Did We Do?

I. FY 22/23: Number of Clients Served: 257

1. **RTT1-133**
2. **RTT2-124**

II. How Well Did We Do?

III. Language Capacity for this Program:

The RTT treatment teams have staffing fluent in both English and Spanish, and one supervisor who is bilingual in Urdu and English. RTT staff had no barriers to providing services to partners with their language of choice during this fiscal year. 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 22/23 Challenges:

Limits on client support funds for housing continue to be a barrier to aiding clients who need the support the most. Depending on the type of housing/length of time support is needed/total cost, etc., it often results in an increased need for financial assistance/use of flex funds.

Lack of affordable/stable housing creates a barrier to clients being able to comfortably engage in treatment goals and fully address mental health needs.

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The California eviction moratorium was lifted during this fiscal year which created additional housing instability and rise in client need for financial support. Many clients experienced increased mental health symptoms due to the financial strain and housing insecurity.

Is Anyone Better Off?

V. FY 22/23 Client Impact:

During this fiscal year, we saw a decrease in hospitalizations. The recidivism rate remained approximately the same as the previous fiscal year. In the 2022-2023 fiscal year, there was an increase in clients housed as well as client employment.

VI. FY 22/23 Additional Information:

Staffing was challenging to navigate this fiscal year. Towards the end of the fiscal year, however, we hired two nurses and a new medication provider for the programs.

VII. FY 23/24 Projections of Clients to be Served:

We project to serve between 275-300 partners collectively between both cohorts during this next FY.

FY 23/24	275-300
FY 24/25	275-300

VIII. FY 23/24 Program or Service Changes:

RTT will continue to maintain minimum census and increase community engagements in the upcoming fiscal year. RTT will utilize our new nursing staff to focus on client wellbeing. This will include collaborating with clients to increase medication compliance, develop wellness focused groups, and promote physical as well as mental well-being. The team will also continue to strategize ways to increase psychiatry services within the programs as a way to reduce client's need to access services from multiple providers. During this fiscal year, the team will work collaboratively to provide a wraparound approach to meeting the needs of our clients to promote engagement and overall well-being.

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Is Anyone Better Off?

V. FY 22/23 Client Impact:

During this fiscal year, we saw a decrease in hospitalizations. The recidivism rate remained approximately the same as the previous fiscal year. In the 2022-2023 fiscal year, there was an increase in clients housed as well as client employment.

VI. FY 22/23 Additional Information:

Staffing was challenging to navigate this fiscal year. Towards the end of the fiscal year, however, we hired two nurses and a new medication provider for the programs.

VII. FY 23/24 Projections of Clients to be Served:

We project to serve between 275-300 partners collectively between both cohorts during this next FY.

FY 23/24	275-300
FY 24/25	275-300

VIII. FY 23/24 Program or Service Changes:

RTT will continue to maintain minimum census and increase community engagements in the upcoming fiscal year. RTT will utilize our new nursing staff to focus on client wellbeing. This will include collaborating with clients to increase medication compliance, develop wellness focused groups, and promote physical as well as mental well-being. The team will also continue to strategize ways to increase psychiatry services within the programs as a way to reduce client's need to access services from multiple providers. During this fiscal year, the team will work collaboratively to provide a wraparound approach to meeting the needs of our clients to promote engagement and overall well-being.

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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 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).

FY 23/24 Program Budget: $491,281 **Cost per Client:** $10,235

How Much Did We Do?

I. FY 22/23: Number of Unique Clients Served: Our program served 48 unduplicated clients.

How Well Did We Do?

II. Language Capacity for this Program: We provided services in all language needs.

III. FY 22/23 Challenges: Short staffing was a challenge, and we lost our program supervisor at the end of the fiscal year.

Is Anyone Better Off?
Clients are better off as evidenced by 11% of clients receiving GA within 2 months. 52% of engaged clients participating in treatment did not recidivate and 63% were engaged and receiving services.

IV. FY 22/23 Client Impact:
73% of clients were successfully linked to community-based support services, 67% of clients completed treatment programs.

V. FY 22/23 Additional Information:
83% of clients had 2 or more sessions within 30 days of intake; 56% of clients remained engaged throughout the entire 18 - 24 mos. treatment period.

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

FY 23/24	Anticipate 40 clients.	**FY 24/25**	Anticipate 40 clients.

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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 and are high utilizers of Alameda County Behavioral Healthcare Services, including patients of Psychiatric Emergency Services.

FY 23/24 Program Budget: $466,409 **Cost per Client:** $1,401

How Much Did We Do?

I. FY 22/23: Number of Unique Clients Served: 333

How Well Did We Do?

Quality Measures	FY 22/23 Data Results	Contract Quality Objective Benchmarks
The percent of Disability Advocacy clients that are closed without obtaining benefits for the following reasons: loss of contact, insufficient merit to proceed, change in eligibility status, or client withdrawal	30%	15%
The percent of clients on the Community Housing Queue that are document ready within 2 months of referral for Housing Navigation services.	43%	80%

II. Language Capacity for this Program:

BayLegal staff communicate directly in English, Spanish, Vietnamese, Mandarin, and Cantonese, and use qualified interpreters to communicate with clients in other languages. In FY 22-23, BayLegal served clients in English, Spanish, Chinese, Khmer/Mon-Khmer, Arabic, Dari, Tagalog, French, Gujarati, Hindi, Korean, Panjabi, Russian, and Vietnamese

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III. FY 22/23 Challenges:

The Social Security Administration (SSA) and the state Disability Determination Service (DDS) remain understaffed resulting in delays in the processing of applications and appeals, and a backlog of pending cases. Access to clients at Santa Rita Jail remains limited. BayLegal has been unable to meet with clients in person at Santa Rita Jail since the start of the pandemic, and communication by phone or video has been unreliable. As a result, BayLegal is unable to communicate with many clients or potential clients as they cycle in and out of Santa Rita Jail, resulting in more cases being closed as unable to contact or in cases limited to advice or brief service because BayLegal was unable to obtain a signed appointment of representative form. We encountered additional challenges in implementing HDAP housing navigation services, including difficulty contacting clients and barriers to communication with clients who are experiencing homelessness, including those who do not have a reliable phone or mailing address, and delays in obtaining necessary documentation from government agencies, including Social Security cards.

Is Anyone Better Off?

BHCS data[3] has previously shown that people who qualify for SSI or Social Security disability benefits experience increased housing stability, and are less likely to experience homelessness, incarceration, hospitalization, or need psychiatric emergency services. Formerly incarcerated people are 10 times more likely to experience homelessness than the general population[4]. 70% of people experiencing homelessness in California are formerly incarcerated[5]. The BHCS SSI Advocacy Trust model helps to break this cycle of incarceration and homelessness.

BayLegal served 333 clients with 350 active cases in FY 22-23. BayLegal closed 145 cases: 7 cases assisted clients with advice and counsel, 31 cases assisted clients with brief services, and 107 cases assisted clients with extended services. Of extended service cases, 85 cases assisted clients with Administrative Agency Decisions, 3 cases assisted clients with court decisions, 1 case assisted clients to negotiate a settlement without litigation, 12 cases assisted clients with extensive services not resulting in settlement or court or administrative action, and 6 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 totaling over $5.4M.

Client Success Story 1:

BayLegal helped TS apply for Title 2 (Social Security) and Title 16 (SSI) disability benefits in 2016 while they were at Santa Rita Jail, based on diagnoses of schizoaffective disorder and physical impairments. Her claim was initially denied and at reconsideration based largely on the opinion of a state medical consultant whose notes called the claimant "lazy" and "pleased with herself...for getting kicked out of so many shelters." At the hearing, her claim was denied by an ALJ finding that drug addiction or alcoholism was material to their disability, despite a six-year period of sobriety. BayLegal appealed to federal court and won a remand order for a new hearing in 2021. BayLegal represented her at another hearing in 2021 after

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3 See, e.g., http://www.acgov.org/probation/documents/SSIAdvocacy_Program&ServicesMeeting_3-22-2018.pdf; https://www.cdcr.ca.gov/ccjbh/wp-content/uploads/sites/172/2019/09/Improving-Effectiveness-of-SSI-SSDI-Advocacy-Program-for-Jail-Incarcerated-Populations-Policy-Brief.pdf

4 https://www.prisonpolicy.org/reports/housing.html

5 https://wclp.org/as-california-closes-prisons-we-must-protect-people-who-were-incarcerated-from-falling-into-homelessness/

she was found disabled in a subsequent Title 16 application. The claim was denied again at the hearing, and BayLegal appealed directly to federal court, where the judge issued an order remanding the case for payment of benefits, which happens in less than 1% of federal court cases. She is now housed and receiving monthly benefits, and BayLegal is now advocating with SSA to process her back pay.

Client Success Story 2:

GC came to BayLegal in 2019 with a pending SSI case at a hearing without representation. The case had undergone some procedural hurdles including a congressional inquiry before coming to BayLegal. No one had ever previously realized that he was potentially eligible for a disabled adult child (DAC) benefits on a parent's earnings record. After BayLegal won his SSI case in October at a hearing with an adjudicated onset date back in 2012 and an application date in 2016, BayLegal also assisted him with a DAC application that was swiftly approved this Spring. Entitlement to DAC benefits can result in a higher monthly benefit without the onerous income and resource limits for receiving SSI.

IV. FY 22/23 Client Impact:

Outcome Measures	FY 22/23 Data Results	Contract Outcome Objective Benchmarks (National Average Approval Rate)
SSI/SSDI Advocacy Contractor shall achieve a SSI/SSDI allowance rate at least equal to that of the national average approval rate.	68.3%	44.1%[6]

V. FY 22/23 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 have limited capacity and delays in processing claims. Technical problems with SSA phone lines have made conducting business by phone more difficult. Cases with DDS are sometimes stalled awaiting assignment to an analyst or scheduling of a consultative examination or additional evidence from treating medical sources. We meet regularly with both DDS and SSA staff to address barriers to timely processing of claims. We have increased advocacy to object to the scheduling of consultative exams with non-treating doctors and to encourage DDS and SSA to make greater efforts to consider medical evidence and opinions from treating medical sources.

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 of claims, appeals, the appointment of representatives, and other forms as part of SSA's COVID workgroup and SSA Quarterly Roundtable meetings with advocates. 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. SSA's Office of Hearing Operations (OHO) has increased the rate of

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scheduling of hearings, and we have seen an increase in favorable hearing decisions, and favorable federal court decisions.

VI. FY 22/23 Projections of Clients to be Served: approximately 300.

FY 23/24	250
FY 24/25	240

Clients will be represented at all stages of SSI/SSDI applications, and staff will advocate for clients with SSA and DDS.

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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.

FY 23/24 Program Budget: $932,817 **Cost per Client:** $2,535

How Much Did We Do?

I. FY 22/23: Number of Unique Clients Served: 368 clients in 378 separate SSI/SSDI cases.

How Well Did We Do?

Quality Measures	FY 22/23 Data Results	Contract Quality Objective Benchmarks
The percent of Disability Advocacy clients that are closed without obtaining benefits for the following reasons: loss of contact, insufficient merit to proceed, change in eligibility status, or client withdrawal	**45%**	15%
The percent of clients on the Community Housing Queue that are document ready within 2 months of referral for Housing Navigation services.	**85%**	80%

* This data is for cases closed, not clients – we do not open or close a client in our database - so is possibly a bit higher than it would be if we were to count overall outcomes for clients.
** We don't count change in eligibility status as a negative outcome, as it is not necessarily negative for the client, and it is not within the advocate's control. We evaluate non-medical eligibility before opening a case, so these closures do not represent a failure to assess on our part.

II. Language Capacity

III. FY 22/23 Challenges:

The high number of cases closed where we lost contact with the client is a challenge for us; those cases

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are the majority of the 45% figure in Quality measure 1, above. The clients with criminal justice connections, especially those who were incarcerated at the time of their referral to HAC had the highest concentration of disappearances. When we look at these numbers across all our contracts, we see an overall 35% of cases with these outcomes – the criminal justice case disappearances are pulling the average down from 32% for the whole agency. We are investigating now to see what the data can tell us about when the disappearances occurred in the process so that we might understand how to prevent it. Overall, cases closed with the disappeared status have been higher than we like for a number of years. COVID was an influence, and a change in the SSA regulations for representatives requiring us to withdraw from the case when we are not in contact with the client at certain milestones.

SSA processing at the field offices continued to be slow in FY 2022 – 2023, and communication continued to be difficult. Both problems are due at least in part to the continued understaffing of SSA offices. As of the end of the FY, it was taking the field offices between 2 – 4 months to complete the processing of an application so that the lengthy disability determination process can start. Until they finish processing an application, a client cannot access the housing subsidy provided to some General Assistance recipients by Alameda County.

Is Anyone Better Off?

IV. FY 22/23 Client Impact:

Outcome Measures	FY 22/23 Data Results	Contract Outcome Objective Benchmarks (National Average Approval Rate)
SSI/SSDI Advocacy Contractor shall achieve a SSI/SSDI allowance rate at least equal to that of the national average approval rate.	38.5%	28%

V. FY 22/23 Additional Information:

Outcome measure 1 of 1, background info: The award rate for all adult SSI claims in 2020, the last year for which there is data, is 27.9. See SSI Annual Statistical Report, 2021 - Outcomes of Applications for Disability Benefits (ssa.gov), Table 69, Outcomes at all adjudicative levels, by age and year of application, 1992-2020 – Ages 18-64. The Award Rate measure is compared above to the final outcome in HAC's cases, which are closed with an allowed status when the client has been awarded benefits.

37 cases were closed with favorable decisions in this fiscal year.

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

FY 23/24	**400**
FY 24/25	**450**

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Prevention and Early Intervention (PEI)

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 to reduce prolonged suffering. PEI services emphasize the development, implementation, and promotion of strategies that are non-stigmatizing and non-discriminatory.

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 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.

1 Proposition 63: Mental Health Services Act 2004
2 MHSOAC PEI Fact Sheet, December 2017

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), 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

3 MHSOAC Memo, January 30, 2020

Prevention and Early Intervention Strategies and Priorities[4]

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.

4 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-BL SKY 6-AHS 6-CERI 7-AFGHAN 8-NAHC		1C-JFCS		1B-CHSC	
EARLY PSYCHOSIS & MOOD DISORDERS						
YOUTH OUTREACH & ENGAGEMENT						
	6-AHS 6-CERI 6-BACH 6-RAMS 7-AFGHAN 7-FAJ 7-HUME 8-NAHC 19-DHTI 1D LA FAM 20A-BRL 20F-RJOY 20E-TRI CIT 20E-PEERSAA 28-HHREC TAY	17A-YU 17B-REACH 24-ROOTS SP	22-MENTOR	4-PEERS-ECC	1B-CHSC	12 CSS-Text 12 CSS-Ed
CULTURE AND LINGUISTIC						
	5-LA CLIN 6-AHS 6-CERI 6-BACH 6-RAMS 6-KCCEB 7-AFGHAN 7-FAJ 7-IRC 7-HUME 8-NAHC 10-PTR 19-DHTI 1D-LA FAM 20A-BRL 20B-BMS 20C-MHAAC 20F-RJOY 20E-TRI CIT 20E-PEERSAA 26-HHREC 10 27-HHREC		1C-JFCS 20C-MHAAC 22-PC TA 28-HHREC TAY	4-PEERS-ECC		
OLDER ADULTS						
	6-BACH 6-RAMS 7-AFGHAN 7-FAJ 7-HUME 8-NAHC 19-DHTI 20E-TRI CIT 20E-PEERS AA	3-GART	22 PC- OLDER OUT 22 PC- MENTOR	4-PEERS ECC		
EARLY IDENTIFICATION						
	1A-BL SKY 5-LA CLIN 6-AHS 6-CERI 6-BACH 6-RAMS 6-KCCEB 7-AFGHAN 7-FAJ 7-IRC 7-HUME 8-NAHC 10-PTR 19-DHTI 20F-RJOY	17A-YU 17B-REACH	1C-JFCS 22 PC- MENTOR		1B-CHSC	12 CSS-Text 12 CSS-Ed 12 CSS-Clinic

% 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%**

PEI Participant Satisfaction and Pre-Post Health Assessment Surveys

ACBH used electronic surveys in 2023 to assess participant satisfaction across the PEI program portfolio. The optional Participant Satisfaction Survey was offered to all Underserved Ethnic and Language Program (UELP)[5] participants who had received four or more services (including preventive counseling, community events, workshops, support groups, and prevention visits) from February to June 2023, and to all PEI program participants who received any service between February and June 2023. The 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 from contracted provider staff to complete paper surveys.

UELP participants additionally receive the Health Assessment Pre-Survey at the start of services. They complete a post-survey when their program participation ends. While the Participant Survey measures satisfaction as a snapshot in time, the Health Assessment measures change over time as a result of participant's exposure to UELP programming. In 2022, providers requested to extend the survey from several months to year-round to increase the number of completed post-surveys from individuals who participate in services for an extended period.

PEI contracted provider volunteers and ACBH staff collaborated in a workgroup to plan the survey launch and implementation process in 2020. 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.

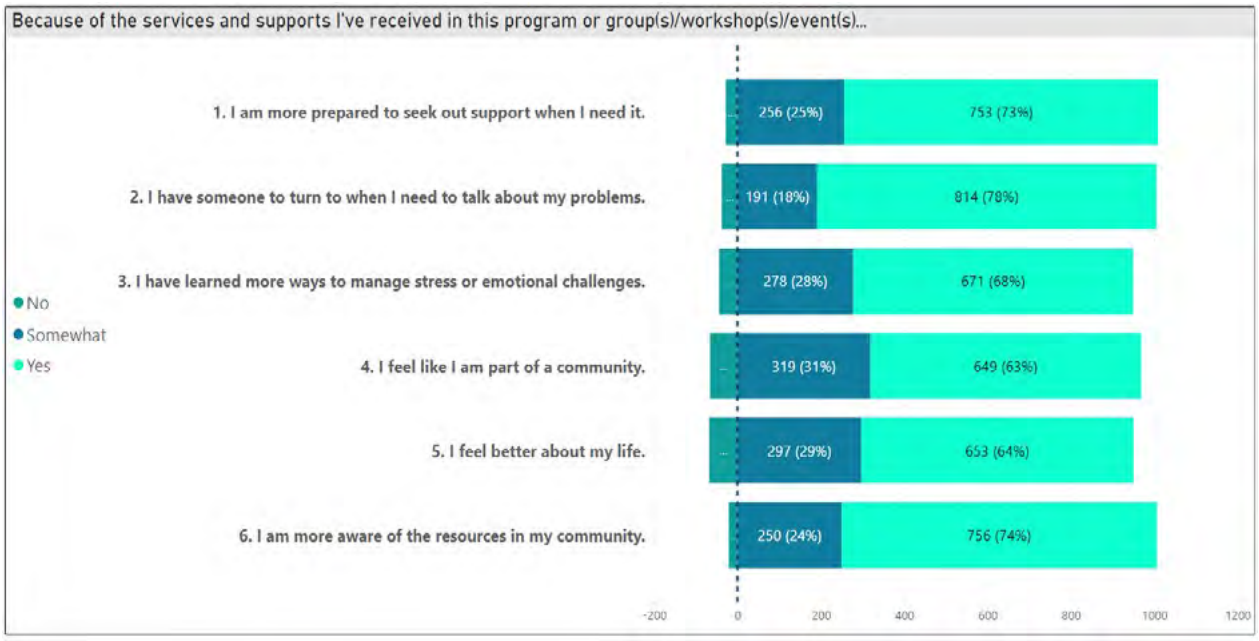
Finally, ACBH coordinated with providers to translate the survey into the various languages representing the diverse communities that receive PEI services: Chinese, Korean, Farsi, Dari, Pashto, Tigrinya, Amharic, French, Arabic, Cambodian, Mein, Vietnamese, Burmese, Spanish, Tagalog, Fijian, Tongan, Urdu, Hindi, and Punjabi.

Following the survey periods across calendar years 2021 and 2022, ACBH staff invited representative providers to re-convene the survey workgroup to evaluate the efficacy of the process to date, to update and clarify survey questions, and to understand the value-add of surveying for staff and their agencies. The workgroup is currently meeting, and its recommendations and insights will directly inform the survey process and outcomes in 2024.

5 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.

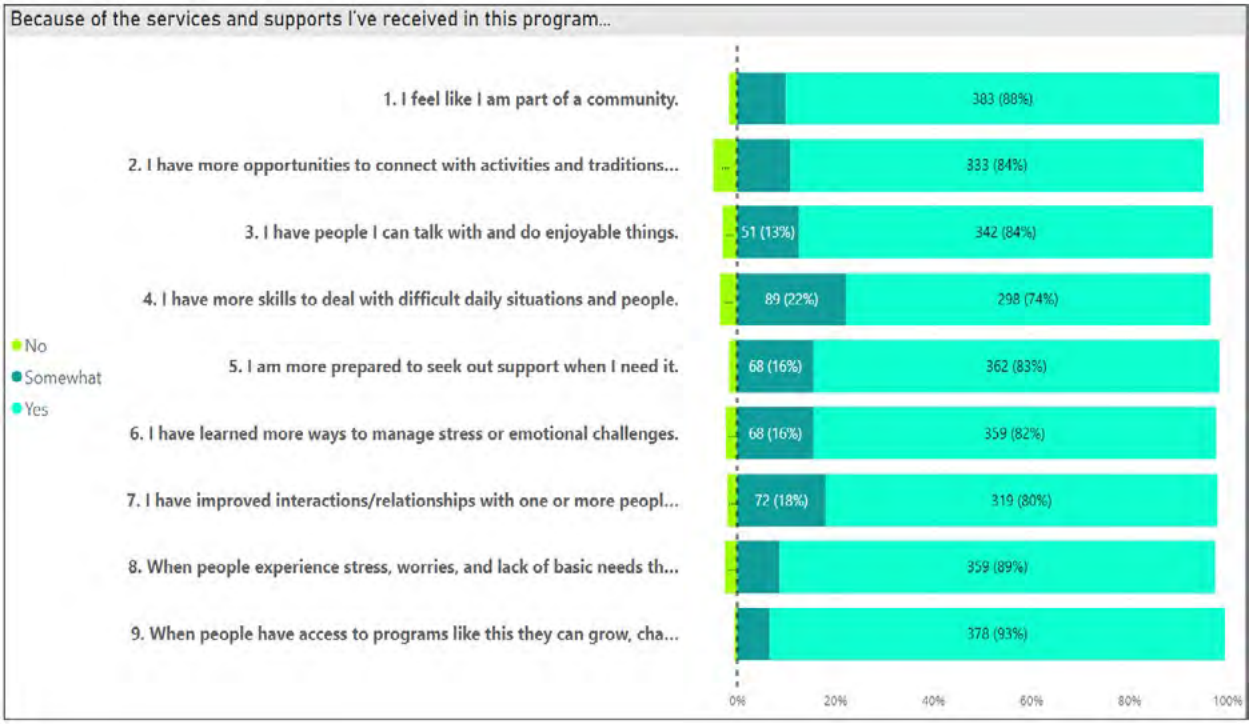
Providers collected 1552 Participant Satisfaction surveys during the 2023 assessment period. Providers collected 173 completed pre-post Health Assessment surveys during the 2023 assessment period. Outcome data from the Participant Satisfaction and from the Health Assessment surveys appears below (please see the full PEI Report in the Appendix D-4 for additional survey data):

PEI Participant Satisfaction Survey Results



Participant Satisfaction survey data indicates that PEI (non-UELP) programs significantly support participants to have someone to talk to about problems (78%). Programs further support participants to be more aware of community-based support resources (74%) and to be prepared to seek needed support (73%). More moderate percentages of participants have learned more ways to manage stress and challenges (68%), to feel better about their lives (64%), and to feel like a part of community (63%).

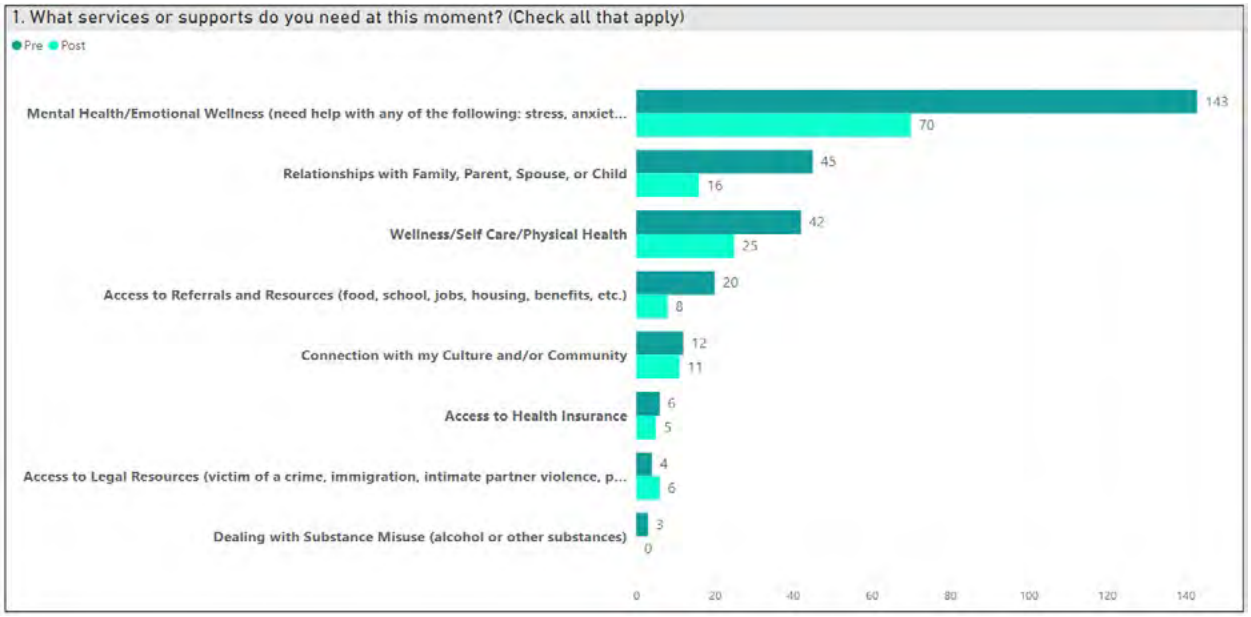
UELP Participant Satisfaction Survey



UELP program participants report a high level of understanding of the impact of stress and worry on mental wellness (88%) and a very high level of understanding about how UELP programs can improve wellness and mental health (92%). Additionally, these programs significantly support participants to feel like they are part of community (88%) and to connect more with traditions and culture (84%). The UELP model centers and deeply values ethnicity and language as the primary channel to reach, to build relationships with, and to serve participants. These programs also show significant outcomes in helping participants to feel more prepared to seek help (82%) and to manage stress and challenges (82%).

Strengths across PEI and UELP programs include support for participants to seek help when they need it and to have people in their lives they can turn to, providing key protective factors for mental wellbeing. Growth opportunities for these programs include increasing support for participants to manage stress and challenges, to feel like part of community, and to feel better overall about life.

UELP Pre/Post Health Assessment Survey



UELP Pre/Post Health Assessment survey data indicates that participant's **need for mental health and emotional wellness services and support was reduced** by almost 49% (pre = 143/post = 70) after receiving services. Significant reductions in needs as a result of receiving services are also shown in other areas, including a 35% reduction in needs for services related to relationships with family, parent, spouse, or child (pre = 45/post = 16); a 59% reduction in needs for services related to overall wellness and health (pre = 42/post = 25), and a 40% reduction in needs for services related to access to referrals and resources (pre = 20/post = 8).

Prevention and Early Intervention Summaries[6]

Below are summary descriptions for each MHSA funded prevention and early intervention program. For additional information please see the Annual PEI Report in Appendix D.

[6] For more information on Prevention & Early Intervention see the PEI Annual Report in the Appendix D-4

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 DESCRIPTION: 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.

Ages/Populations Served: Early Childhood, Birth – 18 months old

Blue Skies Mental Wellness Team-Alameda County Public Health Department	FY 22/23
Clients Served/Reached	180
Cost per Client[7]	$3,763.04

Projected number of to be served in:	
FY 23/24	180
FY 24/25	180

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7 Cost based on the MHSA contribution and may not be representative of the full cost of providing services.

MHSA Program #: PEI 1D

PROVIDER NAME: La Familia Counseling Services

PROGRAM NAME: Outreach, Education & Consultation for Unaccompanied Immigrant Youth (UIY)

PROGRAM DESCRIPTION: 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.

Ages/Populations Served: Immigrant youth and families/caregivers

La Familia Counseling Services	FY 22/23
Clients Served/Reached	7,013
Cost per Client	$ 117.85

Projected number of to be served in:	
FY 23/24	7,000
FY 24/25	7,000

MHSA Program #: PEI 5

PROVIDER NAME: Cultura y Bienestar (La Clinica De La Raza)

PROGRAM NAME: Outreach, Education & Consultation for Latino community

PROGRAM DESCRIPTION: 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 a reduction in prolonged suffering through balance, wellness, and healing in our communities.

Ages/Populations Served: Latino

Cultura y Bienestar (La Clinica De La Raza)	FY 22/23
Clients Served/Reached	1,887
Cost per Client	$ 999.96

Projected number of to be served in:	
FY 23/24	1,800
FY 24/25	1,800

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MHSA Program #: PEI 6

PROVIDER NAME: Asian Health Services

PROGRAM NAME: Outreach, Education & Consultation for the Asian Community

PROGRAM DESCRIPTION: 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.

Ages/Populations Served: Chinese, Hong Kong, Taiwanese, Korean, Japanese

Asian Health Services	FY 22/23
Clients Served/Reached	406
Cost per Client	$ 870.6

Projected number of to be served in:	
FY 23/24	405
FY 24/25	405

MHSA Program #: PEI 6

PROVIDER NAME: Bay Area Community Health (BACH)

PROGRAM NAME: Outreach, Education & Consultation for East Asian Community

PROGRAM DESCRIPTION: 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 navigating and connecting participants to care and resources.

Ages/Populations Served: Chinese, Japanese, Taiwanese, Korean, Mongolian

Bay Area Community Health	FY 22/23
Clients Served/Reached	33
Cost per Client	11,000

Projected number of to be served in:	
FY 23/24	50
FY 24/25	50

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MHSA Program #: PEI 6

PROVIDER NAME: Center for Empowering Refugees and Immigrants (CERI)

PROGRAM NAME: ROYA

PROGRAM DESCRIPTION: 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. Our services reduce mental health symptoms such as depression and anxiety and prevent prolonged suffering.

Ages/Populations Served: Vietnamese, Cambodian, Laotian, Myanmar, Thai, Malaysia, Brunei

Center for Empowering Refugees and Immigrants (CERI)	FY 22/23
Clients Served/Reached	1,435
Cost per Client	$ 492.68

Projected number of to be served in:	
FY 23/24	1,400
FY 24/25	1,400

MHSA Program #: PEI 6

PROVIDER NAME: Korean Community Center of the East Bay (KCCEB)

PROGRAM NAME: Outreach, Education & Consultation for East Asian Community

PROGRAM DESCRIPTION: 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.

Ages/Populations Served: All ages (children, youth, adults, older adults, family, and couples); East Asians (Chinese, Mongolian, Korean, Japanese), and a small percentage of other Asian and Pacific Islanders (API)

Korean Community Center of the East Bay (KCCEB)	FY 22/23
Clients Served/Reached	270
Cost per Client	$ 1,309.13

Projected number of to be served in:	
FY 23/24	250
FY 24/25	250

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MHSA Program #: PEI 6

PROVIDER NAME: Richmond Area Multi-Services, Inc. (RAMS)

PROGRAM NAME: Outreach, Education & Consultation for Pacific Islander Community

PROGRAM DESCRIPTION: 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

Ages/Populations Served: Samoan, Tongans, and all Pacific Islanders

Bay Area Community Health	FY 22/23
Clients Served/Reached	248
Cost per Client	$ 2,468.75

Projected number of to be served in:	
FY 23/24	250
FY 24/25	250

MHSA Program #: PEI 7

PROVIDER NAME: Afghan Coalition

PROGRAM NAME: Outreach, Education & Consultation for South Asian/Afghan Community

PROGRAM DESCRIPTION: 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.

Ages/Populations Served: Afghan

Afghan Coalition	FY 22/23
Clients Served/Reached	1,282
Cost per Client	$ 437.21

Projected number of to be served in:	
FY 23/24	1,200
FY 24/25	1,200

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MHSA Program #: PEI 7

PROVIDER NAME: Afghan Path Toward Wellness (International Rescue Committee (IRC))

PROGRAM NAME: Outreach, Education & Consultation for Afghan Community

PROGRAM DESCRIPTION: Afghan Path Towards Wellness (APTW): Providing wellness and psychosocial support services to the Afghan community of North Alameda County. Primary services include preventative counseling, psychoeducational and educational workshops, community events, socials support groups, wellness assessments, and community provider and leader trainings.

Ages/Populations Served: Afghan

Afghan Path Toward Wellness (International Rescue Committee (IRC))	FY 22/23
Clients Served/Reached	109
Cost per Client	$ 3,243.12

Projected number of to be served in:	
FY 23/24	100
FY 24/25	100

MHSA Program #: PEI 7

PROVIDER NAME: Filipino Advocates for Justice

PROGRAM NAME: Outreach, Education & Consultation for Filipino Community

PROGRAM DESCRIPTION: 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. Our services reduce mental health symptoms such as depression and anxiety and prevent prolonged suffering.

Ages/Populations Served: Filipino

Filipino Advocates for Justice	FY 22/23
Clients Served/Reached	70
Cost per Client	$ 5,050

Projected number of to be served in:	
FY 23/24	75
FY 24/25	75

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MHSA Program #: PEI 7

PROVIDER NAME: The Hume Center

PROGRAM NAME: Outreach, Education & Consultation for South Asian/Afghan Community- South Asian Community Health Promotion Services Program

PROGRAM DESCRIPTION: The South Asian program offers prevention and early intervention services for individuals, couples, and families in distress. These short-term culturally sensitive and language specific services offer support aimed at developing knowledge and skills to work through life. When life becomes too overwhelming, that result can bring changes in how an individual thinks, feels, and acts.

Ages/Populations Served: Bangladesh, Indian, Sri Lanka, Nepalese, Pakistani, Bhutan, Maldives

The Hume Center	FY 22/23
Clients Served/Reached	954
Cost per Client	$ 741.09

Projected number of to be served in:	
FY 23/24	950
FY 24/25	950

MHSA Program #: PEI 8

PROVIDER NAME: Native American Health Center (NAHC)

PROGRAM NAME: Outreach, Education & Consultation for Native American Community

PROGRAM DESCRIPTION: 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. Our services reduce mental health symptoms such as depression, stress, anxiety and prevent prolonged suffering.

Ages/Populations Served: Native Americans

Native American Health Center (NAHC)	FY 22/23
Clients Served/Reached	220
Cost per Client	$ 1,606.82

Projected number of to be served in:	
FY 23/24	220
FY 24/25	220

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MHSA Program #: PEI 10

PROVIDER NAME: Partnership for Trauma Recovery (PTR)

PROGRAM NAME: Outreach, Education & Consultation for African Community

PROGRAM DESCRIPTION: Partnerships for Trauma Recovery (PTR) provides culturally reflective, trauma-informed, linguistically competent, and accessible UELP PEI services to the specific underserved population of forcibly displaced children, youth, adults, and families from African countries currently residing in North and South Alameda County. PTR specializes in providing holistic behavioral health care, psychosocial, and case management support for those who have fled violence and persecution in their home countries.

Ages/Populations Served: African immigrants in the Bay area including but not limited to Eritrean, Ethiopian, Rwandan, Kenyan, Congolese, South Sudan, Nigerian, Ivory Coast, Mali, and others as requested.

Partnership for Trauma Recovery (PTR)	FY 22/23
Clients Served/Reached	177
Cost per Client	$ 1,996.50

Projected number of to be served in:	
FY 23/24	175
FY 24/25	175

MHSA Program #: PEI 19

PROVIDER NAME: Diversity in Health Training Institute (DHTI)

PROGRAM NAME: Outreach, Education & Consultation for Middle Eastern Community

PROGRAM DESCRIPTION: 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. Our services reduce mental health symptoms such as depression and anxiety and prevent prolonged suffering.

Ages/Populations Served: Middle Eastern & Arabic Communities in Alameda County. This includes, but is not limited to, individuals identifying as: Iranian, Iraqi, Syrian, and/or Yemeni.

Diversity in Health Training Institute (DHTI)	FY 22/23
Clients Served/Reached	68
Cost per Client	$ 11,035.94

Projected number of to be served in:	
FY 23/24	65
FY 24/25	65

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MHSA Program #: PEI 1B

PROVIDER NAME: Center for Healthy Schools and Communities (CHSC)

PROGRAM NAME: School-Based Mental Health Access and Linkage

PROGRAM DESCRIPTION: 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.

Ages/Populations Served: Various school sites across Alameda County

Center for Healthy Schools and Communities (CHSC)	FY 22/23
Clients Served/Reached	10,562
Cost per Client	$ 61.48

Projected number of to be served in:	
FY 23/24	10,500
FY 24/25	10,500

MHSA Program #: PEI 1C

PROVIDER NAME: Jewish Family and Community Services East Bay

PROGRAM NAME: Early Childhood Mental Health Outreach and Consultation

PROGRAM DESCRIPTION: 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.

Ages/Populations Served: 0-5 years old

Jewish Family and Community Services East Bay	FY 22/23
Clients Served/Reached	15
Cost per Client	$ 11,882.60

Projected number of to be served in:	
FY 23/24	15
FY 24/25	15

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MHSA Program #: PEI 3

PROVIDER NAME: Alameda County Behavioral Health (ACBH)

PROGRAM NAME: Geriatric Assessment and Response Team

PROGRAM DESCRIPTION: 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.

Ages/Populations Served: Age 60 or over

Alameda County Behavioral Health	FY 22/23
Clients Served/Reached	133
Cost per Client	$ 10,049.84

Projected number of to be served in:	
FY 23/24	135
FY 24/25	135

PEI: Stigma and Discrimination Reduction Programs

MHSA Program #: PEI 4

PROVIDER NAME: Peers Envisioning and Engaging in Recovery Services (PEERS)

PROGRAM NAME: Everyone Counts Campaign (EEC)

PROGRAM DESCRIPTION: 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).

Ages/Populations Served: Peers/Consumers; General Public

Peers Envisioning and Engaging in Recovery Services (PEERS)	FY 22/23
Clients Served/Reached	349
Cost per Client	$ 4,02810

Projected number of to be served in:	
FY 23/24	349
FY 24/25	349

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MHSA Program #: PEI 12

PROVIDER NAME: Crisis Support Services of Alameda County (CSS)

PROGRAM NAME: Text Line

PROGRAM DESCRIPTION: The program provides brief crisis intervention and emotional support to individuals via text/SMS modality with emphasis on school aged youths and TAY. At this time, data is not disaggregated by age due to the focus on the texter and the nature of the call or crisis situation.

Ages/Populations Served: General Public

Peers Envisioning and Engaging in Recovery Services (PEERS)	FY 22/23
Clients Served/Reached	1,464
Cost per Client	$ 451.75

Projected number of to be served in:	
FY 23/24	1,464
FY 24/25	1,464

MHSA Program #: PEI 12

PROVIDER NAME: Crisis Support Services of Alameda County (CSS)

PROGRAM NAME: Community Education Program (CEP)

PROGRAM DESCRIPTION: 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.

Ages/Populations Served: All ages

Crisis Support Services of Alameda County (CSS)	FY 22/23
Clients Served/Reached	14,563
Cost per Client	$ 45.41

Projected number of to be served in:	
FY 23/24	14,500
FY 24/25	14,500

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MHSA Program #: PEI 12

PROVIDER NAME: Crisis Support Services of Alameda County (CSS)

PROGRAM NAME: Clinical Program

PROGRAM DESCRIPTION: 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.

Ages/Populations Served: General Public

Crisis Support Services of Alameda County (CSS)	FY 22/23
Clients Served/Reached	184
Cost per Client	$ 5,015.63

Projected number of to be served in:	
FY 23/24	175
FY 24/25	175

PEI: Early Intervention

MHSA Program #: PEI 17A

PROVIDER NAME: Youth Uprising

PROGRAM NAME: Early Intervention

PROGRAM DESCRIPTION: 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.

Ages/Populations Served: TAY age youth

Youth Uprising	FY 22/23
Clients Served/Reached	137
Cost per Client	$ 3,269.66

Projected number of to be served in:	
FY 23/24	150
FY 24/25	150

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MHSA Program #: PEI 17B

PROVIDER NAME: REACH Ashland Youth Center

PROGRAM NAME: Early Intervention

PROGRAM DESCRIPTION: 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. Our services reduce mental health symptoms such as depression and anxiety and prevent school drop out as well as prolonged suffering.

Ages/Populations Served: Youth

REACH Ashland Youth Center	FY 22/23
Clients Served/Reached	222
Cost per Client	$ 2,410.96

Projected number of to be served in:	
FY 23/24	250
FY 24/25	250

PEI: Outreach

MHSA Program #: PEI 20A

PROVIDER NAME: Beats, Rhymes, and Life (BRL)

PROGRAM NAME: Beats, Rhymes, and Life

PROGRAM DESCRIPTION: Beats Rhymes and Life uses a foundation of Hip Hop music as medium to outreach and engage with youth and TAY, with a focus on youth of color. Our program involves youth in their own healing and each other's healing with creativity, fun, and social interaction as protective factors for mental wellness. BRL meets youth where they are to create and perform music in community settings such as schools, service organizations, parks, and events and uses therapeutic groups to work youth and young adults more personally. Bringing in youth and young adults with music and then delivering prevention services is a culturally congruent way to engage and to keep youth interested. Each year participants produce a music. Showcase of their rhymes for the public. Our services reduce mental health symptoms such as depression and anxiety and prevent school drop out as well as prolonged suffering.

Ages/Populations Served: Youth and TAY, with focus on the African American community

Beats, Rhymes, and Life (BRL)	FY 22/23
Clients Served/Reached	234
Cost per Client	$ 3,712

Projected number of to be served in:	
FY 23/24	200
FY 24/25	200

> Go back to PEI Summaries list

MHSA Program #: PEI 20B

PROVIDER NAME: Black Men Speak

PROGRAM NAME: Culturally Responsive Programs for African Americans – Black Men Speak

PROGRAM DESCRIPTION: 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.

Ages/Populations Served: African American Males and other Men of Color

Black Men Speak	FY 22/23
Clients Served/Reached	N/A
Cost per Client	

Projected number of to be served in:	
FY 23/24	25
FY 24/25	25

MHSA Program #: PEI 20C

PROVIDER NAME: MHAAC

PROGRAM NAME: Culturally Responsive Programs for African Americans – Family Outreach Program

PROGRAM DESCRIPTION: 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.

Ages/Populations Served: Focus on African American families

MHAAC	FY 22/23
Clients Served/Reached	51
Cost per Client	$ 6,462.82

Projected number of to be served in:	
FY 23/24	50
FY 24/25	50

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MHSA Program #: PEI 20E

PROVIDER NAME: Tri Cities Community Development Center

PROGRAM NAME: Culturally Responsive Programs for African Americans – Faith Based

PROGRAM DESCRIPTION: 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 with 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.

Ages/Populations Served: All

Tri Cities Community Development Center	FY 22/23
Clients Served/Reached	480
Cost per Client	$ 633.73

Projected number of to be served in:	
FY 23/24	450
FY 24/25	450

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 DESCRIPTION: 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. Our services reduce mental health symptoms such as depression and anxiety and prevent prolonged suffering.

Ages/Populations Served: All

Peers Envisioning and Engaging in Recovery Services (PEERS)	FY 22/23
Clients Served/Reached	167
Cost per Client	$ 1, 824.80

Projected number of to be served in:	
FY 23/24	150
FY 24/25	150

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MHSA Program #: PEI 20F

PROVIDER NAME: Restorative Justice for Oakland Youth (RJOY)

PROGRAM NAME: Culturally Responsive Programs for African Americans – Africentric Healing Circles

PROGRAM DESCRIPTION: 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. Our services reduce mental health symptoms such as depression and anxiety and prevent prolonged suffering.

Ages/Populations Served: Youth, TAY, Adults, with focus on African American community

RJOY	FY 22/23
Clients Served/Reached	72
Cost per Client	$ 8,108.81

Projected number of to be served in:	
FY 23/24	75
FY 24/25	75

MHSA Program #: PEI 22

PROVIDER NAME: Pacific Center for Human Growth

PROGRAM NAME: Older and Out

PROGRAM DESCRIPTION: 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.

Ages/Populations Served: LGBT older adults

Pacific Center for Human Growth	FY 22/23
Clients Served/Reached	46
Cost per Client	$ 5,812.20

Projected number of to be served in:	
FY 23/24	46
FY 24/25	46

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MHSA Program #: PEI 22

PROVIDER NAME: Pacific Center for Human Growth

PROGRAM NAME: Peer Mentorship Project

PROGRAM DESCRIPTION: 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.

Ages/Populations Served: LGBT older adults

Pacific Center for Human Growth	FY 22/23
Clients Served/Reached	261
Cost per Client	$ 516.51

Projected number of to be served in:	
FY 23/24 250	**FY 24/25** 250

MHSA Program #: PEI 22

PROVIDER NAME: Pacific Center for Human Growth

PROGRAM NAME: Technical Assistance Program

PROGRAM DESCRIPTION: 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.

Ages/Populations Served: LGBT older adults

Pacific Center for Human Growth	FY 22/23
Clients Served/Reached	105
Cost per Client	$ 2,281.35

Projected number of to be served in:	
FY 23/24	105
FY 24/25	105

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MHSA Program #: PEI 24

PROVIDER NAME: Roots Community Health Center

PROGRAM NAME: Sobrante Park

PROGRAM DESCRIPTION: 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, promote community empowerment and reduce prolonged suffering.

Ages/Populations Served: African American and Latino families and individuals who live in Sobrante Park (Oakland)s

Roots Community Health Center	FY 22/23
Clients Served/Reached	27
Cost per Client	$ 12,962.96

Projected number of to be served in:	
FY 23/24	25
FY 24/25	25

MHSA Program #: PEI 26

PROVIDER NAME: Health and Human Resource Education Center

PROGRAM NAME: 10 X 10 Wellness Campaign

PROGRAM DESCRIPTION: 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

Ages/Populations Served: TAY, Adults, Elders

Health and Human Resource Education Center	FY 22/23
Clients Served/Reached	23
Cost per Client	$ 9,053.22

Projected number of to be served in:	
FY 23/24	25
FY 24/25	25

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MHSA Program #: PEI 27

PROVIDER NAME: Health and Human Resource Education Center

PROGRAM NAME: Health Through Art & Black Women's Media Project

PROGRAM DESCRIPTION: Through the program Health Through Art, we reach out to low-income communities 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. Our services help to uplift mental health and reduce prolonged suffering.

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.

Ages/Populations Served: TAY, Adults, Elders

Health and Human Resource Education Center	FY 22/23
Clients Served/Reached	303
Cost per Client	$ 886.59

Projected number of to be served in:	
FY 23/24	300
FY 24/25	300

MHSA Program #: PEI 28

PROVIDER NAME: Health and Human Resource Education Center

PROGRAM NAME: Downtown TAY

PROGRAM DESCRIPTION: 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.

Ages/Populations Served: TAY, Adults, Elders

Health and Human Resource Education Center	FY 22/23
Clients Served/Reached	287
Cost per Client	$ 1,458.77

Projected number of to be served in:	
FY 23/24	300
FY 24/25	300

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Innovation (INN)

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 to increase access to services and improve client/consumer outcomes.

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 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 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**
SHCLA	2024-2025	$759,813
INN CPPP Project	2024-2025	$150,000
Peer-Led Continuum of Forensic Services	2024-2025	$1,112,175

INN Projected 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, 2023*	*Final Outcomes December, 2023*
San Leandro, Oakland, and Hayward continue to have overwhelming majority of call (71.9%) response locations	1,317 calls; 1,201 clients served	1,898 clients served	End goal is to have 12 – 15 teams serving entire county	1,802 responses; 630 transports; CATT Pediatrics added
	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.	**81%** 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*	*Projected Goals for FY24-25*
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.	Continue to work towards purchase of initial property; Seek out partnerships with service provider(s)

Peer-led Continuum for Forensics and Reentry Services: peer-led services for individuals who are justice involved and suffer, or are suffering, from mental illness.

Community	*Achieved Goals for FY23-24*	*Projected Goals for FY24-25*
Mentally ill individuals who are justice involved	• Completed Request for Proposal (RFP) and awarded bidders • Contracts are being negotiated with awarded bidders	• Start-up phase to be completed • Begin providing services to clients • Begin trainings for reentry peer specialists

Completed Innovation Projects:

Community Assessment Treatment Team

Current Innovation Projects:

Supportive Housing Community Land Alliance

Community Program Planning Process (CPPP)

Approved Innovation Projects:

Forensics: Peer-Led Continuum Forensic and Reentry Services*

Alternatives to Confinement Continuum Forensic and Reentry Services**

Future Innovation Projects:

Psychiatric Advance Directives

Children's Mental Health Outreach via School-Home Communications Provider

*This project has gone through procurement.

**This project has yet to go through procurement.

Completed Innovation 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 uses 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 the 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 is to increase access to appropriate services by connecting and transporting clients whether or not they are on a 5150 hold.

In the third year of the CATT program, there were 1,802 responses to CATT calls. Of this total, the largest age group was 18-39 years old at 37.9%; 52% were male; 25.1% were homeless; 1,038 of the 1,802 were clients with only 1 episode; and 72% of all holds were voluntary. More on this data can be found in the CATT metrics in the Appendix G-2.

The final evaluation report has been completed by the CATT project evaluator, Public Consulting Group (PCG). However, the report's data is from the year 2022 when PCG's contract concluded. The report is similar to the data of 2023 and contains highlights and summary of the CATT project's background and overview; process evaluation findings; outcome evaluation findings; response, transport, and involuntary hold dispositions; and program recidivism. A copy of PCG's final evaluation report can be found in the Appendix G-2.

Innovation funding for the CATT project ended in December 2023. The CATT program, it is no longer a pilot project, is now funded with Community Support and Services (CSS) funding from MHSA. The program continues to be well received by the community and plans for its sustainability with other funding streams have become a priority within the county's crisis system of care.

CATT Summary of Challenges and Resolutions

As with any pilot project, challenges are addressed as they arise because new ideas create challenges that were not anticipated. The following challenges were being addressed with resolutions at the end of the 2023:

1. **Staff Hiring and Professional Development** is as with most behavioral health employers today, has been an ongoing challenge throughout the project.
   a. CATT Academy Committee has in person seminal style trainings covering crisis intervention, de-escalation, 5150/5585, harm reduction, motivational interviewing,

CIT, amongst others;

   b. Clinicians are given $1200 stipends to attend conferences and trainings as well as two paid professional days; and
   c. Training academy courses are being looked at for continuing education (CE) credits.

2. **Policy and Procedure** changes include:
   a. Increasing CATT team response from dispatch to arrival on scene from 15-30 minutes;
   b. Hiring license eligible clinicians under clinical supervision;
   c. Allowing CATT EMTs to restrain clients who become a danger to themselves or to others;
   d. Allowing CATT to be assigned to calls or attach themselves to calls;
   e. Updating CATT clinician documentation system, reporting requirements and aligning clinician documentation with the countywide Behavioral Health System.

3. **CATT Program Post Pilot** will continue to be supported by the county. The post pilot goals are:
   a. Develop a formal client outreach and follow-up plan;
   b. Modify policies and procedures for dispatching CATT teams;
   c. Develop relationship with 988 for dispatching/referrals
   d. Community to request CATT directly;
   e. Modify eligibility criteria for referral to CATT;
   f. Expand to 24/7
   g. Increase marketing of all ACBH Crisis Response Teams.

Current Innovation 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.

This 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.

SHCLA Summary of Challenges and Resolutions

The Supportive Housing Community Land Alliance (SHCLA) team has been working over the last year on many primary objectives and short-term outcomes. The following are the highlights:

1. The Board of Directors is to be comprised of nine to twelve individuals. Currently, there are only four members.

2. SHCLA is working towards securing larger sources of capital within the next year. This has included applications to Bay Area Housing Finance Authority (BAHFA) and Homeless Housing, Assistance and Prevention (HHAP) Grant Program.

3. SHCLA has yet to acquire land and property and continues to seek funding opportunities to obtain its first property.

4. SHCLA Executive Director continues to search for ways to collaborate with community organizations and to further make their presence in the community known and to educate, train community members and partners.

The project's evaluation team, Public Consulting Group (PCG), has completed a first-year evaluation report. This report can be found in the Appendix G-4. The report includes an inclusive list of achievements, challenges, and opportunities.

Current Innovation 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 communities within the County. Community involvement from the residents of the county is essential to Innovation planning and program development. ACBH has had challenges in its outreach to many of its diverse populations. These challenges include outreach and engagement to unserved and underserved individuals in both urban and rural areas. The County is dedicated to developing a revitalized and improved approach to ensure more meaningful input from all individuals living in the county.

The Community Project Planning Process (CPPP) occurs every three (3) years as per MHSA Innovation regulations along with smaller community input sessions for yearly plan updates. Alameda County's yearly CPPP was held between October 28, 2023 – December 31, 2023, for the MHSA Plan Update FY2024-2025.

Information for the CPPP events and outcomes are documented in this plan update.[1]

1 CCR, 9 CA ADC § 3200, 3200.060, 3200.270, 3200.90, 3300, 3315, 3320 & WIC 5848(a,b,f) & 5604.2(4)

Approved Innovation Project Name: Forensic and Reentry Services

Project Description: Alameda County Behavioral Health (ACBH) has identified the significant need to support individuals with serious mental health challenges who are involved with the justice system. This is a pervasive and complex issue in Alameda County as well as across the state and nation that requires multiple approaches to address. ACBH has developed a forensic and reentry plan that sets forth the myriad approaches to be implemented, including systems, collaborative, and program initiatives and interventions. The ACBH forensic and reentry plan includes the approaches identified and included in these two innovation projects. All services are voluntary and seek to provide voice and choice, particularly in situations where that autonomy may otherwise be limited by arrest and/or incarceration.

Forensic and Reentry 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.

Two forensic proposals were born out of Alameda County Behavioral Health Services and Forensic System Redesign Plan Update, May, 2021[2]. The two innovation plans, *Peer-led Continuum of Forensic and Reentry Services and Alternative to Confinement Continuum of Forensic and Reentry Services*, arose out of the county's efforts to divert individuals with mental health challenges from the justice system into mental health services. Both innovation plans were developed for and by community stakeholders, including the County's Justice Involved Mental Health Task Force.

These projects were approved by the Mental Health Services Oversight and Accountability Commission on January 25, 2023. MHSA was able to release a Request for Proposal (RFP) for the Peer-led Continuum of Forensic and Reentry Services in 2023. In collaboration with ACBH's contract division, the awarded bidder's contracts are being developed and prepared for services to begin in spring 2024.

Alternatives to Confinement of Forensic and Reentry Services is scheduled to begin being developed for procurement in Spring, 2024.

2 see proposals here

Future Innovation 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 Access, Consumer & Family Empowerment, Best Practices and Health & Wellness.

The following are two innovation ideas currently being researched and discussed about their viability and support within the county.

New INN Programs under Development for Possible Future Procurement

INN IDEAS	Population	Problem Trying to Solve	Strategies
1. Psychiatric Advance Directives (PADs)	All populations	Empowerment for individuals who may capacity to give consent during acute episodes of psychiatric illness retaining their decision-making capacity	Real-time PADs access for authorized Staff i.e. first responders and service providers
2. Children's Mental Health Outreach via School-Home Communications Provider	School children, youth grades K-12	Early intervention and prevention education for parents and caregivers	Passive mental health notifications to educate parents/caregivers via school-home communications provider

1. Psychiatric Advance Directives

Psychiatric Advance Directives (PADs) is a self-directed document that details a person's specific instructions or preferences regarding future mental health treatment. A PAD plans for the possibility that an individual may lose the capacity to give or withhold informed consent to treatment during a mental health crisis.

Currently, there is a Multi-County Mental Health Services Innovation Collaborative pilot project for PADs. There are seven counties who are a part of this innovation project. The outcomes this project is looking to achieve are improved compliance; increase adherence to treatment requests; increase in individual wellness scores; reduction in incarceration/criminal justice involvement as a result of crisis; and reduction in long-term hospitalization. The website with more extensive information can be located here: https://www.padsca.org/

The county is interested in joining the PADs state collaborative because:

- PADs have been shown to improve outcomes for individuals in crisis who are unable to advocate for themselves during a crisis;
- PADs help provide appropriate resources and falls in-line with the goals of the county in its CATT project;
- PADs have been shown to reduce recidivism in local jails and emergency rooms; and
- Using this model empowers individuals in supporting active participation in one's own recovery.

Alameda County has surveyed stakeholders during its community planning process seeking interest and support. The results of the surveys can be found in the CPPP section of this plan update.

2. Children's Mental Health Outreach via School-Home Communications Provider

The Children's Mental Health Outreach via School-Home Communications Provider project would use a school-home communications app to send mental health information via push notifications to help parents become more educated with their child's mental health development, milestones, possible warning signs for learning disabilities, autism, or other mental health challenges. These push notifications would be to educate parents about a child's mental health according to the child's age during the child's school years from elementary to high school. This type of passive campaign would bring information to parents who may not actively seek it out due to stigma, lack of resources, or most likely, do not know the signs of developing problems in their child's mental health.[3]

This project is in the early stages of discussion and research. An initial plan for the project can be found in the Appendix G-3.

3 https://jamanetwork.com/journals/jamapediatrics/article-abstract/2788069

Workforce Education and Training (WET)

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.

1. WORKFORCE EDUCATION & TRAINING (WET) STAFFING

Provides infrastructure to manage the development, implementation, and evaluation of all Workforce Education & Training (WET) programs and initiatives. Spearheads partnerships with community-based organizations, peer-run agencies, educational institutions, and local, regional, and state agencies.

FY 22/23 PROGRAM OUTCOMES

- ACBH Interim WET Manager hired May 2023. Recruitment for a permanent WET Manager began September 2023.
- ACBH WET Training Officer hired May 2023 to provide training support for department & CBO's.
- WET is under the leadership of the ACBH Director who provides valuable support, stability, & guidance through recruitment and staffing transitions.

FY 22/23 PROGRAM IMPACT AND/OR EVALUATION

- No impact.

FY 22/23 PROGRAM CHALLENGES

- In the past 2 years, both the WET Manager & Training Manager retired. The unit is in the process of staff development and restructuring.
- The WET Manager position remains vacant. The new Training Officer is establishing documentation protocols to reduce loss of knowledge as transitions continue to occur.

ANTICIPATED CHANGES FOR FY 23/24

- Increase capacity for training and workforce-related programming.
- ACBH has created new positions to support training efforts: Training Coordinator, Workforce/Pipeline Coordinator, & Administrative Assistant
- ACBH WET, in collaboration with ACBH's Office of Ethnic Services, plans to hire a consultant to help create an integrated Behavioral Health Equity Plan (BHEP) (formerly known as the Cultural Competency Plan) and WET Needs Assessment. The project will begin early 2024.
- The WET Needs Assessment will focus on gathering data on (1) current workforce needs specifically looking at cultural and language needs for our entire system, (2) recruitment and retention strategies, (3) pipeline programs at high school, college, and graduate school levels, & (4) training needs per CLAS standards.
- ACBH WET in collaboration with ACBH's Health Equity Division will support the ACBH Trauma Informed Systems (TIS) initiative. WET staff will become certified staff trainers of the TIS Curriculum which was designed specifically for Alameda County.

2. TRAINING & TECHNICAL ASSISTANCE

The ACBH Training Unit (with is part of Workforce, Education, and Training) 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. The Training Unit is a Continuing Education (CE) provider for the BBS, BRN, CCAAPP, and CPA.

1. TRAINING UNIT – FY 2022/23 GOALS & OUTCOMES

- STATS: For FY 2022-23 (July 1, 2022 – June 30, 2023), the ACBH Training Unit provided or collaborated in a total of **50 training activities** and trained **1932 people consisting of ACBH staff and contracted community-based organizations (CBOs)**.
- Continuing Education credit: The Training Unit sponsored and provided a total of **196 continuing education (CE) credits** to LCSWs, LMFTs, LPCCs, LEPs, Addiction Professionals, and RN's, with **68.5** of those CE hours including Psychologists.

  A complete list of training topics and stats for FY 2022/23 can be seen as Addendum A.
- The training unit hired a consulting psychologist to approve doctorate-level continued education training.
- In August 2023, the Workforce Education and Training team organized its inaugural Spanish-speaking Mental Health First Aid (MHFA) train-the-trainer program. The training was available to both ACBH staff and employees from specific community-based organizations. The cohort successfully produced nine newly certified Adult MHFA trainers, who are now equipped to offer Mental Health First Aid training to the Spanish-speaking community.
- The training unit is rebranding itself, as not only a brokerage for continued education units, but also as training consultants who are responding to our systems training needs, through assessment, planning, and the offering of technical assistance to our systems of care and their constituents.
- The training unit has been taking steps to enhance collaboration and expand the scope of training. We have started organizing grand rounds, where we meet with different systems of care to evaluate the effectiveness of our training programs and identify any training needs. The WET team has created an introductory presentation aimed at introducing each SOC to our mission of providing accessible and relevant training to ACBH and its CBOs.

TRAINING UNIT: FY 2022/23 CHALLENGES

- Contracting delays
- Staffing shortages and delays in hiring process

TRAINING UNIT: FY 2023/24 UPDATES & PROJECTIONS

- For FY2023/24: **July 1, 2023, through December 31, 2023**, the Training Unit has thus far provided or collaborated in a total of **13 training activities** and trained **812 ACBH staff and contracted community-based organization staff (CBOs)**. The Training Unit has sponsored and provided **25 continuing education (CE) credits** to LCSWs, LMFTs, LPCCs, LEPs, Addiction Professionals, and RNs, and **12** CE hours for Psychologists.
- The Training Unit will help Systems of Care develop training plans to enhance service delivery and cultural competence.
- The Training Unit is seeking to recruit new vendors to provide trainings on emerging behavioral health issues requested by our Systems of Care.
- Working on a plan to train non-clinical ACBH and CBO staff, to enhance their knowledge of service delivery and system orientation in behavioral health.

2. ACBH OFFICE OF THE MEDICAL DIRECTOR – WORKFORCE DEVELOPMENT AND TRAINING ACTIVITIES

- Recruited medical practitioners into the public psychiatric field.
- Created training methods for psychiatrist & nurse practitioners.
- Collaborated more with the Office of Medical Director to include CME credits on 3 trainings; two Older Adult System of Care workshops (as part of the two-day Older Adult conference they do), and a six-hour Law and Ethics training.

3. WELLNESS RECOVERY ACTION PLAN (WRAP) – PEERS ENVISIONING & ENGAGING IN RECOVERY SERVICES (PEERS)

- An evidence-based practice where mental health consumers/peers share stories, ideas, insights & create a personal plan for wellness.
- Orientations are virtual once per month and facilitated six ongoing WRAP groups in person and remotely, two of which were in Spanish.
- After completing a cycle of training, participants are eligible to participate in a 5-day training to become facilitators.
- PEERS trains and certifies WRAP facilitators, provides monthly mentoring meetings for facilitators, and provides paid facilitation opportunities for at least 5 certified facilitators per year.

FY 22/23 WRAP PROGRAM OUTCOMES

- In-person WRAP groups at partner agencies (e.g. East Oakland Senior Center, South County Homeless Project, East Bay Community Recovery Project)
- Six ongoing, multi-cycle WRAP groups were offered, with an average of 6 participants per meeting. (exceeded deliverable of 5)
- PEERS hired 6 WRAP facilitators, exceeding our deliverable of offering cofacilitation opportunities to at least 5 certified facilitators.
- Monthly WRAP Facilitator Mentoring Meetings were held, with an average of 9 facilitators participating each month.
- 14 WRAP Orientations reached 132 participants.

WRAP: FY 22/23 PROGRAM IMPACT AND/OR EVALUATION

- The WRAP program served 292 unduplicated participants this year.
- 21% agreed & 75% strongly agreed that "This group was useful to me."
- 25% agreed & 70% strongly agreed that "I understand more about my mental health and wellness."
- 23% agreed & 73% strongly agreed that "This group helped me have hope."
- 24% agreed & 72% strongly agreed that "This group helped me feel that mental health challenges are normal and common."

WRAP: FY 22/23 PROGRAM CHALLENGES

- Inability to host in-person groups earlier in FY22 resulted in few Advanced WRAP facilitators due to staffing, however this is being resolved.
- Difficulty finding a partner organization to host the second TAY WRAP cycle.
- We experimented with partnering with a church from the Hope & Faith African American Mental Wellness and Spirituality Campaign, Memorial Tabernacle, to host a remote TAY WRAP group.
- We will partner with the South Berkeley Senior Center for at least one cycle of WRAP.

WRAP Successes: Qualitatative Evaluation - Participants Quotes

- "I learned the importance of connecting with each other."
- "I learned how to say what I need and ask for support."
- "I learned how to have hope, how to make and maintain an action plan, and to always remain aware that others can help me."
- "I like the camaraderie and the care."

3. Workforce Building – Mental Health Workforce Career Pathways

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.

1. PATHWAYS ACADEMY – BEATS RHYMES AND LIFE (BRL)

Pathways Academy's Workforce, Education, and Training trainees gained supervised experience working in mental health prevention programs supporting the very communities they come from, within Alameda County.

BRL: FY 22/23 PROGRAM OUTCOMES

- 17 Fellows completed over 36 hours of training.
- 95% of monthly life and wellness checks were completed by Fellows.
- 11 Fellows had perfect attendance in life and wellness checks. 14 Fellows created music as part of their services.
- Collaboration of Academy Practicum with Program & Mobile Studio
- Collaboration with Latitude HS as a feeder site for Academy
- Academy cohorts lead workshops with Latitude and Castlemont youth.
- Academy youth led 'Working with TAY' panel talk with Smith College Social Work

BRL: FY 22/23 PROGRAM IMPACT AND/OR EVALUATION

- 100% of fellows enrolled in program left with MAPS plans (TAY Goal: 95%)
- 100% reported learning about mental health through MHA activities (Goal: 65%)
- 82% of fellows completed songs toward an album (Goal 75%)
- 58% reported improvement in their emotional well-being (Goal 50%)
- 88% reported living in a place they call home (Goal 50%)
- 64% reported they have secured employment (Goal 50%)
- 88% reported understanding about money management (Goal 50%)
- 88% reported feeling valued and connected to a community. (Goal 50%)
- 88% completed program with Resume outlining Human Services experience (Goal 95%)

BRL: FY 22/23 PROGRAM CHALLENGES

- Hiring new staff

- Finalizing program design.
- 17 Fellows enrolled (Goal was 20)
- Folding in more mentorship opportunities within a compressed timeframe
- Only 23% reported they have enrolled in college in the Human Services Field (Goal 50%)

BRL: FY 24/25 ANTICIPATED PROGRAM CHALLENGES

- Continued finalizing of program design that matches county goals and is closer to BRL's original design.
- Hiring Part time WET Educator
- Ideal candidate recruitment
- Getting more mentorship hours for academy youth

2. WELLNESS IN ACTION (WIA) – CENTER FOR EMPOWERING REFUGEES AND IMMIGRANTS (CERI)

Wellness in Action (WiA) is a community workforce training program of CERI. WiA focused on the development of the paraprofessional community mental health advocates from unserved and underserved refugee and new immigrant communities in the Bay Area. We offer mini-grant funding, technical assistance to plan and implement funded projects, professional skills trainings, and clinical consultation. WiA also works with government agencies and community-based organizations to develop career paths and pipelines in the public behavioral/mental health field that are relevant for refugee and new immigrant communities.

WIA/CERI: FY 22/23 PROGRAM OUTCOMES

Curriculum Development for Professional Skills Trainings with focus on Community Wellness:

- This curriculum has been under development since beginning of program in 2016 and is updated each year, based on integrated experiential and embodied activities, including drama therapy.
- Listen/Learn - Share - Create - Act: Curriculum was updated to reflect new learning gained from the field. It emphasized silence and witnessing embodied responses as aspects of listening to learn and sharing/dialogue with peers to disseminate knowledge gained.
- Decolonizing Wellness Workshop: The workshop aims to bridge mental health concepts with body systems to disrupt the model of a separate mind/body. Worked on developing the curriculum with Angela Angel. and decided to start with a single workshop rather than a multi-part series. Hope to launch at the beginning of FY23-24.
- Introduction to Abolition for Health Workers: We worked with Jeannia Fu, a social work intern at CERI. Created an introduction to abolitionist thinking and practice for mental health practitioners. Objective to build a critical understanding of State and Institutional Violence, and how racism, anti-Blackness, able-ism, patriarchy, transphobia, homophobia, and racial capitalism shape systems of incarceration and punishment as well as systems of "care."
- Advocacy for Community Wellness: Worked with staff at CERI to begin development of a core curriculum for community advocates that integrated visits from community leaders, with training on topics such as Motivational Interviewing, Cultural Humility, Public Health, what is Mental Health, Immigration and Mental Health, and CERI's model for advocacy.
- Community Cultural Wealth: Curriculum focuses on gaining a strengths-based perspective into immigrant and refugee communities, inspired by the Community Cultural Wealth framework by Tara Yosso. Art Journaling: Curriculum designed to support mental health clinicians in arts-based inquiry and address issues of power and privilege, self-care, therapist's subjectivity, and wellbeing.
- History of Migration to the US: Includes visit to Angel

Island: Class designed to introduce participants to a critical analysis of migration in the US.

- Self-care through Somatics: Curriculum designed with inspiration from generative semantics to support mental health practitioners build self-awareness and skills to understand conditioned tendencies and cultivate more choice and internal safety. Folding in more mentorship opportunities within a compressed timeframe

Mentoring and Community Project Support:
Recruitment of Community Leaders – Embodied Community Wellness Mini-Grant Participants:

- Received 20 applications
- Interviewed 16 candidates
- Invited 12 mini-grant participants
- 10 accepted, 2 declined based on schedule conflicts
- Conducted orientation on Dec 12, 2022
- Training, meetings, and consultations began on January 9, 2023 and completed on June 12, 2023.
- In addition to 28 hours of training, there were biweekly individual technical assistance meetings and mini-grant participants received 5 group consultations for a total of 10 hours.
- Outreach happened through one-on-one presence at meetings/events, partnerships and relationships with local CBOs and community leaders; and WiA public events and listserv. Monthly leadership stipends to mini-grant participants began in January 2023 and completed after submission of final reports in June 2023. Participants received a total of $5,500.

WIA/CERI: FY 22/23 PROGRAM IMPACT AND/OR EVALUATION

Data collected from Trainings offered:

- "Embodied Community Wellness" (ECW) Mini-grant Program: 10 participants were trained from Jan - June 2023, using the Foundational WiA Curriculum; Listen, Share, Create, Act in which participants develop facilitation and coaching skills to run their own 8-week community wellness groups with mentorship and support from the WiA team. Training happened weekly on Mondays for total of 28 hours of training and 10 hours of group consultation.
- Reground: ECW Participants led the development of our final celebration and community event, Reground, facilitating wellness activities and networking for mental health providers and community workers who identify as belonging to refugee and immigrant communities. Reground took place on June 2, 2023 at Strawberry Creek Park with over 50 people in attendance.

This year the event featured movement, live music and drumming, sound healing, hand building with clay, stories of home digital stories screening room, and delicious food.

- 94% (30 people) of post survey respondents indicated that they were satisfied or very satisfied with the event.
- 100% of post survey respondents indicated that they would recommend Reground to colleagues in the future.

Additional Data:

- The Embodied Pathway with Deanna Jimenez, 20 participants, Sept 30, 2022, 3 hours - 90% of participants indicated they were very satisfied with the workshop.
- Revolutionary Love with Melissa Canlas, 15 participants, Oct 13, 2022, 2.5 hours - 80% of participants indicated they were very satisfied with the workshop.
- Love Journal with Dulce Lopez, 15 participants, Nov 11, 2022, 2 hours - 90% of participants indicated they were very satisfied with the workshop.
- Sound Healing with Inez. 54 participants, Jan 6, 2023, 2 hours - multiple attendees shared satisfaction about the experience during the dinner following the workshop.

- Healing Hike with Raynelle Rino, 10 participants, April 10, 2023, 3.5 hours. Three participants went on to do healing hikes with their communities and all 10 participants expressed satisfaction about the experience in a closing circle.
- Community Cultural Wealth: Administered to a cohort of 6 Advocates or Community Wellness over 4 hours on 11/8/22 and 11/15/22.
- Advocacy for Community Wellness: Visits from community leaders and training on topics such as Motivational Interviewing, Cultural Humility, Public Health, What is Mental Health, Immigration and Mental Health, and CERI's model for advocacy happened with 6 Advocates for Community Wellness and 6 CalHOPE team members on 1/31/23, 2/21/23, 2/28/23, 5/9/23.
- 90% of training participants indicated that content was covered in a clear manner and objectives of the training were met.
- 100% of participants indicated satisfaction with the training.
- People shared that they appreciated developing listening skills and learning about everyone's cultures and journeys.
- One participant reflected, "The experience opened up new perspectives for me. I've learned that there are resources out there that I never thought would be possible, such as the support group for those experiencing hearing voices. I want to help make mental health a priority for individuals. Every day, we're constantly dealing with things in our mind and sometimes it can take over our life. It's important to share ideas and thoughts with one another because that's how we'll be able to understand where we come from and how we can share our cultural differences."
- History of Migration to the US, facilitated with 6 Advocates for Community Wellness over 4 hours who then joined a field trip to Angel Island with approximately 50 participants from CERI.
- Introduction to Abolition for Health Workers: Created and facilitated by Jeannia Fu, a social work intern at CERI, this 2-part, 6-hour training happened on May 6th and 13th, 2023 with 15 participants on each day, many who shared gratitude for learning about the topic and hope to bring the conversation to their communities during closing circles. Qualitative feedback from participants two weeks after the workshops:
  - o "I have been talking about it with friends, family members and colleagues since then, wondering h ow I could walk on the path of abolition."
  - o "Continue this discussion and do a deeper dive into how to move toward abolition and how to really handle certain situations- CPS, 5150's, victims of crime, community safety."
  - o "Eloquently speaking about abolition and sharing tragedies happening to real people had a clear impact on my psyche and made me realize the seriousness of police brutality and the need for community care."

WIA/CERI: FY 22/23 PROGRAM CHALLENGES

- Staffing. We had multiple staff changes during the last six months of the fiscal year. Our Program Director transitioned out of her role, a Program Manager began maternity leave, and our Program Coordinator received an agency promotion to another department. Given that we have dedicated & skilled staff and interns at our agency, we were able to manage the transitions, bring on staff, & complete program deliverables; however, team members had to navigate training & on-boarding while managing program delivery.
- Expansion. Given the success of our WET funded program to train and support refugee and immigrant community leaders, MHSOAC awarded CERI funding to strengthen the advocacy aspects of our work. This reaffirmed our strategies to promote community wellness and honored seven years of workforce development programming at CERI. Now we are in a moment of change and trying to remain mindful in the ways that we adapt our grassroots

model for community advocacy & mental health to reach more communities. We want to expand sustainability to increase our workforce.

WIA/CERI: FY 23/24 ANTICIPATED CHALLENGES

Adapting grassroots program model.

This year we launched a new adaptation of our Wellness in Action workforce education and training program for community leaders - over the course of 10-months, 15 participants are invited to explore relationships between community advocacy and mental health through training, group process, one on one coaching, and hands-on learning in the community. We anticipate that participants will build confidence and leadership skills to tell their stories, conduct listening sessions, engage in advocacy with legislators, and facilitate wellness groups. We are also strengthening our training curricula for outreach workers and MSW interns at the agency. It is an exciting time for our workforce education and training programs and managing diverse needs inside of change and growth is an ongoing process with interpersonal dynamics and systemic barriers.

- Funding: We completed recruitment for our core workforce development program, the Wellness in Action cohort of community advocates who we partner with each fiscal year to do community projects. This year we had 50 applicants, interviewed nearly 30 candidates, and invited 15 community leaders to join the program. All 15 accepted the invitation. It was challenging to select participants for the program; we had an incredible pool of applicants with community leaders from diverse backgrounds, bringing creativity and new perspectives to the work. Although we want to reach more refugee and immigrant community members, due to limits in funds and staffing, we could not extend beyond 15 participants for our core program.
- Staffing: staffing and supporting staff is a constant inquiry for us at CERI. As previously mentioned, we had staff changes in the program, shifts in our program model, and new funding deliverables to manage, which pushed our team to adapt at a pace that was at times difficult. Leaders at CERI are engaged in reflection to foster a work environment where staff feel well supported with coaching and supervision, time off, and accommodations to promote quality of life at work. It is a long-term process. We have been strengthening our HR processes for on-boarding and training and seeking ways to thoughtfully integrate interns, MSW and undergraduate students, where there can be reciprocity in how we support their growth and career development, and they strengthen the organization. We are identifying staffing needs in each of our programs and hiring where we see gaps as well. As we adapt our workforce education and training programs to meet the changing needs around us, we will be assessing and reassessing staffing to do the work in a way that is values aligned.

3. FACES FOR THE FUTURE – SCHOOL-BASED WORKFORCE PIPELINE PROGRAM

FACES programs address the full context of a student's life, providing the academic support, case management and mentoring, and youth leadership development opportunities that allow youth to learn about health careers and to have the confidence, skills and support necessary to pursue their dreams.

FACES WORKFORCE PIPELINE: FY 22/23 PROGRAM OUTCOMES

- Behavioral Health Alumni Support: FACES continued to implement direct outreach strategies to support our alumni with information about job opportunities, professional development, and professional networking. To that end, staff meet on a weekly delineate tasks and assign duties

and update data collected. Alumni engagement activities include:

- Alumni Specific Newsletter: This newsletter is published monthly and has a 92% delivery rate. This means that the work FACE staff have done to ensure an accurate listserv has paid off and the newsletter is getting to active email addresses for alumni. Our open rate is about 50% - we are working to increase that but it is in alignment with our general FACES newsletter as well.
- Social Events: These were held online and in person. The intention is to help alumni connect and build upon social interactions to develop a sense of community. These social events will continue into the next grant cycle.
- Mental Health First Aid certification: Through a partnership with Cypress Resilience Project, a full class of alumni were MHFA certified during this grant cycle.
- Alumni Spotlights: FACES alumni like to tell their stories and act as mentors to those who may be coming up the pathway. During this grant cycled we continued to highlight alumni, posting their stories and bios on our social media platforms and in our Alumni newsletters. We find that asking an alum to participate in this storytelling is an effective way to re-engage with them and get them involved in other activities we can offer.
- Direct Calling: FACES continued to contact alumni directly via phone banking to re-connect, offer support and learn more about what types of support would be welcomed. During this grant cycle we spoke with 179 alumni through this process.
- Youth Advisory Council: The Youth Advisory Council at FACES incorporates the voices and perspectives of both current and past students. The YAC meets 5-6 times per year and culminates in a collective project. This year's group chose to design a Health Eating comic to promote nutrition.
- Bright Young Minds Conference: FACES hosted the Bright Young Minds conference in May 2023 at Samuel Merritt University and served 96 students during the day-long event. The team coordinated a variety of partners and co-created the agenda with the WET team at ACBH. We were able to secure the event space at SMU and FACES secured funding from other sources to provide food, incentives and print materials to the students. Students from across Alameda County were exposed to speed-mentoring with behavioral health professionals, workshops on trauma and mental health, as well as a session focused on scenario-based work they did in small groups. The response from students was overwhelming and the event was considered a success. 92% of students said they will use what they learned in the trauma workshop to help themselves or someone else, 94% would recommend the conference to a peer and 82% increased their interest in pursuing a behavioral health career.
- Public Health Youth Corps – focused on Mental Health: FACES continued to work with students in South Alameda County to implement the Public Health Youth Corps with a focus on mental health during this grant cycle. During this year FACES served 80 students who were interested in both public health and mental health. Student activities included presentations, creation and dissemination of materials, social media posts that supported outreach to their peers and community and more. Students were also trained in public health basics, Motivational Interviewing and were certified in Mental Health First Aid, Stop the Bleed, Overdose prevention and intervention including the administration of Naloxone, and CPR/First Aid. These trainings and certification support students in advancing in the health pathway – but it also provides a safety net of emergency skills within the community that can help to save lives.

FACES WORKFORCE PIPELINE: FY 22/23 PROGRAM IMPACT AND/OR EVALUATIONS

FACES Youth Advisory Council (YAC): 12 individuals served.

- Recruited, onboarded, and retained YAC members for 2022-23
- Introduced new YAC members via social media campaign and website
- 2 team planning and implementation meetings
- YAC Member Chairperson Selected and trained
- 3 professional development sessions for YAC Member Chairperson
- 5 YAC meetings conducted
- Each YAC member created an end-of-year project regarding a public health topic impacting them/ their community.

FACES & ACBH Alumni Support: 719 individuals served.

- 8 planning and implementation meetings for the Alumni Engagement team, held on a weekly basis
- Monthly e-newsletter, published according to outreach schedule, containing resources, Alumni spotlight, and opportunities for professional development – delivered to 1019 alumni with a 49.3% open rate.
- 4 social events (via Zoom), 1 in-person
- 1 MHFA Certification Course open to program alumni
- 8 alumni spotlight interviews
- 179 alumni reached through phone banking
- Bright Young Minds Conference (BYM): 96 individuals served.
- 96 high school students participated in the Bright Young Minds
- Conference hosted by FACES at Samuel Merritt University in May 2023. The conference included opportunities for students to network with mental and behavioral health professionals from across Alameda County
- Highlights from post-event surveys included:
- 92% of participants reported that they could use what they learned in the workshop on trauma to help themselves or someone else.
- 94% of participants reported that they would recommend the conference to other students.

FACES WORKFORCE PIPELINE: FY 22/23 PROGRAM CHALLENGES

- FACES for the Future Coalition continued to offer some of its operations in hybrid formats in response to the COVID-19 crisis. Whenever possible, FACES staff offer in-person activities to students being served under this funding while staying in compliance with all required COVID-19 protocols and policies of both our partners and Public Health Institute.
- FACES will continue to collaborate with our partners on the above activities and open to suggestions and feedback on how to make positive and relevant changes.

4. ALAMEDA COUNTY MENTAL HEALTH STUDENT NAVIGATOR TRAINING PROGRAM – OHLONE COMMUNITY COLLEGE STUDENT HEALTH CENTER

Alameda County Mental Health Student Navigator Training Program, spearheaded by Ohlone College's Student Health Center, is a workforce development program to train students on navigating community-based mental health care services. This program also (1) ensures that students who need ongoing care beyond what campus-based services can provide and (2) improves the referral process. Students undergo an intensive eight-week training program on a wide range of mental health issues based on a wellness and resiliency curriculum and are introduced to mental health agencies in Alameda County that may be part of the linkage to care network. We are pleased to host students from four campuses in this cohort: Chabot College, Laney College, Las Positas College, and Ohlone College.

OHLONE COLLEGE NAVIGATORS: FY 22/23 PROGRAM OUTCOMES

- Case Management Efforts: Student navigators continue to be assigned cases to manage until the end of the school year. This year, navigators provided a total of ninety-two cases. Interestingly, the total number of cases is one more than the previous year. The majority (64%) of clients were female which aligns with general help-seeking behavioral trends when it comes to healthcare related matters. Nearly three in five, or 59% of clients needed mental health counseling services, while very few—just 4%--needed health insurance coverage support. One in five clients needed housing resources, which is nearly double from the previous year's figure of 19%; this reflects the ongoing housing crisis in the Bay Area and throughout the state, and the severity of the situation particularly among young adults. Nearly half, or 45% of clients were able to be connected to resources, and although 40% of clients were marked as 'other,' we did not capture specific reasons for not being connected to resources.
- Alameda County College Mental Health Forum: Ohlone College was pleased to host the spring semester convening of the Alameda County College Mental Health Forum on campus on April 5, 2023 with a total of sixteen attendees. The forum's objective is: Develop and strengthen partnerships between community colleges in South Alameda County, county agencies, and community-based mental health service organizations to address complex mental health needs and build a robust referral network for community college students whose needs cannot be met through campus-based services. We were grateful to have opening remarks by Ohlone College's new Dean of Counseling who spoke positively about his support for mental health services and its impact on student retention and achievement. The session most appreciated by attendees was a student panel titled "Engaging students as co-creators of interventions to improve student mental health" which featured student wellness ambassador Megan Hutchison and student mental health navigator Nicole Garetto of Chabot College.
- Success and Challenges: A big success is the completion and full retention of this year's cohort who created a nurturing, safe, and inclusive space for all to participate. We know that friendships were formed throughout the year—and the impact of the program can be measured by the fact that two navigators will be returning next year. The navigator program was also selected by the Chancellor's Office this year to be highlighted in Mental Health Action Week over the course of two days; the first day focused on programmatic elements and had approximately 80 attendees, while the second day featured two of our navigators, Gabriela Aguilar and Eliseo Lopez, which has more than 550 attendees. Five campuses reached out to us after the webinar expressing interest in learning more and asked for technical support so they can consider creating their own navigator program. The Chancellor's Office will commit resources in the fall to host a small learning collaborative for campuses that are interested and ready for program development. We would love to see this program be replicated in other counties so that we may learn from one another and increase the amount of evaluation data to better understand program impact and outcomes. As indicated in some of the challenges outlined in the evaluation section, student navigators struggled with receiving responses from their student clients. Shifting to more in-person case management efforts may help change the tide on this, so we will be more strategic about this next year.

FY 22/23 PROGRAM IMPACT AND/OR EVALUATION
OHLONE NAVIGATOR PROGRAM

- Post-test Evaluation Results: While we hope to conduct a more formal evaluation of the program's impact on students who access navigation services, we continue to collect data on student navigators' learning outcomes and program satisfaction levels.

Figure 1

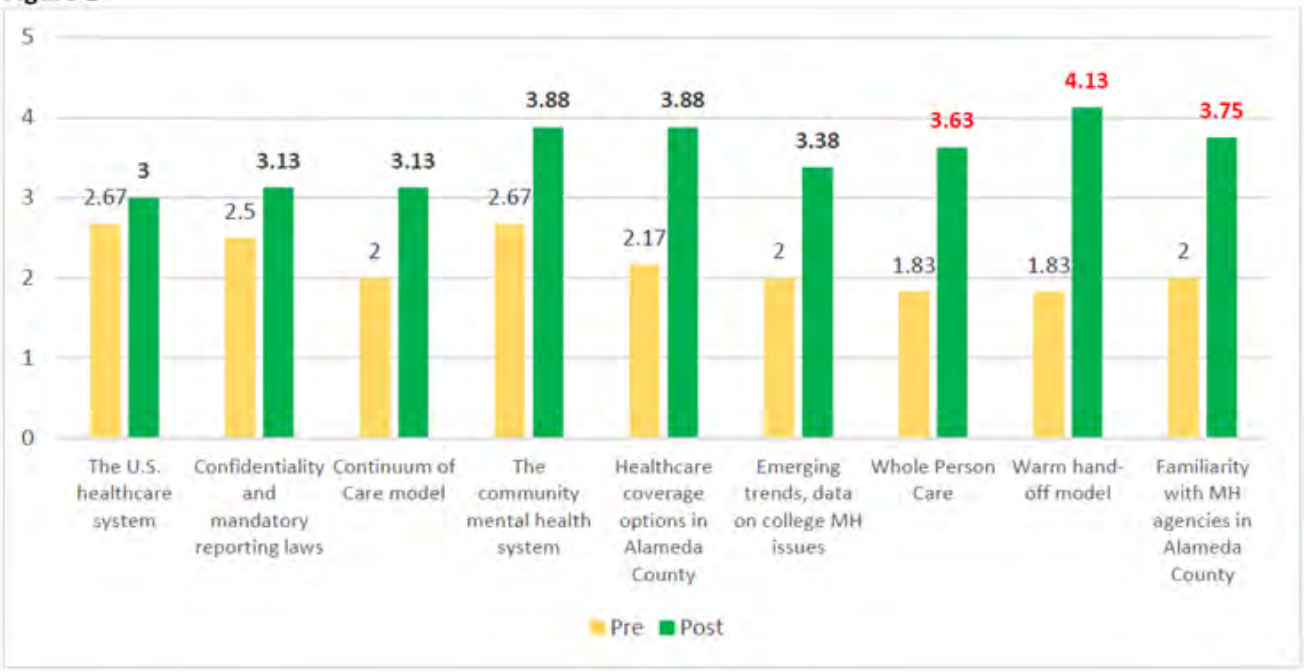


Figure 1. Students' familiarity with various subject matters: Student navigators spent the entire year learning about the mental health care system and community-based resources. Graph 1 highlights major improvements in student navigators' learning on a wide range of topics. The items with the greatest variance included "warm hand-off model," "familiarity with mental health agencies in Alameda County," and "whole person care."

Figure 2

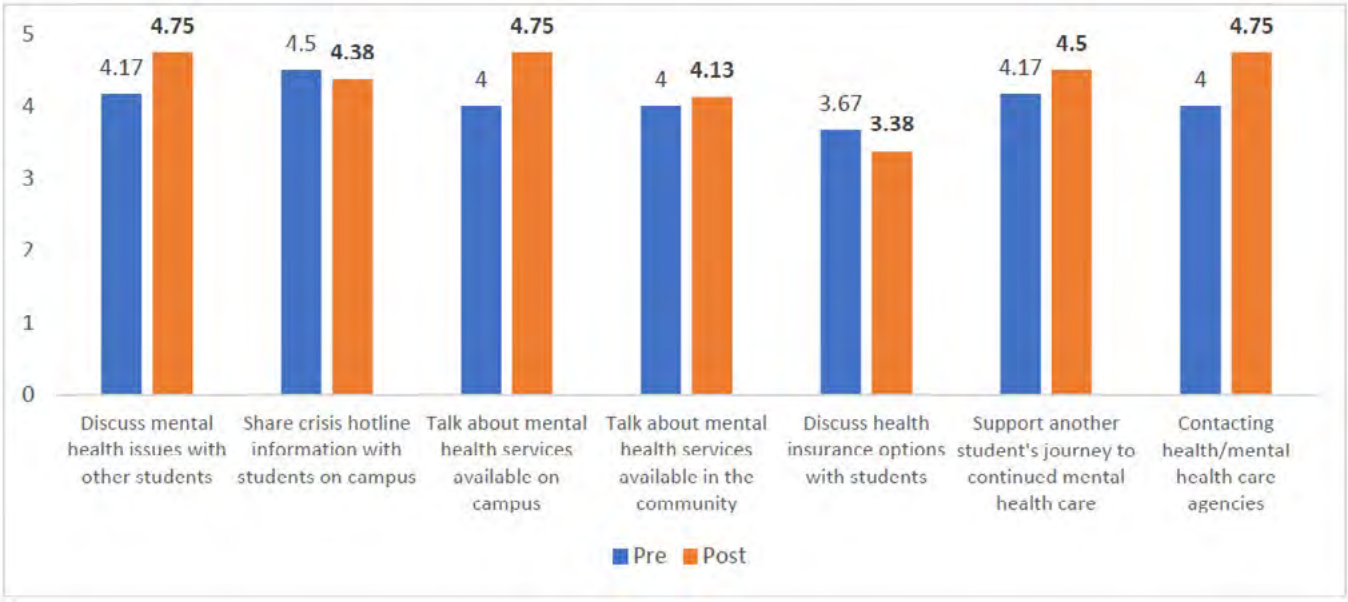


Figure 2. Students' level of confidence on mental health communication and support: Assessment of students' confidence levels to discuss mental health topics and provide support to their peer clients yielded mixed results with several constructs experiencing decreases, albeit small. Despite that, it was comforting to see the largest improvement was on students' confidence to talk about mental health services on campus and contacting health/mental health care agencies.

Figure 3

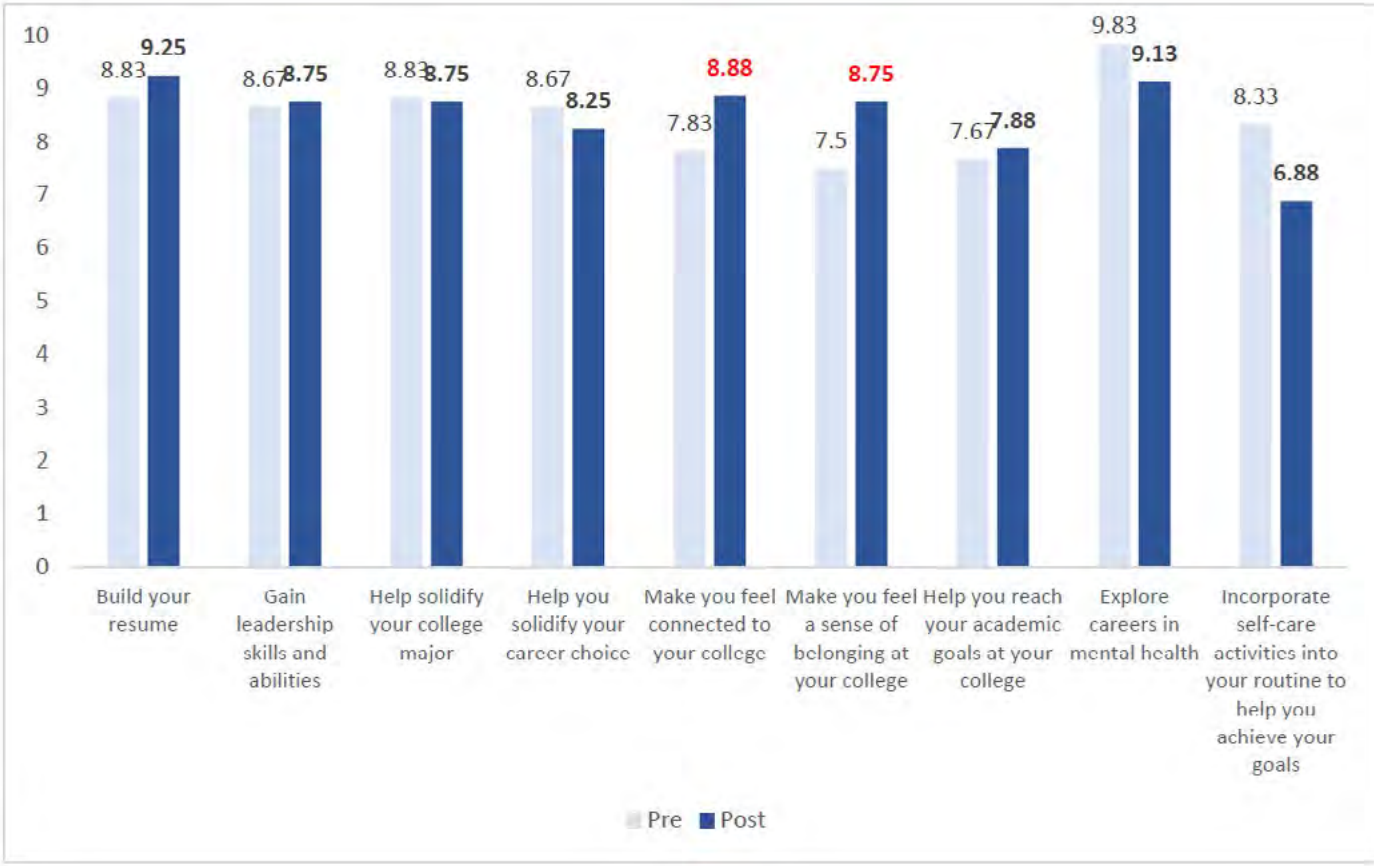


Figure 3. Students' anticipation of the degree to which their participation in the Mental Health Navigators Program will support the following efforts: It is humbling to see a universal increase in students' perspectives on how much the navigator program helped them grow as individuals, scholars, and emerging productive members of society. While pre-test scores were relatively high to begin with, program participation elevated these important milestones in students' development as a whole person and their journey to establish meaningful careers. The items on 'making you feel connected to your college' and 'make you feel a sense of belonging at your college' experienced the greatest increases, from 7.83 to 8.8 and 7.5 to 8.75, respectively, on a ten-point Likert Scale. Research tells us that one of the biggest predictors of student retention is their sense of connectedness and belonging to the institution; the navigator is playing a significant role in advancing this construct. Post-test data show this as well as qualitative responses that are highlighted below. It must also be noted that several of the constructs experienced minor drop-offs in post-test scores; they were generally minor except for the 'self-care' element which we will commit to improving next year.

Figure 4

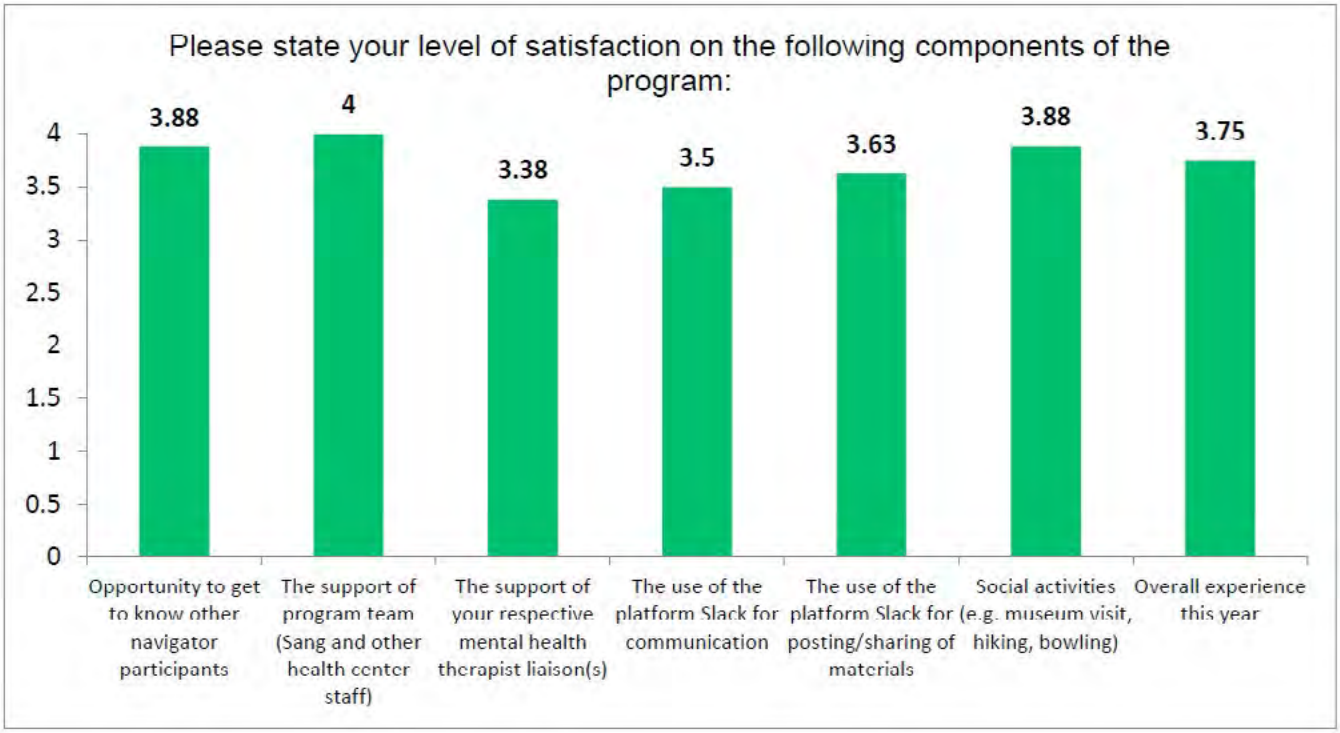
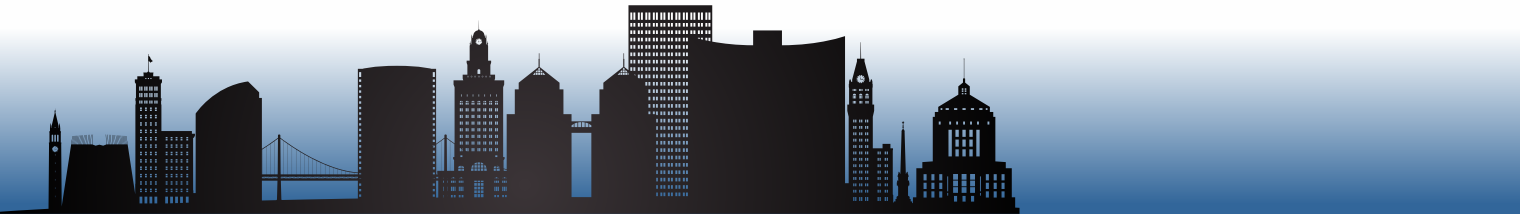


Figure 4. Students' satisfaction on select program components: Student navigators reported high satisfaction with their participation in the program and felt very supported by the team and program infrastructure; of noteworthy mention is the Student Health Center which made us very content because we are a mission-driven group who cares deeply about our students and their development. The weighted average score on overall experience for the year was 3.75 on a four-point Likert Scale (last year's score was 3.8, so very similar). As mentioned earlier, students particularly appreciated connecting with each other in the program and at social events.



OHLONE COLLEGE NAVIGATORS: FY 22/23 PROGRAM CHALLENGES – TAKEN FROM STUDENT NAVIGATOR EVALUATIONS

- "Encouraging students to reach back or respond."
- "The most challenging aspect has been keeping up with the amount of communication that is needed to go on between myself and my clients."
- "Not setting boundaries but *maintaining* them; coming to terms with not being the one that can help them when you really wanted to help.
- "I feel as though I'm not fully able to take advantage of the resources we're learning about because I have nothing to apply them to currently. But I feel confident that I will be able to use those resources in the future."
- "Using a phone to talk to agencies, I am intimidated.
- One struggle was getting students to respond to emails; student response was poor.
- "The most challenging aspect of a navigator in the beginning was having the confidence to apply everything and every resource you learned to the cases. Now it would be to get a response back from client."
- Learning how to understand all of the information (agencies, insurance, etc.) necessary to provide students with the proper resources. It was definitely a lot at first and was very overwhelming but over time it got easier and I was able to get used to it and use the information to help clients."
- "The most challenging aspect of being a mental health navigator is knowing when to stop. Being in this field with opportunities to help others is so liberating and empowering, but it can become suffocating at times too."

OHLONE COLLEGE NAVIGATORS: FY 23/24 ANTICIPATED PROGRAM CHALLENES/ CHANGES

- Recruitment Efforts: We are excited about the growth of the navigator program—going from four participating campuses this year to six campuses next year; all community colleges in Alameda County except for Merritt College will participate in the navigator program for the 2023-24 academic year. We received a total of 38 applications. Next year's cohort will include 16 navigators, two of whom are returning navigators (from Ohlone College and Laney College), with one navigator serving in a dual role as navigator and Student Services Specialist at Laney College (a classified staff position). This year's cohort did a wonderful job of supporting outreach efforts on their respective campuses; they are inherently the best recruiters for the program because they can speak personally about their experience.
- *Note: The Early Childhood Mental Health Postgraduate Certificate Program is longer funded as of FY 22-23.*

4. Internships and Doctoral Residencies

The WET Internship Coordinator is responsible for the development, implementation, coordination, and evaluation of the Alameda County ACBH Internship Program, based upon the California Mental Health Services Act (MHSA) Workforce, Education and Training Plan. Coordinates academic internship programs across the ACBH workforce. Outreaches to educational institutions to publicize internship opportunities.

1. 2022/23 UCSF PUBLIC PYSCHIATRY FELLOWSHIP PROGRAM

- Please refer to Workforce Strategy 4, Residency Internships for descriptions of the UCSF Public Psychiatry Fellowship & Stanford Psychiatry Resident Programs.
- In FY 2022/23, ACBH was not able to host a fellow as UCSF was unable to recruit a participant for the program. ACBH hopes to work in closer collaboration with Alameda County Health Care for the Homeless' Trust Clinic to identify & recruit a fellow for FY 23/24. Special outreach will be made available by the clinic's director who was a past fellow.
- UPDATE: for 23/24, a UCSF fellow for the Trust Clinic residency was recruited.

2. STANFORD SCHOOL OF PUBLIC PSYCHIATRY PROGRAM

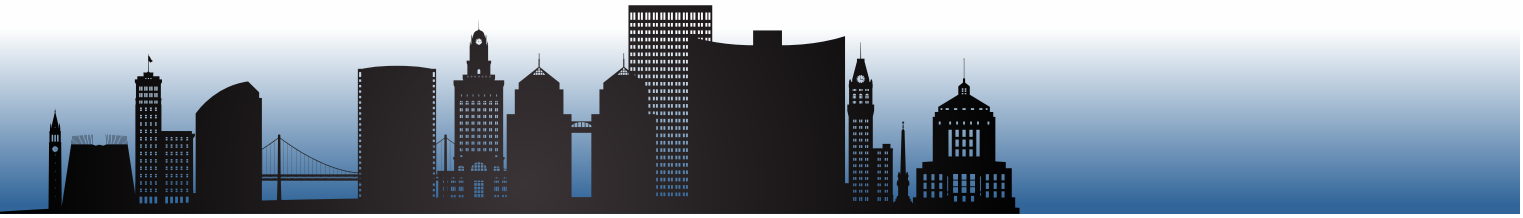
- In FY 2022-23, ACBH was not able to host a Stanford resident for this program. ACBH hopes to work in closer collaboration with Stanford School of Public Psychiatry to identify and recruit a resident for FY 2023-24.
- **UPDATE:** for 23/24 – connection with Stanford School of Public Psychiatry was made by ACBH Office of Medical Director.

3. ACBH GRADUATE CLINICAL INTERSHIP PROGRAM

- The mission and goal of the internship program is to provide training that optimizes student learning, leadership, and overall support & development. Staff also conduct outreach to educational institutions to publicize internship opportunities.

GRADUATE INTERNSHIPS: FY 22/23 PROGRAM OUTCOMES

- 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.
- Transition of previous internship clinical coordinator and introductory training for a new incoming internship clinical coordinator in 2023



- Participated in the panel interviewing process and final selection of new TAP administrative assistant. Provided training, instruction and direction on responsibilities and work duties for 2 staff members. Oversaw outcomes and quality of work products.
- Provide updates and revise documents to the "Onboarding Resource Manual" as needed. This resource manual was created by the internship coordinator in 2016 to provide guidance, structure, and compliance for the internship program.
- Effectively managed and facilitated the two (2) fully executed contract agreements as well as amendments to two (3) practicum agreements for schools in collaboration with county counsel.
- Within the last year, the WET team has been meeting with ACBH units & CBOs to find out what their internship needs are & how we can work together & be more inclusive. The role of the Internship Coordinator has been to establish those relationships and help build the pipelines through the internship program to enhance the program and provide more opportunities for students.
- The WET team has been committed to working collaboratively on developing and finalizing formal practices, policies & procedures for all aspects of the Internship and Stipend programs.
- Re-development, & maintenance of internship components on the ACBH public and internal site. The newly revamped site was essential to present a more user-friendly online presence to provide clarity and effectively communicate to a wider student audience demographic.
- Development of new survey monkey internship application and QR code for quick access.

GRADUATE INTERNSHIPS: FY 22/23 PROGRAM IMPACT AND/OR EVALUATIONS

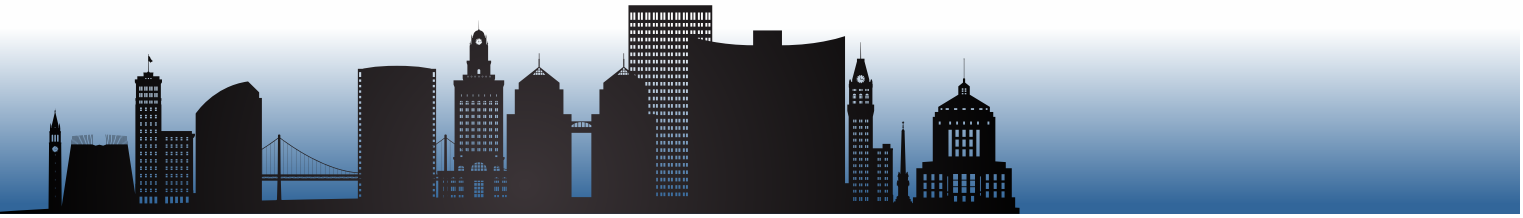
- A total of twenty-two (22) students were onboarded & placed within ACBH programs and units. The number of interns was slightly higher than the previous year. Two (2) interns with the Children's and Young Adults System of Care, Nine (8) Adult & Older Adult System of Care, Eight (6) of those Nursing students, Eight (8) CSS, Two (2) AFBH, One (1) CONREP, One (1) Vocational Services.
- **2022-23 ACBH Intern Statistics– Ethnicity (Number of interns= 22)**

Ethnicity	Count	Percentage
African American	2	9%
Asian	7	32%
Caucasian	9	40%
Hispanic/Latino	4	19%

- **2022-23 ACBH Intern Statistics– Language (Number of interns= 22)**

Ethnicity	Count	Percentage
English	14	64%
Cantonese	1	4%
Mandarin	0	0%
Spanish	3	14%
Tagalog	0	0%
Vietnamese	1	4%
Other	3	14%

- This year 10 CYASOC & CSS student attended over 30 hybrid (in-person or virtual through ZOOM) training sessions, including: Vocational Training, Early Childhood Assessment; Expressive Arts, Documentation Training; Medication Assessment; Family Partnership; Mandated Reporting, Verbal De-escalation, Implicit Bias, Crisis Assessment, Suicide Assessment & Intervention, CBT, DBT, etc.
- In-service training & trainers were extremely beneficial and well received by the interns again this year.
- Coordinated & facilitated annual internship fairs & internship orientations.
- Represented ACBH at local internship fairs for bay area colleges & universities which provided



potential student interns with a first impression of ACBH in a welcoming, low-pressure, & informative settings. These are marketing impact activities, publicizing various learning opportunities & offering information & materials about ACBH's systems of care.

- ACBH Internship Program Representative for (3) virtual internship fairs (between 20-40 students) from Cal State East Bay, USF and SJSU.
- The ACBH Intern Orientation is a full two (2) day event, collaborative effort with the clinical coordinator to offer a positive and successful start to the internship assignment. Students are provided with presentations, tours, and group interaction. ACBH Intern Orientation was conducted virtually.
- Manage & facilitate the overall internship program performance cycle by providing mid-year and end of year intern engagement surveys.
- Developed a system of methods for collecting data & managing the results of evaluations to best meet the needs of the ACBH department.
- Facilitate, collect, & manage training and internship 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 seeks to gather information from the intern perspective for continuous improvement.
- Research & compile data and statistics using survey evaluations & other documentation to provide yearly State required reports and needs assessments per program.
- Curated and created an Internship Program presentation to highlight important information, details, & successes.
- Along with members of WET team attend formal meeting presentations to introduce and showcase Internship Program information, details, & data to ACBH department units and stakeholders, to enhance & strengthen services.

GRADUATE INTERNSHIPS: FY 22/23 PROGRAM CHALLENGES

- In Creating bandwidth across the systems of care impacted teams poses 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 Native Black American/African American and Latino, particularly Black/African American male intern applicants.
- Increased cultural competence training for interns & 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 & 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.
- Having the ability to expand pipeline opportunities requires more staff members, fortunately within the last year the WET team has managed to hire a new Administrative Assistant to help grow and increase capacity for the internship program to expose students to a variety of different units within the ACBH department.

- There is a need to find creative ways to incentivize intern supervision within systems of care to host student interns.

GRADUATE INTERNSHIPS: FY 23/24 ANTICIPATED CHALLENGES

- In the process of developing a new internship onboarding portal using Citrix Sharefile. The onboarding portal will be a one stop shop to manage and facilitate everything student intern related. Specifically onboarding, retrieving resumes, resources, etc.
- The onboarding portal will involve a combination of technology, communication, and clear guidelines to ensure smooth transition for interns and intern supervisors.
- Once completed, we will be able to effectively manage the following tasks electronically:
  - o Ability to upload all internship documents.
  - o Send welcome emails to all new interns.
  - o Prepare intern welcome packets to include all essential documentation, policies, guidelines & organizational charts.
  - o Create an onboarding schedule to include important dates, activities, events, etc.
  - o The ability for students to be able to have access to their file to read and complete all onboarding paperwork.
  - o Create a file per intern.
- Finalize internship program formal policies and procedures to further enhance services.
- Development of a diversity stipend
- Establishing a yearly high school, student certificate and undergrad program in collaboration with CBO's, stakeholders, & cohorts
- Reestablish certificate program to honor the completion of internship assignments by college students.
- Creating a social media presence (Instagram, LinkedIn, Twitter, est.) is imperative for the internship program to better communicate to wider student audience demographic and promotion of program.

4.MENTAL HEALTH ASIAN PIPELINE PROGRAM – KOREAN COMMUNITY CENTER OF THE EAST BAY (KCCEB)

- In the process of developing a new internship onboarding portal using Citrix Sharefile. The onboarding portal will be a one stop shop to manage and facilitate everything student intern related. Specifically onboarding, retrieving resumes, resources, etc.

KCCEB: FY 22/23 PROGR AM OUTCOMES

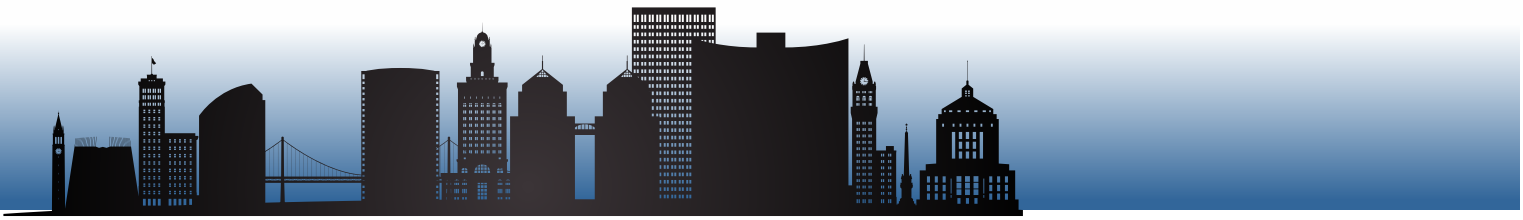
- KCCEB trained 6 MSW/MA/MFT students for MHAP's third cohort (3 first year & 3 second-year; 2 males, 4 females). Interns came from CSU East Bay, Dominican University, Golden Gate University, and Palo Alto University.
- Cohort spoke the following languages: Korean, Japanese, Cantonese, and Mandarin in addition to English. Services were offered in Korean, Cantonese, Mandarin, and English.
- Interns provided services to community members who are youth (6 interns), seniors (5 interns), limited English proficient (LEP) (5 interns), immigrants & refugees (5 interns), LGBTQ2S (3 interns), have disabilities (3 interns), have substance us dependency (2 interns) and are undocumented (1 intern).
- KCCEB operated a hybrid-model with all interns seeing clients in-person and some interns providing services online or using the phone. In-person clients were seen at home, at KCCEB's center, senior housing sites, and schools. Five interns focused on school-based services at Alameda Science and Technology, San Leandro High School, Mt. Eden High School, and Martin Luther King Middle School.

KCCEB: FY 22/23 PROGRAM IMPACT AND/OR EVALUATION

- Demographics of Cohort:
  - o Returning adult students: 83%
  - o First-generation college student: 17%
  - o First-generation living in the U.S.: 83%
  - o KCCEB first experience in an Asian-serving organization: 67%
- Many were passionate about wanting to serve the API community & have a strong desire to use their bilingual and bicultural skills and cultural lived experience to fill the gap of services in their community. Some of these students mentioned that their own backgrounds and struggles (ie., 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.
- At the end of their internship, students filled out evaluation forms on how well the organization supported them in gaining exposure to the 9 Core Social Work competencies. Students' ratings were on a 1-5 scale (1=Did not gain any exposure, 5=Gained a great amount of exposure). KCCEB scored above average on the 8 Competencies with a total average score of 4.26. One competency area scored 3.75 out of 5, namely Engaging in Policy Practice. Overall, our evaluation indicated that we have successfully met our interns' learning objectives and expectations.

KCCEB: FY 22/23 CHALLENGES

- Greater Community Needs: One of the challenges we are seeing this year is an increase in mental health service needs both from youth and from the Korean community. The pandemic has impacted peoples' mental health & we are seeing more complex cases. Due to the ongoing crisis of COVID, KCCEB is seeing an increased need for mental health needs in the API community, especially the Korean community.
- Compared to last year, we are seeing an increase in referrals: 98 referrals compared to 50 from last year. With the support of interns, KCCEB provided counseling services to 61 clients for this fiscal year, which surpassed our grant contract deliverables of serving 45 clients per year. For example, we noticed that counseling services jumped from 2 Korean clients served last fiscal year to 15 clients served this fiscal year. Many reported symptoms of heightened stress level, PTSD symptoms, anxiety, depression, and increased family conflicts. 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.
- In the school site settings, we are seeing students experiencing anxiety, depression, and other traumas in returning to school or being in public settings, facing Anti-Asian sentiments and microaggressions, bullying due being blamed because of the pandemic, grief and loss of people who have passed away or transitions with people leaving home, family conflicts and stress, social anxiety, self-esteem and self-image issues, suicidal ideation, etc. One thing we continue to notice about our Asian students is that they are more likely to be reluctant to share with their parents that they need mental health support. As we have a UELP contract, we can take students who are not asked to obtain parental consent. With the support of the interns, we were able to expand our school partnership to Hayward to provide counseling services to isolated API students.
- The pandemic has shone light on the multiple disparity and inequity of services in the Korean and other API communities, especially in different counties and states. KCCEB has become a safety net to many Koreans locally and nationally, but our county restrictions limit our ability to expand our mental health services beyond Alameda County. Our Give in May fundraising effort this year raised over $78K to support providing mental health



services to Asians across California for telehealth counseling services.

- Client needs: One of the challenges we faced this year was that our clients' symptoms were more moderate to severe. As a result, we had to have more crisis intervention (i.e. higher suicide risk that need more monitoring, more severe symptoms that require higher care, but refusing service due to stigma and fear of parenting finding out) leading to needing to support interns and train interns more intensely to be able to provide high quality and clinically competent care to their clients. This also led to supervisors doubling their supervision times, more hours to closely support interns during crisis and managing their vicarious trauma and countertransference.
- Navigating the mental health system: Even though some of our clients want higher levels of care, they face challenges in navigating the complex mental health system. We have tried to connect them to insurance, which has led to longer wait times and limited high-quality culturally responsive mental health care services. This has unfortunately had impacts such as increasing the risk of MH symptoms worsening, or clients falling through the cracks.
- Intern Support: In order to better prepare students for higher-need clients, this year's curriculum integrated more skills training and practice such as crisis management, trauma-informed interventions, motivational interviewing (i.e. active listening, reframe, avoiding righting reflex, dealing with roadblocks to communication, using open-ended questions, affirmations, reflections, summaries), addressing vicarious trauma and countertransference, and cognitive behavioral interventions (i.e. doubt conceptualization, developing problem and goal list, cost benefit analysis).

KCCEB: FY23/24 ANTICIPATED CHALLENGES

- For FY 23-24: Cohort includes 6 interns, 3 who are bilingual in Korean, 1 who is trilingual Cantonese, Mandarin, and Vietnamese, and 1 who speaks Cantonese and Mandarin.
- Training Model: We are always making improvements and listening to our interns to see how we can improve. With their feedback, for 2023-2024, we are making the following changes to the training model:
- Providing more comprehensive clinical onboarding and training which is changing from 9 days to 21-day intensive training.
- Expanding our robust clinical training through encouraging interns to attend external clinical training, such as Seneca, PSI, etc.
- Incorporating more diverse holistic and traditional healing practices, especially with unserved communities (eg., Mongolian, Mien, Khmu), in our clinical training curriculum
- Expanding collaborative partnerships with other graduate educational institutes (i.e. San Jose State University, San Francisco State University)
- Agency: One agency level challenge we noticed this year is the difference between MSWs and MFTS regarding policy advocacy and case management support. Students in the MFT program had challenges seeing the importance of case management support as a part of clinical practice. This limited their ability to support client wrap-around services and work with the client from a holistic lens, which is critical in community mental health settings. In addition, they did not acquire the skills necessary to support clients in navigating the public service systems. Because KCCEB is a community mental health agency, we believe in = the importance of case management support in meeting clients where they are at with basic needs in addition to providing mental health support. There are times when peoples' mental health challenges are a result of basic needs not being met, which makes openness to receive mental health services difficult.
- Moving forward, as an agency we are prioritizing selecting students who value or want to learn about

community mental health, including being involved in policy advocacy opportunities (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) and case management cases. We will also incorporate policy practice activities for our upcoming interns: Encouraging their participation in our local, county, and statewide coalition work to see the importance of advocacy in community mental health work. We hope that this will help increase our rating on the Policy Advocacy Competency Score.

5. BESTNOW: PEER WELLNESS

- BestNow is a program of the Peer Wellness Collective and provides complete support that includes: assessments, job preparation, job placement, and job coaching to TAY, Adults, and Family Members with behavioral health challenges, or who have had lived-experience with the mental health system.

BESTNOW: FY22/23 PROGRAM OUTCOMES

- Offered training in Spanish and English for a total of 20 bilingual individuals with lived experience with mental health challenges.
- Offered two cycles of ten-hour Peer Support Specialist (PSS) refresher training for up to 30 individuals who have previously completed BestNow! PSS Training and/or who have been working behavioral health field for at least one year.
- Offered employment coaching support for up to 30 individuals following their completion of the PSS training, prioritizing those with limited work experience.
- Best Now successfully hosted two graduating classes. Allowing graduates to celebrate their accomplishments with friends and family. The most recent graduation had close to 90 people in attendance. BestNow also continues to host study guide sessions to help peers prepare for die state exam. BestNow is expecting to go into 2023, continuing to host study guide sessions.

BESTNOW: FY22/23 PROGRAM IMPACT AND/OR EVALUATION

- Going into the third quarter the BestNow team continues to be fully staffed with 4 program trainers and 1 program manager. We revamped all our training slides and made them more interactive. using them for the first time with our January cycle. We continue to have many students enrolling in our training & attending our Law & Ethics courses & our refresher/study sessions.
- Additionally, BestNow ran cycles with a very diverse demographic group. So far in FY 2022-2023, we have had 38.3% of Olli 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.

BESTNOW: FY22/23 PROGRAM CHALLENGES

- 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 lo meet this requirement. Since the first quarter of our deliverables, we have hosted 10 Law & ethics training sessions. These training courses have consistently had over 70 peers in attendance each time.
- Additionally, peers have been struggling with the initial scholarship and grandparenting scholarship applications. Due to this, we decided to host webinars showing our peers step by step how to apply and help them with the application in real time. Since June there have been 5 scholarship

webinars with 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.

- One lesson we learned was in restructuring our PowerPoint slides we realized we had to make multiple copies of them to accommodate the new training we are offering such as Law & Ethics. Another lesson we learned was how to navigate the bigger class sizes. Initially we struggled with making sure everyone was on mute, participating, and general logistical things. We had to take some time to really learn and build on our facilitation skills.

BESTNOW: FY23/24 ANTICIPATED PROGRAM CHALLENGES

- 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 to be accepted into the BestNow course.
- Stipend supported no more than ten individuals to complete a three-month, part- time internship. The program shall prioritize those with very limited or no work experience who would otherwise be unlikely to gain employment without on-the-job work experience.

5. 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. Behavioral Health Loan Repayment Program for eligible clinical staff who complete a service obligation in public behavioral health in Alameda County.

1. ACBH GRADUATE INTERN STIPEND PROGRAM (GISP)

- Offers financial incentives as a workforce recruitment & retention strategy while increasing workforce diversity.
- Financial Incentives are offered to graduate interns placed at ACBH and contracted community-based organizations.
- Retain individuals who are linguistically and or culturally able to serve the underserved and unserved populations of the County.

GISP: FY 22/23 PROGRAM OUTCOMES

- Administered the 11th cycle of the Graduate Intern Stipend Program
- Awarded 22 students with stipends in the amount up to $6,000 each for 720 internship hours. Of the 22 awardees, 77% represent the diverse communities of Alameda County.
- Graduate Intern Stipend Program continues to focus on interns across system, including behavioral health interns in primary care settings and increasing interns who speak one or more threshold languages: Spanish, Cantonese, Mandarin, Vietnamese, and Tagalog.
- Review, update and make changes to the GISP application according to the current guidelines and/or changing regulations.
- Provide yearly GISP language and ethnicity applicant and awardee data charts and graphs for statistical purposes. Currently in the process of developing policy, procedure, and guidelines for the Graduate Intern Stipend program.
- Created a Graduate Intern Stipend Program presentation to highlight important information, details, and successes.
- Along with members of WET team presented information to introduce and showcase GISP information, details, and data to ACBH department units and stakeholders.

FY22/23 GRADUATE INTERN STIPEND AWARDEES - ETHNICITY

Ethnicity	#	Percentage
African American	5	23%
Asian	6	27%
Caucasian	5	23%
Hispanic/Latino	5	23%
Pacific Islander	1	4%
Total	22	100%

FY22/23 GRADUATE INTERN STIPEND AWARDEES - LANGUAGE

Language	#	Percentage
English	14	63%
Farsi	1	5%
Cantonese	0	0%
Mandarin	1	5%
Spanish	4	18%
Tagalog	0	0%
Vietnamese	0	0%
Other	2	9%
Total	22	100%

FY22/23 PROGRAM CHALLENGES

- Finding creative ways to promote and advertise the GISP program to a wider audience.
- Finding more effective ways to receive updates regarding Alameda County Threshold language information.
- More timely notifications to prospective applicants of the GISP program
- FY 24/25 - Re-establish certificate program for GISP applicant awardees.
- FY 24/25 - Create instructional Q&A video on how to complete GISP application.

2. FY22/23 ALAMEDA COUNTY BEHAVIORAL LOAN REPAYMENT PROGRAM (BLRP)

- The purpose of BHLRP is to provide financial incentive to retain qualified, eligible employees in hard-to-fill/retain positions in the Alameda County Behavioral Health Care system, including employees of community-based organizations.

BLRP: FY22/23 PROGRAM OUTCOMES

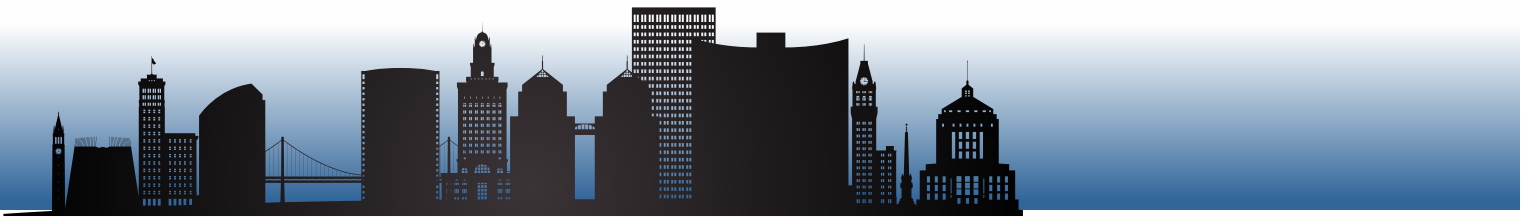
- October 2022 - ACBH WET & CalMHSA launched the second round of the local Behavioral Health Loan Repayment program.
- 110 individuals & 76 clinicians from Alameda County & CBOs received up to $10,000 towards their outstanding student loans.
- In this round, approximately $611,500 was awarded in loan repayment in exchange for a 12-month service obligation.

BLRP: FY22/23 PROGRAM CHALLENGES

- Sufficient outreach in a timely manner
- Notifications of application extensions
- In a continued partnership with CalMHSA and HCAI, ACBH WET will work with the Greater Bay Area counties to implement the final round (Round 3) of the Behavioral Health Loan Repayment Program (BHLRP). As with the previous round, in exchange for up to $10,000 loan repayment, BHLRP awardees will commit to a 12-month service obligation.

3. ALAMEDA COUNTY COMMUNITY COLLEGE BH CAREER PIPELINE

- ACBH, in collaboration with other counties in the region, has partnered with the California Mental Health Services Authority (CalMHSA) and the California Department of Health Care Access and Information (HCAI) to make scholarship available



to educational students in exchange for service obligations in a Public Mental Health System (PMHS).

- This scholarship program is a financial incentive strategy designed to support students from participating community colleges who have a desire to work in California's public mental health system.
- Scholarships will be awarded to individuals to support their academic journey & preparation for entry into a behavioral health career.

COMMUNITY COLLEGE PIPELINE: FY22/23 OUTCOMES

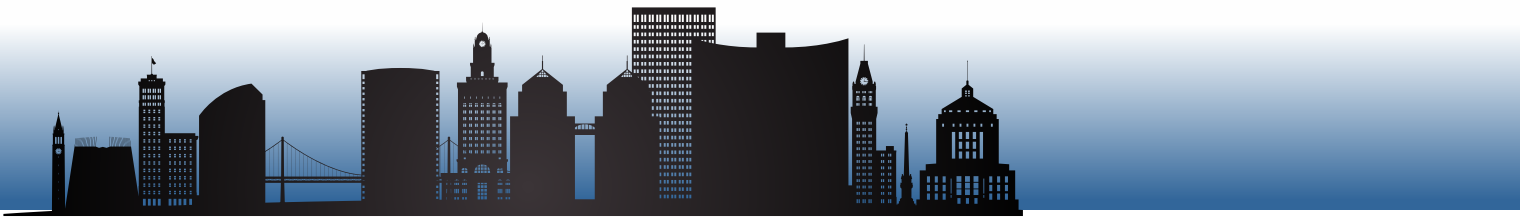
- The Alameda County Behavioral Health Career Pipeline Scholarship & Mentorship Program accomplished its programmatic goals in this first year of the program.
- Eleven former community college students were awarded academic scholarships to support their tuition fees, which were immensely helpful especially for first generation & low-income students. They all participated in a year-long mentorship program where they were able to cultivate meaningful relationships.
- ACBH WET hosted four convenings: 2 mentorship speaker sessions, 1 cohort team meeting, & a year-end recognition.
- The final cohort meeting in April served as a wrap up session to assess how students were preparing for the end of the academic year & their summer plans for internship, employment, or graduate school preparation.
- The year ended with a recognition and celebration event held at Ohlone College to honor all students involved with Ohlone College's student engagement programs: Student Wellness Ambassadors, Student Mental Health Navigators, Student Wellness Counselors, Research Assistants, Scholarship & Mentorship students.
- Students received certificates of participation, a book on healing & self-care, & a journal to collect their reflections.

FY22/23 PROGRAM IMPACT AND/OR EVALUATION

- All 11 students completed their academic year & matriculated to the next level – to their senior year or graduated with their bachelor's degree.
- Example: student "TB" graduated with his public health degree from UC Berkeley & secured a part time teaching position at his community college alma mater, Berkeley City College. TB will also serve as a mental health liaison for our Alameda County Mental Health Navigator Program.
- Student "LD" graduated with her undergraduate public health degree from San Jose State University & secured a full-time health educator position working on an Asian American mental health program for youth with Public Health Institute.
- Student "GA" will finish her final year at Cal State East Bay in the fall & will assume a new program assistant role with Ohlone College's Mental Health Navigator Program. Her involvement is only possible because of ACBH's commitment to supporting all students regardless of their immigration status—a real testament to diversity, inclusion, and equity.
- FY 24/25 - Re-establish certificate program for GISP applicant awardees.

FY22/23 PROGRAM CHALLENGES

- Scheduling that accommodates everyone's schedules, participation fatigue, especially as the year progresses and students are at times overly committed and juggling many responsibilities while maintaining their academic focus.
- This year's three wonderful mentors are part of our system—the college and county behavioral



health. We are fortunate that was the case for this first year but recognize that we will have to diversify our list of mentors to include those from the community so that our students benefit from wider representation.

FY23/24 ANTICIPATED PROGRAM CHALLENGES

- We were also challenged with not having as many in-person events as we would have liked; nothing replaces in-person interactions & relationship development. We recognize these challenges and will work on improving them at the administrative & programmatic levels in the next school year.

The Capital Facilities & Technological Needs (CFTN) component of the MHSA "works towards the creation of a facility that is used for the delivery of MHSA services to mental health clients and their families or for administrative offices. Funds may also be used to support an increase in peer-support and consumer-run facilities, development of community-based settings, and the development of a technological infrastructure for the mental health system to facilitate the highest quality and cost-effective services and supports for clients and their families".

It should be noted that CFTN funding was originally a 10-year block grant, which ended on June 30, 2017. However, through Assembly Bill (AB) AB 114, ACBH was given a grace period to utilize previously reverted MHSA funding through June 30, 2020. For more information on ACBH's spending plan for AB 114 funds, please see ACBH's AB 114 Plan at https://acmhsa.org/reports-data/#mhsa-plans.

In addition to the CFTN funds identified in Alameda's AB 114 Plan, ACBH continues to transfer CSS funds to the CFTN component for various programs and projects. Pursuant to Welfare and Institutions Code Section 5892(b), Counties may use a portion of their CSS funds for WET, CFTN, and the Local Prudent Reserve. The total amount of CSS funding used for this purpose shall not exceed 20% of the total average amount of funds allocated to that County for the previous five years.

ACBH's MHSA funded Capital Facilities projects are in alignment with Alameda County's Vision 2026. More on this vision can be seen at https://vision2026.acgov.org/index.page.

New Projects Approved for funding, implementation FY 24/25

No new CFTN projects have been identified or allocated new funding in FY 24/25. Please see the following section for updates on ongoing CFTN programs and projects that are in various stages of implementation.

Ongoing Projects

During FY 23/24-24/25 the following CFTN projects were in process. These projects were listed as new programs/projects in previous Plan Updates (FY 18/19 and 19/20) and/or the current MHSA Three Year Plan FY 23/24-25/26. Updates on progression of these programs and projects were provided in last year's MHSA Three Year Plan FY 23/24-25/26 under the ongoing section of the Plan. Several of these projects will be completed this fiscal year (FY 23/24) and others will be continued and completed in FY 24/25 and beyond.

Project Name:
CF2 Respite Bed Expansion and CF4 Alameda Point Collaborative

Project Description: Capital Project Investments to Expand Respite Beds for Individuals with Serious Mental Illness and Physical Health Care Needs and Alameda Point Collaborative (APC) Senior Housing and Medical Respite Wellness Center (AWC). Detailed information can be found in the previous MHSA Three Year Plan FY 23/26 HERE.

FY 24/25: As funding is winding down in these two programs, there has been a decision to combine the final amount of funds into CF2 under the general program topic of respite bed expansion.

ACBH in collaboration with the Office of Homeless Care and Coordination, a division within the county's parent agency Health Care Services Agency, will continue to seek new opportunities to develop medical respite opportunities. The remaining funds within this workplan's original six-million-dollar allocation ($3M for medical respite CF2 and $3M for Alameda Pt Collaborative CF4) will be directed towards the Alameda Point Collaborative Project (formerly workplan #CF4) and a new project called the St. Regis. The St. Regis is a building that was purchased by a local non-profit, Bay Area Community Services (BACS), where ACBH hopes to develop multiple residential mental health services including medical respite. The St. Regis project has been slow to begin as BACS is awaiting a Behavioral Health Continuum Infrastructure Program (BHCIP) award. More information will be provided as this project develops.

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.

FY 23/24 Progress: ACBH, in partnership with the Alameda County General Services Agency (GSA) department, is in the process of purchasing a property at 1912 MLK Way in Oakland for the development of the African American Wellness Hub Complex (HUB).

In preparation for the Wellness Hub services, the Office of Health Equity has conducted multiple listening sessions 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 2024.

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 23/24 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. Due to capacity issues there has been a delay in the implementation of this project. More information on the implementation and completion of the garden project will be published when available.

Project Name:
TN1. MHSA Technology Project

Project Description: Purchase, installation and maintenance of a new Behavioral Health Management Information System (EHR), to include: billing, managed care, e-prescribing functions, data interoperability and functions as needed to support clinical and fiscal operations of ACBH. Additional expenditures for the necessary support staff during the implementation process, and other projects that provide access to consumers and family members to their personal health information and other wellness and recovery supports.

FY 23/24 Progress: 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 legacy 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 workflow challenges and facilitate enhanced flexibility for data sharing. SmartCare was scheduled to go live on 07/01/2023, though this has been somewhat delayed to early 2024.

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 2024. An informational update on this process will be shared in the FY 25/26 MHSA Plan Update.

Additionally, under this project ACBH has been utilizing CFTN funds for the following items that have assisted ACBH in being more efficient and effective with utilization and outcome data:

- TN1: Behavioral Health Management Contracting System (to assist with the contracting process), called Apttus (phases 1-4)
- TN1: Computer/Technology Technical Assistance
- TN1:Electronic File Storage and Document Imaging (Veeam Software)
- TN2: Web-based performance outcome dashboard System, called YellowFin
- TN3: County Equipment and Software Update (includes Zoom and Teams software)
- TN4: Clinician's Gateway Interface
- CFTN Administration

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.

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 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 new **Plan Administrator** who oversees and creates linkages among ACBHS's core administrative functions (e.g. MHSA, Quality Improvement/Quality Management, Information Systems, Financial Services and most recently added in 2023, Data Analytics)
- Public Information Manager: 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.

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.

Future strategic planning activities. The above-mentioned new positions will also: 1) support MHSA efforts, particular around the upcoming implementation of BHSA; 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, BHSOAC) and 5) develop 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.

Finance 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 internal 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 restructuring in which all contracts and service agreements 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. 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, including Cal AIM; 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 percentage 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

The MHSA division is incorporating data visualization tools such as PowerBI to display data in the MHSA FY24/25 Update and on the www.acbhcs.org website to make data available in real-time.

In addition to PowerBI, ACBH uses a web-based data and outcome reporting system called YellowFin. MHSA staff are utilizing different tools to provide Alameda County residents with a variety of visualizations to display data.

The MHSA team 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 24/25 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.

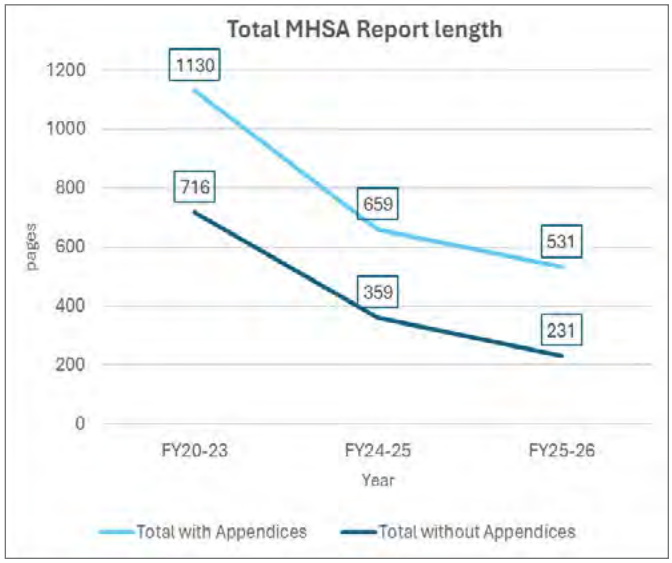
The Prevention and Early Intervention programs called the Underserved Ethnic Language Programs (UELPs), Evaluation Workgroup has finished its first round of changes to the yearly UELP evaluation. The workgroup redesigned the logic model and worked with a graphic designer to create a graphical version of it and re-worded and updated both the Pre/Post Health Assessment and Participant Satisfaction Surveys. Both have been implemented during FY 24/25 using Survey Monkey and the results will be used during the evaluation.

MHAB Recommendations

The Alameda County Mental Health Advisory Board (MHAB) strives to ensure that Alameda County's Behavioral Health Care Services offer quality care to the community with dignity, courtesy and respect. This involves advocacy, education, review and evaluation of mental health needs. MHAB consists of 16 members that meet monthly in a public setting with Alameda County Behavioral Health Care Leadership. At the November 27th, 2023, MHAB meeting, the MHAB recommended several recommendations to MHSA reporting. The MHSA team adhered to the requests of the MHAB and made several changes to the MHSA FY24/25 Update:

The MHAB recommends that the MSHA Annual Reports are shorter in length and more navigable for users.

- The MHSA team integrated navigable hyperlinks and tabs throughout this report that allows the reader to more easily locate the information they are looking for. The MHSA team shortened the length of the MHSA report from 716 pages to 359 pages. The MHSA team is continuing to enhance reporting templates and procedures to further shorten the report in subsequent years.
- The MHAB recommends that the MHSA conduct the CPPP to include people who are traversing psychiatric facilities, jail, homelessness and recovery.
    - o To accomplish this, the MHSA team conducted listening sessions with community groups and providers to obtain a diverse range of community feedback. Notably, the MHSA team went in-person and met with 12 clients from the Jay Mahler Recovery Center to receive their input and requests for mental health services from Alameda County. The MHSA team also promoted the community input survey throughout the county to gain better insight into community needs.
- The MHAB also encouraged the MHSA team to create quantifiable approaches to measuring the success of PEI programs. The MHSA team addresses these methods, please see the following section below: (Performance & Early Intervention (PEI) Unit Performance Efforts).
- In meetings with the MHAB there was also a request for an increased public comment period in order to have more time for review. The MHSA team has increased the public comment time from 30 to 45 days for this Annual Update for FY 24/25.



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. ACBH facilitates bi-annual monitoring of all PEI contracts with a site visit to each program:

- To receive programming and service updates per contractual, RFP, or funding requirements.
- To remain in close relationship with organizational and program leaders and staff.
- To conduct compliance checks on relevant policies, procedures, and evidence/community-based practices, where applicable, and
- To collect documentation to support state audit processes and logistics.

Provider staff first completes a compliance self-check (using ACBH's checklist) and then attends the site visit with ACBH staff to confirm and to clarify documentation and other service delivery artifacts and outcomes. Per ACBH request, providers may create, update, or revise documentation to offer evidence of programming. ACBH may provide technical assistance, as needed, to support providers to achieve compliance in one or more domains.

Providers routinely include staff across the organization during the site visit to add context and nuance about programming, successes, and challenges. Providers may also invite participants to the site visit to include the valuable "end user" perspective.

MHSA Audit

The Department of Health Care Services (DHCS) conducted its review of Alameda County's Mental Health Services Act (MHSA) program on April 25-27, 2023. Alameda County's strengths include:

- The use of data and data visualization through the platform called Yellowfin;
- A multitude of diverse Prevention and Early Intervention (PEI) programs specifically focused on underserved ethnic and linguistic populations,
- The integration and co-location of several of the Full Service Partnership programs with a Wellness Center, 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, geographic distance across the county, continued recovery from the COVID-19 pandemic, 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 number of clients served, cost per client and needs of the unmet populations, and
- Revising the FSP policy and procedure document to include information and implementation of the use of the FSP Partnership agreement.

MENTAL HEALTH SERVICES ACT (MHSA)

STAKEHOLDER GROUP MEETING CALENDAR, 2023

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

DATE	TIME	LOCATION	MEETING THEMES
January 27, 2023	2:00-4:00pm	Go To Meeting	• Presentation: El Timpano • Three-Year Plan Update • Calendar Brainstorm
March 24, 2023	2:00-4:00pm	GoToMeeting	• Review MHSA-SG Applications • Presentation: African American hub • CPPP/INN recommendation
April 28, 2023	1:00-3:00pm	Go To Meeting	• Program Spotlights: Pilot API mental health program
June 23, 2023	1:00-3:00pm	Teams	• Presentation: Primary Care Integration Programs.
August 25, 2023	1:00-3:00pm	Zoom	• Presentation: SB 326 Modernization
October 27, 2023	1:00-3:00pm	Zoom	• Presentation: MHSA CPPP Planning Committee Update • MHSA Listening Sessions schedules & locations • New MHSA Senior Planner, Mr. Noah Gallo • Calendar/Next meeting: December 15th 1-3pm
December 15, 2023	1:00-3:00pm	Zoom	• MHSA CPPP Planning Committee Update • MHSA Listening Sessions schedules & locations • Survey Outreach

MENTAL HEALTH SERVICES ACT (MHSA)

CPPP PLANNING COMMITTEE MEETING CALENDAR, 2023

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

DATE	TIME	LOCATION	MEETING THEMES
September 20, 2023 (Wednesday)	2:00-3:15pm	Zoom	• MHSA CPPP Overview • CPPP Committee Members Tasks ○ Outreach Plan ○ Listening Session Discussion ○ Data Deep Dive
October 4, 2023 (Wednesday)	2:00-3:15pm	Zoom	• Review Draft of Areas of Needs List • Test the Listening Session Polls • Listening Sessions – In the Works (7) ○ AA Family Outreach Project ○ 2 Casa Ubuntu WC (In-Person – ○ English & Spanish) ○ Veteran Court Hybrid (In-Person & Virtual) ○ Scheduling for Asian Health Services. & Fremont Family Resource Center • Survey Development ○ Survey will mirror the Listening Session Questions ○ Survey Distribution Discussion ○ Distribution Assistance
October 19, 2023 (Thursday)	2:00-3:15pm	Zoom	• Completed Areas of Needs List • Listening Sessions – Updates and In the Works (12) ○ AA Family Outreach Project

DATE	TIME	LOCATION	MEETING THEMES
			○ 2 Casa Ubuntu WC (English & Spanish, both In-Person) ○ Veteran Court Hybrid (In-Person & Virtual) ○ MHSA Stakeholder Grp. (Virtual) ○ Swords to Plowshares (Virtual) ○ FERC (Virtual) ○ ACBH Cultural Responsiveness Committee (Virtual) ○ Planning for 2 with Asian Health Services (In-Person) ○ Planning with MHAAC Chinese Communities (In-Person) • Survey Development ○ Survey translations processing ○ Survey Flyer for Outreach almost complete ○ Advice on Survey Distribution ○ Survey Distribution Assistance • Summary of CPPP Demographic from last year • Bike Rack (data or other request for ACBH to complete) ○ Children's Data
November 1, 2023 (Wednesday)	2:00-3:15pm	Zoom	• Listening Sessions – Updates and In the Works (13) ○ AA Family Outreach Project completed ○ 2 Casa Ubuntu Wellness Center (English and Spanish) – completed ○ Veterans Court hybrid in person/virtual – completed ○ MHSA Stakeholder Group virtual 12/15/23 ○ Swords to Plowshares 11/2/23 (In-Person) ○ Family Educa□on Resource Center (FERC) Fremont 11/3/23 (Virtual)

DATE	TIME	LOCATION	MEETING THEMES
			○ ACBH Cultural Responsiveness Committee 11/21/23 (Virtual) ○ Planning with Asian Health Services (In-Person) ○ Planning with MHA Chinese Communities (In-Person) ○ Key Informant Interviews, planning process ○ Multiple other sessions in process based on feedback • Listening Session with CPPP Planning Committee Members • Bike Rack (data or other request for ACBH to complete) ○ Children's Data
November 29, 2023 (Wednesday)	2:00-3:15pm	Zoom	• Listening Sessions ○ Supportive Housing Community Land Alliance 11/29/23 ○ Asian Health Services TAY Group 11/29/23 ○ City of Alameda 11/30/23 ○ FERC-English 11/30/23 ○ City of Fremont 12/1/23 ○ POCS 12/1/23 ○ First 5 Alameda County 12/4/23 ○ Alameda County Fatherhood Support Group 12/4/2023 ○ ACBH Pride Coalition 12/6/23 ○ La Familia 12/5/23 ○ PEERS Tay Group 12/6/23 ○ Jay Mahler 12/7/23 ○ LGBTQ Center 12/7/23 ○ Bay Area Community Services 12/8/23

DATE	TIME	LOCATION	MEETING THEMES
			○ Trauma Recovery Partners 12/8/23
December 13, 2023 (Wednesday)	2:00-3:15pm	Zoom	• Discuss CPPP outreach strategies. ○ Review of previous efforts ○ Plan ahead ○ Update Marketing plan ○ Discuss event outreach • Review Listening Session Data • Listening Sessions ○ MHSA Stakeholder Group 12/15/23 ○ FERC Spanish 12/18/23 ○ CARES Alameda 12/21/23 ○ Alameda/Contra Costa Medical Association 1/4/24 ○ PEI and UELP 1/10/24 ○ PEERS 1/16/24
January 17, 2024 (Wednesday)	2:00pm-3:15pm	Zoom	• Summary of our CPPP activities • Preliminary look at the data results.

Outreach & Marketing Plan:

Alameda County MHSA Community Input & Public Comment

Alameda County MHSA Senior Planner Noah Gallo
Oakland Fruitvale Posada – 12/16/23

Empowering Communities, Improving Mental Health Together

Stakeholders **Providers** **Community**

Alameda County MHSA Annual Plan Update FY2024-2025

Brainstorm | **Engage Stakeholders** | **Create Plan** | Execute | Collect Data | Analyze Data | Draw Conclusions

	Target	Cohesive Internal & External Stakeholder Agreement on Outreach	Results
☑	10/28/23	MHSA CPPP Outreach & Marketing strategy including outreach, goals, strategies, metrics, & outcomes.	1. Stakeholder meetings 2. Listening Sessions 3. Key Informative Interviews 4. Community Input Survey 5. Demographics Survey 6. Marketing Material 7. Metrics to track outcomes
☑	1. 1/27/23-12/15/23 2. 9/20/23-1/17/24	Develop committees and meetings to encourage stakeholder collaboration.	1. Stakeholder Group Meetings (7 held) 2. Community Program Planning Process Meetings (8 held)
☑	10/2/23-1/16/24	The MHSA strategically engaged a variety of demographics throughout Alameda County to ensure that our community feedback was diverse and inclusive.	1. Target diverse communities to ensure inclusion. 2. Utilized flyers that appeal to different demographics. 3. Community Input Survey 4. Listening Sessions that represented all groups. 5. Accessible channels to provide feedback. 6. Multilingual MHSA Staff
☑	11/16/23-12/31/23	Create a multilingual Community Input Survey in English, Spanish, Chinese.	1. Survey created by MHSA team. 2. The survey was distributed in digital and paper formats to community groups,

			leaders, nonprofits, clinics, street outreach, and Alameda County staff. 3. The survey was promoted on the ACMHSA website and on social media. 4. Survey provides respondents to provide direct feedback to MHSA team.
☑	10/28/23-12/31/23	Community groups identified to participate in the Community Planning Process.	1. 340 organizations contacted. 2. Based on strategic geographic location in the county. 3. Based on the population they serve.
☑	11/27/23	ACMHSA.org website enhancement.	1. Community can access information & provide feedback about MHSA programs in Alameda County 2. ACMHSA Website hosts flyers, surveys, MHSA fact sheets, press/media tool kit & program information. 3. New Community Input page, INN idea form, and Pop-up message live 11/27/23

Brainstorm | Engage Stakeholders | Create Plan | **Execute** | Collect Data | Analyze Data | Draw Conculsions

	Target	Promote awareness to Alameda County Residents	Results
☑	10/28/23-12/31/23	Community groups engaged to participate in the Community Planning Process.	1. 340 organizations contacted. 2. Based on strategic geographic location in the county. 3. Based on the population they serve.
☑	10/28/23-12/31/23	Community outreach through various media channels: 1. Newspapers 2. E-Newsletters 3. Text Messages 4. Event outreach	Community outreach through various media channels: 1. Newspapers a. Bay Area News Group – 59,527 subscribers b. East Bay Express – 15,000 subscribers 2. E-Newsletters a. PEERS – 2,500 subscribers b. Crisis Support Services – 7,000 subscribers. c. Asian Health Services – 483 external subscribers, 584 intra email, d. HHREC – 548 subscribers e. ACMHSA – 2,541 subscribers f. African American Family Outreach Project- 500 subscribers g. OCCS Vets – 15 subscribers h. Swords to Plow Shares – 63 subscribers i. Alameda-Contra Costa Medical Assosciation – 5,500 subscribers j. First 5 Alameda County – 1,000 subscribers

			3. Text Messages a. El Timpano – 1,761 subscribers 4. Event outreach a. Dewey Academy – 100 students b. Life learning Academy – 42 students c. HHREC Christmas events – 108 participants d. Fruitvale Posada event – 60 surveys
☑	10/28/23-12/31/23	Social Media Engagement: 1. HCSA 2. Providers 3. LinkedIn posts	Social Media Engagement: 1. Paid Advertisement a. Facebook, Instagram – i. 150,669 reach ii. 615,038 impressions iii. CPC $1.35 2. HCSA a. HCSA Facebook – 5,500 followers b. HCSA Instagram – 1,145 followers c. HCSA Twitter – 8,500 followers 3. Providers a. First 5 Alameda County – 1,600 followers b. Family Education Resource Center – 3,400 followers 4. LinkedIn posts a. City of Oakland – 17,000 followers b. East Bay Economic Development Alliance – 2,000 followers
☑	10/28/23-12/31/23	1. Alameda County Internal Efforts 2. Library Participation	1. Alameda County Staff a. Board of Supervisors i. Newsletter – 62,283 ii. Facebook - 65 iii. Instagram - 468 iv. Twitter - 116 v. WeChat - 500 b. HCSA Newsletter – 10,000 subscribers c. ACBH System of Care Directors – 251 subscribers d. Office of Equity – 78 subscribers e. Prevention & Early Intervention – 140 subscribers f. MHSA Stakeholders – 20 subscribers g. Consumer Family Workgroup – 31 subscribers h. Intranet – 693-2,000 subscribers 2. Library Participation a. Alameda County Library b. City of Fremont Library Community c. City of Dublin Library Community

Brainstorm | Engage Stakeholders | Create Plan | Execute | **Collect Data** | **Analyze Data** | Draw Conculsions

	Target	Outreach to encourage historically underserved and unserved communities to participate in MHSA funded activities	Results
☑	10/2/23-1/16/24	Conduct Listening Sessions & Key Informative Interviews in different regions in Alameda County. Develop materials, questionnaire, create list of 11 categorized areas of community need, craft culturally appropriate standardized dialogue. Educate providers on MHSA changes, programs, and updates. Encourage providers to facilitate information to their consumers and families.	1. 23 Listening Sessions a. Community groups b. Consumer groups c. Senior groups d. TAY groups e. Multilingual groups 2. 13 Key Informative Interviews a. City leadership b. Agency leadership c. Provider leadership 3. MHSA team analyzed and standardized community response into a reviewable framework. a. Community Input Survey data b. Listening Session and KII data
☑	10/2/23-1/16/24	The MHSA team conducted email marketing, social media marketing, event outreach; street outreach and provided printed flyers to encourage community input. Surveys were distributed to stakeholders in a paper format to ensure we were targeting communities that did not have access to the internet & digital devices.	1. Email marketing 2. Social Media marketing 3. Event outreach 4. Street outreach 5. Community Input Surveys 6. MHSA Flyers

Brainstorm | Engage Stakeholders | Create Plan | Execute | Collect Data | Analyze Data | **Draw Conclusions**

	Target	Educate community on the results of the CPPP MHSA Funded activities	Results
☑	1/16/24-2/1/24	MHSA team reviewed collected data and made recommendations on how to solve community needs.	1. MHSA team analyzed and standardized community response into a reviewable framework. 2. Shared with Agency Leadership. 3. Located in MHSA Plan Update.
☑	10/2/23-1/16/24	Update MHSA materials with new community input data.	1. Update MHSA Presentations 2. Update ACMHSA Website 3. Program fund distributions.

Outreach Plan for Public Comment
MHSA FY24/25 Annual Update Plan

Brainstorm → Create Plan → Engage Stakeholders → Execute → Collect Data → Analyze Comments → Draw Conclusions

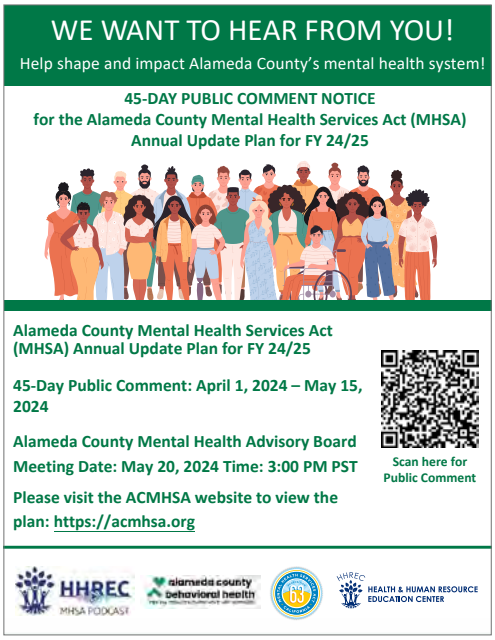
	Target	Outreach to obtain Public Comment on the MHSA FY24/25 Annual Plan	Results
☑	3/1/24-3/29/24	Create Public Comment Outreach Materials.	1. Create Online Survey 2. Create Flyer 3. Create Video explaining plan – recorded 3/15/24
☑	4/1/24-5/15/24	Engage community and local partners to encourage feedback and critique of the MHSA FY24/25 Annual Plan.	1. Outreach to local providers/agencies 2. Outreach to MHSA SG 3. Post on ACMHSA website. 4. Community Presentations 5. Newspapers Ads 6. Email distribution campaigns. 7. HCSA Social Media postings.
☑	5/15/24	Incorporate Public Comment recommendations into MHSA FY24/25 Annual Plan.	1. Analysis of public recommendations. 2. Implementation of public recommendations.
☑	5/20/24	Public Hearing at Mental Health Advisory Board	1. Present MHSA FY24/25 Annual Plan to Mental Health Advisory Board.
☑	6/24	Board of Supervisor Meeting – Health Committee	1. Discussion 2. Approval of MHSA FY24/25 Annual Plan


WE WANT TO HEAR FROM YOU!
Help shape and impact Alameda County's mental health system!
Community Program Planning Process
for the Alameda County Mental Health Services Act FY 24/25 Annual Plan Update
HHREC
MHSA PODCAST
alameda county behavioral health
HEALTH & HUMAN RESOURCE EDUCATION CENTER
MHSA INVITES YOU TO TAKE THE COMMUNITY INPUT SURVEY
SURVEY IS AVAILABLE IN THREE LANGUAGES
English Spanish Chinese
Select the language of your choice on the right side of the beginning portion of the survey
CLICK HERE TO TAKE THE SURVEY
Or scan QR Code to take the survey
For more information go to www.ACMHSA.org


期待听到您的声音!
帮助打造和影响阿拉米达县的精神健康体系!
社区计划规划流程
阿拉米达县精神健康服务法案24/25财年年度计划更新
HHREC
MHSA PODCAST
alameda county behavioral health
MHSA诚邀您参与社区意见调查
调查问卷共提供三种语言
英文 西班牙文 中文
在调查问卷的右上角可选择语言
点击此处参与调查
或者扫描二维码参与调查
更多信息，请访问 www.ACMHSA.org


¡QUEREMOS SABER TU OPINIÓN!
¡Ayuda a dar forma e impactar el sistema de salud mental del condado!
Proceso de Planificación Comunitaria
para la Actualización del Plan Anual FY24/25 de la Ley de Servicios de Salud Mental del Condado de Alameda
HHREC
MHSA PODCAST
alameda county behavioral health
HEALTH & HUMAN RESOURCE EDUCATION CENTER
MHSA TE INVITA A PARTICIPAR EN LA ENCUESTA DE APORTES COMUNITARIOS
LA ENCUESTA ESTÁ DISPONIBLE EN TRES IDIOMAS:
inglés español chino
Selecciona el idioma de tu preferencia en el lado derecho de la parte inicial de la encuesta.
HAZ CLIC AQUÍ PARA REALIZAR LA ENCUESTA
O escanea el código QR para participar en la encuesta
Para más información, visita www.ACMHSA.org


Your input can shape the future of mental health in Alameda County
Be Well
ALAMEDA COUNTY HEALTH CARE SERVICES AGENCY
Behavioral Health Department


WE WANT TO HEAR FROM YOU!
Help shape and impact Alameda County's mental health system!
45-DAY PUBLIC COMMENT NOTICE
for the Alameda County Mental Health Services Act (MHSA)
Annual Update Plan for FY 24/25
Alameda County Mental Health Services Act (MHSA) Annual Update Plan for FY 24/25
45-Day Public Comment: April 1, 2024 – May 15, 2024
Alameda County Mental Health Advisory Board Meeting Date: May 20, 2024 Time: 3:00 PM PST
Please visit the ACMHSA website to view the plan: https://acmhsa.org
Scan here for Public Comment
HHREC
MHSA PODCAST
alameda county behavioral health
HEALTH & HUMAN RESOURCE EDUCATION CENTER


¡Queremos escuchar tus opiniones!
Ayuda a dar forma e impactar el sistema de salud mental del condado de Alameda.
Aviso de comentario público de 45 días para la ley de Servicios de Salud Mental del Condado de Alameda (MHSA) Plan del Programa para el año fiscal FY 24/25
Servicios de Salud Mental del Condado de Alameda (MHSA). Plan del Programa para el año fiscal FY 24/25.
Comentario público del: 1 Abril, 2024 – 15 Mayo, 2024
Fecha de la junta del Comité Asesor de Salud Mental del Condado de Alameda: 20 Mayo, 2024, tiempo: 3:00 PM PST
Visite el sitio web de ACMHSA para ver el plan: https://acmhsa.org
Escanee el código QR para obtener comentarios públicos
HHREC
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alameda county behavioral health
HEALTH & HUMAN RESOURCE EDUCATION CENTER

alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

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

MHSA Key Informant Interview (KII) Process
Summary Sheet

Interviewee: Name/Title/Agency:
KII DATE/TIME: Click or tap to enter a date.

Introduction and Explanation:
Thank interviewee for their time today and explain that the Mental Health Services Act, also known as MHSA or Prop 63, is a state funding stream funded through a 1% tax on California residents that earn over $1 million dollars/year. It requires that each year community input is gathered from a diverse group of stakeholders like themselves, which is why we've contacted them for their perspective and expertise.

The MHSA Team, along with a community planning committee has identified 11 community behavioral health needs that we'd like your opinion on and solutions to the top ranked needs for your [insert name of city or department].

The information provided will be used for our planning purposes for FY 24/25 and will be included in our next MHSA Report that will be published in the spring of 2024.

Transition to the Interview Questions
Share your screen and review the 11 areas of need. Then ask the interviewer to identify the top 3 or 4 areas of need for their city or department.

Note: (Once you confirm a KII please send the interviewee the Areas of Need document so they can read it before hand if they'd like, so that they're prepared for the interview).

1. Ranking of Community Needs:

Community Need	Ranking
Access, Coordination and Navigation to Services	Choose an item.
Behavioral Health Workforce	Choose an item.
Crisis Continuum	Choose an item.
Housing Continuum	Choose an item.
Substance Use	Choose an item.
Community Violence and Trauma	Choose an item.
Child/Youth/Young Adult Needs	Choose an item.
Adult/Older Adult Needs	Choose an item.
Needs of Family Members	Choose an item.
Needs of Veterans	Choose an item.
Needs of the Re-entry Community	Choose an item.

MHSA KII Q&A Workbook
Creation Date: October 31, 2023
Once COMPLETE, put the document here: LS Notes_Summaries in the MHSA Share Point Site

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

Once the interviewee has identified the top 3 or 4 Areas of Need tell them you'd like to hear about their ideas and opinions on *solutions* to these top ranked needs.

2. **Ranking #1**
   Record/Solutions/Strategies/Ideas to address this need:

3. **Ranking #2**
   Record/Solutions/Strategies/Ideas to address this need:

4. **Ranking #3**
   Record/Solutions/Strategies/Ideas to address this need:

5. **Ranking #4**
   Record/Solutions/Strategies/Ideas to address this need:

   Once this process is complete, ask them if there's anything we missed or anything else they would like to share with us.

6. **What Else, What Did we Miss**:
   Record/List Answers

   This is for your own notes afterwards to summarize and synthesize the information

   Overall Summary of the Listening Session

MHSA KII Q&A Workbook
Creation Date: October 31, 2023
Once COMPLETE, put the document here: LS Notes_Summaries in the MHSA Share Point Site

FACILITATOR NAME/AGENCY: ACBH Pride Coalition Meeting
FOCUS GROUP DATE/TIME: 12/6/2023
# of Attendees: 13
County/MHSA: 6 – Amy Saucier, Janice Adam, Margaret Salmond, Sarina Hill, Noah Gallo, (Abigail C. *had audio malfunction during the meeting*)

I. **Ranking of Community Needs:**

Community Need	Top Three (3) Ranking	Tally numbers
Access, Coordination and Navigation to Services	Ranking the Votes	2
Behavioral Health Workforce	3	3
Crisis Continuum	Ranking the Votes	1
Housing Continuum	Ranking the Votes	2
Substance Use	1	4
Community Violence and Trauma	Ranking the Votes	1
Child/Youth/Young Adult Needs	Ranking the Votes	1
Adult/Older Adult Needs	Ranking the Votes	
Needs of Family Members	Ranking the Votes	1
Needs of Veterans	Ranking the Votes	2
Needs of the Re-entry Community	2	4

II. **Ranking #1**: Substance Use
Record/Solutions/Strategies/Ideas to address this need:

- The Pride Coalition needs funding for education, prevention, and treatment to all school levels. (because there's no funding to get into middle schools where the majority of the kids should be receiving education and prevention).
- There's a great need to focus on all stages of education level with regards to SU education, prevention, and treatment.
    - Issues on vaping and cannabis in middle school of youth in general not just LGBTQIA. By the time they see those kids w/SU is in High School/9th grade where they've already had a history of SU since 13 years old or same as the national statics of SU within the US. Unfortunately, it's outside of their grant with county to do presentation of substance use education to middle school and elementary. Although the county has prioritized TAY and youth there's a still a big gap that's not being served.
    - There's a great need to focus on all stages of education level with regards to SU education, prevention, and treatment.
- Need to have higher priority to prevention in effective ways.

- In reality, SU has been a manifestation of Trauma from the community, and adverse childhood experiences.
- Need Traumatic support and programs as catalyst in effective and variety of ways.
  - Issues of substance abuse and mental health illness due to lack of support to traumatic experiences of our young people among all other things.

Ranking #2: Access, Coordination and Navigation to Services (Topic Discussed)
Record/Solutions/Strategies/Ideas to address this need:

- We can strategize around coordination that's based with collaboration.
- Enhance linking clients to services/program that they need and follow through.
- How to collect useful feedback that clients' facing in accessible manner.
  - There's a constant/rapid change of information, policy, practice and human capacity of organization.
  - Instead, often times the evaluation/feedback collected was geared towards adults, thinking about literacy and comprehension. There's still a gap thinking about housing and other needs.
  - Someone being served may not always be able to come into the office and sit down or go out to the home for many different reasons, so just thinking about how to meet the client's need and be creative.
  - And many times, within the data a larger story was missing and may not be aligned with the numbers because there's really no space to really tell the fullness of what's happening and what folks are experiencing.
  - There's not much opportunity for collaboration that can begin to enhance linking clients/folks to services.
  - And some ways the system not just behavior health but the system within the county can do better at centering the needs of folks in ways that are transformative and not just in terms of reforms that we have a lot of crises that are happening that we need to hold our political bodies accountable.
- Need to be developed in-house particularly this dept. within the county to be LGBTQIA informative as other counties. Be more user friendly.
  - It's been over 10 years and our county's process has progressed very slowly and is being left behind by our neighboring counties. ACBH should reflect to other county around us comparably to Santa Clara County website and San Mateo in terms of providing information for LGBTQIA services.
- CATT and CSS need to have a different number without calling 911 (under Crisis Continuum)
  - In cases that CATT or CSS aren't available, when clients call 911, law enforcement tend to response instead which creates resistance.
  - Client doesn't want police involvement.
- Need more investment or budget for CATT and CSS staffing.
  - CATT and CSS are understaffed.
  - CSC dropped; CATT got overwhelmed.
- Need more service or program or replicate the following that's none police affiliated:

- MACRO link: City of Oakland | The Mobile Assistance Community Responders of… (oaklandca.gov);
- MH First Oakland has EMT entire staff link: MH First Oakland — APTP (antipoliceterrorproject.org)
- Being institutionalized and lack of autonomy has been barrier.

- Unincorporated areas of the county will have the Alameda County Sheriffs or CHP
- Need for preventive services, trauma education and teaching people how to navigate that will minimize/lesson people to falling back into cycle.
  - dealing with trauma (prognosis is livid), education and the need for healing.

Ranking #3: Housing Continuum (Topic Discussed)
Record/Solutions/Strategies/Ideas to address this need:

- Great need for residential site program mainly for youth in general who have medical/do not have insurance. There's no service whether those youth can even have access to residential site outside our county.
  - There's no housing for young people at all in our county.
  - LGBTQIA transitional age youth in South County are having tremendous challenge accessing housing, mental health services, and gender reform services. As a provider, it has been typical for them to be the clearing house for service information for the county.

III. **What Else, What Did we Miss**: (other areas/topic discussed)
Record/List Answers

A. If possible, to include diversion w/re-entry or as its own category.
B. All inter-connected and inter-related are the Child/Youth/Young Adult Needs, Substance Abuse & Prevention, Incarceration and Reentry, and Community Violence & Trauma:
   - Need to have higher priority to prevention including support at its best and effective ways in all these areas of needs and to be available to the whole community from youth, older adults, and to their parents that will help at least minimize or lessen all these areas of needs.
     - The majority of these areas of needs are manifestation of trauma from the community, adverse childhood experiences, which has been the source of higher rate of Incarceration and the workforce shortage.
C. Crisis Continuum
   - Need more emphasis on non-law enforcement crisis support access services.
     - clients do not even want to reach out for help in times of crisis, having mostly the only option of law enforcement provided because the response team is limited.
     - It's mostly been a deterrent for clients to call CATT through 911 to be able to access.

Overall Summary of the Listening Session

The ACBH Pride Coalition meeting was attended by ACBH Health Equity Division, Family Behavioral Health Care & Ethnic Services, and other CBOs like Quality Assurance Dept & Co-Chair Pride Grp.,

Restorative Justice for Oakland Youth, Horizon Treatment Services, Intake & Quality Assurance, Pacific Center for Human Growth, and Pathways to Wellness Clinics. The ACBH Senior Planner was a guest on this meeting, co-facilitated and talked briefly about MHSA history. Then the ACBH Senior Planner shared his screen of the 11 Categorized Areas of Community Needs for the participants to rank their top 3 areas of needs. The ACBH Senior Planner explained that this listening session aimed to get strategies, solutions, and feedback that would help the MHSA Division gather data for the FY 24/25 Update Plan that goes to the BOS and then the State. Afterwards the ACBH Senior Planner elaborated on each Community Areas of Needs and requested participants to cast their vote in the chat, which got tallied and ranked the top 3 topics focused on. Participants suggested a great need to provide funds for Substance Use education, prevention, and treatment at all school levels. The tremendous need for youth housing services entirely. The need to re-design the ACBH website on LGBTQIA information services/program and to be more user-friendly. The vital need for effective ways and more emphasis on prevention, education, and support for Trauma as a whole and especially for children and young people. Need expansion and replication for MACRO, MH First Oakland and CATT without police affiliation or involvement. One-stop-shop linking clients to appropriate services needed. Lastly, the ACBH Senior Planner launched in the chat the Community Input Survey and encouraged everyone to take part and share it with others. Finally, the ACBH Senior Planner expressed appreciation for this very thoughtful feedback provided by the attendees and to connect with him for future invitation of conducting this listening session in their or other gathering or meeting.

MHSA COMMUNITY PROGRAM PLANNING PROCESS
LISTENING SESSION ANSWER SHEET

FACILITATOR NAME/AGENCY: Alameda Contra Costa Medical Association
FOCUS GROUP DATE/TIME: 1/4/2024
# of Participants: 13

1. Ranking of Community Needs:

Community Need	Ranking
Access, Coordination and Navigation to Services	3
Behavioral Health Workforce	2
Crisis Continuum	Choose an item.
Housing Continuum	Choose an item.
Substance Use	Choose an item.
Community Violence and Trauma	1
Child/Youth/Young Adult Needs	4
Adult/Older Adult Needs	Choose an item.
Needs of Family Members	Choose an item.
Needs of Veterans	Choose an item.
Needs of the Re-entry Community	Choose an item.

2. **Ranking #1** Community Violence and Trauma

Record/Solutions/Strategies/Ideas to address this need:

There is a debate on how to deal with community violence and trauma in terms of strengthening police forces or allocating money to services. They would like to see more programs that address the mental health of victims of community violence. They would like to see non-law enforcement responses be available to different parts of the county in a timely manner.

3. **Ranking #2** Behavioral Health Workforce

Record/Solutions/Strategies/Ideas to address this need:

A local/municipal student loan repayment program to incentivize physicians/providers to practice in the community. This could be a good use of MHSA funds to incentivize strengthening behavioral health workforce. If we can increase the number of trained providers, then the level of care will increase. There is a need for more providers to have more linguistic and cultural capacities. They are looking for mental health and medical extenders to help serve non-English speaking populations. They are concerned about how long it takes for people to become medical professionals and not enough people going into the field. They would like to see more internship positions to create pathways for non-medical professionals to help serve non English-speaking clients.

4. **Ranking #3** Access, Coordination and Navigation to Services

Record/Solutions/Strategies/Ideas to address this need:

Providers are limited so the access to care is limited and wait times are longer. They would like to see more housing programs with wrap around services for clients. They are concerned with the number of programs that could be cut or changed with the new proposition 1. The need for bilingual navigators is continuing to rise and they would like to see more funding into creating a larger bilingual workforce.

Overall Summary of the Listening Session

The MHSA team met with the Alameda Contra Costa Medical Association to conduct a virtual listening session. The providers shared their top concerns for community needs as Community Violence and Trauma, Behavioral Health Workforce, and Access, Coordination and Navigation to Services. There was a theme in the discussion about strategies to ensure that the staffing for medical professionals is sufficient. The group discussed how non licensed staff can be utilized through internships and as navigators for multilingual and multicultural needs diverse clients. The group also discussed the need for wraparound services at housing sites to ensure that clients' needs are being met. Lastly, the group is concerned by the potential changes to programs from Proposition 1 and they would like to write a letter advocating for mental health programs.

MHSA COMMUNITY PROGRAM PLANNING PROCESS
LISTENING SESSION ANSWER SHEET

FACILITATOR NAME/AGENCY: African American Family Outreach Project
FOCUS GROUP DATE/TIME: 10/2/2023
# of Participants: 15

1. Ranking of Community Needs:

Community Need	Ranking
Access, Coordination and Navigation to Services	1
Behavioral Health Workforce	Choose an item.
Crisis Continuum	Choose an item.
Housing Continuum	2
Substance Use	Choose an item.
Community Violence and Trauma	Choose an item.
Child/Youth/Young Adult Needs	3
Adult/Older Adult Needs	Choose an item.
Needs of Family Members	Choose an item.
Needs of Veterans	Choose an item.
Needs of the Re-entry Community	Choose an item.

2. **Ranking #1** Access, Coordination, and Navigation to Services

Record/Solutions/Strategies/Ideas to address this need:

- Greater access to ACCESS
- Central place to get what you need - dial 1 number
- Create/distribute brochures that identify level of service
- Need for long term care and more room in those facilities
- Connections to right facilities to get loved ones into
- No one leaves JG without follow up treatment plan including pre-set appointment
- How do you get information?
- Make clear which crisis services involve police
- More consistency of services when dialing 911
- We don't have enough resources
- Information and resources for family members (not just patients)

3. **Ranking #2** Housing Continuum

Record/Solutions/Strategies/Ideas to address this need:

- License board and care in short supply and many are going out of business
- Emergency housing should last a minimum of 6 months, followed by long term supportive housing
- More supportive housing

- Affordable housing connected with supporting housing
- Community land trust to permanently house folks affordably
- Housing safely and programming should be licensed and evaluated every year
- Monitoring of board and cares (they currently self report) locations; surprise visit monitoring
- Supportive housing locations have direct relationship with day treatment program
- More social activities in board and care to prevent isolation
- I have to go to San Mateo and Concord for social activities (I have MH issues)

4. **Ranking #3** Child/Youth/Young Adult Needs

Record/Solutions/Strategies/Ideas to address this need:

- Knowledge about social activities. Are wellness centers engaging? Engagement could be higher.
- Supporting work would be helpful.
- Parents don't understand youth issues; they need more connections; parents don't have skill set.
- Give parents tools they need for how not to overreach and be judgmental
- Give parents an overview of what's normal and abnormal with kids and teens. How to know when my child needs help. Provide information at PTA meetings.
- Peer to peer support; more comfortable talking to peers
- Substance abuse issues; strengthen MH programs with SUD and youth.
- More education about SUD for youth/teens.
- Respite care for youth (mail; showers).

5. **What Else, What Did we Miss**:

Record/List Answers

- Social engagement - mobile units for providers who do not provide this
- Stop reporters/police from immediately labeling mass shooters as mentally ill
- Community violence - talk more about this.
- Needs of family members - we can't help with medical or therapy; need someone to vent to (get a break, support services)
- Police brutality of black, brown, trans people
- Police violence is a way that many end up with substance abuse as a way to cope with stress.

Overall Summary of the Listening Session

MHSA cohosted a listening session with African American Family Outreach Program participants. Participants identified streamlining service access with a centralized system, consistent crisis response, and comprehensive aftercare plans. They also addressed urgent housing needs requiring longer emergency stays, increased supportive and affordable housing, and better oversight for program safety. Finally, the participants addressed family and youth support gaps through education, peer support, expanded mental health programs, and respite care. Additionally, emphasizing community engagement and changing mental health and violence narratives.

MHSA Key Informant Interview (KII) Process
Summary Sheet

Interviewee: Name/Title/Agency: First 5 Fatherhood Summit
KII DATE/TIME: 12/4/2023

Introduction and Explanation:
Thank interviewee for their time today and explain that the Mental Health Services Act, also known as MHSA or Prop 63, is a state funding stream funded through a 1% tax on California residents that earn over $1 million dollars/year. It requires that each year community input is gathered from a diverse group of stakeholders like themselves, which is why we've contacted them for their perspective and expertise.

The MHSA Team, along with a community planning committee has identified 11 community behavioral health needs that we'd like your opinion on and solutions to the top ranked needs for your [insert name of city or department].

The information provided will be used for our planning purposes for FY 24/25 and will be included in our next MHSA Report that will be published in the spring of 2024.

Transition to the Interview Questions
Share your screen and review the 11 areas of need. Then ask the interviewer to identify the top 3 or 4 areas of need for their city or department.

Note: (Once you confirm a KII please send the interviewee the Areas of Need document so they can read it before hand if they'd like, so that they're prepared for the interview).

1. Ranking of Community Needs:

Community Need	Ranking
Access, Coordination and Navigation to Services	1
Behavioral Health Workforce	2
Crisis Continuum	8
Housing Continuum	5
Substance Use	9
Community Violence and Trauma	6
Child/Youth/Young Adult Needs	3
Adult/Older Adult Needs	10
Needs of Family Members	7
Needs of Veterans	11
Needs of the Re-entry Community	4

Once the interviewee has identified the top 3 or 4 Areas of Need tell them you'd like to hear about their ideas and opinions on *solutions* to these top ranked needs.

2. **Ranking #1** Access, Coordination and Navigation to Services

Record/Solutions/Strategies/Ideas to address this need:

The county needs to continue to be proactive in how we promote, coordinate and help clients navigate mental health resources. There needs to be a continued emphasis in how we provide access to free or low-cost mental health resources for fathers.

3. **Ranking #2** Behavioral Health Workforce

Record/Solutions/Strategies/Ideas to address this need:

They recognize the need for workforce diversity and cultural alignment to work with the different ethnicities of fathers they assist. They are also aware that it has become increasingly more difficult to hire qualified providers to work with clients.

4. **Ranking #3** Child/Youth/Young Adult Needs

Record/Solutions/Strategies/Ideas to address this need:

They are receiving feedback from the fathers they serve that there needs to be more attention to mental health support for children and young adults. They are seeing that the different age groups of children and young adults require different levels of mental health services.

5. **Ranking #4** Needs of the Re-entry Community

Record/Solutions/Strategies/Ideas to address this need:

This population requires need to address immediate mental health challenges for people coming in and out of the justice system. They are also seeing some fathers needing to find housing, jobs and overall community reintegration support.

This is for your own notes afterwards to summarize and synthesize the information

Overall Summary of the Listening Session

The MHSA team spoke with leaders of the Fatherhood Summit with First 5 Alameda County to address the needs of fathers in the mental health landscape. Discussed were challenges fathers encounter when accessing low-cost mental health services and the need for support and understanding in their mental health wellness. They advocate for more mental health resources and programs designed for fathers, that seek to engage both involved and disengaged fathers without judgement or bias. The conversation highlighted the importance of changing the discussion around mental health resources for fathers, specifically the black and brown communities, by extending available and culturally aligned services.

MHSA COMMUNITY PROGRAM PLANNING PROCESS
LISTENING SESSION ANSWER SHEET

FACILITATOR NAME/AGENCY: AHS TAY Group
FOCUS GROUP DATE/TIME: 11/29/2023
# of Participants: 4

1. Ranking of Community Needs:

Community Need	Ranking
Access, Coordination and Navigation to Services	1
Behavioral Health Workforce	3
Crisis Continuum	Choose an item.
Housing Continuum	1
Substance Use	Choose an item.
Community Violence and Trauma	4
Child/Youth/Young Adult Needs	Choose an item.
Adult/Older Adult Needs	Choose an item.
Needs of Family Members	Choose an item.
Needs of Veterans	Choose an item.
Needs of the Re-entry Community	Choose an item.

2. **Ranking #1**Housing
Record/Solutions/Strategies/Ideas to address this need:

3. **Ranking #2** Access, Coordination and Navigation
Record/Solutions/Strategies/Ideas to address this need:
Stigma and knowledge. Doubt the effect of certain services, especially related to MH, so more ways to show that the services are helpful, youth-social media platforms, really depends on the community, for the Chinese community they use we chat (sp) how efforts are mobilized, in person community outreach, tabling outside grocery stories face to face is very important. Phone banking to follow up.

4. **Ranking #3**Workforce
Record/Solutions/Strategies/Ideas to address this need:
Provide exposure and inspiration for youth about different routes to MH careers and experiences. Scholarship programs, loan assumption.

5. **What Else, What Did we Miss**: Community violence and trauma: healthy relationship trainings especially in school healthy communication boundary setting Sharing information on the different heritage events each month, expose others to different cultures.

Safety in college campus, lift rides, hosting a lot of events to showcase other race/ethnicities, security presence

Record/List Answers

Overall Summary of the Listening Session

MHSA cohosted a listening session with Asian Health Services for college-aged youth. The top mental health issues mentioned included Access, Coordination and Navigation to Services, Housing, Behavioral Health Workforce and Community Violence and Trauma. Participants identified solutions such as media projects to reduce stigma/discrimination regarding mental health services as well as stories and information on how effective or helpful mental health services can be. A variety of outreach strategies were mentioned including social media platforms such as Instagram and WeChat, event outreach, and phone banking. The group stressed linking outreach efforts to the various needs of specific communities. Other solutions included school-based training on boundary setting and healthy relationships-for the purpose of preventative approaches to domestic violence. Demographics included: Asian identified young adults ages 18-24.

MHSA Key Informant Interview (KII) Process
Summary Sheet

Interviewee: Name/Title/Agency: Jennifer Penny, Chief Behavioral Officer, Axis Community Health
KII DATE/TIME: 11/20/2023

Introduction and Explanation:
Thank interviewee for their time today and explain that the Mental Health Services Act, also known as MHSA or Prop 63, is a state funding stream funded through a 1% tax on California residents that earn over $1 million dollars/year. It requires that each year community input is gathered from a diverse group of stakeholders like themselves, which is why we've contacted them for their perspective and expertise.

The MHSA Team, along with a community planning committee has identified 11 community behavioral health needs that we'd like your opinion on and solutions to the top ranked needs for your [insert name of city or department].

The information provided will be used for our planning purposes for FY 24/25 and will be included in our next MHSA Report that will be published in the spring of 2024.

Transition to the Interview Questions
Share your screen and review the 11 areas of need. Then ask the interviewer to identify the top 3 or 4

Share your screen and review the 11 areas of need. Then ask the interviewer to identify the top 3 or 4 areas of need for their city or department.

Note: (Once you confirm a KII please send the interviewee the Areas of Need document so they can read it before hand if they'd like, so that they're prepared for the interview).

1. Ranking of Community Needs:

Community Need	Ranking
Access, Coordination and Navigation to Services	6
Behavioral Health Workforce	2
Crisis Continuum	1
Housing Continuum	7
Substance Use	8
Community Violence and Trauma	3
Child/Youth/Young Adult Needs	4
Adult/Older Adult Needs	5
Needs of Family Members	9
Needs of Veterans	10
Needs of the Re-entry Community	11

Once the interviewee has identified the top 3 or 4 Areas of Need tell them you'd like to hear about their ideas and opinions on *solutions* to these top ranked needs.

2. **Ranking #1** Crisis Continuum

Record/Solutions/Strategies/Ideas to address this need:

There is a need to expand services to additional cities (Livermore, Castro Valley). There are not a lot of mental health services available in the region, the county covers ¼ of the cost for their current mental health services. Axis developed an alternative mental health response program in Pleasanton with the Police department. A plain clothes police officer responds to calls and this approach has helped reduce 5150 rates by 60% from 2019 to 2023. Axis has partnered with a local county hospital to write their own 5150s.

3. **Ranking #2** Behavioral Health Workforce

Record/Solutions/Strategies/Ideas to address this need:

Recruiting difficulties have caused several positions to be vacant for an extensive period. There have been challenges in hiring counselors who reflect the diverse population and those that speak different languages. The trauma clients that staff are working with have influenced staff, but retention efforts have been effective. There has also been a scarcity of psychiatrists, and this has caused Axis to use costly outside providers.

4. **Ranking #3** Community Violence and Trauma

Record/Solutions/Strategies/Ideas to address this need:

There has been a rise in PTSD diagnosis and acute trauma and stress due to the pandemic. There has also been an increase in trauma related to immigration issues and global conflicts. This has impacted families, and the workload has impacted staff burnout.

5. **Ranking #4** Access, Coordination and Navigation to Services

Note: (Once you confirm a KII please send the interviewee the Areas of Need document so they can read it before hand if they'd like, so that they're prepared for the interview).

1. Ranking of Community Needs:

Community Need	Ranking
Access, Coordination and Navigation to Services	5
Behavioral Health Workforce	1
Crisis Continuum	3
Housing Continuum	4
Substance Use	2
Community Violence and Trauma	7
Child/Youth/Young Adult Needs	8
Adult/Older Adult Needs	9
Needs of Family Members	10
Needs of Veterans	11
Needs of the Re-entry Community	6

Once the interviewee has identified the top 3 or 4 Areas of Need tell them you'd like to hear about their ideas and opinions on *solutions* to these top ranked needs.

2. **Ranking #1** Behavioral Health Workforce

Record/Solutions/Strategies/Ideas to address this need:

They recognize there is a crisis, and they face challenges in recruitment, development, and retention of licensed professionals. There is high demand for professionals and not enough workers to fill the demand.

3. **Ranking #2** Substance Abuse

Record/Solutions/Strategies/Ideas to address this need:

There is a disconnect between behavioral health and substance abuse services which causes obstacles for individuals to access support. Mental health needs require a larger workforce with support and sustainable infrastructure.

4. **Ranking #3** Crisis Continuum

Record/Solutions/Strategies/Ideas to address this need:

There are differences in understanding the community resources that the clients need. This can lead to not effectively using the crisis stabilization units which causes a disconnect between services. The staff needs to continue to be trained to provide more accessible crisis intervention services.

5. **Ranking #4** Housing Continuum

Record/Solutions/Strategies/Ideas to address this need:

There needs to be more housing for and housing support that is affordable for clients. There needs to be more service enriched housing programs, this is a greater need than just shelter. These housing programs can address the mental health needs of clients they house.

Overall Summary of the Listening Session

MHSA conducted a key informant interview with Jovan Yglecias Chief Program Officer and Katherine Lutz Associate Director of Programs, Bay Area Community Services. The top needs highlighted were addressing the crisis in the behavioral health workforce, creating integrated systems to address substance abuse, minimizing gaps in crisis intervention services, and creating service enriched housing programs. BACS emphasizes the need for culturally sensitive navigation services, support for the reentry community, difficulties faced by veterans and for Alameda County to continue to refine and seek community input on how resources are spent to enhance mental health services in the region.

MHSA COMMUNITY PROGRAM PLANNING PROCESS
LISTENING SESSION ANSWER SHEET

FACILITATOR NAME/AGENCY: Casa Ubuntu English Listening Session
FOCUS GROUP DATE/TIME: 10/24/2023
# of Participants: 5

1. Ranking of Community Needs:

Community Need	Ranking
Access, Coordination and Navigation to Services	1
Behavioral Health Workforce	Choose an item.
Crisis Continuum	Choose an item.
Housing Continuum	2
Substance Use	3
Community Violence and Trauma	4
Child/Youth/Young Adult Needs	Choose an item.
Adult/Older Adult Needs	Choose an item.
Needs of Family Members	Choose an item.
Needs of Veterans	Choose an item.
Needs of the Re-entry Community	Choose an item.

2. **Ranking #1** Access, Coordination and Navigation to Services

Record/Solutions/Strategies/Ideas to address this need:

- Coordination
- Navigation
  - Difficult finding the right services, need more non-profit support.
  - Language should be geared towards person in need.
  - PEER support helps because they have in-house or lived in experience.
  - Need more peer-support groups.

- Casa Ubuntu-need more places similar to the kind of services they offer.
- More outreach with shared information
- 12 steps of recovery is one solution that supported navigating services.
- Places with dual diagnosis can provide resources and support.
- More booklets or pamphlets with resources support.
  - Libraries, Santa Rita, Wellness Centers, Dr's Office, WIC, Grocery stores

3. **Ranking #2** Housing Continuum

Record/Solutions/Strategies/Ideas to address this need:

- Homelessness
  - Packets are way too thick.
  - Shortening processes would help.
  - Streamline approach in applications.
- Tiny Homes
  - Bonita House assists with housing; we should have programs throughout Alameda to get housing for all.
  - Affordable housing, affordable rates
- Supportive services
  - Driving support for those who are disabled or cannot drive themselves.
  - Moving items, like moving support in the event someone who can't package their own belongings get support with that.

4. **Ranking #3** Community Violence & Trauma

Record/Solutions/Strategies/Ideas to address this need:

- Address youth support needs
  - Early intervention
  - Prevention services
- Housing
  - Troubles/Issues within the home
  - Rent cap for young people like Bonita House for TAY
  - More access to therapy service for unique diagnosis/speal-knowledge
  - Housing Academy (Former Program that Ubuntu had)
    - Rent subsidies
    - Housing training/support
    - BACS – other wellness center support

5. **What Else, What Did we Miss**: Substance Abuse

Record/List Answers

- 12 Steps program is beneficial
- Need more 12 step programs that are non-spiritual
- More sponsors
- More road to recovery programs
- Under Access:
  - Being around others or more peer-support helps

- Transportation support for access to services & buildings that offer program services

Overall Summary of the Listening Session

During the Casa Ubuntu English speaking listening Session, we presented information regarding the needs of the community that were based off collected data over prior years. These were the highlights for three key areas of concern: This group identified access to services with solutions that solves issues involving the challenge of finding appropriate services and the need for more non-profit support, peer support groups, and accessible resources. One of the main concerns was homelessness, with recommendations including simplifying housing applications, promoting tiny home programs, and ensuring affordability. Supportive services for those with disabilities are crucial. Another main concern was addressing community violence & trauma with the focus in this area which focuses on youth support, emphasizing early intervention, better housing conditions, and increased access to therapy services. Programs like the Housing Academy are suggested. In addition, addressing substance abuse is also a priority, with suggestions for non-spiritual 12-step programs, more sponsors, and improved access through peer support and transportation services.

MHSA COMMUNITY PROGRAM PLANNING PROCESS
LISTENING SESSION ANSWER SHEET

FACILITATOR NAME/AGENCY: Ubuntu Spanish Listening Session
FOCUS GROUP DATE/TIME: 10/24/2023
# of Participants: 14

1. Ranking of Community Needs:

Community Need	Ranking
Access, Coordination and Navigation to Services	Choose an item.
Behavioral Health Workforce	Choose an item.
Crisis Continuum	Choose an item.
Housing Continuum	Choose an item.
Substance Use	Choose an item.
Community Violence and Trauma	1
Child/Youth/Young Adult Needs	Choose an item.
Adult/Older Adult Needs	2
Needs of Family Members	Choose an item.
Needs of Veterans	Choose an item.
Needs of the Re-entry Community	3

2. **Ranking #1 Community Violence & Trauma**

Record/Solutions/Strategies/Ideas to address this need:

- Faster police responses
- Trauma when police don't come
- There are more shootings, need more patrols especially on the weekends its more prevalent
- Police don't come when called, need more support in response times
- The community would be safer with community workers or advocates
- Transportation incentives
- There's a lot of bullying in schools, families need support for parents from police and schools
    - More psychologists, mentors, advocates for youth in school
    - More suicide prevention in schools
    - Escorts for our elders who work later hours or early hours to feel safer when leaving their homes/work

3. **Ranking #2** Adult/Older Adult Needs

Record/Solutions/Strategies/Ideas to address this need:

- More social services
- More support for DACA/Undocumented
- Services for disabled/low-mobility
- More job fairs in the community
- Community group to help with fast response for emergencies
- Better information for elders
- Literacy programs
- Teach people to use transport
- Easily accessible housing

4. **Ranking #3** Needs of the Re-entry Community

Record/Solutions/Strategies/Ideas to address this need:

- Education during/after jail
- Online classes to make it easier
- Free computer programs for undocumented people
- Access to the internet and technology
- Teorary housing after jail/prison
- Programs to learn trade skills for re-entry citizens
- Benefits for undocumented people
- Shorter waiting times for housing lists for undocumented people
- Programs for immigration(getting your citizenship)

5. **What Else, What Did we Miss**: Substance Abuse

Record/List Answers

- Help for emergencies
- Resources for employment
    - Mentioned “Bay Area Community Resources”
    - Mentioned “Bay Area Community Support”
- Help with domestic worker abuse problems

Overall Summary of the Listening Session

- From the Casa Ubuntu’s Spanish Speaking group perspective, the most pressing community needs include addressing issues related to Community Violence & Trauma, where they emphasize the importance of faster police responses, increased patrols, better support for families and youth in schools, and safe transportation for both youth and elders. Additionally, they underscore Adult/Older Adult Needs, advocating for more social services, support for DACA/Undocumented individuals, job fairs, literacy programs, transportation assistance, and accessible housing. The group is also committed to addressing the needs of the Re-entry Community, focusing on education, online classes, access to technology, housing, and benefits for undocumented individuals. Lastly, though not a top-ranked concern, they seek help for substance abuse emergencies and employment resources while mentioning specific organizations like "Bay Area Community Resources" and "Bay Area Community Support."

MHSA Key Informant Interview (KII) Process
Summary Sheet

Interviewee: Name/Title/Agency: Shanna Bowie, Community Programs Director, Pacific Center
KII DATE/TIME: 11/20/2023

Introduction and Explanation:
Thank interviewee for their time today and explain that the Mental Health Services Act, also known as MHSA or Prop 63, is a state funding stream funded through a 1% tax on California residents that earn over $1 million dollars/year. It requires that each year community input is gathered from a diverse group of stakeholders like themselves, which is why we’ve contacted them for their perspective and expertise.

The MHSA Team, along with a community planning committee has identified 11 community behavioral health needs that we’d like your opinion on and solutions to the top ranked needs for your [insert name of city or department].

The information provided will be used for our planning purposes for FY 24/25 and will be included in our next MHSA Report that will be published in the spring of 2024.

Transition to the Interview Questions
Share your screen and review the 11 areas of need. Then ask the interviewer to identify the top 3 or 4 areas of need for their city or department.

Note: (Once you confirm a KII please send the interviewee the Areas of Need document so they can read it before hand if they'd like, so that they're prepared for the interview).

1. Ranking of Community Needs:

Community Need	Ranking
Access, Coordination and Navigation to Services	4
Behavioral Health Workforce	4
Crisis Continuum	2
Housing Continuum	1
Substance Use	3
Community Violence and Trauma	Choose an item.
Child/Youth/Young Adult Needs	Choose an item.
Adult/Older Adult Needs	Choose an item.
Needs of Family Members	5
Needs of Veterans	Choose an item.
Needs of the Re-entry Community	4

Once the interviewee has identified the top 3 or 4 Areas of Need tell them you'd like to hear about their ideas and opinions on *solutions* to these top ranked needs.

2. **Ranking #1** Housing Continuum
Record/Solutions/Strategies/Ideas to address this need:

There are a limited number of housing options for severely mentally ill people to live independently. The complexities of the coordinated entry system have acted as a barrier for clients to access timely housing. There is not enough support to help mental health clients and clients with substance abuse.

3. **Ranking #2** Crisis Continuum
Record/Solutions/Strategies/Ideas to address this need:

They expressed the need for more crisis stabilization services and wrap around models. There are not enough supportive environments between inpatient and community settings which leads to client destabilization. There needs to be more support to help clients transition from crisis facilities to community.

4. **Ranking #3** Substance Use
Record/Solutions/Strategies/Ideas to address this need:

The rise of addictive drugs has made the issue worse. There needs to be a continued need for attention and support for people struggling with substance abuse.

5. **Ranking #4** Behavioral Health Workforce, Access, Coordination and Navigation to Services, Needs of the Re-entry Community

Record/Solutions/Strategies/Ideas to address this need:

They are seeing difficulty in hiring qualified behavioral health professionals. They are looking to hire people that are skilled and diverse and have experience. Higher salaries can increase the likelihood of hiring and retaining professionals. Integrating programming with housing, and combining housing specialists with medical, psychiatry, additional and mental health services. They have seen clients that are re-cycle in and out of the justice system and their treatment must start over again.

Overall Summary of the Listening Session

The MHSA team conducted a key informative interview with the City of Alameda Social Services team. The city of Alameda identified the Housing Continuum, Crisis Continuum and Substance Abuse as the top 3 needs of Alameda. The conversation highlighted the difficulties recruiting and retaining qualified professionals, with diverse backgrounds and clinical training. The public's access to mental health services is a critical concern, with the need to overhaul a complex system to expedite access to ensure individuals can navigate resources more effectively. Housing remains a top concern with the need to provide mental health services in a residential setting. Substance abuse has increased due to the availability of drugs and the potency of them. They are also seeing a need to support individuals transitioning from the justice system to the workforce and the reintegration to society.

MHSA Key Informant Interview (KII) Process
Summary Sheet

Interviewee: Name/Title/Agency: City of Fremont Human Services team
KII DATE/TIME: 11/8/2023
City of Fremont Staff: 4

Introduction and Explanation:
Thank interviewee for their time today and explain that the Mental Health Services Act, also known as MHSA or Prop 63, is a state funding stream funded through a 1% tax on California residents that earn over $1 million dollars/year. It requires that each year community input is gathered from a diverse group of stakeholders like themselves, which is why we've contacted them for their perspective and expertise.

The MHSA Team, along with a community planning committee has identified 11 community behavioral health needs that we'd like your opinion on and solutions to the top ranked needs for your [insert name of city or department].

The information provided will be used for our planning purposes for FY 24/25 and will be included in our next MHSA Report that will be published in the spring of 2024.

Transition to the Interview Questions
Share your screen and review the 11 areas of need. Then ask the interviewer to identify the top 3 or 4 areas of need for their city or department.

Note: (Once you confirm a KII please send the interviewee the Areas of Need document so they can read it before hand if they'd like, so that they're prepared for the interview).

1. Ranking of Community Needs:

Community Need	Ranking
Access, Coordination and Navigation to Services	2
Behavioral Health Workforce	1
Crisis Continuum	4
Housing Continuum	3
Substance Use	5
Community Violence and Trauma	Choose an item.
Child/Youth/Young Adult Needs	Choose an item.
Adult/Older Adult Needs	6
Needs of Family Members	Choose an item.
Needs of Veterans	Choose an item.
Needs of the Re-entry Community	Choose an item.

Once the interviewee has identified the top 3 or 4 Areas of Need tell them you'd like to hear about their ideas and opinions on *solutions* to these top ranked needs.

2. **Ranking #1** Behavioral Health Workforce

Record/Solutions/Strategies/Ideas to address this need:

The City of Fremont is experiencing a recruitment shortfall of qualified candidates with licensures. Some positions have taken an extended time to hire and remain vacant. Planning for new initiatives has been difficult when there is uncertainty around whether the staffing will be sufficient. One suggestion is to allow MSW students to gain more on-the-job training to fill the void in open positions, this would help clients get some sort of knowledgeable care.

The increasing cost of living has decreased the number of people that want to go into the BH field. The amount of education time and tuition cost when compared with salaries are factors that could lead to the decreasing labor pool. Suggestions for Alameda County are to start a home purchasing program for BH providers that would encourage people to enter the field and be able to live where they work at.

They believe that this has also led to a decrease in culturally aligned and bilingual service providers. For instance, 65% of the Fremont population is Asian and clients have indicated that they would like to be served by a provider that is culturally aligned or bilingual. There is a stigma around the AAPI community accessing MH services and a culturally aligned workforce could help reduce this stigma.

There is a need to also expand the Peer Support program so there is more interaction with people with lived experiences.

Examples of staffing deficiencies: new initiative of Wellness Centers at Schools and the lack of Clinicians available to staff the centers. Another example is the creation of a new program for a mobile evaluation team and only receiving 2 qualified job applicants.

3. **Ranking #2** Access, Coordination and Navigation to Services

Record/Solutions/Strategies/Ideas to address this need:

The county can increase prevention services to help limit cultural barriers for accessing mental health services. Fremont is working towards increasing community engagement to reduce the stigma of partaking mental health services.

Resources for youth have not been adequate and the reliance on schools for behavioral health needs has been inefficient. Accessing, coordinating, and helping clients navigate services has proven difficult in Fremont due to its geographical size of 90 square miles.

4. **Ranking #3** Housing Continuum

Record/Solutions/Strategies/Ideas to address this need:

Services targeted to the unhoused and the close to being unhoused. This population needs services so they can become self-sufficient and then maintain self-sufficiency. Several solutions are to make subsidies available and to find a way for developers to build even when the building subsidies are not available. The city views housing and substance abuse services as two areas that work together to provide a stable environment for the client. They would like there to be more residential treatment facilities available in or near the city of Fremont. There is also an ongoing need to keep the aging population housed.

5. **Ranking #4** Substance Use

Record/Solutions/Strategies/Ideas to address this need:

They would like substance use services closer to the city of Fremont. Fremont is 90 square miles and often the police do not have the capacity to drive people north of Hayward to various substance abuse facilities. The CATT program is helpful but sometimes the CATT services cannot reach Fremont fast enough. Fremont has no Residential treatment programs, and this is an ongoing need that blends the need for more housing and substance abuse services to provide clients with ongoing support. There are also no programs for youth with substance abuse issues.

This is for your own notes afterwards to summarize and synthesize the information

Overall Summary of the Listening Session

MHSA conducted a key informative interview with the city of Fremont Human Services division. The listening session featured 4 participants that worked in youth, young adult, adult, and older adult services for the city of Fremont. The cultural diversity of the city of Fremont and the neighboring cities requires a diverse BH workforce to reduce community stigma. There is a continued need for bilingual staff to communicate with clients. In recent years staffing has become more difficult due to stated concerns about the increase in the cost of living, student loans expenses and the ability to purchase a local home on a provider salary. The city of Fremont has asked the county for assistance in helping create programs to attract new talent. The geographical location and size of the city of Fremont has limited timely non law enforcement response for substance abuse services. There are few residential treatment program opportunities for clients in the Fremont area and this has created a recurring loop for clients in need of residential treatment. There is an ongoing need to continue to educate clients about the services available to them. Fremont's geographical location limits client's accessibility to nearby mental health services.

MHSA Key Informant Interview (KII) Process
Summary Sheet

Interviewee: Name/Title/Agency: Josh Thurman, Human Services Programs Manager
Housing and Human Services Division, Community Development Department, City of Livermore

KII DATE/TIME: 11/17/2023

Introduction and Explanation:
Thank interviewee for their time today and explain that the Mental Health Services Act, also known as MHSA or Prop 63, is a state funding stream funded through a 1% tax on California residents that earn over $1 million dollars/year. It requires that each year community input is gathered from a diverse group of stakeholders like themselves, which is why we've contacted them for their perspective and expertise.

The MHSA Team, along with a community planning committee has identified 11 community behavioral health needs that we'd like your opinion on and solutions to the top ranked needs for your [insert name of city or department].

The information provided will be used for our planning purposes for FY 24/25 and will be included in our next MHSA Report that will be published in the spring of 2024.

Transition to the Interview Questions
Share your screen and review the 11 areas of need. Then ask the interviewer to identify the top 3 or 4 areas of need for their city or department.

Note: (Once you confirm a KII please send the interviewee the Areas of Need document so they can read it before hand if they'd like, so that they're prepared for the interview).

1. Ranking of Community Needs:

Community Need	Ranking
Access, Coordination and Navigation to Services	1
Behavioral Health Workforce	2
Crisis Continuum	2
Housing Continuum	4
Substance Use	3
Community Violence and Trauma	11
Child/Youth/Young Adult Needs	6
Adult/Older Adult Needs	7
Needs of Family Members	9
Needs of Veterans	5

Needs of the Re-entry Community	8

Once the interviewee has identified the top 3 or 4 Areas of Need tell them you'd like to hear about their ideas and opinions on *solutions* to these top ranked needs.

2. **Ranking #1** Access, Coordination and Navigation to Services
   Record/Solutions/Strategies/Ideas to address this need:

   More physical presence of services in the Tri Valley. When services are physically located here relationships develop, staff know the neighborhoods, easier to navigate and access services as compared to having to travel. Helpful to have more drop-in services and various, local locations need to be accessible for all behavioral health services. City of Livermore is willing to partner to bring services locally.

3. **Ranking #2** Behavioral Health and Crisis Continuum
   Record/Solutions/Strategies/Ideas to address this need:

   Local IHOT program. Too difficult to respond quickly to situations or coordinate housing navigation services for the unhoused.

4. **Ranking #3** Substance Use
   Record/Solutions/Strategies/Ideas to address this need:
   There's a need for detox and respite centers in Tri Valley in addition to more access to a wide-ranging level of care to treat SUD/co-occurring disorders (not just weekly group meetings/low-level outpatient treatment).
   Also support for youth. Youth are under a great deal of academic pressure. Intensive services for the unsheltered.

   Overall Summary of the Listening Session

MHSA conducted a key informative interview with Mr. Josh Thurman, Human Services Programs Manager Housing and Human Services Division, Community Development Department, City of Livermore. Central themes from the interview included the need for services and support to be *physically located in the Tri Valley Area*. Having services in the Tri Valley area allows for relationship development and knowledge of residents and neighborhoods, which helps increase access, coordination, and navigation of services. This theme of local services includes crisis, SUD detox, cooccurring services, not simply weekly group meetings/low-level outpatient treatment. Additionally, youth and youth services were mentioned in response to the heavy academic pressure that children and youth are facing.

MHSA Key Informant Interview (KII) Process
Summary Sheet

Interviewee: Name/Title/Agency: Executive Team, City Oakland Human Services Department
KII DATE/TIME: 11/13/2023

Introduction and Explanation:
Thank interviewee for their time today and explain that the Mental Health Services Act, also known as MHSA or Prop 63, is a state funding stream funded through a 1% tax on California residents that earn over $1 million dollars/year. It requires that each year community input is gathered from a diverse group of stakeholders like themselves, which is why we've contacted them for their perspective and expertise.

The MHSA Team, along with a community planning committee has identified 11 community behavioral health needs that we'd like your opinion on and solutions to the top ranked needs for your [insert name of city or department].

The information provided will be used for our planning purposes for FY 24/25 and will be included in our next MHSA Report that will be published in the spring of 2024.

Transition to the Interview Questions
Share your screen and review the 11 areas of need. Then ask the interviewer to identify the top 3 or 4 areas of need for their city or department.

Note: (Once you confirm a KII please send the interviewee the Areas of Need document so they can read it before hand if they'd like, so that they're prepared for the interview).

1. Ranking of Community Needs:

Community Need	Ranking
Access, Coordination and Navigation to Services	2
Behavioral Health Workforce	8
Crisis Continuum	4
Housing Continuum	4
Substance Use	5
Community Violence and Trauma	1
Child/Youth/Young Adult Needs	3
Adult/Older Adult Needs	6
Needs of Family Members	4
Needs of Veterans	7
Needs of the Re-entry Community	4

Once the interviewee has identified the top 3 or 4 Areas of Need tell them you'd like to hear about their ideas and opinions on *solutions* to these top ranked needs.

2. **Ranking #1** Community Violence and Trauma
Record/Solutions/Strategies/Ideas to address this need:

Continual attention is required to meet the demands related to community violence and trauma. An increase in domestic violence incidents has been observed, this has caused Oakland to look for new ways to prevent and support with the aftermath of families who experience domestic violence. There is ongoing effort and strategies to address community violence. Homeless encampments have become targets for violence and there needs to be more support for them. Efforts have been made to understand statistics and various prevention methods to help foster youth not become victims of violence.

3. **Ranking #2** Access, Coordination and Navigation to Services

Record/Solutions/Strategies/Ideas to address this need:

Families require access to professional expertise at a higher frequency than is currently offered. They are looking to help clients find peer support and making that process a more seamless client experience. There is also ongoing evaluation of services providers with the goal that clients are obtaining valuable resources with decreasing obstacles.

4. **Ranking #3** Child/Youth/Young Adult Needs

Record/Solutions/Strategies/Ideas to address this need:

Children and youth needs is an ongoing discussion that they would like to have with the county. They have explored trauma response and trauma informed practices with community organizations. The foster care children and young adults have ongoing needs that require attention and support which they would like to have more county collaboration on.

5. **Ranking #4** Crisis Continuum, Housing Continuum, Needs of Family members, Needs of the Re-Entry Community

Record/Solutions/Strategies/Ideas to address this need:

These four needs received equal votes. These needs require different strategies to address the issues. The city of Oakland has developed programs to advocate for non-law enforcement engagement in mental health crises. There is an ongoing need to find housing for unhoused people and they are paying attention to the new Proposition 1 and potential funding streams in the future. Services for the reentry community is growing and this is an area where they are looking to expand and create new services.

This is for your own notes afterwards to summarize and synthesize the information

Overall Summary of the Listening Session

MHSA met with the City of Oakland Human Services team. The participants discussed needs and challenges focusing on the diverse demographic groups. Community Violence and Trauma are a top priority to address escalating domestic violence and homeless violence threats. New approaches and strategies are being created from statistics with the goal of protecting youth from violence. Access, Coordination, and Navigation to services is an issue that requires timeliness service, and the absence of expert professionals makes the service wait times longer. There is an increased effort to offer peer support services to fill this void, to provide residents have guidance. Child, Youth, and Young Adult needs discussions are ongoing with the hopes of addressing trauma informed practices for foster care youth. Non law enforcement strategies to approach mental health crises have been in the forefront of discussions and expansions to current programs are being reviewed. Oakland is making efforts to secure housing for the homeless and expand its reentry services. The meeting participants were knowledgeable about the needs of the Oakland residents and were willing to participate in feedback and potential ways to improve care.

MHSA COMMUNITY PROGRAM PLANNING PROCESS
LISTENING SESSION ANSWER SHEET

FACILITATOR NAME/AGENCY: Community Planning & Processing Committee
FOCUS GROUP DATE/TIME: 10/27/2023
# of Participants: 12
Gina M Lewis
Abigail Chente – ACBH
Tracy Hazelton – ACBH
Gavin O' Neill – OCCS
Carole Wang – MHACC
Mona Shah –
Noah Gallo – ACBH
Bianca Anderson – FERC
Ingrid Chung –
Danielle Guerry – OCCS
Odessa Caton – FERC
Robert Williams - HHREC

1. Ranking of Community Needs:

Community Need	Ranking
Access, Coordination and Navigation to Services	3
Behavioral Health Workforce	8
Crisis Continuum	6
Housing Continuum	10
Substance Use	4
Community Violence and Trauma	5
Child/Youth/Young Adult Needs	2
Adult/Older Adult Needs	11
Needs of Family Members	7
Needs of Veterans	9
Needs of the Re-entry Community	1

2. **Ranking #1**Re-Entry

Record/Solutions/Strategies/Ideas to address this need:

- A lot more supports such as housing & training that are necessary before they begin to transition to civilian life, may need to be connected back to family.
- Navigation of the systems

- How to obtain case management, no neutral sign up, some sort of re-entry navigation services that isn't court ordered
- Re-entry programs/ organizations should work more collaboratively
- More coordination for mental health
- Incarcerated loved ones aren't receiving mental health support, if a loved one is going to re-join civilian life, receiving support for mental health will make that a much more holistic during incarceration
- We need more funds and focus toward setting up re-entry citizens for success
- Reintegration with family care, having in-home mental health services, not just the re-entry citizen but the family as a whole
- Parolees pairing with firefighters, volunteer opportunities, re-integrating re-entry citizens and pairing them with positive communities(firefighters) to have a better outlook toward the community
- Compassion of care when it comes to re-integrating re-entry citizens into society
- Family reunification, if there has been little contact between re-entry citizen and children, that could be something they may need
- Needing more education on financial planning

3. **Ranking #2**Child/Youth/Young Adults

Record/Solutions/Strategies/Ideas to address this need:

- Educating family members and parents, due to kids not understanding what is going on mentally

and parents not accepting it, helping parents understanding what their kids are learning in school

- Have constructive dialogue for parents/guardians to hear their kids out
- Integrating mental health/behavioral health in public schools
- More prevention/early intervention programs
- More assessments
- There is an equity gap, is there a means or something that is covered by the county
- Having more counselors in the schools
- Knowing where to get help and how to get help
- Mental Health Assessment: looking between K-3 a real intensive something, then elementary and middle school, transitioning to support services in high-school and college
- Having official mental health assessments
- More wellness centers in schools and more wellness center learning in these high schools
- Hearing each other's stories, so they feel less alone
- Education around child development for parents to be able to have appropriate expectations for their kids, it needs to be presented in a culturally respectful way while considering the appropriate way to have proper or some expectations of where their kids are at with mental health
- More peer counselors, especially those with lived experience, support peer to peer services

- There's that piece of family culture and aspects of how "we" all were "raised" often, so it's not about judgement but learning new subjects and presenting it in a non-stigmatizing way
- A level care is missing between school, school counselors, and truancy, so more school counselor engagement is needed

4. **Ranking #3**Access, Coordination, & Navigation to Services

Record/Solutions/Strategies/Ideas to address this need:

- Have some type of online resource for linkage that can connect you to the proper supportive services
- To have a master program from Alameda County that is sent from Alameda County, and residents to manage the program, listing by ethnicity
- More collaborative support/conference type of needs where all programs come together to learn more about each other's programming
- If we had a county access system to where people can go in to make linkages, a feature where a provider can update their information
- Providers are isolated
- Residents/participants are isolated
- Having an expert in MHSA services that links clients to services they qualify for
- Linkage should be holistic
- Having navigators from specific communities, that look like them, talk like them, and understand lived in-experience
- Feeling seen and heard by their community
- More access for folks that are unhoused that are on-site with a huge array of resources
- Making sure clients have a way to get to these services

5. **What Else, What Did we Miss**:

Record/List Answers

- Need more money
- Having services in a more centralized online place

Overall Summary of the Listening Session

The Community Planning & Processing Committee had 12 participants identify community needs, and solutions are as follows: 1. For Re-Entry (Ranking #1), providing pre-transition support, simplifying system navigation, fostering collaboration among re-entry programs, improving mental health coordination, and ensuring incarcerated individuals receive mental health support. 2. For Child/Youth/Young Adults (Ranking #2), educating parents, integrating mental health into public schools, enhancing early intervention, and reducing stigma through peer counseling. 3. For Access, Coordination, & Navigation to Services (Ranking #3), establishing a comprehensive online resource, creating a county-wide linkage system, and employing navigators from diverse communities to enhance accessibility. Additional funding and a centralized online platform for services are also vital community priorities.

MHSA Key Informant Interview (KII) Process

Summary Sheet

Interviewee: Name/Title/Agency: Jessica Lobedan, Human Services Director, City of San Leandro
KII DATE/TIME: 11/16/2023

Introduction and Explanation:
Thank interviewee for their time today and explain that the Mental Health Services Act, also known as MHSA or Prop 63, is a state funding stream funded through a 1% tax on California residents that earn over $1 million dollars/year. It requires that each year community input is gathered from a diverse group of stakeholders like themselves, which is why we've contacted them for their perspective and expertise.

The MHSA Team, along with a community planning committee has identified 11 community behavioral health needs that we'd like your opinion on and solutions to the top ranked needs for your [insert name of city or department].

The information provided will be used for our planning purposes for FY 24/25 and will be included in our next MHSA Report that will be published in the spring of 2024.

Transition to the Interview Questions
Share your screen and review the 11 areas of need. Then ask the interviewer to identify the top 3 or 4 areas of need for their city or department.

Note: (Once you confirm a KII please send the interviewee the Areas of Need document so they can read it before hand if they'd like, so that they're prepared for the interview).

1. Ranking of Community Needs:

Community Need	Ranking
Access, Coordination and Navigation to Services	4
Behavioral Health Workforce	5
Crisis Continuum	1
Housing Continuum	2
Substance Use	3
Community Violence and Trauma	11
Child/Youth/Young Adult Needs	7
Adult/Older Adult Needs	6
Needs of Family Members	9
Needs of Veterans	8
Needs of the Re-entry Community	10

Once the interviewee has identified the top 3 or 4 Areas of Need tell them you'd like to hear about their ideas and opinions on *solutions* to these top ranked needs.

2. **Ranking #1** Crisis Continuum

Record/Solutions/Strategies/Ideas to address this need:
Efforts are being made to provide faster non-law enforcement solutions that can reach individuals faster. Recruiting mobile clinicians to work in the mobile crisis field has been a challenge. Family members have advocated for improved access to mobile services that can reach clients directly rather than relying on law enforcement. They think that more residential treatment facilities would be effective in serving clients.

3. **Ranking #2** Housing Continuum

Record/Solutions/Strategies/Ideas to address this need:
There is a need for supportive services and housing interventions. The housing being offered does not include wraparound services. They need additional funding for operational support to meet the needs of the community.

4. **Ranking #3** Substance Abuse

Record/Solutions/Strategies/Ideas to address this need:
They are seeing that there is a need for more resources and an integrative model that ties to crisis services. They think that there needs to be a location where people could go for crisis de-escalation services in the community.

Once this process is complete, ask them if there's anything we missed or anything else they would like to share with us.

5. **What Else, What Did we Miss**:

Record/List Answers: For the homeless they need more insight into services and how they can access them. They think that the county should speak with law enforcement during the planning process to gain better insight into their needs in supporting MH clients.

This is for your own notes afterwards to summarize and synthesize the information

Overall Summary of the Listening Session
The conversation was with Jessica Lobedan, Human Services Director. She indicated that the top needs are Crisis Continuum, Housing Continuum, Substance Use and Access, Coordination and Navigation to Services. Housing is a top need and the ability to help mental health clients at housing locations. The need for crisis intervention services is a recurring topic that they think will be needed in the future. They are looking for continued collaboration and assistance with accessing services for their residents. There has been an expressed interest in having a community center for de-escalation services.

MHSA COMMUNITY PROGRAM PLANNING PROCESS
LISTENING SESSION ANSWER SHEET

FACILITATOR NAME/AGENCY: Family Education and Resource Centers (FERC)
FOCUS GROUP DATE/TIME: . 11/03/2023
# of Participants:
County: 4 [Tracy, Noah, Abigail, Brian]

FERC Staff And Participants: 13

1. Ranking of Community Needs:

Community Need	Ranking	Tally numbers
Access, Coordination and Navigation to Services	Choose an item.	2
Behavioral Health Workforce	Choose an item.	2
Crisis Continuum	Choose an item.	1
Housing Continuum	Choose an item.	4
Substance Use	Choose an item.	1
Community Violence and Trauma	Choose an item.	6
Child/Youth/Young Adult Needs	Choose an item.	0
Adult/Older Adult Needs	Choose an item.	4
Needs of Family Members	Choose an item.	6
Needs of Veterans	Choose an item.	0
Needs of the Re-entry Community	Choose an item.	2

2. **Ranking #1**: Community Violence and Trauma

Record/Solutions/Strategies/Ideas to address this need:

- Pattern/cycle of violence: how can we break it?
- East Oakland is bad. Lots of theft and gun violence
  - Feels like if you are not a life-threatening emergency it's not a police priority
  - We've normalized things that are not normal
- Can Alameda County pressure the City of Oakland
- Oakland looks distressing: clean it up, start with the aesthetics
- Need places where young folks can go to have something to do
  - Put these organizations in place
  - Need to be results oriented. Cut ties with ineffective agencies and programming
  - Certain illegal activities (like sideshows) is due to youth being bored with nothing to do
  - Cultivate youth engagement
  - Deal with agencies and non-profits fighting over funding
- Schools are lacking resources for recreational activities
  - Is there a way to leverage PEI to provide programming for TAY youth?
- Community one-stop shops so folks and youth can access services

3. **Ranking #2**: **Needs of Family Members**

Record/Solutions/Strategies/Ideas to address this need:

- Encourage the us of peer-run programs to teach families healthy communication practices
  - Groups like bayareahearingvoices.org
- Work with transit agencies to encourage safe usage so people feel safe accessing services

- Increase safety advocacy
- Develop peer-led/family-led safe places for community interactions
    - It's hard to focus on mental health when the environment is unsafe

4. **Ranking #3**: **Housing**

Record/Solutions/Strategies/Ideas to address this need:

- Income-based accommodation for seniors like Strawberry Creek Lodge
    - Organizations like this are self-governed
    - Promotes good relationship with local management
    - Co-housing with divers demographic profiles
- Include seniors in branding and collateral advertising
- Housing navigation
    - Streamline housing access
    - Keep decisions and process transparent
- There is no housing/housing shortage
    - Most housing is owned or being bought by corporate entities
    - There are state bills to prevent evictions: support affirmative advocacy in this matter
        - This is county AND a state issue
    - Advocate for bills like SB4 to promote zoning flexibility
        - Would allow educational and religious institutions to develop housing
- More low barrier housing
    - Many co-occurring or SUD block eligibility for housing
    - This would help people stay off street
    - Promote outreach to help folks, especially unhoused folks, navigate housing access
        - Face-to-face contact, "Boots on the ground"
- Advocate for development of abandoned spaces such as Alameda Navy Base.

5. **What Else, What Did we Miss**:

Record/List Answers

- Trauma healing through culturally syntonic traditional healing practices that would be familiar, to community members provide safe healing spaces.
    - Would support mental health well being
    - Also support community building
- Re-examine the notion that there is something wrong with us
    - Stigma reduction is critical
    - Especially for children
- How do we get treatment for those with SMI that are unwilling to seek or access treatment?
- Promote the use of peer groups facilitated by those with lived experiences
    - Folks will be more receptive to engaging treatment if they have an understanding peer.
    - Extant groups providing these services should be helped with obtaining funding
- More access for harm reduction education
- Access to NARCAN and similar life saving products and training
- More access for peers and caregivers to develop professional careers

Overall Summary of the Listening Session

During a recent online gathering for the Fremont Education Resource Center, participants, totaling 13, discussed pressing community needs and offered insights. Participants voiced concerns about the cycle of violence, theft, and gun violence in East Oakland, highlighting the need for changes in police priorities, aesthetics improvement, and the creation of safe spaces for youth. Additionally, they stressed the importance of effective agency management. Suggestions for promoting healthy communication practices in families through peer-run programs and ensuring safe access to services were discussed. Participants emphasized the connection between a safe environment and mental health focus. Housing-related concerns included income-based accommodation for seniors, co-housing, and transparency in housing access. Advocacy for preventing evictions and developing low-barrier housing were key points. Lastly, participants advocated for culturally syntonic traditional healing practices, stigma reduction, and treatment for those unwilling to seek help. Peer-led groups, funding support for existing groups, harm reduction education, access to life-saving products, and career development for peers and caregivers were also recommended. These insights will inform future community initiatives.

MHSA Key Listening Session Answer Sheet

Interviewee: Name/Title/Agency: Family Education Resource Center Spanish Listening Session
KII DATE/TIME: 12/18/2023

Introduction and Explanation:
Thank interviewee for their time today and explain that the Mental Health Services Act, also known as MHSA or Prop 63, is a state funding stream funded through a 1% tax on California residents that earn over $1 million dollars/year. It requires that each year community input is gathered from a diverse group of stakeholders like themselves, which is why we've contacted them for their perspective and expertise.

The MHSA Team, along with a community planning committee has identified 11 community behavioral health needs that we'd like your opinion on and solutions to the top ranked needs for your [insert name of city or department].

The information provided will be used for our planning purposes for FY 24/25 and will be included in our next MHSA Report that will be published in the spring of 2024.

Transition to the Interview Questions
Share your screen and review the 11 areas of need. Then ask the interviewer to identify the top 3 or 4 areas of need for their city or department.

Note: (Once you confirm a KII please send the interviewee the Areas of Need document so they can read it before hand if they'd like, so that they're prepared for the interview).

1. Ranking of Community Needs:

Community Need	Ranking
Access, Coordination and Navigation to Services	2
Behavioral Health Workforce	6
Crisis Continuum	6
Housing Continuum	3
Substance Use	7
Community Violence and Trauma	4
Child/Youth/Young Adult Needs	1
Adult/Older Adult Needs	5
Needs of Family Members	3
Needs of Veterans	Choose an item.
Needs of the Re-entry Community	4

Once the interviewee has identified the top 3 or 4 Areas of Need tell them you'd like to hear about their ideas and opinions on *solutions* to these top ranked needs.

2. **Ranking #1** Child/Youth/Young Adult Needs

Record/Solutions/Strategies/Ideas to address this need:

The group talked about the need for early mental health support especially for awareness programs targeted to children, youths, and young adults in schools. They advocated for programs that promoted children to seek help as well as programs that can identify mental health issues among youth.

3. **Ranking #2** Access, Coordination and Navigation to Services

Record/Solutions/Strategies/Ideas to address this need:

Accessing programs in Spanish has proved difficult for many of the group since they are monolingual. There is also a stigma concern with seeking mental health support which prevents them from accessing services. They also think the information is not accessible and comprehensive which is leading to difficulties in their navigation services.

4. **Ranking #3** Housing Continuum

Record/Solutions/Strategies/Ideas to address this need:

The instability of housing is affecting the mental health of clients. They believe housing is the first pillar of mental health that must be addressed and then unemployment and financial obstacles. The group had questions around Section 8 and the need to help register people they know.

Once this process is complete, ask them if there's anything we missed or anything else they would like to share with us.

This is for your own notes afterwards to summarize and synthesize the information

Overall Summary of the Listening Session

The MHSA team met with the Family Education & Resource Center (FERC) Spanish Group. The discussion focused on the mental health challenges and solutions to addressing the mental health needs of the

Spanish speaking population. The group highlighted the barriers to language accessibility, the stigma around receiving mental health services, and the lack of accessible information. The group also spoke about how important housing is to mental health as well as culturally competent individual mental health professionals. The group discussed the need for preventative programs for youth and adults, trauma informed care, and family support services.

MHSA Key Informant Interview (KII) Process
Summary Sheet

Interviewee: Name/Title/Agency: Laura Otero, Administrator, First 5 Help Me Grow
KII DATE/TIME: 12/1/2023

Introduction and Explanation:
Thank interviewee for their time today and explain that the Mental Health Services Act, also known as MHSA or Prop 63, is a state funding stream funded through a 1% tax on California residents that earn over $1 million dollars/year. It requires that each year community input is gathered from a diverse group of stakeholders like themselves, which is why we've contacted them for their perspective and expertise.

The MHSA Team, along with a community planning committee has identified 11 community behavioral health needs that we'd like your opinion on and solutions to the top ranked needs for your [insert name of city or department].

The information provided will be used for our planning purposes for FY 24/25 and will be included in our next MHSA Report that will be published in the spring of 2024.

Transition to the Interview Questions
Share your screen and review the 11 areas of need. Then ask the interviewer to identify the top 3 or 4 areas of need for their city or department.

Note: (Once you confirm a KII please send the interviewee the Areas of Need document so they can read it before hand if they'd like, so that they're prepared for the interview).

1. Ranking of Community Needs:

Community Need	Ranking
Access, Coordination and Navigation to Services	1
Behavioral Health Workforce	2
Crisis Continuum	Choose an item.
Housing Continuum	4
Substance Use	Choose an item.
Community Violence and Trauma	3
Child/Youth/Young Adult Needs	Choose an item.

Adult/Older Adult Needs	Choose an item.
Needs of Family Members	Choose an item.
Needs of Veterans	Choose an item.
Needs of the Re-entry Community	Choose an item.

Once the interviewee has identified the top 3 or 4 Areas of Need tell them you'd like to hear about their ideas and opinions on *solutions* to these top ranked needs.

2. **Ranking #1** Access, Coordination and Navigation to Services

Record/Solutions/Strategies/Ideas to address this need:

The need for more support for families looking for resources can continue to be streamlined when providing referral services. Providers need to continue to enhance behind the scenes collaboration to help guide families and clients.

3. **Ranking #2** Behavioral Health Workforce

Record/Solutions/Strategies/Ideas to address this need:

There needs to be continued recruiting and retaining talent strategies to ensure there are enough providers. It is helpful when providers are multilingual and cultural to help address and relate to the needs of the family. The waitlist for seeing a qualified provider has continued to grow.

4. **Ranking #3** Community Violence and Trauma

Record/Solutions/Strategies/Ideas to address this need:

The child population that they support requires them to assist with the aftermath of domestic violence and trauma. For youth that experience community violence and trauma they must address conflict and stress related problems.

5. **Ranking #4** Housing Continuum

Record/Solutions/Strategies/Ideas to address this need:

For families with housing insecurities, they make sure to have information related to finding shelters and temporary housing.

This is for your own notes afterwards to summarize and synthesize the information

Overall Summary of the Listening Session

MHSA conducted a key informative interview with Laura Otero Administrator with First 5 – Help Me Grow. The Help Me Grow team works with children ages 0-5 and their families. First 5 – Help Me Grow indicated that they are seeing clients' top needs as: Access, Coordination and Navigation to Services, Behavioral Health Workforce, Community Violence and Trauma and the Housing Continuum. There is a continued need to help families seamlessly access and locate services. Recruiting and retaining credentialed providers and ensuring staff are multilingual and cultural remains a top priority. They continue to have to aid in supporting the youth and family clients as they recover and cope with domestic violence and trauma related incidents. Housing has continued to be a main issue with families needing temporary housing and they see an increase organizing with shelters.

MHSA COMMUNITY PROGRAM PLANNING PROCESS
LISTENING SESSION ANSWER SHEET

FACILITATOR NAME/AGENCY: Jay Mahler Recovery Center
FOCUS GROUP DATE/TIME: 12/07/2023
# of Participants: 10 Participants, 2 Facilitators (Noah/Brian)

1. Ranking of Community Needs:

Community Need	Ranking
Access, Coordination and Navigation to Services	5
Behavioral Health Workforce	5
Crisis Continuum	6
Housing Continuum	1
Substance Use	2
Community Violence and Trauma	6
Child/Youth/Young Adult Needs	4
Adult/Older Adult Needs	4
Needs of Family Members	7
Needs of Veterans	5
Needs of the Re-entry Community	3

2. **Ranking #1**: Housing Continuum
   - Need more housing for folks, especially the houseless
   - Housing tailored towards folks with mental illness, since it is particularly hard for this group to obtain
   - "Housing is a barrier."
   - Women face sexual and domestic violence when trying to obtain
     - Develop safer ways for houseless
   - Lack of documents is a barrier to access
     - make it easier to obtain if you don't have all of the paperwork.
     - Harder to do if you have signs and symptoms of mental illness, or pre-existing medical and psychiatric conditions
   - More subsidized housing, especially for assisted living.
     - People with serious mental illness have one of the highest needs for permanent and/or supportive housing

3. **Ranking #2:** Substance Use
   - Need better *quality* of substance use disorder treatment providers, not just *quantity*

- There are lots providers in Alameda County, but the treatment seems to repetitive or "cookie cutter" and does not promote real recovery like more expensive, intensive inpatient treatment programs

4. **Ranking #3**: Needs of the Reentry Community
   - Not enough services or help finding resources.
   - A list or guide with *up-to-date* service and provider data would be helpful.
   - More care navigators, especially those focused on the needs of those experiencing mental illness.
   - Assistance with finding and maintaining employment
     - "The hardest part of reentry is finding a job."
   - More companies or organizations that focus specifically on hiring reentry population
     - Urban Alchemy Services in San Francisco is an example of one such employer
     - CiviCorps in the East Bay is another
   - Incentivization of both cities or governmental districts **and** employers to recruit from and hire reentry population would be helpful
     - Example: City of SF hired Urban Alchemy to clean up city for the 30th APEC summit in 2023

5. **What Else, What Did we Miss**:

Record/List Answers: *Group did not offer any comments when Noah asked if we missed anything.*

Note: *This group went through all 11 areas of need in order. Rankings were derived by voting on whether or not a given area of need was a concern. Rankings were selected from he final tally for all 11 areas of need. Below are notes on the other 8 areas of need that were not in the top 3 most important ranking.*

Access, Coordination, and Navigation to Services:
- Medi-Cal services:
  - Improve Med-Cal service navigation to make process easier
  - Limited Medi-Cal service offerings; increase these, particularly with respect to mental and behavioral health.

Behavioral Health Workforce
- Quantity of providers is not an issue; it's the quality of service that they render
  - Improve treatment offerings
  - Work with providers to focus on the case history and holistic picture of patient
    - Many patients feel that the providers do not read charts or otherwise familiar themselves with patient history prior to meeting with them.
    - "Feels like we are an order in a fast food restaurant" due to mechanical and repetitive treatment approaches

Crisis Continuum
- Reach more and/or more isolated patients by offering mobile services, such as CATT or Oakland's MACRO
- Service like BACS are doing a good job of providing outreach and crisis service in cities like Fremont

- "Fremont has good services."

Community Violence and Trauma

- Increase the number of confidential "safe houses" for victims of domestic and sexual violence.
- Train staff in maintaining confidentiality to protect patient safety, especially in small, local communities such as Oakland
- Help create, promote, and maintain employment linkages for victims of domestic and sexual violence.

Children/Youth/Young Adult Needs

- Need more services for kids and young adults
  - Specifically, services geared towards depression and serious mental illnesses
- More reunification services
  - Adoption outspends family reunification, according to one participant
- In schools
  - Smaller class sizes for kids with behavioral and SMI challenges
  - Teacher and staff training that know how to deal with issues
  - More hands on instruction with special needs kids

Adult/Older Adult Needs

- More "good" services like Woodrow House for adults
- Assistance with finding housing and employment
- Programs for older folks (> 65 YO) that address elder abuse and prevent its occurrence
- More community involvement:
  - Wellness checks on isolated adults
  - Mobile services including medical and psychiatric care, as well as care navigators

Veterans

- More housing for veterans, especially those returning from deployment with serious mental and physical health issues.

Overall Summary of the Listening Session

The MHSA team held a listening session with 10 participants at Jay Mahler Recovery Center. The top needs of the group were the Housing Continuum, Substance Use, and the Needs of the Re-entry Community. The group expressed the need for more housing for the unhoused and detailed how housing is a barrier to mental health. They are looking for Alameda County to improve substance abuse services that are repetitive and provide more intensive inpatient treatment programs. They were concerned that the needs of the re-entry community are not being adequately addressed and there needs to be more care navigators available to help with accessing community services. Overall, the group was knowledgeable on the resources that Alameda County offers, however they would like Alameda County to provide more resources and guides to help consumers connect with services more efficiently.

MHSA Key Informant Interview (KII) Process

Summary Sheet

Interviewee: Name/Title/Agency: Aaron Ortiz, CEO, La Familia
KII DATE/TIME: 12/6/2023

Introduction and Explanation:
Thank interviewee for their time today and explain that the Mental Health Services Act, also known as MHSA or Prop 63, is a state funding stream funded through a 1% tax on California residents that earn over $1 million dollars/year. It requires that each year community input is gathered from a diverse group of stakeholders like themselves, which is why we've contacted them for their perspective and expertise.

The MHSA Team, along with a community planning committee has identified 11 community behavioral health needs that we'd like your opinion on and solutions to the top ranked needs for your [insert name of city or department].

The information provided will be used for our planning purposes for FY 24/25 and will be included in our next MHSA Report that will be published in the spring of 2024.

Transition to the Interview Questions
Share your screen and review the 11 areas of need. Then ask the interviewer to identify the top 3 or 4 areas of need for their city or department.

Note: (Once you confirm a KII please send the interviewee the Areas of Need document so they can read it before hand if they'd like, so that they're prepared for the interview).

1. Ranking of Community Needs:

Community Need	Ranking
Access, Coordination and Navigation to Services	1
Behavioral Health Workforce	2
Crisis Continuum	8
Housing Continuum	5
Substance Use	9
Community Violence and Trauma	6
Child/Youth/Young Adult Needs	3
Adult/Older Adult Needs	10
Needs of Family Members	7
Needs of Veterans	11
Needs of the Re-entry Community	4

Once the interviewee has identified the top 3 or 4 Areas of Need tell them you'd like to hear about their ideas and opinions on *solutions* to these top ranked needs.

2. **Ranking #1** Access, Coordination and Navigation to Services

Record/Solutions/Strategies/Ideas to address this need:
Streamlining access to services can help those in need find services quicker and more efficiently. The county needs to continue to have a structured framework for easy navigation of services. There needs to be prioritization of client needs determining key access and entry points. There needs to be pre-assessment strategies to prevent crises and early intervention methods.

3. **Ranking #2** Behavioral Health Workforce

Record/Solutions/Strategies/Ideas to address this need:
He recognizes that there is an essential need for a skilled and adequate behavioral health workforce. There needs to be a proactive approach to addressing the right workforce to prevent it from becoming a barrier to effective program delivery. Continuous clinical leadership training and building programs.

4. **Ranking #3** Child/Youth/Young Adult Needs

Record/Solutions/Strategies/Ideas to address this need:
The services the county offers to children, youth and young adults need to be routinely identified and properly tailored to what the community needs and requests. There needs to be discussions on safe spaces and counseling for children and youth as preventive measures.

5. **Ranking #4** Needs of the Re-entry Community

Record/Solutions/Strategies/Ideas to address this need:
The continuous recognition of identifying the challenges faced by the re-entering population after incarceration. There is still a necessity to have more programs and refinement to support mental health, housing, and employment for the re-entry populations.

Once this process is complete, ask them if there's anything we missed or anything else they would like to share with us.

This is for your own notes afterwards to summarize and synthesize the information

Overall Summary of the Listening Session

MHSA conducted a key informant interview with Aaron Ortiz CEO of La Familia. The discussion reviewed the complexities of structuring mental health services in Alameda County. The discussion highlighted the essential need for increased access, efficient coordination, and successful navigation of the services available to mental health clients in Alameda County. The topics discussed varied from the significance of workforce development and crisis management strategies to the housing continuum and concentrated support for children, adults, and the reentry communities. There is a necessity for more tailored mental health services to address community members' needs across different demographic groups to make a greater impact on substance use, community violence, trauma, and family member support.

MHSA COMMUNITY PROGRAM PLANNING PROCESS
LISTENING SESSION ANSWER SHEET

Interviewee: Name/Title/Agency: Executive Team, LGBTQ Center

KII DATE/TIME: 12/7/2023

Introduction and Explanation:
Thank interviewee for their time today and explain that the Mental Health Services Act, also known as MHSA or Prop 63, is a state funding stream funded through a 1% tax on California residents that earn over $1 million dollars/year. It requires that each year community input is gathered from a diverse group of stakeholders like themselves, which is why we've contacted them for their perspective and expertise.

The MHSA Team, along with a community planning committee has identified 11 community behavioral health needs that we'd like your opinion on and solutions to the top ranked needs for your [insert name of city or department].

The information provided will be used for our planning purposes for FY 24/25 and will be included in our next MHSA Report that will be published in the spring of 2024.

Transition to the Interview Questions
Share your screen and review the 11 areas of need. Then ask the interviewer to identify the top 3 or 4 areas of need for their city or department.

Note: (Once you confirm a KII please send the interviewee the Areas of Need document so they can read it before hand if they'd like, so that they're prepared for the interview).

1. Ranking of Community Needs:

Community Need	Ranking
Access, Coordination and Navigation to Services	4
Behavioral Health Workforce	3
Crisis Continuum	7
Housing Continuum	1
Substance Use	Choose an item.
Community Violence and Trauma	6
Child/Youth/Young Adult Needs	5
Adult/Older Adult Needs	2
Needs of Family Members	Choose an item.
Needs of Veterans	Choose an item.
Needs of the Re-entry Community	Choose an item.

Once the interviewee has identified the top 3 or 4 Areas of Need tell them you'd like to hear about their ideas and opinions on *solutions* to these top ranked needs.

2. **Ranking #1** Housing Continuum

Record/Solutions/Strategies/Ideas to address this need:
Their mental health clients are having difficulty finding housing that is affordable and would like to see a care navigator on-site to help them access services. The trans community that is

unhoused is fearful of violence being done to them and faces constant threats at homeless encampments. They are seeing the elderly population become more socially isolated, especially in senior homes and the elderly population also faces housing displacement. The providers of housing are not making LGBTQ friendly accommodations, nor are there any housing complexes that are specifically for LGBTQ people. There is also a lack of gender accommodation for people of multiple genders in new housing complexes.

3. **Ranking #2** Adult/Older Adult Needs

Record/Solutions/Strategies/Ideas to address this need:

The seniors that they work with have become more distant and are becoming more socially isolated in their residences. The social isolation has led to mental health issues as well as socially anxiety for seniors that were once part of the LGBTQ community but do not feel comfortable being visible as they age. The elder LGBTQ population needs a care navigator specifically assigned to them that can visit elders in their residences and on-site at the LGBTQ center. There needs to be more programs to support the LGBTQ seniors like the Lavendar Seniors program.

4. **Ranking #3** Behavioral Health Workforce

Record/Solutions/Strategies/Ideas to address this need:

There needs to be more trainings on harassment and bullying towards the LGBTQ community. There also needs to be qualified staff that are from the LGBTQ community and have the background to speak with different age groups. There needs to be regular capacity building support groups for MH clients with other agencies and the county.

5. **Ranking #4** Access, Coordination, and Navigation to Services

Record/Solutions/Strategies/Ideas to address this need:

There needs to be more programs for LGBTQ people with HIV. There also needs to be more care navigators that can help LGBTQ Black and Latino people navigate the various services available to them. The LGBTQ Center would like a care navigator stationed at their center. Overall, the LGBTQ population wants to continue to be included in county programs.

Once this process is complete, ask them if there's anything we missed or anything else they would like to share with us.

This is for your own notes afterwards to summarize and synthesize the information

Overall Summary of the Listening Session

The MHSA team spoke with the Executive team at the LGBTQ Center in Oakland and learned more about the needs of its clients and the LGBTQ Community. They are seeing a need for more programs to address social isolation in the elderly population. The housing being developed is not created with LGBTQ concerns in mind and accommodations for the LGBTQ community are leading to displacement from new developments. Also, needs for LGBTQ people in homeless encampments need to be addressed due to rising threats and violence. HIV is an ongoing problem that is receiving less resources but still needs to be addressed. Overall, the LGBTQ Center is looking to bring on a care navigator and would like to continue to participate in county programs.

MHSA COMMUNITY PROGRAM PLANNING PROCESS
LISTENING SESSION ANSWER SHEET

FACILITATOR NAME/AGENCY: Mental Health Association for Chinese Communities
FOCUS GROUP DATE/TIME: 1/4/2023
# of Participants: 12

1. Ranking of Community Needs:

Community Need	Ranking
Access, Coordination and Navigation to Services	1
Behavioral Health Workforce	2
Crisis Continuum	10
Housing Continuum	4
Substance Use	9
Community Violence and Trauma	4
Child/Youth/Young Adult Needs	3
Adult/Older Adult Needs	4
Needs of Family Members	4
Needs of Veterans	10
Needs of the Re-entry Community	4

2. **Ranking #1** Access, Coordination and Navigation to Services

Record/Solutions/Strategies/Ideas to address this need:

It's difficult to find therapy services, most services don't accept Medi-Cal, one solution is a type of voucher program for Medi-Cal or Medi-Care recipients. Stigma of having a mental illness or mental health issue also needs to be addressed. For more access to therapeutic services there can be advocacy at the state level for California to join the Psychology Interjurisdictional Compact (PSYPACT®), which is an interstate compact designed to facilitate the practice of telepsychology and the temporary in-person, face-to-face practice of psychology *across* state boundaries, https://psypact.org/
Another solution mentioned was the development and maintenance of a resource directory that includes geographic locations and language capacity. This would be very helpful as a tool to use for all of the warm line callers. MHACC runs a warmline in three languages: Mandarin, Cantonese and English. Kaiser has a new resource for its members (including Medi-Cal members) to find MH services and to connect their members to various resources.

3. **Ranking #2** Behavioral Health Workforce

Record/Solutions/Strategies/Ideas to address this need:
Expand Loan forgiveness program, scholarships are also helpful tools.
In order to reduce possible stigma about entering this job field, you have to make it attractive to people, show how this profession is making a difference, be inspirational, e.g. you're going to be a hero and well respected. Retention bonus or a sign on bonus, plus the need for more peer/family support opportunities and more in person services.

4. **Ranking #3** Child/Youth/Young Adult Needs

Record/Solutions/Strategies/Ideas to address this need:
Meet kids and youth where they're at and what they're interested in. The act of physically doing an activity, like art is very helpful and therapeutic. MHACC is working on a booklet right now for youth.
These populations need more awareness programming to better understand MH issues and solutions.
Hosting a youth leadership summit. Hosting Townhall settings where students bring their families and different MH topics can be discussed, like bi-polar disorder, which will give space for the family to talk and open up about different issues. Engaging with youth to empower them and for them to know how special they are. "When people believe they're precious they will act precious".
Dedicated funding for the warm line, youth are calling the warm line or parents are calling about their youth. More events to incorporate youth and family together…"Healing the parents is important to heal the child".

5. **What Else, What Did we Miss**:

Housing is still a very difficult issue, especially for older adults. One gentleman stated it took over a year to find and secure housing for his mother. Lots of bureaucracy. Without his help she would've been homeless. Nonprofits who are supposed to be helpful with housing vacancies or housing navigation sometimes are not and there is little recourse for the family or individual, would like to know how to report these nonprofits to the state. Kaiser has a new housing resource for its members, with housing counselors that actually follow up and are *proactive* with support.

Other comments made at the listening session: When people truly feel worthless, invisible, insignificant, or powerless, they generally tend to self-destruct. Either quickly (suicide) or very slowly (drugs, alcohol, gambling, overwork, etc).

I think if you really want to improve mental health, try to convince people that they are not worthless, insignificant, invisible, or powerless. You can brainstorm as to how to convince people that they are worthy, significant, visible, and capable.

I think it's helpful to also address trauma. How much do family members and society at large abuse, neglect, abandon, bully, humiliate and belittle each other.

Overall Summary of the Listening Session

MHSA co-facilitated a listening session with community members from the agency, Mental Health Association for Chinese Communities (MHAAC) 美國華裔精神健康聯盟 资深副執行長

The top mental health needs included access/coordination/navigation of services, workforce and children/youth/young adult needs. Frustration with housing services was also brought up. Participants identified many solutions including the need for a resource directory of all behavioral health services, expanded loan forgiveness programming, more activities/events for youth and families to do together for joint learning (one participant said… Healing the parents is important to heal the child). Other solutions included activities to reduce stigma, dedicated funding for their tri-lingual warm-line, youth leadership activities and advocacy at the state level for California to opt into Psychology Interjurisdictional Compact (PSYPACT®), an interstate compact designed to facilitate therapeutic services *across* state boundaries. A memorable quote from the session was, "I think if you really want to improve mental health, try to convince people that they are not worthless, insignificant, invisible, or powerless. You can brainstorm as to how to convince people that they are worthy, significant, visible, and capable". Demographics included 12 individuals who identified as Chinese.

MHSA Key Informant Interview (KII) Process
Summary Sheet

Interviewee: Name/Title/Agency: Shanna Bowie, Community Programs Director, Pacific Center
KII DATE/TIME: 11/20/2023

Introduction and Explanation:
Thank interviewee for their time today and explain that the Mental Health Services Act, also known as MHSA or Prop 63, is a state funding stream funded through a 1% tax on California residents that earn over $1 million dollars/year. It requires that each year community input is gathered from a diverse group of stakeholders like themselves, which is why we've contacted them for their perspective and expertise.

The MHSA Team, along with a community planning committee has identified 11 community behavioral health needs that we'd like your opinion on and solutions to the top ranked needs for your [insert name of city or department].

The information provided will be used for our planning purposes for FY 24/25 and will be included in our next MHSA Report that will be published in the spring of 2024.

Transition to the Interview Questions
Share your screen and review the 11 areas of need. Then ask the interviewer to identify the top 3 or 4 areas of need for their city or department.

Note: (Once you confirm a KII please send the interviewee the Areas of Need document so they can read it before hand if they'd like, so that they're prepared for the interview).

1. Ranking of Community Needs:

Community Need	Ranking
Access, Coordination and Navigation to Services	1
Behavioral Health Workforce	2
Crisis Continuum	4
Housing Continuum	6
Substance Use	9
Community Violence and Trauma	7
Child/Youth/Young Adult Needs	3
Adult/Older Adult Needs	6
Needs of Family Members	5
Needs of Veterans	10
Needs of the Re-entry Community	11

Once the interviewee has identified the top 3 or 4 Areas of Need tell them you'd like to hear about their ideas and opinions on *solutions* to these top ranked needs.

2. **Ranking #1** Access, Coordination and Navigation to Services

Record/Solutions/Strategies/Ideas to address this need:

This is an important aspect of their mission to assist their clients. Pacific Center engages various groups, offers training programs, and provides mental health services. They routinely facilitate interaction between different providers and individuals in need of direct services. The Pacific Center states the need to prioritize bilingual services to support multiple languages in their growing client base.

3. **Ranking #2** Behavioral Health Workforce

Record/Solutions/Strategies/Ideas to address this need:

They are focusing on recruiting diverse clinicians who can speak different languages. There is also a need to hire LGBTQ Clinicians. The challenges in clinical training are magnified by the expensive living costs in the Bay Area. They would like a program for trained clinicians where apprentice hours can help cover living expenses especially for supporting clinicians from underrepresented backgrounds.

4. **Ranking #3** Child/Youth/Young Adult Needs

Record/Solutions/Strategies/Ideas to address this need:

They are seeing a need to address the diverse needs of children, youth, and young adults from diverse and marginalized communities. There is a need for an active effort to bridge funding disparities and resource gaps that affect LGBTQ youth to provide comprehensive services. The Pacific Center aims to provide unique services for these individuals to promote inclusivity and understanding about their services.

5. **Ranking #4** Crisis Continuum

Record/Solutions/Strategies/Ideas to address this need:

They apply a non-law enforcement crisis response method; they offer peer support groups and assist local peers as facilitators to help those in crisis. They strive to have language resources and crisis intervention services for the various LGBTQ communities.

This is for your own notes afterwards to summarize and synthesize the information

Overall Summary of the Listening Session

MHSA conducted a key informant interview with Shanna Bowie, Director of Programs at the Pacific Center. The Pacific Center offers wide ranging programs, including support groups and mental health services. The Pacific Center indicated that they are seeing clients' top needs as: Access, Coordination and Navigation to Services, Behavioral Health Workforce, Child/Youth/Young Adult Needs, and the Crisis Continuum. There is a need for a more diverse and culturally competent behavioral health workforce. They suggest more training of clinicians to better serve LGBTQ groups. They also recommend addressing gaps in services and including funding specifically around the needs of children, youth, and young adults. The Pacific Center has increased services and resources for the crisis continuum and is focusing on non-law enforcement intervention to support individuals experiencing a mental health crisis.

MHSA COMMUNITY PROGRAM PLANNING PROCESS
LISTENING SESSION ANSWER SHEET

Interviewee: Name/Title/Agency: Peers Transitional Age Youth Group,
KII DATE/TIME: 12/6/2023

Introduction and Explanation:
Thank interviewee for their time today and explain that the Mental Health Services Act, also known as MHSA or Prop 63, is a state funding stream funded through a 1% tax on California residents that earn over $1 million dollars/year. It requires that each year community input is gathered from a diverse group of stakeholders like themselves, which is why we've contacted them for their perspective and expertise.

The MHSA Team, along with a community planning committee has identified 11 community behavioral health needs that we'd like your opinion on and solutions to the top ranked needs for your [insert name of city or department].

The information provided will be used for our planning purposes for FY 24/25 and will be included in our next MHSA Report that will be published in the spring of 2024.

Transition to the Interview Questions
Share your screen and review the 11 areas of need. Then ask the interviewer to identify the top 3 or 4 areas of need for their city or department.

Note: (Once you confirm a KII please send the interviewee the Areas of Need document so they can read it before hand if they'd like, so that they're prepared for the interview).

1. Ranking of Community Needs:

Community Need	Ranking
Access, Coordination and Navigation to Services	1
Behavioral Health Workforce	Choose an item.
Crisis Continuum	Choose an item.
Housing Continuum	2
Substance Use	4
Community Violence and Trauma	5
Child/Youth/Young Adult Needs	3
Adult/Older Adult Needs	Choose an item.
Needs of Family Members	Choose an item.
Needs of Veterans	Choose an item.
Needs of the Re-entry Community	Choose an item.

Once the interviewee has identified the top 3 or 4 Areas of Need tell them you'd like to hear about their ideas and opinions on *solutions* to these top ranked needs.

2. **Ranking #1** Access, Coordination and Navigation to Services

Record/Solutions/Strategies/Ideas to address this need:

They are concerned with client's access to mental health and the rising costs, they think this is stopping more people from accessing mental health care. There also needs to be more promotion on the mental health stigma to inform people from different cultures it is acceptable to receive mental health care. There needs to be more focus groups to provide clients with a community voice and more in-person events so people can attend.

3. **Ranking #2** Housing Continuum

Record/Solutions/Strategies/Ideas to address this need:

Housing solutions and resources need to be advertised more. There needs to be more educational workshops for renters and first-time homebuyers. These workshops need to be done in multiple languages to serve all populations to help people remain housed and to become housed.

4. **Ranking #3** Child/Youth/Young Adult Needs

Record/Solutions/Strategies/Ideas to address this need:

There needs to be more PEI programs that focus on marginalized youth. The group stated that a lot of the youth are not being given an opportunity and the barriers to succeeding are becoming increasingly difficult. They think that staff should be trained to provide restorative justice to prevent and solve conflicts before they escalate. There also needs to be more mental health resources in school and in the classroom for youth to have their problems addressed urgently. Young adults should be provided with a stipend to incentivize them to reach out to mental health resources, an incentive can encourage them to break the mental health stigma.

5. **Ranking #4** Substance Use

Record/Solutions/Strategies/Ideas to address this need:

For youth and young adults more substance abuse training while in their younger years can prevent substance abuse later in life. They think that there needs to be more substance abuse trainings in the classrooms.

Once this process is complete, ask them if there's anything we missed or anything else they would like to share with us.

This is for your own notes afterwards to summarize and synthesize the information

Overall Summary of the Listening Session

MHSA team conducted a Listening Session with 7 community members from the PEERS TAY group. The group is comprised of youth and young adults who were vocal about sharing their concerns and recommendations for the MHSA services in Alameda County. The Peers TAY group highlighted their top concerns as: Access, Coordination and Navigation to Services, Housing Continuum, Child/Youth/Young Adult Needs and Substance Use. They addressed that there needs to be cultural destigmatization around mental health services and incentivization for youth to want to come forward to access mental health services. There are numerous members of the group who live in unsafe communities and believe their mental health issues stem from their environment. The group thinks there needs to be more mental health resources in schools to help youth address issues immediately, and not wait to access services after school or on the weekend. The group encourages MHSA to continue to conduct focus groups to listen to strategies and solutions to community members mental health needs.

MHSA COMMUNITY PROGRAM PLANNING PROCESS
LISTENING SESSION ANSWER SHEET

FACILITATOR NAME/AGENCY: Peers Org. Comm. Change (POCC) MHSA Planning Meeting
FOCUS GROUP DATE/TIME: 11/21/2023
# of Participants: 30
County: 4 [Mary Hogen, Tracy, Noah, Abigail]
Survey Participants: 26

I. **Ranking of Community Needs:**

Community Need	Top Three (3) Ranking	Tally numbers
1. Access, Coordination and Navigation to Services	1	11
2. Behavioral Health Workforce	2	9
3. Crisis Continuum	3	5
4. Housing Continuum	3	6
5. Substance Use	Ranking the Votes	3
6. Community Violence and Trauma	Ranking the Votes	2
7. Child/Youth/Young Adult Needs	Ranking the Votes	2
8. Adult/Older Adult Needs	Ranking the Votes	5
9. Needs of Family Members	Ranking the Votes	2

10. Needs of Veterans	Ranking the Votes	1
11. Needs of the Re-entry Community	Ranking the Votes	5

II.**Ranking #1**: Access, Coordination and Navigation to Services

Record/Solutions/Strategies/Ideas to address this need:

- We need more Navigators out in the field, meeting people where they're that are in crisis to connect and support them.
  - Many providers are at their desk instead of reaching the community in need.
  - Planting a seed that there's help out there for them.
- Have other avenues to meet the people in need where they're at.
  - Home visits, going to homeless camps or other ways.
  - Have a community van, medvan (medical van) because there's a lot of people dying out there in substance abuse and in cold weather.
- Need for more funding in the shelter.
  - Shelter hours are limited, especially in the winter times. There's a stipulation and they're only open when it's below 44 degrees and if it's 45 degrees they're close.
  - It doesn't change the state of those people who are homeless that are in those weather that have health issues.
- Look at all the criteria, even those people who are housed and not just wait for people to become homeless because we didn't meet their needs when they needed it the most before they fell on the pit of homelessness.
- Issues to address implementation on when the rubber meets the road. Is the implementation effective or not.
- Are we in the spaces, places delivering services in a timely manner when our organizations are needed?
  - At times there are processes that fall down.
- Having useful data that identifies the services, processes, as what was said "time is money" and who are imposing those services.
- Need to funnel those services that are efficient and figure out which ones gives the best results in reaching the community in need.
  - Need to map thing out to get a clear view of the process that follow through (who's doing what services, the coordinated services, navigation, and special services and figuring out what it really looks like on how the community is being reached out in a timely manner).

Ranking #2: Behavioral Health Workforce

Record/Solutions/Strategies/Ideas to address this need:

- Workforce staff who dedicated themselves to their job aren't being paid well.
- Need for support in the workforce when staff also experience crisis.
  - they shouldn't get fired but provided therapy or help
  - Workforce experience backfire (saying that they have pre-existing MH issues, and it didn't happen because of this but because you are already like this)
- Evaluation on pay scale for Peer Support Specialist in current economy.
- Funding training to support the staff to be well equipped in the work they do.
- Need for after business hours and weekends to connect with staff, services, programs, and access to county portal.

- Need to address the "Friday after three services" for people with serious MH challenges, housing need, the availability of portal company needs in ALCO employee services, since MH challenges doesn't have a day off or time off.
- Only available are John George, Highland hospital.
- Had experienced being told that it cannot be addressed until Mon or Tues. which is 48 hours wait window and the only option is to go to JG or Highland which is a trigger form and not a welcoming space for people w/MH challenges and to meet them where they are at and provide them services. And they end up being held in custody.
- In JG and Highland hospital all they can do was to pick up their medicine and be placed in a program.

- Provide safe and welcoming places and spaces for those people with MH challenges that provide them direct services and housing they need (stop creating more trauma).
  - There's the CATT team services (instead of 911) but they have to start all over again and bring them to the bottom that bring about those triggers.
  - When clients come to the County to seek services and admit to their substance use or need housing they're brought to a place where they're traumatized all over again instead of bringing them to the direct Access services they need.
- Need staffing or hire more peer support specialist w/lived in experience for well needed response.
  - When people call phone numbers like Access, 211, they may be under staff because they don't get immediate response, or support.
- Need to hire more peer respite support and care.
- Need funding for more respite care services and to have a clear reduced timeline for those in critical condition.
  - Three (3) clients passed because they're not provided with the housing services they need in a timely manner.
- We need to advocate for 2% for MHSA, 1% Tax isn't enough. Programs that are providing benefiting services get cut and it shouldn't happen.

Ranking #3: Crisis Continuum & Housing Continuum

A. Crisis Continuum

<u>Record/Solutions/Strategies/Ideas to address this need:</u>

- Emphasis on support system put in place for the workforce.
- Having more trauma informed work e.g. CIT, so people can continue to be informed, continue to examine their biases, can provide cultural responsive services.
- Crisis are very broad. It could be MH, financial, housing etc.
  - MH issues, there should be a clear process on where they can go or who they can talk to on a personal level that they can trust.
  - Be mindful of the age group on how to address/meet people during their crisis.
  - Living circumstance which is different approach to tackle.
- Peer respite care that is continuum and is a one-stop-shop peer run program.
  - Assessment in 2 weeks, more support, then move to another program that they don't need to move to different location.
- Mobile Crisis Van at times cannot reach people in times of need because they're short staff.
  - Need to hire a certified peer support specialist.
- There should be a mandatory training workshop for the community area.

- e.g. First Aid Mental Health training given to workforce staff like peer support specialist, to doctor, family, neighbors, community.
- People experience crisis even their Dr. who cannot see them or cancelled an appt. because the Dr. is also in crisis and not well fit to perform.

- Need for service provider with lived in experience that can provide wellness care and empowerment and hold on to their own agencies.
  - the highly educated clinician or doctors but doesn't have all the components in place and they may provide inaccurate care which led to waste in funding.
- Need to provide or create 24/7 services and programs available instead of turning people away.
  - Temporary Triage
  - Real life experience in accessing services and care which were not available. They called and there's no bed available and was told that they need to walk in and come in not until Monday to get service they need. So, they resort to calling an ambulance to get help. And when it resorts to the person committing a crime like shooting, beating or something because they're not given help and press broadcast it's a MH person but prior to the event the MH person was seeking help but wasn't provided services.

B. Housing Continuum

Record/Solutions/Strategies/Ideas to address this need:

- Systemic issues need to be addressed, historic data shows that housing and healthcare has been out of reach of people for a very long time.
  - Service should reach people in need, on time and not when they have already passed away.
- Need to have accountability and have a check and balance in housing programs and services.
- Housing resource access
- Transparency in decision making in housing.
  - What's the dominoes on how long it took or how much time for you to get housing to the homeless (time is money; when the funding on certain programs for housing doesn't get the job done, then that funding needed to be shift somewhere else where they can provide real results (peer support specialist or programs that are working)

III.**What Else, What Did we Miss**:

Record/List Answers

- Create a group home to undocumented people (latino community who are unserved)
- People in MH crisis, there's no time when their trigger happens, and they break down.
- Evening crisis, under medical, they don't provide any therapy support.
- In Casa Ubuntu Wellness center they serve people who are in need but cannot bill people that already have case manager in BACS, Telecare and other places.
  - There's recognition there.
- Need to develop a comprehensive digital platform and master directory that has contact people, assessment, subcontractors and resources of all supportive mental health and services in ALCO that's updated with diff. resources like hospitalization, housing, treatment etc.
  - There's no easy transmission of information in the Mental Health treatment system and access services.

- When James worked in Berkeley, they had a bluebook which was a comprehensive directory, e.g. in highland hospital emergency where Sutter can provide all the person's emergency information in matter of seconds.
- Lack of utilization and access to information/resources which causes delay and lack of cohesiveness.
- People mostly only get access to services through word of mouth.

- Need to have a department or responsible part that's paid to update the master directory.
- Suggesting that there should be another page to HRMIS for providers contact information on who provides what service.
  - Unfortunately, there's a culture in providers funding that they don't connect because they're fighting for funding. They don't share each other's resources and services instead of cross-training each other and get broader wide availability and exposures of shared resources in ALCO.
- Being able to disseminate information and have paper copy is very handy since not everyone has internet and electronic devices.
- Digital division need to be addressed.

Tracy expressed the impact of the community survey which turned into data that gets rolled back to the County and examined by the executive leadership team and the BOS. And when there's additional funding, then this data can be used. Just like in the previous community input sessions, the agency were able to fund programs that are coming like the LGBTQI and QS, new early childhood program, Innovation project for the reentry community, new awarded peer respite program, new wrap services for the reentry community, training, additional staffing to court system. Additionally, this data is useful also in the implementation of our services.

IV. Action Items:

- Mary will provide compensation (stipends) to the participants.
- Mary will send Tracy the invites of the POCC holiday event (Dec. 7th in Holiday Inn) that Gordon mentioned.
- Tracy/Abigail will provide swags and give it to Mary.
- Mary will bring all the swags to the Holiday Cultural event.

<u>Overall Summary of the Listening Session</u>

POCC Meeting was held via Zoom video conferencing that were attended by total of 30 attendees among them were 26 expected survey participants. It's hosted by Mary Hodgen and facilitated by Tracy Hazelton and Noah Gallo. A demographic survey was launched in the beginning. Then the areas of needs were presented and elaborated to the participants for the main goal of getting their feedback and insights. Afterward the participants cast their top three (3) votes of topic in the chat, then were tabulated and identified the most voted topic for discussion and input.

Participants have asserted that services and assistance need to meet people where they are at literally (going to homeless camp) and in other avenues of their current situations. They've pointed out that there's a great need for after-hours and weekend services, especially for people with MH challenges, that's a safe and welcoming space or place, including temporary triage. They are advocating hiring more peer support specialists to team with clinicians and doctors as a whole component in providing complete care services. To have an analysis of data that can show which has effective results in reaching the needs of the community. To have a one-stop-shop for respite care continuum. To have a check and balance in housing and transparency in its decision-making. In the end part of the forum, it was added to create a group home for undocumented Latino community experiencing MH crisis. And final suggestion to hire a position and develop a comprehensive master directory that gets updated with different resources like hospitalization, housing, treatment etc.

MHSA COMMUNITY PROGRAM PLANNING PROCESS
LISTENING SESSION ANSWER SHEET

Interviewee: Name/Title/Agency: Teslim Ikharo, Executive Director, Board of Directors, Supportive Housing Community Land Alliance (SHCLA)

KII DATE/TIME: 11/29/2023

Introduction and Explanation:
Thank interviewee for their time today and explain that the Mental Health Services Act, also known as MHSA or Prop 63, is a state funding stream funded through a 1% tax on California residents that earn over $1 million dollars/year. It requires that each year community input is gathered from a diverse group of stakeholders like themselves, which is why we've contacted them for their perspective and expertise.

The MHSA Team, along with a community planning committee has identified 11 community behavioral health needs that we'd like your opinion on and solutions to the top ranked needs for your [insert name of city or department].

The information provided will be used for our planning purposes for FY 24/25 and will be included in our next MHSA Report that will be published in the spring of 2024.

Transition to the Interview Questions
Share your screen and review the 11 areas of need. Then ask the interviewer to identify the top 3 or 4 areas of need for their city or department.

Note: (Once you confirm a KII please send the interviewee the Areas of Need document so they can read it before hand if they'd like, so that they're prepared for the interview).

1. Ranking of Community Needs:

Community Need	Ranking
Access, Coordination and Navigation to Services	3
Behavioral Health Workforce	2
Crisis Continuum	2
Housing Continuum	1
Substance Use	Choose an item.
Community Violence and Trauma	5
Child/Youth/Young Adult Needs	5
Adult/Older Adult Needs	4
Needs of Family Members	Choose an item.
Needs of Veterans	5
Needs of the Re-entry Community	5

Once the interviewee has identified the top 3 or 4 Areas of Need tell them you'd like to hear about their ideas and opinions on *solutions* to these top ranked needs.

2. **Ranking #1** Housing Continuum

Record/Solutions/Strategies/Ideas to address this need:

They recognize that housing is a major factor in the mental health of individuals. They also seek to provide services to clients that are housed to help teach clients how to live inside a residence. Often, they are witnessing clients live homeless inside of their room or apartment. There needs to be wraparound services onsite to help clients. They think that housing should be based on income and the amount the mental health client can afford. Older adults are being left out of housing solutions and there needs to be constant outreach to assist elderly people in finding housing.

3. **Ranking #2** Behavioral Health Workforce, Crisis Continuum

Record/Solutions/Strategies/Ideas to address this need:

They see that peer navigators with lived experiences are the most effective for helping mental health clients. The peer navigators need to be given more tools and training so they can help clients access resources.

4. **Ranking #3** Access, Coordination and Navigation to Services

Record/Solutions/Strategies/Ideas to address this need:

They believe that peer navigators can make a difference for unhoused mental health clients. They want more services that are mobile and can meet clients where they are at. They also want to have more navigators located on-site at different housing complexes to assist mental health clients immediately. They are looking for more Latino outreach and engagement to serve the new immigrant population that is not forthcoming to access services.

5. **Ranking #4** Substance Use

Record/Solutions/Strategies/Ideas to address this need:

There needs to be substance abuse services that can go into the community to help the unhoused. They said that clients become housed then the substance abuse services need to be available in the residences so clients can access them quickly.

Once this process is complete, ask them if there's anything we missed or anything else they would like to share with us.

6. **What Else, What Did we Miss**:

Record/List Answers

This is for your own notes afterwards to summarize and synthesize the information

Overall Summary of the Listening Session

7. The MHSA team presented at the Supportive Housing Community Land Trust board meeting to board members and community members. The top needs of the clients were the Housing Continuum, Behavioral Health Workforce, Crisis Continuum, Access, Coordination and Navigation to Services, and Substance Abuse. The group wanted to emphasize that more affordable housing needs to be made in different areas of the county. They also want there to be more wraparound services for mental health clients in residential buildings. The participants praised the Supportive Housing Community Land Trust model for providing them with the opportunity to be invested in their living situation as opposed to being homeless or a renter.

MHSA COMMUNITY PROGRAM PLANNING PROCESS
LISTENING SESSION ANSWER SHEET

FACILITATOR NAME/AGENCY: Swords to Plowshares (STP)
FOCUS GROUP DATE/TIME: Click or tap to enter a date. **11/02/2023**
# of Participants: 17 Veterans (including Robert Williams), 2 MHSA Staff (B.Godwin, N. Gallo), STP Staff (E. Spiru), Razon (HHREC)

1. Ranking of Community Needs:

Community Need	Ranking
Access, Coordination and Navigation to Services	Choose an item. 3
Behavioral Health Workforce	Choose an item. 2
Crisis Continuum	Choose an item. 2
Housing Continuum	Choose an item. 1
Substance Use	Choose an item. 2
Community Violence and Trauma	Choose an item.7
Child/Youth/Young Adult Needs	Choose an item. 2
Adult/Older Adult Needs	Choose an item.5
Needs of Family Members	Choose an item. 2
Needs of Veterans	Choose an item. 8
Needs of the Re-entry Community	Choose an item. 3

2. **Ranking #1: Needs of Veterans**

Record/Solutions/Strategies/Ideas to address this need:

- Solution: Swords to Plowshares helps Veterans
  - Helps with community involvment
- Need more scenarios like Sword to Plowshares
  - Place to get access, coordiantion, navigation to services
  - This is a place that helps Vets with multiple services

- More “one stop shops”
- Keep access in safe and secure location
  - Violent areas are bad for calming mind
  - Need a place with internet/tech/computer access
- More community members trained to be mental health specialists
  - Psychologists, psychiatrists, social workers
  - Government decisions to close hopsitals and clinics hurts Veterans
    - If the government cared, solutions would be found.
    - These groups do no accurately capture the needs and concerns of Veterans
    - Need more action, not words. Don’t go in circles; do something
- Keep hospitals and clinics open; don’t close state hospitals
- Veterans/community also have responsibility to police and safeguard community
  - Minimize fraud
  - Strengthen audit systems, which are weak now
  - Mental health follow up is missing in civilian wolrd; we need someone to take responsibility for helping keep treatment going
- Advocate for self-empowerment: use the VA
- Public awarness to help Veterans. Need strong representation from public or well known figures.
  - “Respect the Veterans from the top.” from state/Federal leadership
  - Need someone to push for support after service. This will help morale with Vets that are struggling.
- Take care of yourselvesto help **everybody.**
  - Need to be more connected and united
  - Need to stand up and say “Don’t forget about us."
- Financial coountability from government-funded entities
  - More money going to people, not organizations

3. **Ranking #2**: **Community Violence And Trauma**

Record/Solutions/Strategies/Ideas to address this need:

- More crisis support teams on the streets
- More gun violence mitigation
- Reconciliation between warring or violent factions that live in the same community
  - Help folks broaden geographic awareness
- Recognize that Bay Area is no longer safe and suitable for healing
  - Help with relocation assistance
  - Speed up services during crisis periods
- Work programs for minor offenders
  - Monitor government funding
  - Create accountability so funds are not used for personal use
  - Organizations like “Helmets to Hardhats”
  - Reallocate funds to people served, not admin.
- Civics training and education: help citizens understand the law
- Lots of drug use and homelessness in local communities
  - Petty crimes and drug use make it unsafe to live in certain areas

- Things get better, than get worse again
- "Everybody wants to feel safe."
- Solutions that don't necessarily involve cooperation with law enforcement
- Advocacy for STP to provide safety and services for Vets and senior community in impacted areas
- "It hurts me inside because I know my hands are tied."
- Living supplies for folks that need them (furniture, bedding, and so forth) to help these folks
- The ***whole area*** is impacted right now by violence
  - "Have to be in by 6pm because I'm a target."
  - Strips away privacy and privilege when you live under threat of violence
  - Takes away our peace
- People care about where they live; they want to be able to settle down
-

4. **Ranking #3: Adult/Older Adult Needs [*Not done due to time constraints]***

Record/Solutions/Strategies/Ideas to address this need:

5. **What Else, What Did we Miss**:
   - Are Veterans entitled to same rights as civilians for habitable conditions?
     - Are there separate criteria for Veterans?
     - Need habitable conditions for younger Veterans?

Overall Summary of the Listening Session

MHSA co hosted a listening session with 17 Swords to Plowshares veterans program participants. Participants identified Veterans' Need are more Advocacy centers like Swords to Plowshares, emphasize more mental health training, addressing impacts of hospital closures, and call for ongoing support. To prevent community violence and trauma, the participants talked about pushing for more prevention crisis teams, reconciliation efforts, relocation aid, and faster crisis services, while addressing societal issues impacting safety.

MHSA Key Informant Interview (KII) Process
Summary Sheet

Interviewee: Name/Title/Agency: Tizita Tekletsadik, African Communities Program Manager, Partnerships for Trauma Recovery

KII DATE/TIME: 12/8/2023

Introduction and Explanation:

Thank interviewee for their time today and explain that the Mental Health Services Act, also known as MHSA or Prop 63, is a state funding stream funded through a 1% tax on California residents that earn over $1 million dollars/year. It requires that each year community input is gathered from a diverse group of stakeholders like themselves, which is why we've contacted them for their perspective and expertise.

The MHSA Team, along with a community planning committee has identified 11 community behavioral health needs that we'd like your opinion on and solutions to the top ranked needs for your [insert name of city or department].

The information provided will be used for our planning purposes for FY 24/25 and will be included in our next MHSA Report that will be published in the spring of 2024.

Transition to the Interview Questions
Share your screen and review the 11 areas of need. Then ask the interviewer to identify the top 3 or 4 areas of need for their city or department.

Note: (Once you confirm a KII please send the interviewee the Areas of Need document so they can read it before hand if they'd like, so that they're prepared for the interview).

1. Ranking of Community Needs:

Community Need	Ranking
Access, Coordination and Navigation to Services	1
Behavioral Health Workforce	Choose an item.
Crisis Continuum	Choose an item.
Housing Continuum	Choose an item.
Substance Use	Choose an item.
Community Violence and Trauma	2
Child/Youth/Young Adult Needs	3
Adult/Older Adult Needs	4
Needs of Family Members	5
Needs of Veterans	Choose an item.
Needs of the Re-entry Community	Choose an item.

Once the interviewee has identified the top 3 or 4 Areas of Need tell them you'd like to hear about their ideas and opinions on *solutions* to these top ranked needs.

2. **Ranking #1** Access, Coordination and Navigation to Services

Record/Solutions/Strategies/Ideas to address this need:

They are seeing the need to provide navigation to housing, employment, and immigration support. The coordination of different service providers for women, girls, boys, and immigrant needs has led them to think about hiring more navigators. This issue is further complicated by having to support immigrants from 55 different countries who speak different languages. They can support 23 different languages. They offer services at their office, and community gatherings depending on the safety, privacy, and accessibility.

3. **Ranking #2** Community Violence and Trauma

Record/Solutions/Strategies/Ideas to address this need:

They are seeing more clients that come to them with various forms of violence from their current home and from their previous country. They are offering trauma informed care and support to target clients' abilities to access resources and capabilities rather than regarding clients as victims. They are seeing more of a need to provide services requested from the community that are culturally sensitive and culturally appropriate.

4. **Ranking #3** Child/Youth/Young Adult Needs

Record/Solutions/Strategies/Ideas to address this need:

They are seeing more unaccompanied minors, so they have had to adapt services to assist immigrant youth. They have found that their clients want to access services where they are already at, so they have started offering more youth workshops in schools, churches and mosques. With the teenager and young adult population they have addressed mental health challenges around experiences of racism and navigation law enforcement.

5. **Ranking #4** Adult/Older Adult Needs

Record/Solutions/Strategies/Ideas to address this need:

Family members are taking care of elderly who are experiencing isolation and difficulty in completing responsibilities. They have received feedback from parents that they are facing anxiety from being in a new county and a new culturally different environment. They are looking to create programs to bridge the gap in communication between parents and youth so that each better understand each other and their new immigrant experiences.

Once this process is complete, ask them if there's anything we missed or anything else they would like to share with us.

This is for your own notes afterwards to summarize and synthesize the information

Overall Summary of the Listening Session

7. The MHSA team met with the African Program Manager at Partnerships for Trauma Recovery. The conversation highlighted their top needs as Access, Coordination and Navigation to Services, Community Violence and Trauma, Child/Youth/Young Adult Needs, and Adult/Older Adult Needs. The conversation discussed how many of their clients are new immigrants from 55 African countries speaking over 23 different languages. Their clients have experienced violence in their home country, violence on their immigration journeys to the United States and some have experienced violence here. They encourage the Alameda County services to be culturally sensitive, provide linguistic accessibility, and to be mobile in the community. They see the need to bring together the different age groups of the new African immigrants so they can better understand each other with the goal of African youth, adults and elders improving the family dynamics and alleviating the elders needs of social isolation and caretaking duties.

MHSA COMMUNITY PROGRAM PLANNING PROCESS
LISTENING SESSION ANSWER SHEET

FACILITATOR NAME/AGENCY: Robert Williams/Veterans Collaborative Courts (Telecare)
FOCUS GROUP DATE/TIME: 10/24/2023 10/27/202
# of Participants: 6

- **Robert Williams (HHREC, Active National Guard Member)**
- **Brian Godwin (MHSA-Alameda County)**
- **Danielle Guerry- (Collaborative Courts c/o Telecare)**
- **Jorge Hernandez- (United States Armed Forces Veteran)**
- **Noah Gallo- (MHSA-Alameda County)**
- **Denise Cash- (United States Armed Forces Veteran)**
- **Gary Ransom (United States Armed Forces Veteran)**

1. Ranking of Community Needs:

Community Need	Ranking
Access, Coordination and Navigation to Services	1
Behavioral Health Workforce	3
Crisis Continuum	Choose an item.
Housing Continuum	2
Substance Use	Choose an item.
Community Violence and Trauma	Choose an item.
Child/Youth/Young Adult Needs	Choose an item.
Adult/Older Adult Needs	Choose an item.
Needs of Family Members	Choose an item.
Needs of Veterans	Choose an item.
Needs of the Re-entry Community	Choose an item.

- Ideas/Solutions/ Strategies to Address The Needs Noted Above
    - **Ranking #1: Access, Coordination, and Navigation to Services**

- Denise:
    - More local facilities
    - Transportation to facilities

- Jorge:
    - --Many veterans are very stubborn but have severe injuries like PTSD
    - --Get benefit information to younger Vet population exiting the military
    - --Create a Veteran workforce that recently discharged Veterans can reach out to
    - --similar to resource centers on campus
    - --Make knowledge of services like Abode and Swords to Ploughshares. Motivate younger Vets to use.
    - --Many Veterans are lost in the initial stages of separation and reintegrate into society

- --Start a Veteran to Veteran group
- --Need to focus on retaining support staff and members
- --Utilize community/community centers like library to advertise and support community events
  - "More community events"
  - --"Veterans language is food!"
  - --Incentives also work to attract Veterans to events. Understand what is important to Veterans and tailor care packages to them.

- Robert
  - Swords to Plowshares is helpful in preventing homelessness

  - **Ranking #2: Housing Continuum**

  - Jorge:
  - Housing specific to Veterans, regardless of discharge status
  - Housing vouchers are useful
  - Housing costs can make great impacts on fixed income. Might not be qualified for food stamps even though rent impacts pension funds.
  - Employment resources also helps to ease housing pressure Veterans feel.
    - Workforce to help navigate housing and employment resources, especially if workforce are also Veterans.
    - "Veterans love Veterans."

  - Denise
  - More housing vouchers like VASH (sp.?) voucher
  - Like housing vouchers
  - Having a stable housing environment helps with mental health issues

  - Robert
  - Rent cap so rent is affordable
  - "Inhouse network that is for Veterans, by Veterans."

  - Gary
  - Give Veterans information and access to housing programs
    - Share this information with the folks in counseling programs.
  - Use housing from decommissioned military bases to house homeless Veterans, like at Treasure Island and Alameda Naval Stations
  - One-stop shops that can offer resources and access to benefits

- **Ranking #3: Behavioral Health Workforce**

- Jorge:
  - Workforce in VA is not open to public
    - Have to have a connection like a case worker or Social Worker
  - Use a model like BACS:
    - Get at-risk individuals into immediate shelter and food acquisition

        - Get into County system quickly
        - Help with housing situation
        - Should include outreach specific to Veterans accessing mental health
        - More assistance and community involvement in accessing resources
    - Increase network with VA to help Veterans involved with local organizations
    - Workforce should assist Veterans with identifying healthy emotional coping mechanisms
        - Similar to the TriWest program, but more community friendly
        - Programs should be more "Community friendly" and not necessarily tied to the VA process
        - A lot of Veterans ae being left out due to discharge or active-versus-reserve status
    - For provider training, they should understand Veteran-specific issues and resources like the VA and Swords to Ploughshares.

- Denise
    - Have a workforce trained to address substance abuse disorders concurrently with other
    - Organizations like BACS would benefit from more information on how to help Veterans and address specific concerns

    - Robert
    - Enlist VA help in assisting well-run community organizations and non-profits
    - The VA should be involved in ground-level work being performed at the local level
        - Would help to minimize the perceived stigma around VA access
    - Produce a pamphlet that offers Veteran-specific pamphlets that describe various benefits and programs.
        - Included in this would be a provider or other human that can support the Veteran by explaining the information contained therein

- **What Else, What Did we Miss**:
- Denise:
    - Events or functions where Veterans can meet up with VA and other Veteran-specific resources
    - Live events that help ease loneliness and isolation

- Jorge:
    - Encourage to VA providers to interact more with the community

- <u>Overall Summary of the Listening Session</u>
    - In ranking #1, the primary focus is on enhancing access, coordination, and navigation to services for veterans. Suggestions include the need for more local facilities and improved transportation options to these facilities. Additionally, there's an emphasis on reaching out to younger veterans exiting the military, establishing a veteran workforce, and creating veteran-to-veteran support groups. There's also recognition of the value of organizations like Swords to Plowshares in preventing homelessness.

- In ranking #2, the discussion centers on the housing continuum, with an emphasis on housing vouchers, affordable housing, and the use of decommissioned military bases for housing homeless veterans.

- In ranking #3, the focus shifts to the behavioral health workforce, with recommendations for better training and the development of more community-friendly programs. The suggestions aim to enhance support for veterans in accessing housing, services, and mental health resources while fostering a stronger sense of community among veterans. Additional ideas include organizing events to connect veterans with resources and encouraging VA providers to engage more with the community.

- "How do you feel about this listening session?"

- Jorge
  - Strategize on how to engage the Veteran population
  - This listening session is a good example of dialogue and word-of-mouth information sharing.
    - Would be improved by having some sort of resource like a website that canserve as a next step after these types of sessions or conversations occur

  - Denise
  - More folks at the ground level to share information and guide Veterans to resources and benefits. Leverage word of mouth

  - Gary
  - There are lots of Veterans on the streets that have not accessed resources yet, so make sure outreach is directed to them to offer services.
  - Service like Homeless Action Center, BACS, REACH, and so forth are good resources for all folks, Veterans and non-Veterans, to access resources.

alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

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

MHSA COMMUNITY PROGRAM PLANNING PROCESS
LISTENING SESSION ANSWER SHEET

FACILITATOR NAME/AGENCY: Families Advocating for the Seriously Mentally Ill (FASMI)
FOCUS GROUP DATE/TIME: 1/12/2024
# of Participants: 7

1. Ranking of Community Needs:

Community Need	Ranking
Access, Coordination and Navigation to Services	2
Behavioral Health Workforce	Choose an item.
Crisis Continuum	Choose an item.
Housing Continuum	Choose an item.
Substance Use	Choose an item.
Community Violence and Trauma	Choose an item.
Child/Youth/Young Adult Needs	3
Adult/Older Adult Needs	Choose an item.
Needs of Family Members	1
Needs of Veterans	Choose an item.
Needs of the Re-entry Community	Choose an item.

2. **Ranking #1** Needs of Family Members
   Record/Solutions/Strategies/Ideas to address this need:
   There was a discussion about early intervention (EI) programming here in Alameda County. There's a successful EI program in Yolo County that FASMI members would like ACBH to review. Members were curious how people get into the local EI program run by the Felton Institute, how many people served, concerns about the age limit and how is the program marketed. It was suggested that the MHSA SG request Felton to do a presentation on their programming. This will be scheduled for one of the upcoming meetings.

3. **Ranking #2** Access, Coordination and Navigation to Services
   Record/Solutions/Strategies/Ideas to address this need:
   Many participants voiced concern and frustration on the lack of coordination of care for their loved ones. There was also frustration around the ACCESS number in terms of community knowledge of this service and the wait time for assistance. A solution was a type of team that was called and engaged the moment a person was admitted to John George and could then follow that individual through different systems and services in order to support navigation and coordination of care.

MHSA Listening Session Q&A Workbook
Creation Date: October 10, 2023
Once COMPLETE, put the document here: LS Notes_Summaries in the MHSA Share Point Site

2000 Embarcadero Cove, Suite 400
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Carol F. Burton, MSW, Interim Director

Early intervention is hard to be voluntary, people need someone to reach out to and that person be a consistent presence. Participants suggested a program model that helps stabilize clients, provides continuity of care, and ongoing wellness support. A program like this is in Yolo County and has an alumni program within the MH court. This program has proactive alumni/volunteers who reach out and provide support to newer participants.

Other solutions include: having a team approach of people who can be present/available on a daily basis, not just once a month, until they don't need that degree of help anymore. Increased collaboration with therapists. Increased support for family members. Having a family voice in the discussions with ACBH.

4. **What Else, What Did we Miss**:
There was interest in reaching out to other family member groups in the county. Several family groups that ACBH is aware of include: the African American Family Outreach Project, Mental Health Association for Chinese Communities, Family Education Resource Center (FERC), NAMI groups. The ACBH Office of Health Equity may have more information.

There is also still a significant need for hospital beds. There was also a sentiment from the group for the county to embrace the new changes and coming legislation because there's a feeling that what's being done is not working at all. The group would like to see more action and less process.

Overall Summary of the Listening Session
The MHSA Team conducted a session with seven FASMI members. There was interest in understanding the ACBH funded Early Psychosis program as the group was not aware of the program, how to access it, the program guidelines etc. There was overall concern and frustration with the lack of coordination of care for those living with a serious mental illness. Solutions around this included: a program with daily/ongoing/proactive care and check-ins and the provision of overall wellness services and supports. There was also a sentiment from the group for the county to embrace the new changes and coming legislation because there's a feeling that what's being done is not working. There was also an interest in learning about other family member groups to learn from others, increase information sharing and to uplift the family voice.

MHSA Listening Session Q&A Workbook
Creation Date: October 10, 2023
Once COMPLETE, put the document here: LS Notes_Summaries in the MHSA Share Point Site

alameda county behavioral health
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Carol F. Burton, MSW, Interim Director

MHSA COMMUNITY PROGRAM PLANNING PROCESS
LISTENING SESSION ANSWER SHEET

FACILITATOR NAME/AGENCY: Ashland Cherryland Food and Basic Needs Coordination Committee
FOCUS GROUP DATE/TIME: January 9/February 13, 2024
# of Participants: 45

1. Ranking of Community Needs:

Community Need	Ranking
Access, Coordination and Navigation to Services	1
Behavioral Health Workforce	6
Crisis Continuum	8
Housing Continuum	2
Substance Use	8
Community Violence and Trauma	5
Child/Youth/Young Adult Needs	3
Adult/Older Adult Needs	10
Needs of Family Members	6
Needs of Veterans	11
Needs of the Re-entry Community	4

2. **Ranking #1 Access, Coordination and Navigation to Services**
   Record/Solutions/Strategies/Ideas to address this need:
   There are high stress pts around accessing/navigating services including affordability and equity of services. A favored solution was to "double down" on the promotora model to be able to reach community members, which could be Medi-Cal reimbursable under the community health worker classification. This could be very helpful in peer to peer counseling. This is a successfully proven way to bring MH strategies to the community. 211 is not helpful, it's difficult to access computerized forms, community members need technology (computers/laptops/ipads/smart phones) and assistance to access the forms/information and services. More school-linked supports, more resources for community centers, opportunities for parents to connect and parent groups. There also needs to be an increase in language access and cultural representation so that communities can access care from people who look and speak like them.

MHSA Listening Session Q&A Workbook
Creation Date: October 10, 2023
Once COMPLETE, put the document here: LS Notes Summaries in the MHSA Share Point Site

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Carol F. Burton, MSW, Interim Director

3. **Ranking #2 Housing Continuum**
   Record/Solutions/Strategies/Ideas to address this need:
   There are significant issues with evictions, no housing stock. Solutions include: Roving housing navigators to help with finding and keeping housing/navigators who'd have both MH and SUD experience, rental payment assistance, migrant shelter, more transitional housing, more section 8 vouchers. The only housing options right now are sharing a room and this is approximately $600/mo.

4. **Ranking #3 Child/Youth/Young Adult Needs**
   Record/Solutions/Strategies/Ideas to address this need:
   Similar to item #1 above there's a high need for navigation to MH services, which could be done through peer to peer work. It would be very helpful to bolster community grassroots efforts in various languages and through culturally congruent approaches. Parenting groups/trainings/workshops. Also substance use prevention for youth and more substance use information for parents. Coaching and training on how parents can talk to their kids. More group counseling in various languages and leaning in to open spaces, like yoga in the park, having fun while providing education/training etc. There are increasing levels of homelss youth and it's difficult for them to manage/navigate all of the paperwork and documents needed to apply for affordable housing-a solutions is to have roving housing navigators that can move between shelters and aren't connected to a program. This would help enormously. Meeting people where they're at.

   Overall Summary of the Listening Session
   The MHSA Team facilitated a session with members of the Ashland Cherryland Food and Basic Needs Coordination Committee. Participants identified Access/Coordination/Navigation, Housing and Child/Youth Needs as top areas of needs. Solutions included: Utilization of the promotora, peer to peer, model to bring MH to communities, more services/supports for parents,e.g. parent support groups/workshops, more school-linked services, increased language access and cultural representation, roving housing navigators, especially to help youth/young adults, a migrant shelter, and more transitional housing. Participants also suggested substance use education for youth and parents, particularly around cannabis, there's a good deal of self medicating post-covid, supporting the full family, screenings for abuse, providing fun and a sense of community in order to successfully engage with community members and overall meeting people where they're at.

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Priority Area	
Self - Individual	
Crisis	Client doesn't want to contact law enforcement
Crisis	Having more trauma informed work e.g. CIT, so people can continue to be informed, continue to examine their biases, can provide cultural responsive services.
Other	homeless they need more insight into services and how they can access them.
Other	Re-examine the notion that there is something wrong with us - Stigma reduction is critical Especially for children
Access	There also needs to be more promotion on the mental health stigma to inform people from different cultures it is acceptable to receive mental health care.
Substance Use	For youth and young adults more substance abuse training while in their younger years can prevent substance abuse later in life.
Access	There is also a stigma concern with seeking mental health support which prevents them from accessing services.
Workforce	In order to reduce possible stigma about entering this job field, you have to make it attractive to people, show how this profession is making a difference, be inspirational, e.g. you're going to be a hero and well respected.
Child/YA	Engaging with youth to empower them and for them to know how special they are. "When people believe they're precious they will act
Community Violence	They are seeing more of a need to provide services requested from the community that are culturally sensitive and culturally appropriate.
Interpersonal	
Crisis	there should be a clear process on where they can go or who they can talk to on a personal level that they can trust.
Crisis	Emphasis on support system put in place for the workforce.
Crisis	There should be a mandatory training workshop for the community area. First Aid Mental Health training given to workforce staff like peer support specialist, to doctor, family, neighbors, community. e.g. First Aid Mental Health training given to workforce staff like peer support specialist, to doctor, family, neighbors, community.
Access	Start a Veteran to Veteran group
Access	Utilize community/community centers like library to advertise and support community events
Other	Live events that help ease loneliness and isolation
Veterans	More community members trained to be mental health specialists

Comm. Violence	Civics training and education: help citizens understand the law
Other	More community involvement: Wellness checks on isolated adults
Comm. Violence	Need places where young folks can go to have something to do
Comm. Violence	Encourage the use of peer-run programs to teach families healthy communication practices
Access	Information and resources for family members (not just patients)
Child/YA	Parents don't understand youth issues; they need more connections; parents don't have skill set.
Housing	More social activities in board and care to prevent isolation
Adult/OA	Family members are taking care of elderly who are experiencing isolation and difficulty in completing responsibilities. They have received feedback from parents that they are facing anxiety from being in a new county and a new culturally different environment.
Adult/OA	They are looking to create programs to bridge the gap in communication between parents and youth so that each better understand each other and their new immigrant experiences.
Access	Families require access to professional expertise at a higher frequency than is currently offered. They are looking to help clients find peer support and making that process a more seamless client experience.
Access	There needs to be more focus groups to provide clients with a community voice and more in-person events so people can attend.
Other	Sharing information on the different heritage events each month, expose others to different cultures.
Other	healthy relationship trainings especially in school healthy communication boundary setting
Comm. Violence	The community would be safer with community workers or advocates
Comm. Violence	Escorts for our elders who work later hours or early hours to feel safer when leaving their homes/work
Comm. Violence	families need support for parents from police and schools - around bullying, suicide prevention
Re-entry	Reintegration with family care, having in-home mental health services, not just the re-entry citizen but the family as a whole
Re-entry	Family reunification, if there has been little contact between re-entry citizen and children, that could be something they may need
Child/YA	Educating family members and parents, due to kids not understanding what is going on mentally
Child/YA	More events to incorporate youth and family together…"Healing the parents is important to heal the child".
Organizations	
Crisis	provide faster non-law enforcement solutions that can reach individuals faster. improved access to mobile services that can reach clients directly rather than relying on law enforcement.
Housing	There is a need for supportive services and housing interventions. The housing being offered does not include wraparound services. They need additional funding for operational support to meet the needs of the community.

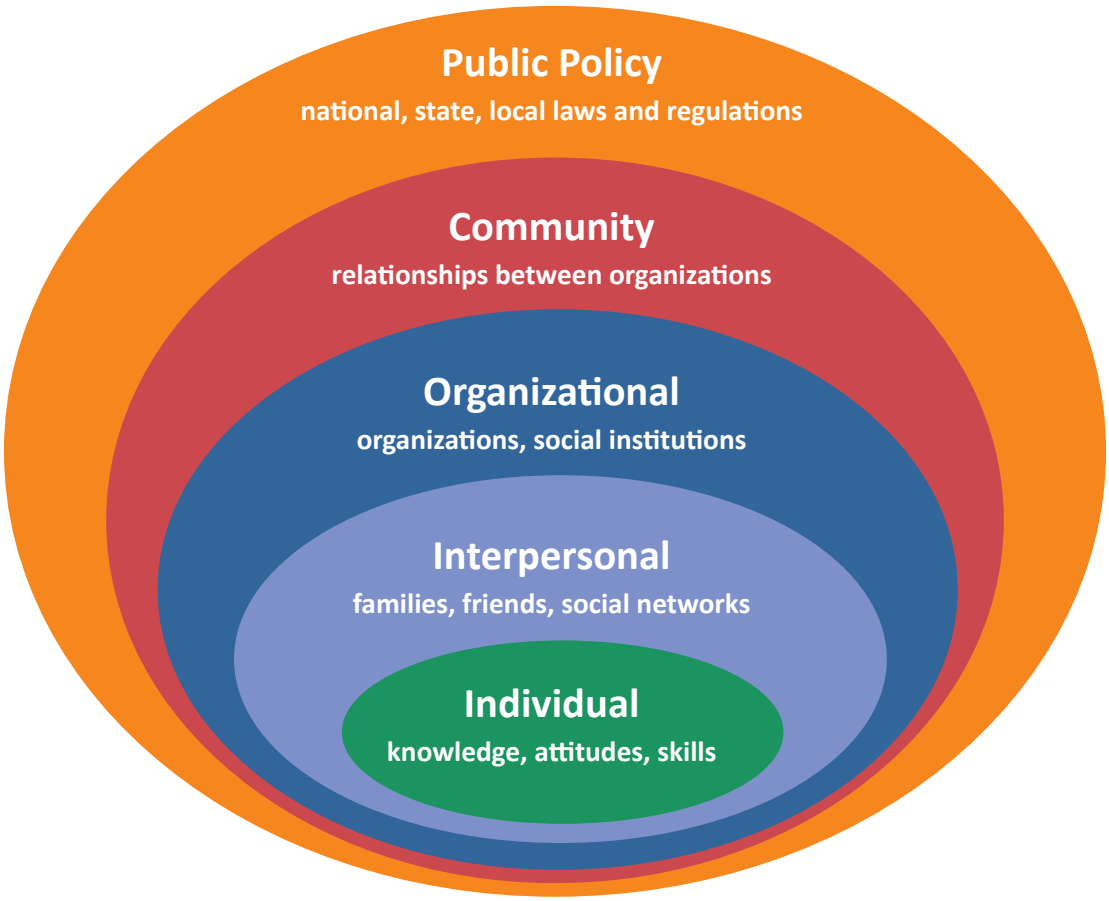
Access	Have a community van, medvan (medical van) because there's a lot of people dying out there in substance abuse and in cold weather.
Workforce	Need for support in the workforce when staff also experience crisis.
Workforce	Funding training to support the staff to be well equipped in the work they do.
Workforce	Provide safe and welcoming places and spaces for those people with MH challenges that provide them direct services and housing they need (stop creating more trauma).
Workforce	Need staffing or hire more peer support specialist w/lived in experience for well needed response.
Crisis	Need to provide or create 24/7 services and programs available instead of turning people away.
Access	prioritize bilingual services to support multiple languages in their growing client base.
Workforce	would like a program for trained clinicians where apprentice hours can help cover living expenses especially for supporting clinicians from underrepresented backgrounds.
Other	there's a great need for after-hours and weekend services, especially for people with MH challenges, that's a safe and welcoming space or place, including temporary triage.
Veterans	Place to get access, coordiantion, navigation to services, a place that helps vets with multiple services; More "one stop shops"
Comm. Violence	More crisis support teams on the streets
Comm. Violence	Work programs for minor offenders
Housing	Housing tailored towards folks with mental illness, since it is particularly hard for this group to obtain
Substance Use	Need better quality of substance use disorder treatment providers, not just quantity - There are lots providers in Alameda County, but the treatment seems to repetitive or "cookie cutter" and does not promote real recovery like more expensive, intensive inpatient treatment
Crisis	Reach more and/or more isolated patients by offering mobile services, such as CATT or Oakland's MACRO
Other	Trauma healing through culturally syntonic traditional healing practices that would be familiar, to community members provide safe healing
Housing	There needs to be more educational workshops for renters and first-time homebuyers. These workshops need to be done in multiple languages to serve all populations to help people remain housed and to become housed.
Child/YA	They think that staff should be trained to provide restorative justice to prevent and solve conflicts before they escalate.
Child/YA	Young adults should be provided with a stipend to incentivize them to reach out to mental health resources, an incentive can encourage them to break the mental health stigma.
Child/YA	They advocated for programs that promoted children to seek help as well as programs that can identify mental health issues among youth.
Access	Accessing programs in Spanish has proved difficult for many of the group since they are monolingual.
Access	Helpful to have more drop-in services and various, local locations need to be accessible for all behavioral health services.

Access	When services are physically located here relationships develop, staff know the neighborhoods, easier to navigate and access services as compared to having to travel.
Child/YA	They have found that their clients want to access services where they are already at, so they have started offering more youth workshops in schools, churches and mosques.
Child/YA	They are seeing more unaccompanied minors, so they have had to adapt services to assist immigrant youth.
Comm. Violence	An increase in domestic violence incidents has been observed, this has caused Oakland to look for new ways to prevent and support with the aftermath of families who experience domestic violence.
Comm. Violence	There is ongoing effort and strategies to address community violence. Homeless encampments have become targets for violence and there needs to be more support for them.
Crisis	Axis developed an alternative mental health response program in Pleasanton with the Police department. A plain clothes police officer responds to calls and this approach has helped reduce 5150 rates by 60% from 2019 to 2023. Axis has partnered with a local county hospital to write their own 5150s.
Workforce	Workforce shortages such as recruiting counselors that reflect the client diversity and the scarcity of psychiatrists are trends that limit hiring.
Workforce	allow MSW students to gain more on-the-job training to fill the void in open positions, this would help clients get some sort of knowledgeable care.
Workforce	expand the Peer Support program so there is more interaction with people with lived experiences.
Housing	Rent cap for young people like Bonita House for TAY
Substance Use	Need more 12 step programs that are non-spiritual
Re-entry	Programs to learn trade skills for re-entry citizens
Re-entry	Education and housinf before/after jail
Child/YA	Mental Health Assessment: looking between K-3 a real intensive something, then elementary and middle school, transitioning to support
Access	Having navigators from specific communities, that look like them, talk like them, and understand lived in-experience
Access	Have some type of online resource for linkage that can connect you to the proper supportive services
Access	Hiring intake person to provide immediate attention to our clients who are in dire needs.
Workforce	Making sure staff are not burned out and have more self-care so they can serve the community well.

Child/YA	Assistance, programs, activities for immigrant children both younger and older
Access	more outreach around the shelter/program and let the ppl know abt. Those
Community Violence	more preventive (focus on youth)
Crisis	There needs to be more support to help clients transition from crisis facilities to community.
Workforce	Higher salaries can increase the likelihood of hiring and retaining professionals.
Access	The county needs to continue to be proactive in how we promote, coordinate and help clients navigate mental health resources. There needs to be a continued emphasis in how we provide access to free or low-cost mental health resources for fathers.
Access	The county needs to continue to have a structured framework for easy navigation of services. There needs to be prioritization of client needs
Re-Entry	There is still a necessity to have more programs and refinement to support mental health, housing and employment for the re-entry
Housing	The providers of housing are not making LGBTQ friendly accommodations, nor are there any housing complexes that are specifically for LGBTQ
Adult	The elder LGBTQ population needs a care navigator specifically assigned to them that can visit elders in their residences and on-site at the
Workforce	There also needs to be qualified staff that are from the LGBTQ community and have the background to speak with different age groups.
Access	There also needs to be more care navigators that can help LGBTQ Black and Latino people navigate the various services available to them.
Housing	There needs to be wraparound services onsite to help clients. They think that housing should be based on income and the amount the mental health client can afford.
Workforce	They see that peer navigators with lived experiences are the most effective for helping mental health clients. The peer navigators need to be given more tools and training so they can help clients access resources.
Access	meet clients where they are at. They also want to have more navigators located on-site at different housing complexes to assist mental health clients immediately.
Substance Use	There needs to be substance abuse services that can go into the community to help the unhoused. They said that clients become housed then the substance abuse services need to be available in the residences so clients can access them quickly
Comm. Violence	more programs that address the mental health of victims of community violence.
Workforce	more internship positions to create pathways for non-medical professionals to help serve non English-speaking clients.
Community	
Access	Need to map thing out to get a clear view of the process that follow through (who's doing what services, the coordinated services, navigation, and special services and figuring out what it really looks like on how the community is being reached out in a timely manner).
Housing	Need to have accountability and have a check and balance in housing programs and services.
Other	Need to develop a comprehensive digital platform and master directory that has contact people, assessment, subcontractors and resources of all supportive mental health and services in ALCO that's updated with diff. resources like hospitalization, housing, treatment etc.
Child/YA	There is a need for an active effort to bridge funding disparities and resource gaps that affect LGBTQ youth to provide comprehensive services.
Other	To have an analysis of data that can show which has effective results in reaching the needs of the community

Workforce	Increase network with VA to help Veterans involved with local organization
Workforce	For provider training, they should understand Veteran-specific issues and resources like the VA and Swords to Ploughshares.
Workforce	The VA should be involved in ground-level work being performed at the local level. Would help to minimize the perceived stigma around VA access
Re-entry	Incentivization of both cities or governmental districts and employers to recruit from and hire reentry population would be helpful
Housing	They believe housing is the first pillar of mental health that must be addressed and then unemployment and financial obstacles.
Child/YA	The foster care children and young adults have ongoing needs that require attention and support which they would like to have more county collaboration on.
Workforce	Alameda County are to start a home purchasing program for BH providers that would encourage people to enter the field and be able to live where they work at.
Housing	make subsidies available and to find a way for developers to build even when the subsidies are not available.
Housing	more residential treatment facilities available in or near the city of Fremont. There is also an ongoing need to keep the aging population housed.
Substance Use	substance use services closer to the city of Fremont and programs for youth with substance abuse issues.
Workforce	for youth about different routes to MH careers and experiences. Scholarship programs, loan assumption.
Re-entry	Parolees pairing with firefighters, volunteer opportunities, re-integrating re-entry citizens and pairing them with positive communities(firefighters) to have a better outlook toward the community
Child/YA	More prevention/early intervention programs
Child/YA	More wellness centers in schools and more wellness center learning in these high schools
Housing	Workforce staffs are also part of the community that needs housing.
Housing	Importance to provide and increase boarding houses and they are point of entry to the community.
Access	Providers need to continue to enhance behind the scenes collaboration to help guide families and clients.
Access	development and maintenance of a resource directory that includes geographic locations and language capacity.
Workforce	A local/municipal student loan repayment program to incentivize physicians/providers to practice in the community.
Public Policy	
Access	Having useful data that identifies the services, processes, as what was said “time is money” and who are imposing those services.
Workforce	We need to advocate for 2% for MHSA, 1% Tax isn’t enough. Programs that are providing benefiting services get cut and it shouldn’t happen.
Workforce	Need funding for more respite care services and to have a clear reduced timeline for those in critical condition.
Housing	Transparency in decision making in housing.

Other	To have a check and balance in housing and transparency in its decision-making.
Housing	Use housing from decommissioned military bases to house homeless Veterans, like at Treasure Island and Alameda Naval Stations
Access	Improve Med-Cal service navigation to make process easier; Limited Medi-Cal service offerings; increase these, particularly with respect to mental and behavioral health.
Child/YA	Smaller class sizes for kids with behavioral and SMI challenges
Child/YA	Teacher and staff training that know how to deal with issues; More hands on instruction with special needs kids
Housing	Advocate for bills like SB4 to promote zoning flexibility
Housing	Emergency housing should last a minimum of 6 months, followed by long term supportive housing
Housing	Community land trust to permanently house folks affordably
Child/YA	There also needs to be more mental health resources in school and in the classroom for youth to have their problems addressed urgently.
Re-entry	We need more funds and focus toward setting up re-entry citizens for success
Housing	Using unused public lands for housing and services
Housing	paperwork streamline or less paperwork
Access	advocacy at the state level for California to join the Psychology Interjurisdictional Compact (PSYPACT®), which is an interstate compact designed to facilitate the practice of telepsychology and the temporary in-person, face-to-face practice of psychology across state boundaries



ALAMEDA COUNTY BEHAVIORAL HEALTH Mental Health Services Act (MHSA)
Community Survey for FY 24/25 Annual Plan Update

Survey Instructions

The Alameda County Mental Health Services Act (MHSA) Division wants your input to help strengthen its mental health and wellness programs to better serve you and your community over the next year.

In preparing this survey, we reviewed various existing data sources of community Behavioral Health needs. We'd like your assistance in prioritizing these existing needs and offering us ideas/strategies/solutions to these needs.

There are 18 voluntary questions in the survey and it takes about 10-15 minutes to complete. All responses are anonymous and optional, you're welcome to leave questions blank. For questions, please contact the MHSA Division at MHSA@acgov.org.

Thank you for your help with this community effort!

1. Do you or a loved one access behavioral health care services (either mental health or substance use) in Alameda County?

- ◯ Yes
- ◯ No
- ◯ Unsure

2. If you answered "yes" to question 1, Has the quality of your life *improved* as a result of accessing behavior health care services?"

- ◯ Yes
- ◯ No
- ◯ Unsure

3. All of the behavioral health concerns identified in our review were categorized into the following eleven broad areas of need. Please rank them in order of importance from ***your*** perspective? (*"1" is most important; "11" is least important)*

☐ **Access, Coordination and Navigation to Services** - this category captures the needs of diverse cultures and identities such as race/ethnicity, language, LGBTQIA+, veteran status and age related to accessing/finding/navigating to mental health and substance use services, including community knowledge and education, language capacity and culturally responsive approaches to engaging communities. There is also a need for successful connection to services after an emergency

- [ ] **Behavioral Health Workforce** - this category captures the needs related to recruiting, developing, supporting and maintaining a sufficient clinical and peer/family member workforce to address the needs and the diversity of the community. This includes a workforce that looks like the community it serves and provides services in a communities languages so clients can be served in their native languages. This category also captures the Provider Support needs around training/core competencies burn out, high turnover and vicarious trauma.

- [ ] **Crisis Continuum** - this category captures needs related to mental health and substance use crisis response and with an emphasis on non-law enforcement response, as well as appropriate community-based supports, early assessment of suicide risk, and stabilization during and after a crisis.

- [ ] **Housing Continuum** - this category captures the housing needs for individuals living with behavioral health challenges ranging from prevention of becoming unhoused, housing navigation, and supports needed to maintain housing. This is particularly needed for those living with disabilities and older adults, who may be facing becoming unhoused for the first time.

- [ ] **Substance Use** - this category captures the increasing need for substance use services and supports that are accessible, integrated and coordinated with mental health services.

- [ ] **Community Violence and Trauma** -this category captures gun violence, domestic violence, human trafficking, gang violence, immigration trauma, poverty, pervasive racism and homophobia, family conflict and stress, school safety and bullying, and post-traumatic stress disorder (PTSD).

- [ ] **Child/Youth/Young Adult Needs** - this category captures mental health and substance use challenges for school to transition-age youth ages 6-25, it also includes specific needs of children 0-5 and their families, respite services, ongoing increased suicide rates, youth runaways, juvenile justice involvement, human trafficking, gang violence, lack of support on how to access services, needs of LGBTQ+, pervasive racism, needs of bi-cultural children, lack of training on the part of schools for students with MH challenges.

- [ ] **Adult/Older Adult Needs** - this category captures mental health and substance use challenges for adults and older adults including social isolation, depression, complex chronic health issues (including Alzheimer's and dementia), general poor mental health outcomes for those living with a severe mental illness, suicide rates, alternatives to incarceration, pervasive racism, LGBTQ+, immigration stress, gun violence, elder abuse, traumatic impact of social unrest-fear, in particular for Asian communities.

- [ ] **Needs of Family Members** -this category captures the ongoing stress, frustration and isolation family members can feel in taking care of their loved ones in a healthcare system that is mainly a "fail first" system, especially for loved ones with severe mental illness and episodes of anosognosia. Numerous navigation issues, especially related to the criminal justice system. High need for 24/7 access to inpatient and outpatient psychiatry services. Suicide (and how this effects the family and entire communities) lack of understanding about Child Protective Services (CPS), intergenerational trauma, and immigration trauma.

☐ **Needs of Veterans** -this category captures the mental health and housing needs of Veterans: Oakland-Berkeley/Alameda County has the 4th highest number of homeless veterans, and second highest (78.8%) percentage of unsheltered homeless veterans in California. Veterans have a higher rate of poor mental health compared to nonveterans and women veterans have a poorer mental health compared to their male counterparts, in particular due to military sexual assault trauma. Additional needs include high suicide rates (16-18/day), stigma, lack of navigation support, lack of focused veteran groups for non-VA (veterans association) connected individuals and the aging veteran population who are older, sicker and more isolated. There is also a misunderstanding that not all veterans are eligible for VA services. In addition to these needs for American veterans, veterans of other countries also have significant needs around problem solving and healthy coping mechanisms.

☐ **Needs of the Re-entry Community** for both Adults and Youth - this category captures the mental health, substance use, housing and employment needs of this community. Difficult to navigate uncoordinated and complicated systems to receive both behavioral and physical health services. Stigma, a high need for services to be provided by people who reflect this community and have lived experience with being justice involved. Additional needs in the areas of: focused treatment for sex offenders (housing, prosocial rehab services etc.). Lack of MH supported recovery residences, cooccurring treatment and focused job training. Needs of specific communities (LGBTQ+, immigrant, communities of color). Housing assistance and support services for those with disabilities to live independently.

4. For the Area of Need that you **ranked as #1, most important**, please share any ideas/strategies/solutions to help us improve this area for communities in Alameda County.

5. For the Area of Need that you **ranked as #2, as second most important**, please share any ideas/strategies/solutions to help us improve this area for communities in Alameda County.

6. For the Area of Need that you **ranked as #3, third most important**, please share any ideas/strategies/solutions to help us improve this area for communities in Alameda County.

7. **What did We Miss?** Please share other concerns or solutions that you have that haven't been mentioned.

8. **NEW Innovation Project Idea:** For someone living with a serious mental illness, Psychiatric Advance Directives (PADs) give them an opportunity to provide direction for thei course of treatment when they are incapable to make those decisions specifically during acute episodes of psychiatric illness.

Alameda County is seeking input on whether to join the multi-county MHSA Innovation PADs collaborative project to assist in developing a user-friendly and secure online tool for people to learn about, complete, and store PADs which will empower individuals the ability and opportunity to plan their own care.

Do you think Alameda County should join the multi-county MHSA Innovation PADs collaborative to *implement a program locally?*

- Yes
- No
- Unsure would like more information
- prefer not to answer

9. My **AGE RANGE** is:

- Under 16
- 16-25
- 26-59
- 60 and over
- Prefer not to answer

10. In which part of Alameda County do you **LIVE?**

Other (please specify)

11. What is your current **GENDER IDENTITY**?

- ◯ Woman/Female
- ◯ Man/Male
- ◯ Genderqueer or Gender Fluid
- ◯ Transgender: Male to Female
- ◯ Transgender: Female to Male
- ◯ Non-binary (neither male nor female)
- ◯ Two-Spirit (a term used by some Native American/Indigenous individuals)
- ◯ Prefer not to answer

Other Gender Identity (please specify)

12. Which of the following **BEST REPRESENTS** how you think of yourself?

- ◯ Straight/heterosexual (not lesbian or gay)
- ◯ Gay/Lesbian
- ◯ Bisexual
- ◯ Same gender loving
- ◯ Other (please specify)
- ◯ Asexual
- ◯ Pansexual
- ◯ Prefer not to answer

13. What is your **ETHNICITY**?

- ◯ Hispanic/Latino
- ◯ Non-Hispanic/Non-Latino
- ◯ Prefer not to answer

14. What is your **RACE**? (Please select all that apply)

- ☐ African-American/Black
- ☐ American Indian/Alaskan Native
- ☐ Asian
- ☐ Pacific Islander/Native Hawaiian
- ☐ White/Caucasian
- ☐ Prefer not to answer

Other (please specify):

15. If you marked "**ASIAN OR PACIFIC ISLANDER**" under question 14, please tell us about your nationality or country of origin? (Please select all that apply)

- [ ] Asian Indian
- [ ] Cambodian
- [ ] Chinese
- [ ] Filipino/a
- [ ] Japanese
- [ ] Korean
- [ ] Samoan
- [ ] Taiwanese
- [ ] Tongan
- [ ] Vietnamese
- [ ] Other (please specify):

16. Which of the following STAKEHOLDER GROUP(s) do you primarily represent (Please select all that apply).

- [ ] Active Military/Veteran
- [ ] Consumer
- [ ] Education
- [ ] Faith Community
- [ ] Family member
- [ ] Law enforcement agency
- [ ] Provider of mental health or substance use disorder programming
- [ ] Student
- [ ] Prefer not to answer

Other (please specify)

17. Please provide your contact information if you'd like to be entered into our raffle.

Full Name	
Agency/Org	
Email Address	
Phone Number	

18.
Thank you again for taking the time to provide your input on the County of Alameda's MHSA Community Survey. We appreciate you! To learn about more ways to get involved, please visit our website at https://acmhsa.org/

This area is to rate the ease of completing this survey with 5 stars being the easiest and 1 star being difficult.

Mental Health Services Act Community Education & Input Meeting

MHSA Annual Update for FY 24/25

Presented by: Alameda County Behavioral Health – MHSA Division and Health & Human Resource & Education Center (HHREC)

MHSA Listening Session Agenda

Listening Session Purpose: Education and Information sharing about MHSA, Stakeholder Engagement and Information Gathering

Meeting Process for Today:

- Why we are here
- Looking at the many known behavioral health needs
- Wanting to identify/rank problems or areas of need and then focus on *solutions*
- Conducting a ranking process
- Talking about the top 3 areas
- Time for any other comments and feedback
- Demographic Survey
- Wrap Up

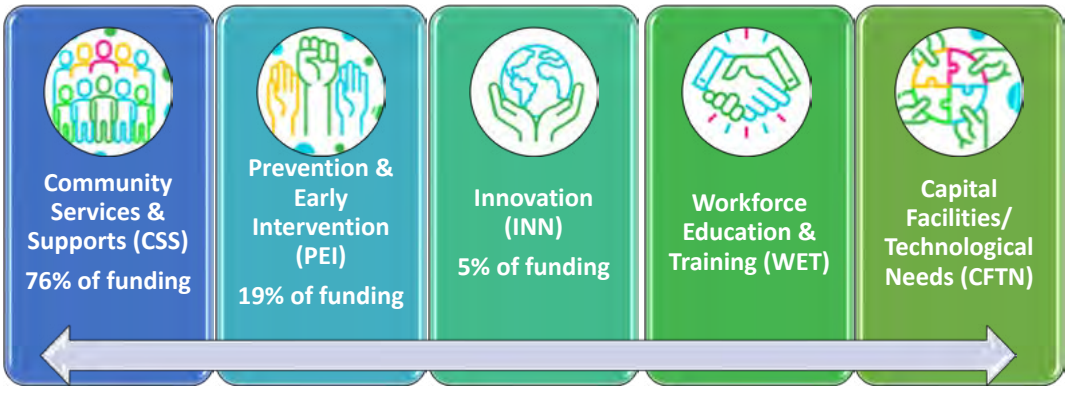
2

Community Agreements

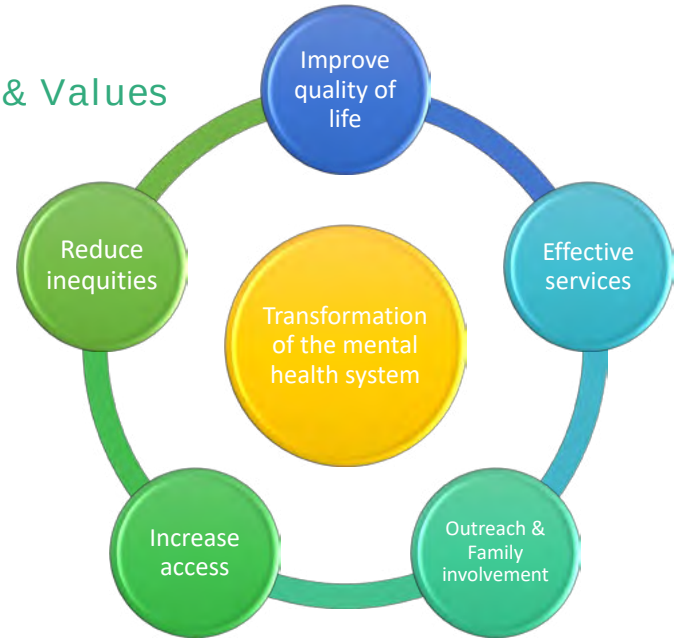
- *Keep your mic on mute unless talking*
- *Use the chat box to ask a question*
- *Pause/Breathe: We have a variety of people participating using different communication methods (phone, webcam, etc.) we might take time to pause throughout the presentation to address comments/questions*
- *Have fun and participate*

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:



MHSA Goals & Values



5

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.

6

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 January 30, 2024

*Title 9 CCR § 3300

7

MHSA Funding from Previous Community Input Sessions

Provider capacity building funds to address workforce crisis

Increased funding for programs that have a focus on race/ethnicity and/or culture.

New Early Childhood early intervention programming

8

Listening Session

9

Known Top Behavioral Health Needs in Alameda County

Access, Coordination and Navigation to Services - this category captures the **needs of diverse cultures and identities such as race/ethnicity, language, LGBTQIA+, veteran status and age** related to accessing/finding/navigating to mental health and substance use services, including community knowledge and education, language capacity and culturally responsive approaches to engaging communities. There is also a need for successful connection to services after an emergency.

Behavioral Health Workforce - this category captures the needs related to **recruiting, developing**, **supporting and maintaining a sufficient clinical and peer/family member workforce** to address the needs and the diversity of the community. This includes a workforce that looks like the community it serves and provides services in a communities languages so clients can be served in their native languages. This category also captures the **Provider Support** needs around training/core competencies burn out, high turnover and vicarious trauma.

Crisis Continuum - this category captures needs related to mental health and substance use crisis response and with an emphasis on non-law enforcement response, as well as appropriate community-based supports, early assessment of suicide risk, and stabilization during and after a crisis.

10

Known Top Behavioral Health Needs in Alameda County

Housing Continuum - this category captures the housing needs for individuals living with behavioral health challenges ranging from prevention of becoming unhoused, housing navigation, and supports needed to maintain housing. This is particularly needed for those living with disabilities and older adults, who may be facing becoming unhoused for the first time.

Substance Use - this category captures the increasing need for substance use services and supports that are *accessible, integrated and coordinated* with mental health services.

Community Violence and Trauma-this category captures gun violence, domestic violence, human trafficking, gang violence, immigration trauma, poverty, pervasive racism and homophobia, family conflict and stress, school safety and bullying, and post-traumatic stress disorder (PTSD).

Child/Youth/Young Adult Needs - this category captures mental health and substance use challenges for school to transition-age youth ages 6-25, it also includes specific needs of children 0-5 and their families, respite services, ongoing increased suicide rates, youth runaways, juvenile justice involvement, human trafficking, gang violence, lack of support on how to access services, needs of LGBTQ+, pervasive racism, needs of bi-cultural children, lack of training on the part of schools for students with MH challenges.

11

Known Top Behavioral Health Needs in Alameda County

Adult/Older Adult Needs - this category captures mental health and substance use challenges for adults and older adults including social isolation, depression, complex chronic health issues (including Alzheimer's and dementia), general poor mental health outcomes for those living with a severe mental illness, suicide rates, alternatives to incarceration, pervasive racism, LGBTQ+, immigration stress, gun violence, elder abuse, traumatic impact of social unrest-fear, in particular for Asian communities.

Needs of Family Members-this category captures the ongoing stress, frustration and isolation family members can feel in taking care of their loved ones in a healthcare system that is mainly a "fail first" system, especially for loved ones with severe mental illness and episodes of anosognosia. Numerous navigation issues, especially related to the criminal justice system. High need for 24/7 access to inpatient and outpatient psychiatry services. Suicide (and how this effects the family and entire communities) lack of understanding about Child protective Services (CPS), intergenerational trauma, and immigration trauma.

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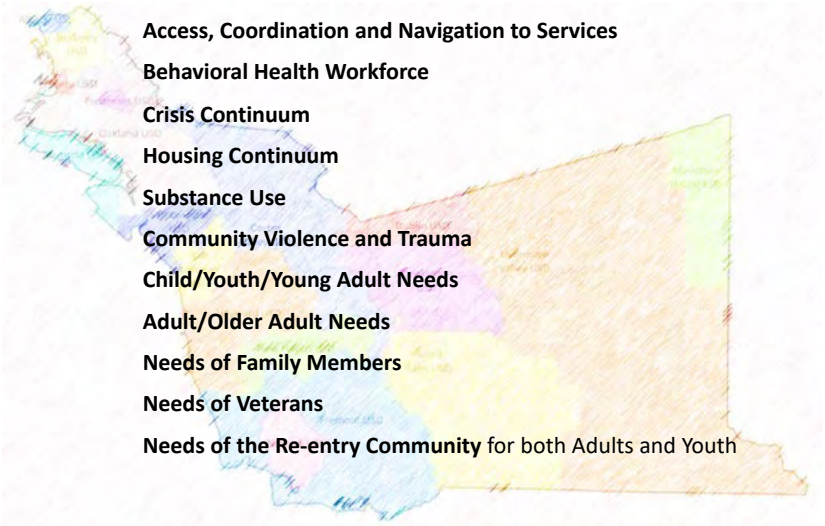
Known Top Behavioral Health Needs in Alameda County

Needs of Veterans-this category captures the mental health and housing needs of Veterans: Oakland-Berkeley/Alameda County has the 4th highest number of homeless veterans, and second highest (78.8%) percentage of unsheltered homeless veterans in California. Veterans have a higher rate of poor mental health compared to nonveterans and women veterans have a poorer mental health compared to their male counterparts, in particular due to military sexual assault trauma. Additional needs include high suicide rates (16-18/day), stigma, lack of navigation support, lack of focused veteran groups for non-VA (veterans association) connected individuals and the aging veteran population who are older, sicker and more isolated. There is also a misunderstanding that *not all veterans are eligible for VA services.* In addition to these needs for American veterans, veterans of other countries also have significant needs around problem solving and healthy coping mechanisms.

Needs of the Re-entry Community for both Adults and Youth- this category captures the mental health, substance use, housing and employment needs of this community. Difficult to navigate uncoordinated and complicated systems to receive both behavioral and physical health services. Stigma, a high need for services to be provided by people who reflect this community and have lived experience with being justice involved. Additional needs in the areas of: focused treatment for sex offenders (housing, prosocial rehab services etc.). Lack of MH supported recovery residences, cooccurring treatment and focused job training. Needs of specific communities (LGBTQ+, immigrant, communities of color). Housing assistance and support services for those with disabilities to live independently.

13

Time to Rank the Three(3) Community Need Areas you would like to talk about today



Access, Coordination and Navigation to Services

Behavioral Health Workforce

Crisis Continuum

Housing Continuum

Substance Use

Community Violence and Trauma

Child/Youth/Young Adult Needs

Adult/Older Adult Needs

Needs of Family Members

Needs of Veterans

Needs of the Re-entry Community for both Adults and Youth

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Documents used for the Assessment of Needs Areas

- MHSA Three Year Plans FY 20/23 and 23/26
- Community Program Planning Report FY 22/23
- Alameda County point in time Homeless data
- Alameda County Cultural Competency Plan
- ACBH Utilization data for Mental Health Services
- MH and SUD prevalence data FY 21/22, from the California Department of Health Care Services (DHCS)
- California Health Information Survey data
- Alameda County Health Status profile
- 2020 suicide data from the California Department of Public Health
- Healthy Alameda website
- Swords to Ploughshares Veterans data
- Various journal articles on housing, mental health, psychiatric needs

Links to all data and information used will be specified with links in the next MHSA report

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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

Categorized Areas of Community Need in Alameda County

1. Access, Coordination and Navigation to Services - this category captures the needs of diverse cultures and identities such as race/ethnicity, language, LGBTQIA+, veteran status and age related to accessing/finding/navigating to mental health and substance use services, including community knowledge and education, language capacity and culturally responsive approaches to engaging communities. There is also a need for successful connection to services after an emergency

2. Behavioral Health Workforce - this category captures the needs related to recruiting, developing, supporting and maintaining a sufficient clinical and peer/family member workforce to address the needs and the diversity of the community. This includes a workforce that looks like the community it serves and provides services in a communities languages so clients can be served in their native languages. This category also captures the Provider Support needs around training/core competencies burn out, high turnover and vicarious trauma.

3. Crisis Continuum - this category captures needs related to mental health and substance use crisis response and with an emphasis on non-law enforcement response, as well as appropriate community-based supports, early assessment of suicide risk, and stabilization during and after a crisis.

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5. Substance Use - this category captures the increasing need for substance use services and supports that are accessible, integrated and coordinated with mental health services.

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Summary of Areas:

Access, Coordination and Navigation to Services

Behavioral Health Workforce

Crisis Continuum

Housing Continuum

Substance Use

Community Violence and Trauma

Child/Youth/Young Adult Needs

Adult/Older Adult Needs

Needs of Family Members

Needs of Veterans

Needs of the Re-entry Community for both Adults and Youth

Appendix B-9 | Sources of Data to Create 11 Categorized Areas of Community Need

The following local plans, assessments, evaluation reports, and data were reviewed to identify prominent mental health and substance use needs reported across service sectors and the community. Reviewing relevant and existing behavioral health data as compared to starting from a blank slate allowed the community stakeholders to focus on solutions and strategies for improvement and have an overall asset mindset as compared to being deficit focused. The MHSA and CPPP Planning team prioritized reviewing local data needs and information, but also discussed larger data trends in their assessment.

Alameda County MHSA FY 20-21-22/23 Three-Year Plan

https://acmhsa.org/wp-content/uploads/2021/03/MHSA2020Plan_FINAL_WEB_update_02.pdf

Alameda County MHSA FY 23/24-25/26 Three-Year Plan

California Health Interview Survey (CHIS), University California Los Angeles

https://healthpolicy.ucla.edu/our-work/health-profiles/adult-health-profiles

https://healthpolicy.ucla.edu/our-work/health-profiles/raceethnicity-health-profiles

https://ask.chis.ucla.edu/ask/SitePages/AskChisLogin.aspx?ReturnUrl=%2fAskCHIS%2ftools%2f_layouts%2fAuthenticate.aspx%3fSource%3d%252FAskCHIS%252Ftools%252F%255Flayouts%252FAskChisTool%252Fhome%252Easpx&Source=%2FAskCHIS%2Ftools%2F%5Flayouts%2FAskChisTool%2Fhome%2Easpx

2021 and 2022 Point in Time Homeless Data Count

https://everyonehome.org/main/continuum-of-care/everyone-counts-2022/#:~:text=9%2C747%20people%20in%20Alameda%20County,(1%2C725%20people)%20since%202019

Alameda County Behavioral Health (ACBH) Cultural Competency Plan

Toward a New Understanding: The California Statewide Study of People Experiencing Homelessness: June 2023

https://homelessness.ucsf.edu/sites/default/files/2023-06/CASPEH_Report_62023.pdf?utm_id=102035&sfmc_id=1894793

MH and SUD prevalence data FY 21/22, from the California Department of Health Care Services (DHCS), see appendix xx for data

ACBH Penetration data FY 21/22 and 22/23

Alameda County Perinatal and Infant Health Indicators

https://acphd-web-media.s3-us-west-2.amazonaws.com/media/data-reports/mpca/docs/acphd-mpcah-indicators-slides-feb-2023.pdf

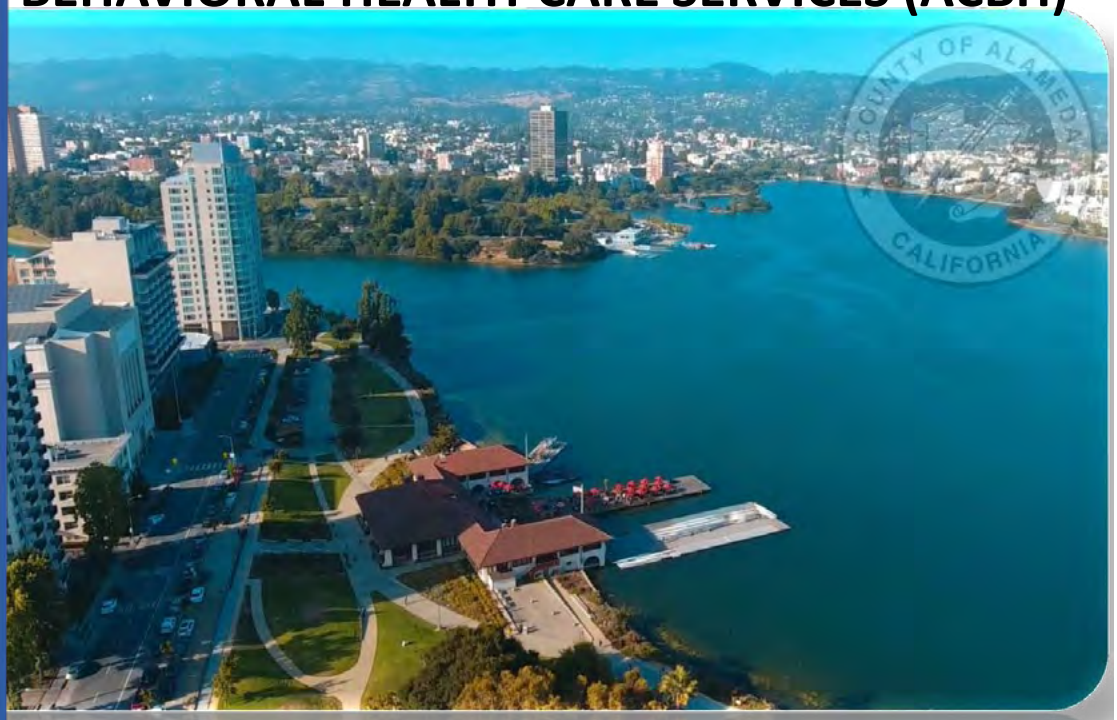
Opioid data, Alameda County

https://acphd.org/opioid-story.html

County Health Status Profiles 2023 https://www.cdph.ca.gov/Programs/CHSI/CDPH%20Document%20Library/CHSP2023_Final_Draft_v10.pdf

ALAMEDA COUNTY

BEHAVIORAL HEALTH CARE SERVICES (ACBH)



CULTURAL COMPETENCE PLAN

BEHAVIORAL HEALTH &
HEALTH EQUITY INITIATIVES

December 2023 | Plan Update

A Department of Alameda County
Health Care Services Agency

Executive Summary

Alameda County Behavioral Health Care Services (ACBH) is a department committed to the promotion of health equity-based, quality driven services that seek to proactively focus on a more accessible and inclusive system of care. The Health Equity Division's (HED) Health Equity Office (HEO) at ACBH has operated for two years, and it has successfully implemented many initiatives to help more appropriately serve the diverse Alameda County community. To that end, the Executive Leadership team's goals have materialized with the establishment of the Health Equity Division which has been steering internal and external processes in line with fundamental principles.

During organizational restructuring, a priority framework was devised to guide strategic decision-making. This framework *(Alignment, Communication, and Organizational Structure)* emphasizes Alignment with county, agency, and departmental mission, vision, values; enhanced Communication with internal and external stakeholders; and continuous improvement of Organizational Structure and service delivery, now defines established practices. As the HEO enters its third year, the inaugural initiatives have transitioned into established practices, shaping how ACBH leadership approach their work and informs everyday decision-making.

The following Cultural Competence Plan includes many historical activities, and includes important pivots that have been made, new projects that have been launched, and the re-evaluation of several strategies that were adopted over several decades. To that end, we invite potential readers to evaluate this content critically and with an eye towards our eventual goal: a health equity driven workplace that promotes and provides equity-based services throughout the community. Our ultimate aims are to continually reenvision our practices, set into motion policies and procedures that strengthen our commitment to the provision of quality services; and to eliminate health disparities for all who seek or need services through our integrated system.

Thank you in advance for reviewing this most recent update. We look forward to continued progress and outcomes which can help to inform our decision-making and measure our success in the future.

Submitted By:

Mona Shah, MSW
Office of Ethnic Services, Interim Ethnic Services Administrator Alameda County Behavioral Health Care Services, Health Equity Division

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Stephanie Montgomery, MSW
Health Equity Division Director, Health Equity Officer
Alameda County Behavioral Health Care Services, Health Equity Division

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Table of Contents

Introduction

This report represents the annual update of the ACBH departmental Cultural Competency Plan (CCP), which aligns with the Cultural, Linguistic, and Ability Standards (CLAS). The update highlights key areas of progress and success, as well as some of the challenges with implementing these standards within our department across our five systems of care (*Child/Young Adult; Adult/Older Adult; Substance Use; Forensic, Diversion, and Re-entry; and Crisis Services System of Care*). This document also forecasts what we plan for the reminder of the current Fiscal Year (FY 23-24).

For context, ACBH has adopted a set of "True North Metrics" which serve as a guide to our leaders and team members as we drive system change across our system. The five (5) True North Metrics of Quality, Investment in Excellence, Accountability, Financial Sustainability, and Outcome-Driven Goals are helping to re-align our focus more strategically on equity and culturally affirming work at all levels. Specifically, our intentional attention to ***Quality***, at every level of our service continuum; and within our administrative units, focuses our efforts on the essential client, family, and community focused services our department provides. Similarly, ***Investment in Excellence*** will be a key component of how our department will align its efforts. Our department has refocused its efforts to include an affinity for both internal and external strategies. To that end, we hope to continually develop opportunities and work with our agency and external partners to ensure that we invest in the inherent value of the work of our employees, including training and overall wellness in the workplace. ***Accountability*** in leadership, performance, and our goals are critical as we intend for them to drive the improvement processes, we have engaged (and those yet to be identified). Ensuring that we take seriously, the immense responsibility of serving as a steward to public funds; and responsibly approach our fiscal resources (***Financial Sustainability***) will help us, in the future, collaboratively identify and develop clear ***Outcome-Driven Goals*** (and metrics) that continually measure our progress, service impacts, and administrative efficiencies.

Because our department places a high value on fostering Diversity, Equity, Belonging and Inclusion (DEBI) within our systems of care, the CLAS standards are a cornerstone of our department's commitment to DEBI. We are proud to report that we continue to collaborate across the department, within our internal infrastructure (finance, contracting, human resources and information systems), with our community stakeholders, in partnership with Peers & Family members who receive our services, and in collaboration with community-based organizations and consultants all to uphold and deliver CLAS focused-approaches while promoting equity within our department. Evidence of this commitment is clearly documented by our creation of a Health Equity Division led by a departmental Health Equity Division Director, Health Equity Officer (HEO). In addition to other programs, this division is comprised of the Office of Ethnic Services (OES) and the Ethnic Services Administrator

In this update, we continue to follow the eight criteria from the original CCP plan to eliminate health disparities and improve overall health outcomes of all Medi-Cal beneficiaries. ACBH remains committed to creating a welcoming, healing, wellness and recovery centered environment for individuals and families of all cultures, languages, and abilities.

CRITERION 1: *Commitment to Cultural Competence*

ACBH Vision, Mission, and Values

Alameda County Behavioral Health Care Services serves both as the specialty mental health and substance use (Drug Medi-Cal) system within Health Care Services Agency (HCSA). Our vision, mission, and values (noted below), represents both our current operations and aspirational goals in relation to how we see ourselves as a public service organization.

Vision

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

Mission

To support and empower individuals experiencing mental health and substance use conditions along their path towards wellness, recovery, and resiliency.

Values

Access, Consumer and Family empowerment, Best Practices, Health & Wellness, Culturally Responsive, & Socially Inclusive.

Health Equity Division

The Office of Health Equity (OHE) was established in the fall of 2020 with the goal of providing a stronger foundation for the incorporation and promotion of Diversity, Equity, Belonging and Inclusion practices throughout our system of care and supporting individuals, families, community-based organizations, stakeholders, and the workforce. The OHE is comprised of five units: the Office of Ethnic Services (OES), Office of Family Empowerment (OFE), the Office of Peer Support Services (OPSS), Patients' Rights (PR) and, the Health Equity Policy and Systems Coordination (HEPSC) team.

HED Activities

Activity	Duration/Timeframe
Opioid Listening Sessions: Committed to communication with the Alameda County community about critical healthcare issues	September 5, 15th, 18th, 26th 2023
Mapping and planning for technical assistance and team building opportunities to address systemic and cultural bias awareness and strengthen communication within the Forensics system of care.	Ongoing
Established October 2022 the Latino/X Advisory Board	October 2022 - present

Championing Introduction of County co -created curriculum *Building Resilience Together: Trainer Training Trauma Informed System 101* Survey First Cohort Trainers trained	Ongoing January 2023 November 2023
Co leading with General Services Agency the design of the African American Wellness Hub	September 2023 - present
Participating member of internal/external Care Court Implementation Planning Teams	October 2023- Present

SB 43

Senate Bill 43, seeking amendments to the Lanterman-Petris-Short Act, presents unique challenges to our system, particularly concerning potential disparate impacts on black and brown communities. Recognizing these concerns, our county Board of Supervisor unanimously voted pause implementation at the time of this update. We will move to implement by 2026. This pause allows us the necessary time to carefully consider and address any unintended consequences, ensuring a fair and equitable application of the amended Lanterman-Petris-Short Act. In expanding the definition of 'gravely disabled' to include severe substance use disorders and co-occurring mental health disorders, we acknowledge the complexity of the issues at hand. During this pause, we remain committed to transparency, accountability, and ongoing collaboration to refine and improve the implementation of the amended Lanterman-Petris-Short Act as outlined in Senate Bill 43

Care Courts

The implementation of Care Courts has been a meticulously considered endeavor, marked by thoughtful planning and strategic decision-making. ACBH has approached this initiative with a keen awareness of the impact it can have on individuals and the community.

Care Courts, designed to provide a structured and supportive legal framework for mental health and substance abuse cases, has been introduced with a focus on ensuring fairness, accessibility, and sensitivity.

The careful consideration extends to factors such as the well-being of individuals involved, the efficiency of the legal process, and the overall improvement of mental health and substance abuse treatment outcomes.

Through extensive planning and collaboration, ACBH has sought to address potential challenges and optimize the positive impact of Care Courts. This includes aligning the initiative with existing systems, engaging stakeholders, and integrating trauma-informed principles into the legal proceedings.

Moreover, the Health Equity Officer within ACBH and the Medical Director of the Health Care Services Agency, have extended their engagement efforts through Opioid Settlement Listening Sessions. These sessions were held on September 5, 15, 18, and the 26th, further emphasizing the commitment to community involvement and the addressing of critical healthcare issues.
These listening sessions, collectively, represent a commendable effort to address healthcare disparities and promote health equity across diverse communities within Alameda County. The Health Equity Division's commitment to inclusivity, engagement, and empowerment is evident through these initiatives, which have contributed significantly to a more equitable healthcare landscape.

Utilization

As a crucial aspect of ACBH's dedication to cultural competency, cultural humility, wellness, healing, recovery, and health equity, we consistently assess and monitor utilization patterns within our diverse cultural communities. Through this analysis of data, we aim to identify any potential patterns that may contribute to inequities and work to address them. This ongoing process aides in our efforts to ensure that our services within our systems of care are accessible and equitable for our beneficiaries.

FY 2022-2023 Figure 1. (Yellow Fin, 2022) Beneficiaries ACBH:

Ethnic Group	Number of Beneficiaries	Served with Medi-Cal	Penetration Rate	Served in Outpatient Settings	% Served with Medi-Cal, Served in Outpatient	Outpatient Penetration Rate	Served without Medi-Cal	Total Served
Alaska Native or American Indian	1,137	92	8.09%	69	75%	6.07%	42	134
Asian or Pacific Islander	104,467	1,536	1.47%	1,361	88.6%	1.3%	1023	2,559

Black or African American	73,894	5,801	7.85%	4,364	75.2%	5.91%	1,900	7,701
Hispanic or Latino	138,237,	5,374	3.89%	4,752	88.4%	3.44%	112	5,486
Other/Unknown	147,400	6,057	4.11%	4,703	77.6%	3.19%	1,991	8,048
White	49,257	2,667	5.41%	2,145	80.4%	4.35%	1,513	4,180
Total:	**514,392**	**21,527**	–	**17,394**	–	–	**6,581**	**28,108**

The above chart (Figure 1) provides data on the number of beneficiaries within the ACBH system of care, their ethnicity, and the percentage of beneficiaries who received Medi-Cal and who are served in outpatient settings. This data is a snapshot from our 2022 – 2023 fiscal year and the largest ethnic group served in our system are Other/Unknown and White, followed by Black or African American. The smallest group within our system of care is Alaska Native or American Indian.

The overall penetration rate for all ethnic groups is 4.39%. The penetration rate for each individual ethnic group ranges from the low end of 1.4% for Asian or Pacific Islander to the highest penetration rate of 7.85% for Black or African American.

As previously reported, the Asian American and Pacific Islander (AAPI) community consistently experiences low penetration rate in our system of care. We remain committed to addressing this issue and are also examining the high penetration rate among African Americans, who often receive care in the most severe forms of mental health treatment. It is crucial that we address these disparities and work towards providing equitable healthcare access for all communities.
This update will highlight and provide examples of ACBH'S ongoing efforts to address health inequities and disparities, improve the quality of services, ensure equitable care, and respond to the needs of underserved or inappropriately served beneficiaries. These efforts include providing culturally specific services, implementing community based and culturally responsive practices, offering language services, and building and supporting a diverse workforce that reflects the population we serve.

Additionally, the report will outline ACBH's commitment to strengthening the Office of Health Equity (OHE), integrating service delivery, supporting, and promoting Peers and Family advocates employed within our system of care who are certified to bill Medi-Cal, and addressing the emergent needs of beneficiaries, including new arrivals/refugees who reside within our county.

Cultural Activities/Accomplishments

The utilization of cultural activities and culturally congruent interventions and programs is a key component of ACBH's strategy to address inequities within our system. These culturally affirming practices have been effective in engagement and outreach to diverse communities, as well as reducing stigma that too often surrounds accessing behavioral health care. The cultural initiatives updated and outlined in this report aim to strengthen current practices, highlight accomplishments, and forecast some of our fiscal year 2023-2024 objectives. In addition, this approach supports creating a sense of community, wellness, belonging and inclusiveness. Many of these noteworthy activities we have organized, sponsored and/or participated have been included below:

- Cultural and Linguistically Appropriate Services (CLAS) Trainings across cultural groups
- African American Wellness Hub introduction to the Hub design video project (revised for 2023)
- Second annual "Suffer in Silence No More", Asian American, Native Hawaiian & a Pacific Islander panel on mental health and wellbeing within this community- focus was on:
    - Understanding the Sources of Anti-Asian Racism and Reflect on its Impact on the Community
- Latino/Latinx Advisory Committee Kickoff in Livermore, June 2023
- Latino/Latinx Utilization Report (in progress)
- Día De Los Muertos event in Oakland, October 2023
- Oakland Pride Festival, September 2023
- Black Joy Festival in Oakland, February 2023
- Juneteenth Festival in Berkeley, June 2023
- District 7 - Day of Action
- Eid Resource Fair in Hayward, May 2023
- Unity Celebration of Resilience, September 2023)
- Mental Health First Aid Event
- World Mental Health Day Candlelight Vigil, October 2023
- Hep B Under the Mango Tree July 2023
- Weaving Resources for clergy, June 2023
- Coffee Break with The Fellas, June 2023
- English Newcomers Welcome video (and website) publicly launched:

- Newcomers Welcome | Alameda County | (acgov.org) - The video has English subtitles, but also options for subtitles in other languages as well Dari and Pashto; Dari and Pashto Newcomer Welcome websites will launch in January 2024.

- Annual Youth Health Equity Summit
- Securing funding to help with the development of the Asian American Native Hawaiian Pacific Islander Advisory committee; and Recruited members for the ACBH Asian American Native Hawaiian Pacific Islander Advisory committee launching in early 2024.

Noted Challenges & Opportunities

In February 2023, Mona Shah was appointed to be the new Health Equity Policy and Systems Manager and in May 2023 was appointed Interim Office of Ethnic Services Administrator. The Interim OES Administrator has been continuing to redesign, redefine and strengthen the Office of Ethnic Services in collaboration with the Health Equity Officer.

The ACBH executive leadership continues to shift the scope of addressing CLAS and equity work from one unit, team, or division to ensuring that the work of addressing these issues is embedded across our systems of care. The HED is an essential part of integrating this work. Sharing the weight of this work across our system of care can create the conditions necessary to usher in a more inclusive and collaborative environment and increase our culturally appropriate care and quality of care for all.

Policies, Practices & Procedures

Below are ACBH policies and procedures that highlight our commitment and prioritization of the national standards for Culturally and Linguistically Appropriate Standards (CLAS). Highlighted policies are primarily new or updated and focus on 1) access to care, 2) appropriate, right matched, integrated and coordinated care, 3) beneficiary outcomes and experience.

ACBH Policies and Procedures (Links):

- Alameda County Board of Supervisors adopted “Care First, Jails Last” policy in Alameda County
- 100-2-5 Telehealth Policy
- 100-3-1 Criteria for Beneficiary Access to Specialty Mental Health Services
- 100-3-2 No Wrong Door for Mental Health Services Policy
- 150-2-1 DMC ODS Requirements for Period 2022-2026
- 150-1-5 Naloxone Distribution Program
- 404-1-1 Mobile Crisis Team Services Policy

The above sample of ACBH policies and procedures all play a crucial role in promoting and improving the

Alameda County behavioral health continuum of care. California Advancing and Innovating Medi-Cal (CalAIM) addresses access to integrated and coordinated care (i.e. physical health, mental health, substance use and dental services), and improving outcomes. The Board of Supervisors (BOS) Care First policy affirms the county's commitment to a comprehensive continuum of care for individuals, rather than incarceration. Due to the public health emergency (i.e. COVID -19) and the COVID-19 flexibilities telehealth services have become a critical clinical service delivery mechanism and have been particularly beneficial for individuals with limited access to transportation or other barriers to in-person care. Telehealth has also increased health equity, by improving access to culturally and linguistically matched providers and care; and by improving privacy and alleviating some stigma considerations. In 2022, ACBH created a new Crisis Services System of Care. To date, ACBH has expanded its crisis and mobile crisis services, and will continue with the soon to be finalized DHCS Mobile Crisis Implementation Plan. Alameda County continues to strive towards systemwide integration and improvements, focusing on target populations, by operating a full continuum of care that includes mental health, substance use, forensic, and crisis services.

Reviewing/Pending:

- Policies and billing codes for Family/Peer Advocates certified to bill Medi-Cal
- Policies that guide how to capture race, ethnicity, and language preferences more precisely for our data system.
- Clinical Practice Guidelines: Guidance on Evidence-Based and Best Practices: covers ACBH's overarching Practice Guideline Values, 1) Culture, Community, and other Considerations, 2) CLAS Standards, 3) Recovery-Oriented Care, 4) Outreach and Engagement (publication anticipated in January 2024)

Broad Goals Fiscal Year 24-25:

- Continue to train on how to capture demographic data;
- Create A Risk Register for Health Equity;
- HED Dashboard and Heat Map;
- Consultation And Support Three-Year Plan CCP;
- African American Wellness Hub Facility development/purchase;
- Equity And Bias Training Created for All ACBH Staff; and
- Trauma Informed Systems 101 Training All ACBH Staff
- WET Needs Assessment
- Board Resolution that names racism as a health crisis (in progress)
- Language, Interpretation and Translation
- Stakeholder Engagement
- Leverage/focus joint HED and QM/QI Meetings on quality improvement metrics/data and projects

CRITERION 2: *Updated Assessment of Service Needs*

Alameda County Demographics

Alameda County is in San Francisco Bay Area of California and has a vibrant diverse population. According to the latest United States Census population estimate there are 1,682,353 people who reside in Alameda County. Alameda County is the 50th largest county based on area. (Bureau, 2021) The following link shows demographic data based on age and sex as collected by the United States Census (we acknowledge that diverse gender data sets are not included) the choice for sex is a binary choice of either male or female.

(Link) Demographic Assessment from the U.S. Census 2020 - Alameda County estimates

The demographic assessment from the United States Census 2020 for Alameda County estimates the following:

- American Indian & Alaska Native total population in Alameda County is estimated at 19,659 persons
- Asian total population Alameda County estimated at 545,261 persons
- Black or African American total population in Alameda County is estimated at 164,879 persons
- Hispanic or Latino total population in Alameda County is estimated at 393,749 persons
- Native Hawaiian and Pacific Islander total population in Alameda County is estimated at 14,123 persons
- Some other race total population in Alameda County is estimated at 223,779 persons
- Two or more races total population in Alameda County is estimated at 190,816 persons • White total population in Alameda County is estimated at 523,836 persons

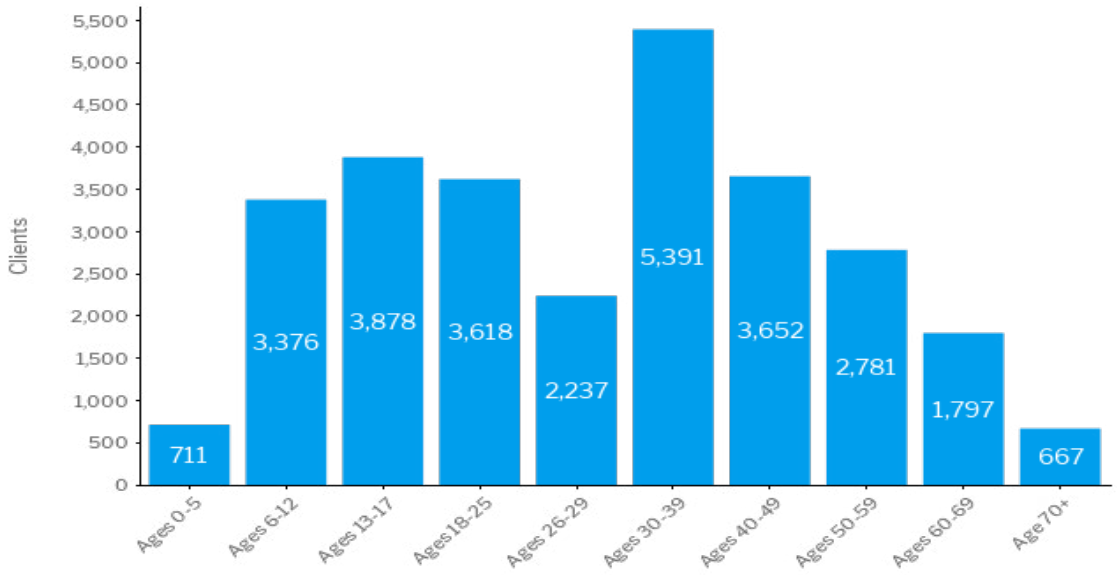
It is noted that the “some other race” and “two or more races” demographics is intended to capture racial identities that are not represented in the other categories, that may be unique to an individual or do not fit the standard categories; and the folks identifying as having more than one racial identity are captured. The combined total of the “some other race” and “two or more races” is 414,595 making this category the third largest in Alameda County. This is of particular interest for the ACBH system of care as this growing category across Alameda County, the state of California and the United States in total is also occurring within our system of care.

Types of Languages Spoken at home in Alameda County

Figure 2. Languages Spoken at home Alameda County Residents (Bureau, 2020):

Fiscal Year	Language Group	Clients	% of Clients
FY 2022-2023	Arabic	43	0%
	Chinese	350	1%
	English	22,907	81%
	Farsi	206	1%
	Other	514	2%
	Spanish	3,844	14%
	Tagalog	43	0%
	Unknown	51	0%
	Vietnamese	150	1%
		28,108	**100%**

Figure 3. Age Distribution Beneficiaries ACBH (Yellow Fin, 2023):



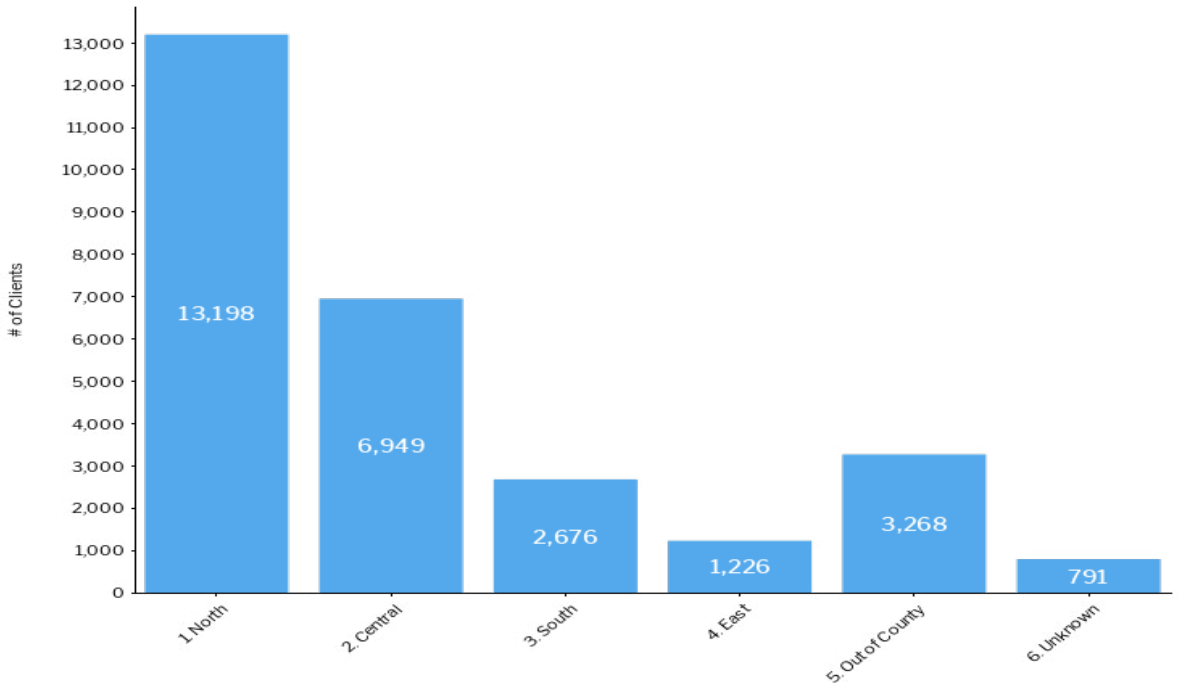
Alameda County Behavioral Health Demographics

Age group distribution across ACBH Mental Health Services based on the data retrieved from ACBH *Yellow Fin* it shows that the age group with the largest representation among the client population is 30-39, comprising 5,391 clients. The next highest representation is among the 13-17 age group, comprising 3,376 of clients. Meanwhile, the lowest representation is among clients who are 70 or older, comprising only 667 of the client population, and among clients who are 0-5, comprising 711 of the client population as shown in *Figure 3.*

Regional Demographics ACBH Five Districts, Alameda County

According to our data, most beneficiaries enrolled in our program live in North County. This information is important for us to consider as we plan and deliver services, as it helps us to understand the needs and demographics of our community and ensure that we are meeting the needs of those we serve. By tracking this data and analyzing it over time, we can also identify any trends or changes in the distribution of our beneficiaries, and adapt our policies and practices as needed to better meet the needs of our community as shown in *Figure 4.*

Figure 4. Number of Beneficiaries Served ACBH By Region (Yellow Fin, 2023):



From an equity point of view, it is important for us to pay attention to the needs and demographics of rural parts of our county, as these areas may have unique challenges and needs when it comes to accessing mental health services. Additionally, gentrification can often lead to poorer individuals being pushed out of metropolitan areas, and these are the individuals that we typically serve. By considering the impacts of gentrification and working to address any barriers or inequalities in access to care in these areas, we can ensure that all members of our community can receive the support and care they need. By tracking and analyzing data on the distribution and demographics of our beneficiaries, we can better understand the needs of our community and adapt our policies and practices as needed to meet these needs.

Sexual Orientation and Gender Identity (SOGI) Demographics

The ACBH has been working to improve its systems for collecting data on sexual orientation and gender identity since the passage of AB959. In the summer of 2022, the Data Governance committee was established, including a sub-committee focused on improving data collection for SOGI. As the ACBH moves towards using SmartCare for data collection, the data governance team received a presentation from the

SOGI subcommittee on best practices, the history and importance of collecting this data, and guidelines for recording SOGI data correctly. Some of the recommendations shared during this presentation included: do record both sex and gender in separate fields, in the absence of government identification or physician documentation, do ask the patient their sex at birth, and do not assume the patient's sex based on visual appearance.

There are several reasons why our data set shows a higher unknown rate in the three SOGI data sets. One reason is that capturing this data is new to our system and for the CBOs providing services on our behalf and folks may not have been asked about their SOGI demographical information. Second, we may have a skill set deficit in inquiring and discussing SOGI data and we will continue to train and support staff at all levels and specifically those charged with collecting demographic data on promising and best practices for capturing this data, as shown in *Figures 5, 6,* & *7* below.

Across all five systems of care, the Office of Ethnic Services (OES) and the Health Equity Division (HED) are working with multidisciplinary committees and groups to support the collection and use of data on sexual orientation and gender identity (SOGI). This is essential for advancing diversity, equity, belonging, and inclusion (DEBI) practices within our system of care. By gathering this data our system, organizations/CBOs, and community can better understand and acknowledge the diversity of the communities served and the ways in which different SOGI groups may experience mental health differently.

This continued cross system and stakeholder approach will support design and implementation policies, practices, and interventions that are more inclusive and responsive to the needs of diverse SOGI communities, and to create a more welcoming and supportive environment for all individuals.

Figure 5. ACBH Beneficiaries Sexual Orientation (Yellow Fin, 2023):

Fiscal Year	Sexual Orientation	Clients	% of Clients
FY 2022-2023	Unknown	11,786	42%
	Heterosexual	7,592	27%
	Missing	6,909	25%
	Gay	1,041	4%
	Bisexual	253	1%
	Prefer Not to Answer	167	1%
	Lesbian	111	0%
	Other	101	0%
	Questioning	56	0%
	Multiple Sexual Orientations	53	0%
	Queer	39	0%
		28,108	**100%**

Figure 6. Beneficiaries ACBH Gender Identity (Yellow Fin, 2023):

Fiscal Year	Gender Identity	Clients	% of Clients
FY 2022-2023	Male	9,319	33%
	Missing	7,126	25%
	Female	6,278	22%
	Unknown	5,002	18%
	Multiple Gender Identities	94	0%
	Intersex	58	0%
	Other	57	0%
	Non-Conforming	52	0%
	Prefer Not to Answer	50	0%
	Queer	30	0%
	Female to Male	29	0%
	Male to Female	13	0%
		28,108	**100%**

Figure 7. Beneficiaries ACBH pronoun Preference (Yellow Fin, 2023):

Fiscal Year	Pronoun	Clients	% of Clients
FY 2022-2023	He/Him	8,070	29%
	Unknown	7,209	26%
	Missing	6,882	24%
	She/Her	5,661	20%
	They/Them	135	0%
	Multiple Pronouns	84	0%
	Prefer Not to Answer	37	0%
	Other	30	0%
		28,108	**100%**

The number of individuals who speak other languages other than English in Alameda County compared to the data collected in our language group "needs by client" is not in alignment within the overall population. This reality is true for several possible reasons: there may be barriers with understanding about how to access language services that exist within ACBH; underrepresentation of beneficiaries who are in our who speak other languages; and the need to increase the numbers and create a more linguistically and culturally appropriate system of care.

Figure 8. Beneficiaries ACBH Primary Language (Yellow Fin, 2023):

Fiscal Year	Language Group	Clients	% of Clients
FY 2022-2023	Arabic	43	0%
	Chinese	350	1%
	English	22,907	81%
	Farsi	206	1%
	Other	514	2%
	Spanish	3,844	14%

Tagalog	43	0%
Unknown	51	0%
Vietnamese	150	1%
	28,108	**100%**

Diversity Equity Belonging & Inclusion: In Focus

ACBH has implemented an equity-focused approach to problem-solving and decision-making, which considers the potential disproportionate impact of issues on different groups within our care. This approach is aimed at directing resources and efforts towards addressing the specific needs and challenges faced by populations that are most in need. Each system of care within ACBH has equity-driven workplans in place. However, ACBH is not immune to the social determinants of health that affect the county. Health is significantly influenced by various social and environmental factors, and access to secure, affordable housing, safe neighborhoods, quality education, and physical and mental healthcare is crucial. However,

access to these favorable conditions can vary greatly based on factors such as racial identity, language spoken, geographic location, and socio-economic status (Blomme et al., 2020).

According to Race Counts, Alameda County ranks 37th most disparate county in California out of 58 counties (Race counts, 2022). In addition, Black/African Americans across all indicators (crime/justice, democracy, healthy built environment, economic opportunity, housing, education, and health access) suffer the most racial disparity (Race counts, 2022). In addition, our continued low penetration rates within the Asian American & Pacific Islander community remains a priority.

A sample goal that addresses equity within the Adult and Older Adult System of Care has been included below:

- Promote equity in all RFP processes: AOASOC has committed to requesting a review of all draft RFPs by both our POCC department and our Health Equity Division to welcome a diverse provider pool who can provide services to a diverse beneficiary population that are meaningful and relatable.

Broad Goals Fiscal Year 23-24:

- Continue to develop system-wide policies, practices, and procedural guidelines to reduce the use of the 'other' category and decrease the number of unknown beneficiaries within the racial and ethnic demographics.
- Data Governance team subcommittee will continue to meet until a new policy is created to address capturing data on ethnicity and race.
- Culturally Responsive Committee continues to work with the OHE/ESM on beginning a plan to support the creation of a community driven and five system of care collaboration CCP update for ACBH.
- OHE/ESM will continue to work on multidisciplinary teams to support increasing the number of eligible beneficiaries of AA&PI background access services.
- HED division and the new HEPSC team continues to work across all systems to develop guidelines and practices that support the creation of equity goals and workplans as well as baselines and measurements to track improvements.
-

CRITERION 3: *Strategies and Efforts for Reducing Racial, Ethnic, Cultural, and Linguistic Mental Health Disparities*

The mission of the African American Steering Committee for Health & Wellness (AASCHW)

To ensure that the Behavioral Health system in Alameda County provides quality, culturally responsive, and integrated care that is delivered in an honoring and respectful manner to African American consumers, family members, and the community-at-large. The vision of the AASCHW is to have a Behavioral Health system where African Americans are equal partners with Behavioral Health Services and are always included in the decision-making process that creates, designs, develops, and implements policies, procedures, and services for the African American community.

Mission Statement:

The African American Steering Committee for Health and Wellness is dedicated to ensuring Alameda County's Behavioral Health system provides quality, culturally responsive and integrated care that is delivered in an honoring and respectful manner to African American consumers, family members and the community-at-large.

Vision Statement:

The vision of the African American Steering Committee for Health and Wellness is to have a behavioral health system where African Americans are equal partners with behavioral health services and are included decision-making process that create, design, develop, and implement, policies, procedures, and services for the African American community.

Their charge:

- Identify the African American community's greatest concerns and challenges surrounding mental health and drug and alcohol abuse services.
- Address inconsistency in outcomes despite serving African Americans at a disproportionately higher rate than other ethnic communities, and often in restrictive settings such as hospitals and jails.
- Develop procedures and guidelines for the delivery of African American culturally responsive services and treatment. *(Update: funding secured to facilitate the introduction of the Tele-Therapist in Residency Response project that aims to train the workforce and volunteers within our system of care how best to work with African American clients.)*
- Increase educational and training opportunities for African American community members. This is an ongoing activity through the outreach and networking with the African American community.
- Increase outreach, engagement, and support to the Black community. During FY 2020-2021 the AASCHW did great outreach to the Black community. The Committee has an extensive listserv that includes a variety of service providers, consumers and family members, fraternal and professional organizations, county agencies leadership and staff, and community-based organizations. The

Committee outreached to the Black community through meetings, webinars, and town hall meetings. During this FY, the Committee conducted eight (8) Webinars and one (1) Town Hall Meeting.

- Coordinate and host the annual African American Conference in collaboration with ACBH
- Organize the annual AASCHW member retreat to develop and revise a 5-year work plan
- Increase the number of culturally responsive programs designed for African Americans that are funded by ACBH

Additionally, the Health Equity Officer, in partnership with the Alameda County Board of Supervisors Districts, has demonstrated a commitment to equity through four collaborative listening sessions held in April, May, and June that asked what services the community would want to see in the African American Wellness Hub. These sessions have provided a platform for dialogue, understanding, and collaboration among stakeholders. The number of participants for each session is as follows:

- April 17 - 41 participants
- April 20 - 43 participants
- May 31 - 16 participants
- June 22 – 10 participants

Moreover, the Health Equity Officer within ACBH and the Medical Director of the Health Care Services Agency, have extended their engagement efforts through Opioid Settlement Listening Sessions. These sessions were held on September 5, 15, 18, and the 26th, further emphasizing the commitment to community involvement and the addressing of critical healthcare issues.

These listening sessions, collectively, represent a commendable effort to address healthcare disparities and promote health equity across diverse communities within Alameda County. The Health Equity Division's commitment to inclusivity, engagement, and empowerment is evident through these initiatives, which have contributed significantly to a more equitable healthcare landscape.

Afghan, New Immigrant, and Asylee Mental Health Initiative

Afghan, New Immigrant and Asylee Mental Health Initiative (ANIAMHI) efforts began in 2016 with a collaboration between the Office of Ethnic Services and the MHSA Unit to better understand and improve mental health services to new immigrants arriving to Alameda County. To better understand the needs of our immigrant communities, the Office of Ethnic Services maintain ongoing communication and relationships with the Afghan, Latino, and other immigrant providers to gain insight on some of the community's mental health challenges and needs. The mission and vision below are those established by the Office of Ethnic Services.

Mission

Empower all immigrants by connecting them to culturally appropriate resources that enables them to live successful and enriched lives.

Vision

Ensure services for recent and new immigrants are offered with respect and compassion. Also, ensure all are welcomed and provided culturally and linguistically appropriate care.

Highlights:

- Continue to collaborate with a local Afghan American psychologist to conduct a community-focused two- part webinar series to educate the community about the lives of Afghan refugees; and
- Continue to attend high-level meetings with a cross-sector of stakeholders to assess, identify and collective work to address immediate and long-term needs of new arrivals.
- English Newcomers Welcome video (and website) have publicly launched:
  - Newcomers Welcome | Alameda County | (acgov.org)
- Dari and Pashto Newcomers Welcome videos have been produced, edited, and finalized
- Launching the Dari and Pashto Newcomers Welcome websites in January 2024

Objectives:

- Increase access to culturally relevant mental health programs for immigrant, asylee, and refugee by 50% for organizations in the southern region of Alameda County. ***In Progress.***
- Assemble a team of community experts to support Alameda County Behavioral Health to conduct a mental health needs assessment for the Afghan community. ***In Progress.***

Mission

To empower and increase the visibility of Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, Intersex, Asexual (LGBTQIA+) and Non-Gender Conforming communities by uniting individuals and organizations to work for equality and inclusiveness in Alameda County.

Vision

Promote an environment of equity for all gender and non-gender conforming individuals by affirming and supporting one's lived experiences

Highlights:

- Multidisciplinary team across ACBH system of care working on best and promising practices to help capture SOGI data for the populations we serve.
- Annual Oakland Pride Event sponsored by ACBH
- Ongoing monthly ACBH Pride Coalition meetings
- Participated and sponsored the annual Pride Prom
- LGBTQIA+ Health Equity and Cultural Humility Training by Kobi Rodriguez (CLAS Training): 6/22/23
- With recent anti-LGBTQIA+ legislation implemented across the United States creating a fearful environment for the LGBTQIA+ community. ACBH developed the Y/YA LGBTQIA+ Early Intervention Program designed to provide early intervention services
- As part of our ongoing efforts to address the mental health needs of the LGBTQIA +community, the ACBH ***LGBTQIA + Mental Health Initiative*** has been working to create policies, procedures, and practices that better serve this population. We have also been collaborating with the Pride Committee and other community organizations to identify and address disparities in care and improve the overall mental health outcomes for LGBTQIA+ individuals. In the coming fiscal year, we will continue to focus on these efforts and work towards creating a more inclusive and welcoming environment for all members of the LGBTQIA+ community
- The September 2023 Older Adult Training and Certification included a training specific to the LGBTQIA Older adult community that was well attended and well received

Strengthening Cultural Practices:

- Continuing to collect Sexual Orientation and Gender Identity (SOGI) data to inform our efforts to improve services and programs
- Increase services for Transgender and Gender Non-Conforming individuals; and
- Advise leadership to implement policies that reflect the needs of LGBTQIA+ community.
- Developed a County maintained resource list for LGBTQ+ support across cultural and linguistic communities

Objectives:

- Continue to develop Sexual Orientation and Gender Identity (SOGI) resource and training materials to support providers in Alameda County Behavioral Health system develop an inclusive and welcoming environment for the LGBTQQI2-S community. ***In progress.***
- Resource brochure

The Asian American Native Hawaiian Pacific Islander

(AANHPI) Mental Health Initiative is currently focused on improving access and care for the AANHPI community in Alameda County. This population represents a significant portion of Medi-Cal beneficiaries, but their utilization of behavioral health services remains low. To better understand the cultural and linguistic barriers that may be hindering access to care for the AANHPI community, the Initiative is committed to increasing the penetration rates for this group and implementing strategies to remove any barriers to care.

Mission

Increase culturally specific and appropriate mental health opportunities for the AANHPI community that values and respects their norms, beliefs, and diverse backgrounds.

Vision

To decrease stigma among AANHPIs accessing mental health services by providing culturally and linguistically appropriate care.

Highlights & Accomplishments:

- Offered a CLAS Standards training focused on Trauma Informed and Culturally-Responsive Practices in Working with Asian American, Native Hawaiian and Pacific Islander (AANHPI) Clients
- Health Equity Division and Office of the Medical Director received funding for a five Year Pilot Project to assist in enhancing health equity for the Asian and Pacific Islander communities, through increasing access and utilization of behavioral health services and improved health outcomes for those Alameda County residents who have from emerging to persistent, and severe mental health conditions
- Engagement of AANHPI providers and partners to establish an AANHPI Advisory Committee (launching in early 2024) to focus on strategies for increasing utilization of BH services

Strengthening Racial/Ethnic and Cultural Practices:

- Work more closely with ACBH QI Coordinators around API—PIP
- Provide Behavioral Health Interpreter Trainings for Cantonese/Mandarin speaking providers during EQRO focus groups
- Work to disaggregate PI data from API data
- Facilitate cross-cultural activities between other cultural committees and groups

Objectives:

- Increase the penetration rates of Asian American Medi-Cal beneficiaries needing behavioral health services by at least 50% by offering culturally appropriate and responsive services, including language access and telehealth. ***Ongoing***
- Analyze and report penetration rates by disaggregated data for racial/ethnic groups and English proficiency. ***Ongoing***
- Conduct at least two focus groups within Alameda County's Southeast Asian community to explore ways to better address stigma and linkage to culturally appropriate services. ***Re-evaluating***
- Conduct a survey with a statistically significant sample size and oversampling for smaller Asian population groups (at least 500) to understand barriers and enabling factors for accessing mental health services. ***Re-evaluating***
- Collaborate with county partners to maintain the Regional Pacific Islanders Stakeholder Meeting to address the health and mental health challenges in the Pacific Islander community

Latino/Latinx Mental Health Initiative

The Latino Advisory Committee for Behavioral Health in Alameda County is committed to optimizing behavioral health services for Latinx communities, ensuring equitable access, bridging gaps, and fostering collaboration with community agencies. The committee aims to increase cultural awareness, advocacy, and improve the overall mental health of the Latinx communities.

Vision Statement:

The vision of the Latino Advisory Committee is to create a behavioral health system that provides quality, culturally responsive care, and addresses the specific needs of Latinx communities. The committee envisions a system where Latinx individuals are equal partners in decision-making processes, contributing to the design, development, and implementation of policies, procedures, and services.

Charge:

- ***Identify Concerns***: Identify and address the mental health and substance abuse concerns within the Latinx communities, focusing on the unique challenges they face.
- ***Address Disparities***: Work towards reducing inconsistencies in outcomes, especially in restrictive settings, by collaborating with relevant agencies and systems of care.
- ***Culturally Responsive Services***: Develop and implement procedures and guidelines for the delivery of culturally responsive behavioral health services and treatment for the Latinx community.
- ***Educational Opportunities***: Increase educational and training opportunities for Latinx community members, aiming to enhance awareness and understanding of mental health issues.
- ***Outreach and Support***: Expand outreach, engagement, and support to BIPOC communities, Indigenous and American Indian communities, Spanish-speaking communities, and Alameda County residents.

- ***Advocacy and Research***: Advocate for policies and systems change, conduct research, and evaluate data to inform decision-making processes related to behavioral health services.
- ***Community Engagement***: Actively engage with the community through outreach initiatives, committee presence, and collaboration with community agencies.
- ***Representation***: Ensure representation from diverse backgrounds, including Afro-Latinx members, agencies such as Family Paths, Axis Community Health, The Hively, and Alameda County Public Health Department, as well as subject matter experts in data analysis and substance abuse prevention.
- ***Committee Skill Sets***: Leverage diverse skill sets within the committee, including event coordination, data and evaluation, collective impact frameworks, marketing, youth programming, project management, and spiritual health.

By fulfilling these objectives, the Latino Advisory Committee aims to contribute to the improvement of behavioral health services, advocacy, and overall well-being of the Latinx communities in Alameda County.

Highlights & Accomplishments:

Latino/LatinX Advisory Group

Helping to stand up the Latino/X Advisory Committee from conception is also a win for the HED this year. Our efforts have begun to bear fruit by:

- Establishing the Latino/LatinX Committee to ensure the mental health needs of the Latin community are addressed.
- Funding the group to ensure that the mission of the group is met

Supporting outreach activities sponsored by the group since its inception as it creates an identity and awareness in the community it wishes to serve:

- Ongoing meetings with County contracted providers serving the Latino/LatinX community; and
- CLAS Training: **Mental Health Services With Latinx Populations: An Antiracist And Intersectional Approach by Dr. Lorena Moreno on 10/16/23 Utilization Report (in progress) : Survey Findings on Timeliness and Access to Behavioral Health Services at ACBH. Introduction:** This survey was conducted during the "Liberation through Community" event, which brought together Latino families and friends for a day focused on enhancing community through the power of mental health awareness. Surveys were administered with the assistance of interpreters, and some surveys were conducted in Spanish, acknowledging that the results and completeness of answers may vary depending on the surveyor.
- The survey findings highlight the importance of addressing language accessibility, provider availability, and communication to enhance the timeliness and accessibility of behavioral health services at ACBH.

It is important to note that the survey was conducted during the "Liberation through Community" event, with surveys administered via interpretation, and that the results and completeness of answers may have varied depending on the surveyor.

The American Indian/Alaska Native

A population that represents less than 1% of the total. In Alameda County, this population is also less than 1%. Over the past ten fiscal years, the penetration rate for Alaska Native and Native American individuals in the Medi-Cal system has fluctuated, ranging from a high of 12.59% in FY 2011-2012 to 8.06% in FY 20192020 and 6.35% in FY 20-21 and 5.89% in FY 21-22. The number of beneficiaries has also varied, from a low of 929 to a high of 1413, with a total of 1071 in FY 20-21. The penetration rate for this group is higher than African Americans and the Office of Ethnic Services will continue to work with the Native American Health Center to identify culturally affirming strategies to increase access to care and better understand the needs of the indigenous communities. It is possible that there may be more individuals in these communities who are eligible for Medi-Cal and in need of behavioral health services.

Mission

To serve Native Americans in and around Alameda County by providing mental health support and resources that uplifts the spirits, heritage, and traditions of the whole community.

Vision

Increase access to mental health services to all Native Americans in urban, rural, and isolated communities and promote community healing.

Highlights & Accomplishments:

- Continuing to reach out and collaborate with the Native American Health Center;
- CLAS Training: The Cultural Toolbox: An Indigenous Perspective on Deep Healing; and

Strengthening Racial/Ethnic and Cultural Practices:

- Collaborate more with Native American Health Center and other community leaders;
- Create trainings specific to the needs of Native Americans;
- Promote indigenous community health practices;
- Lift up Native American healing practices;
- Organize cultural events honoring the contributions of Native Americans; and • Build partnerships to elevate the voices of the Native American community.

Objectives:

- Increase partnership with Indigenous leaders throughout Alameda County to better understand the behavioral health needs of Indigenous people in rural and urban communities.
- Examine the intersection of culture and mental health among the Indigenous communities by offering culturally specific trainings to Alameda County staff and providers.
-

CRITERION 4: *Client/Family Member/community Committee: Integration of the Committees within the County Mental Health System*

Peer and Family Driven

The Office of Family Empowerment, Office of Peer Support Services, Office of Ethnic Services, and Patient's Rights within the Health Equity Division, fully support and champion Criterion 4: Client/Family Member/Community Committee: Integration of the Committees within the County Mental Health System.

The Health Equity Division understands that it is crucial to involve clients, family members, and community members in the decision-making process for mental health care delivery, as they have firsthand experience and knowledge of the challenges and needs of their communities. By integrating these committees within the county mental health system, we can ensure that the perspectives and voices of those most impacted by mental health issues are heard and integrated into the development of policies and practices. We are committed to actively promoting the involvement and participation of these committees in all aspects of mental health care delivery, and to creating a system that is truly responsive to the needs of the communities we serve.

Office of Peer Support Services

The Office of Peer Support Services is dedicated to revolutionizing the behavioral health system through the active engagement, promotion, and empowerment of peers receiving services and peer-run organizations and programs. To achieve this, the Office of Peer Support Services is partnering with community stakeholders to ensure that Alameda County becomes a leader in the certification of Peer Support Specialists. We are committed to making sure that peer support services and trainings are widely available and easily accessible to all individuals with mental health and co-occurring needs, to support them on their journey towards wellness and recovery.

The Office of Peer Support Services, a vital component of the Health Equity Division, has also played a significant role in promoting open dialogue and collaboration within the community. Noteworthy sessions hosted by the Office of Peer Support Services during January and September 2023 include:

- 1/30/2023 - POCC CARE Courts Townhall - 34 participants
- 8/30/2023 - POCC Continuous Improvement Townhall - 68 participants

- 9/06/2023 - POCC Continuous Improvement Townhall (2) - 71 participants

These townhall sessions have attracted a substantial number of participants, fostering engagement and ensuring that diverse voices are heard and considered in the continuous improvement efforts

Office Of Family Empowerment

The OFE is a component housed within the Health Equity Division. The OFE proudly continues their efforts to provide support and empowerment to families impacted by mental health and substance use issues. Through our various projects and initiatives, we aim to improve the quality of life for county residents and provide a platform for family members to have a strong and influential voice in the behavioral health care system. Our technical assistance, training, and support programs are designed to foster a sense of community and collaboration, and to promote a recovery-focused, culturally responsive approach to care.

The Office of Family Empowerment has demonstrated a strong commitment to community engagement and empowerment through a series of impactful listening sessions. These sessions, held during the fiscal year 2022-2023, have played a pivotal role in fostering meaningful dialogue and promoting awareness of critical mental health issues. Here is a summary of the sessions hosted by the Office of Family Empowerment:

- January 26th: Health Equity Officer: Health Equity Division – 26
- February 23rd: Care Court Information/Listening Session – Indigo Project - 7
- April 27th: Data Needs for Family Member Advocacy Info Session - 15
- May 25th: Public Guardians Office – Conservatorship in Alameda County - 26
- June 22nd: Family Caregiver Program and Family Education and Resource Center Services - 15
- August 24th: Crisis Services Information –- 20
- September 28th: Scheduled for Care Court Part 2 – Indigo Project
- November 30th: Scheduled for Psychiatric Advance Directives – Painted Brain

These sessions have provided valuable opportunities for families, caregivers, and community members to gain insights, access critical information, and engage in discussions about essential healthcare topics.

SB 803 Joint Project between OFE and OPSS

SB 803 is a bill in California that aims to establish statewide requirements for counties to develop certification programs for peer support specialists, who are individuals with personal experience in mental illness or substance use disorder recovery. These certification programs would be subject to approval by the state's Department of Health Care Services, and the department would also seek federal waivers to establish a demonstration or pilot project for the provision of peer support services in participating

counties. The goal of this bill is to provide opportunities for peer and family members to have equity in mental health services, as well as increase diversity in staffing across mental health care organizations.

The Peer Support Specialist Certification Act can greatly improve team building within mental health care organizations by allowing for the certification of individuals who have lived experience with mental illness or substance use disorder. This has provided a unique perspective and understanding to the recovery process and has allowed for the creation of more diverse and inclusive teams.

The Office of Family Empowerment (OFE) and the Office of Peer Support Services (OPSS) have been instrumental in implementing this important legislation into our system of care. Both units have worked to provide technical assistance, coaching, and training to individuals seeking certification as peer support specialists, as well as to mental health care organizations looking to integrate peer support into their services.

The OFE and OPSS have also collaborated with community partners to raise awareness about the importance of peer support and the benefits it can bring to individuals in recovery. Overall, the implementation of SB 803 has been a major step forward in improving team building and promoting equity within mental health services.

Highlights:

- ACBH opted into Peer Certification
- Submitted Reimbursement Rate for DMC ODS
- Created lists of Peers and Families for possible selection for being “Grand parented” for certification; and
- Met with the ACBH Finance, Billing, Quality Assurance team and the compliance officer
- OPSS started the Beneficiary Program focused on individuals in locked and long-term facilities in Alameda County, to ensure that our county benefits from the invaluable peer voice perspectives and their needs are meth throughout our mental health and substance use services.
- OPSS POCC (Peer Organizing Community Change) addressed the digital divide among its Peers/Consumers by educating and providing trainings on the use of virtual platforms providing access to Alameda County programs.
- In 2023 OPSS/POCC created a POCC peer run housing committee to address the housing crisis in Alameda County. A video was created and sent to the state as a deliverable for one of the OAC grants that we collaborated on.
- The Office of Family Empowerment (OFE) in collaboration with the FERC have sponsored a group of family members to plan and host virtual Parent Cafes including Spanish speaking cafes.
- hosted a Black Family Educate, Equip & Support (EES), a 14-week Mental Health Education program written and facilitated by parents of school-aged children and adolescent
- OFE has held several presentations to members of the Family Dialogue Group (FDG meets monthly) to inform Family Members about critical aspects of our system. There were several presentations on

the Care Act and its implementation for Alameda County and have provided the Advisory Council with two Family Member representatives.

Next steps:

- Add new billing codes to InSyst, CG and Electronic Health Records (E.H.R.)
- Develop Classifications within ACBH
- Partner with agencies offering Family & Peer Certification training; and
- Participate in the CalAim workgroup
- OFE developed a work group with Family Members and OPSS and Peer Consumer to develop a proposal to change "stipend" to "Community Expert Compensation" and increase the hourly rate from $20 to $40/ hour. This proposal will be shared with leadership in early 2024.

The Patients' Rights Advocates program in Alameda County, run by the Mental Health Association of Alameda County, employs a team of 8 staff members who work to ensure that individuals receiving mental health treatment in facilities, including those involuntarily committed, have their rights upheld. These rights, outlined in the Welfare and Institutions code, include freedom from abuse and neglect, privacy, dignity, and humane care, and basic procedural protections in the commitment process. The program responds to complaints and inquiries from individuals being treated in psychiatric hospitals or facilities, as well as those living in long term or adult residential facilities, who believe their rights have been violated.

The Office of Ethnic Services (OES) is committed to advancing health equity by creating racially, linguistically, and ethnically equitable access to Alameda County Behavioral Health (ACBH) services. OES has an ongoing commitment to the practice of cultural humility which embodies self-reflection and selfexamination, as well as an understanding of the power dynamics between the provider and consumer, and ACBH and the community. In addition to their commitment to cultural humility, OES is responsible for the facilitation of cultural projects, involvement in CRC Sub-Committees (Governance, Communications, Compliance), conducting Culturally and Linguistically Appropriate Services (CLAS) trainings, building and maintaining positive relationships with community partners, and collaborating with staff, managers, operational leads, and providers across the mental health and substance use systems of care.

Culturally Responsive Committee Alameda County Behavioral Health's Client/Family Member/Community Committee is called the Cultural Responsiveness Committee (CRC). The CRC serves as a safe space for consumers, family members and staff to foster a healthy working relationship to address and lift the cultural, racial, and linguistic mental health and substance abuse needs of our Medi-Cal beneficiaries and others throughout Alameda County. The CRC, in compliance with the State of California – Health and Human Services Agency— Department of Health Care Services, works with the Office of Ethnic Services to ensure that policies, procedures, and practices demonstrate the following:

1) Participants are included in the overall planning and implementation of services at the county level.

2) Reports are provided to the Quality Assurance and/or Quality Improvement Program.
3) An annual report of CRC activities is completed as required in the Cultural Competency Plan.
4) Training programs are implemented to improve the cultural competence skills of staff, management, and contract providers.
5) The Cultural Responsiveness Community is comprised of a diverse group of dedicated individuals who reflect the racial, ethnic, cultural, and linguistic diversity of the County.

The Office of Family Empowerment, Office of Peer Support Services, Office of Ethnic Services, and Patient's Rights are all integral components of the new **Health Equity Division**. Together with the **Health Equity Officer and the Health Equity Policy and Systems Coordination (HEPSC) team** Health Equity, these units are fully committed to advancing the principles of Cultural and Linguistically Appropriate Services (CLAS) and working towards the realization of health equity within Alameda County Behavioral Health.

Through ongoing collaboration and strategic planning, these units will leverage their unique strengths and expertise to develop innovative strategies and models that promote inclusive, equitable access to mental health and substance abuse services for all members of our community. Whether through the provision of technical assistance, the empowerment of families and peers, the promotion of cultural humility, or the advocacy for patient rights, each unit is dedicated to creating a more inclusive, responsive, and effective system of care.

Listening Sessions

The Health Equity Division, encompassing the Office of Family Empowerment, Office of Peer Support Services, Patients' Rights, Office of Ethnic Services, and Health Equity Policy Unit, has undertaken a concerted effort to foster inclusivity and engagement. In the fiscal year 2022-2023, this division has proactively organized and conducted numerous listening sessions across all five systems of care.

These listening sessions have been thoughtfully designed to provide a platform for specialized populations, beneficiaries, and family members to voice their concerns, experiences, and perspectives. The primary objective of these sessions has been to ensure that the healthcare services and policies implemented by the Health Equity Division are reflective of the diverse needs and aspirations of the communities it serves. Through these sessions, the Health Equity Division has demonstrated its commitment to equity, inclusivity, and responsiveness to the unique challenges and requirements of different groups within the healthcare landscape. By actively engaging with and listening to these voices, the division has taken significant steps toward the advancement of healthcare that is truly equitable, accessible, and patient-centered.

CRITERION 5: *Culturally Competent Training Activities*

At Alameda County Behavioral Health, we are committed to ensuring that our trainings and services are culturally competent and responsive to the diverse needs of our community. We take Criterion 5: Culturally Competent Training Activities of CLAS seriously and have a variety of trainings planned for the coming year that will help providers, staff, and community members better understand and address the unique cultural, linguistic, and ethnic needs of our clients. These trainings, led by expert instructors, will cover a range of topics, including trauma-informed care, LGBTQ+ inclusivity, and intergenerational trauma, and will provide valuable insights and practical tools for working with diverse populations. We are dedicated to creating a welcoming and inclusive environment for all and are committed to continually improving our cultural competence as we strive to achieve health equity for all our Medi-Cal beneficiaries and the community at large.

Trauma Informed System of Care

Health Equity Administered Survey to Support Trauma Informed Systems Change

Commissioned and championed by the Health and Equity Office (HEO), recent initiatives at Alameda County Behavioral Health (ACBH) focus on fostering a trauma-informed organizational culture. The Tools for a Trauma-Informed Work Life Survey, spearheaded by the HEO amidst the challenges of the COVID-19 pandemic, engaged 214 out of 760 employees. Despite these circumstances, ACBH received commendable scores in stress management, cultural humility, compassion, dependability, resilience, and recovery.
Identified areas for growth, notably in Safety and Stability, and Collaboration and Empowerment, highlight the organization's commitment to continuous improvement.

In response, ACBH has launched the Building Resilience Together initiative, with the Trainer Immersion Program as a cornerstone. This program, commissioned and championed by the HEO, strategically embeds trauma content experts within the organization, aligning with survey results. The aim is to enhance organizational and workforce functioning, focusing on identified areas for improvement.
In essence, the initiatives underscore the HEO's proactive approach to employee well-being, utilizing survey insights to inform targeted interventions through the Trainer Immersion Program. The organization, under the HEO's leadership, remains dedicated to fostering a resilient, trauma-informed environment, with a focus on continuous growth and positive impact

Curated List of Trainings that support CLAS:

CLAS Trainings 2023 (African American Technical Assistance):

- Emergency Room: How it Impacts Healthcare Disparities in African Americans – 01/27/2023, 9:00 am – 1:30 pm

- Student Faculty Mental health: In the Setting of the Rise of School Shootings and School Violence and How it Impacts African American Students
  – 02/24/2023, 9:00 am – 1:30 pm

- Geriatric Mental Health Among African Americans
  – 03/24/2023, 9:00 am – 1:30 pm

- Substance Use Among Black Youth: Understanding the Influence of Social Determinants of Mental Health and Developing Strategies to Address the Impact on Black Youth – 04/21/2023, 9:00 am – 1:30 pm

- Deconstructing Gang Culture in African American Adolescents: Communal Insights and Interventions
  – 05/19/2023, 9:00 am – 1:30 pm

- When Plus One Equals Three: The Illusion (Chimerism) of Co-Occurring Disorders – 06/23/2023, 9:00 am – 1:30 pm

- Diagnosis and Management of Anxiety in African Americans: from Childhood to Young Adulthood
  – 10/27/2023, 9:00 am – 1:30 pm

- And Still I Rise Success Strategies For Reentry, Formerly Incarcerated And Justice System Impacted
  – 12/02/2023, 10:00 am

- Self-Care Leadership Development
  – 12/05/2023, 10:00 am

- Financial Understanding and Wellness
  – 12/11/2023, 10:00 am – 11:30 am

- Life Coach and Strategist
  – 12/14/2023, 10:00 am – 11:30 am

CLAS Trainings through ONTRACK 2023:

- Connecting the Dots: Historical Trauma Toxic Stress and Indigenous Communities
  – 05/18/2023, 10:30 am – 12:30 pm

- LGBTQIA+ Health Equity & Cultural Humility – 06/22/2023, 10:30 am – 12:30 pm
- What's Going On?! And How to Help: Black Racial Stress, Trauma and Healing – 06/08/2023, 10:30 am – 12:30 pm
- CLAS Standards & Stigma: Discrimination Reduction in Behavioral Health – 07/20/223, 10:30 am - 12:30 pm
- Trauma-Informed and Culturally Responsive Practices in Working with Asian American, Native Hawaiian and Pacific Islander (AANHPI) Clients – 08/31/2023, 10:00 am – 12:00 pm
- Creating Welcoming and Affirming Spaces for Latinx Communities – 10/12/2023, 10:30 am – 12:30 pm
- Creating Welcoming and Affirming Spaces for Latinx Communities – 10/12/2023, 10:30 am – 12:30 pm
- Mental Health Services with Latinx Populations: An Antiracist and Intersectional Approach – 10/16/2023, 10:30 am – 12:30 pm
- The Spiritual Inheritance of Indigenous Communities and How It Can Inform The Healing of All People – 11/16/2023, 10:30 am – 12:30 pm

Community Based Learning trainings:

- Session 1/5 - Wellness NOW: Where Do We Need to Get To? – 02/15/2023, 10:00 am – 11:30 am
- Session 2/5 - Cross-Cultural Collaboration & Coalition-Building – 02/20/2023, 10:00 am – 11:30 am

- Session 3/5 - Decolonizing the Psyche; Restoration and Renewal
– 02/22/2023, 10:00 am – 11:30 am

- Session 4/5 - Recognizing and Reducing Stress Symptoms
– 02/23/2023, 10:00 am – 11:30 am

- Session 5/5 - Blessed not to be Stressed
– 02/24/2023, 10:00 am – 11:30 am

- Fostering Emotional Safety in Our Communities
– 04/27/2023, 10:00 am – 11:30 am

- Returning Citizens – Families of Formerly Incarcerated
– 04/27/2023, 1:00 pm – 2:30 pm

- Getting Back to Basics, Family and Community Health
– 04/28/2023, 1:00 pm – 2:30 pm

- Part I: Knowing The Traumatized Afghan Refugee
– 06/02/2023, 9:00 am – 2:00 pm

- Part II: Knowing The Traumatized Afghan Refugee
– 06/28/2023, 9:00 am – 2:00 pm

- Part II: Knowing The Traumatized Afghan Refugee
– 07/14/2023, 9:00 am – 2:00 pm

- Returning Citizens Series - Topic: Housing, Homelessness & Hope
– 09/28/2023, 10:00 am – 11:30 am

- Part 1/4 - Groundbreaking Liberatory Leadership Certificate Program
– 10/11/2023, 9:00 am – 12:00 pm

- Part 2/4 - Groundbreaking Liberatory Leadership Certificate Program
– 10/18/2023, 9:00 am – 12:00 pm

- Black Man It's Okay To Cry
– 10/21/2023, 11:00 am

- Part 3/4 - Groundbreaking Liberatory Leadership Certificate Program – 10/25/2023, 9:00 am – 12:00 pm

- Returning Citizens Virtual Series – 10/26/2023, 10:00 am – 11:30 am

- Part 4/4 - Groundbreaking Liberatory Leadership Certificate Program – 11/01/2023, 9:00 am – 12:00 pm

- Holiday Blues & Suicide Prevention Awareness – 11/11/2023, 11:00 am

- Returning Citizens Virtual Series: Family and Children – 11/16/2023, 10:00 am – 11:30 am

Events:

- ACBH honors Black History Month through a panel discussion: BLACK DON'T CRACK? Dispelling the Myth, Uplifting Excellence, Mental Health and Wellness in the African American Community on February 23, 2023.
- Annual Black Joy Festival and Parade on 2/26/2023
- Berkeley Junteenth Festival on 6/18/2023
- Latinx Advisory Committee Kick off and Celebration organized by the ACBH Latino/Latinx Advisory Committee on 6/11/2023
- Liberation Through Community: A Celebration of The Latino/Latinx Community organized by the Office of Ethnic Services, Health Equity Division.
- The ACBH Latino. Latinx Committee invites you to Liberation Through Community, a free cultural community event for families on September 23, 2023
- ACBH's local partner in the AAPI/Native Hawaiian communities compiled a list of resources for those in the community who would like to aid in the healing of the people of Lahaina Town and Maui and support for the Native Hawaiian Community on Maui.
- ACBH Pride Panel to acknowledge the disheartening and dangerous impact of the antiLGBTQIA+ legislation, 9/7/2023.
- African American Wellness Hub Listening Session-April and May 20023
- Día de Los Muertos: Sunday, October 29, 2023
- Oakland Pride 2022 – September 4,2022
- Alameda Couty Behavioral Health Honors November as Native American Heritage Month: ACBH honored, and acknowledged the history, spirit and tradition, culture, and land of indigenous communities, with a special focus on the Ohlone people of the region.

- Homeless Resources Fair on November 9, in partnership with the Office Board President Nate Miley. Health Equity Division and local agencies on November 9, 2023, 10 am – 3 pm at East Oakland Faith Deliverance Center Parking Lot.

CRITERION 6: *County's Commitment to Growing a Multicultural Workforce: Hiring and Retaining Culturally and Linguistically Competent Staff*

At ACBH, we recognize the importance of diversity and inclusivity in all aspects of our organization, including our staff. That is why we are committed to Criterion 7 of the CLAS standards, which focuses on hiring and retaining culturally and linguistically competent staff, as well as creating a welcoming and inclusive environment for all.

To further this commitment, we have recently added four new positions that reflect our dedication to diversity and inclusion. The Health Equity Officer will work to implement system-wide health equity priorities and departmental change on behalf of a variety of community members. The Forensic Diversion and Re-entry Services Director will help individuals with severe mental illness and substance use disorders understand their behaviors, find alternative resources, and identify potential risk factors that may lead to interactions with the criminal justice system.

The Public Information Officer will be responsible for all internal and external communication strategies and management, with the goal of improving relations between the department and community partners. Finally, the Associate Medical Director will provide leadership and support to the Office of the Medical Director.

By hiring and retaining a diverse and culturally competent workforce, we aim to better serve and represent the cultural diversity of our communities. We believe that this is crucial to keep pace with a constantly changing world and ensure that our organization is truly inclusive and welcoming to all.

The Alameda County Workforce Development, Education & Training (WET) Unit is committed to addressing the ongoing occupational shortages in the public mental health field within the county. To achieve this goal, the WET Unit conducts assessments of the county's needs and capacity to fund various strategies, such as; Academic pipelines, Internships, and Financial Incentive Programs. A consultant has been hired to support this work.

A key collaboration for the WET Unit is with the Office of Ethnic Services, which helps review and evaluate Graduate Intern Stipend Program Applications. This ensures that applicants selected have the necessary skills and qualifications to provide services to consumers in one of the department's threshold languages, such as Spanish or Cantonese. To be eligible for these stipends, applicants must be enrolled in a qualifying school and pursuing a master's degree in a relevant field, such as social work, psychology, or nursing.

In addition to the Graduate Intern Stipend Program, the WET Unit also manages a range of ongoing programs designed to increase diversity and inclusion in the mental health workforce. These programs include, but are not limited to:

- The Community College Career Pathway, which targets ethnically and culturally diverse populations.
- The African American Focused Transitional Aged Youth Academic and Career Pathway Pilot Project; • The Behavioral Health Loan Re-Payment Program; and
- The Undergraduate Scholarship & Mentor Program.

These initiatives demonstrate the WET Unit's commitment to building a diverse and culturally competent workforce in the field of public mental health.

CRITERION 7: *Language Capacity*

At ACBH, we are committed to Criterion 7 of the CLAS standards, which focuses on hiring and retaining culturally and linguistically competent staff. To support this commitment, we continue to offer ongoing interpreter trainings designed to help our staff achieve linguistic competency in our threshold languages. By building a pool of certified and qualified mental health interpreters, we aim to provide effective language interpretation services to consumers and family members at county meetings, trainings, conferences, and throughout the system of care.

Additionally, we have a program called the Underserved and Ethnic Language Population (UELP), which is specifically designed to provide language-specific services to those within our threshold languages. We also have language providers who are responsible for providing high-quality, culturally congruent services to consumers who prefer to receive services in their native language. All these initiatives demonstrate our dedication to ensuring that our organization is inclusive and welcoming to all members of the community, regardless of language or cultural background.

CRITERION 8: *Adaptation of Services*

At ACBH, we are committed to Criterion 8 of the CLAS standards, which focuses on the adaptation of services to meet the needs of diverse populations. We have implemented several *SMART* goals to help us achieve this goal, and we have established specific measures to track our progress and ensure that we are meeting our objectives.

One of our *SMART* goals is to increase the number of language-specific services we offer by 10% over the next year. To measure our progress towards this goal, we will track the number of language-specific services we provide each month and compare it to the number of services we provided in the previous year. This

will allow us to see if we are on track to meet our goal and will also help us identify any challenges or barriers that may be preventing us from making progress.

Another *SMART* goal is to increase the cultural competency of our staff by 10% over the next year. To measure our progress towards this goal, we will administer a cultural competency assessment to all staff at the beginning and end of the year. This will allow us to determine how much our staff's cultural competency has improved over the course of the year and will help us identify any areas where additional training or support may be needed.

Finally, we continue to increase the number of community partnerships we have by 15% over the next year. To measure our progress towards this goal, we will track the number of new partnerships we establish each month and compare it to the number of partnerships we had in the previous year. This will allow us to see if we are on track to meet our goal and will help us identify any challenges or barriers to building new partnerships.

By tracking our progress and measuring our success, we can ensure that we are making progress towards our *SMART* goals and effectively adapting our services to meet the needs of our diverse communities.

Summary

As this report is concluded, it is important to emphasize the significance of considering the eight (8) CRITERIA for Culturally and Linguistically Appropriate Services (CLAS) in all policies and practices. These criteria, including valuing diversity, promoting language access, and engaging in cultural and linguistic competency, are vital for ensuring that responsive and inclusive care is provided to all members of the community. By keeping these principles in mind, efforts can be made towards creating a more equitable and just mental health system for all individuals.

Thank you for taking the time to review this update report. Together with our partners, our system looks forward to continuing to work together to promote CLAS within the organization.

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Alameda County Cultural Responsiveness Committee Alameda
County Health Care Services Agency
California Behavioral Health Solutions Complex Team
County Behavioral Health Directors Association of California (CBHDA); and CBHDA Cultural Competency, Equity, and Social Justice Committee
County of San Mateo, CA
Dr. Khalil Rahmany
Health & Human Resources Education Center
La Familia
Latino/Latinx Advisory Committee
ONTRACK Program Resources
SF Bay Area Ethnic Services Managers Committee

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ACT REVIEW GUIDE

Updated

June 2nd, 2021

Alameda ACT Review Guide

Purpose:

The purpose of this guide is to provide an overview of the key elements of the ACT model and the Fidelity Review process. The Dartmouth Assertive Community Treatment Scale (DACTS) will be used to measure fidelity and is comprised of 28 items over 3 categories. Each item is rated from 1 to 5. The higher the score the higher the Fidelity. The categories are:

(H) Human Resources: Structure & Composition

(O) Organizational Boundaries

(S) Nature of Services

This guide will highlight the basics of the ACT model. To assist you with preparing for a fidelity review this packet also provides the DACTS measurement tool and how each item is scored along with how the data is collected for each item.

The purpose of the fidelity review is to improve upon the quality of services. Our goal is to create and foster a strong collaborative partnership where the best practices can be shared and utilized.

Thank you for all of your efforts and great work!

Table of Contents:

Alameda ACT Review Guide

Background: What is ACT?

Assertive Community Treatment (ACT) is an evidence based practice designed to assist adults with serious mental illness.

- Extensively researched since the 1970's with demonstrated positive outcomes
- Earned the status as an Evidence-Based Practice (EBP) in the 1990's

Philosophy and How to develop Your Team:

The ACT team serves as the single point of responsibility for its consumers. ACT team members work as a group and provide supports based upon the consumer's stated preferences and needs. The team shares responsibility and each member contributes their area of expertise in a way that addresses the consumers agreed upon plan. Additionally, it is expected that all team members become familiar with consumers and receive cross training in order for them to work outside of their areas of expertise as needed.

24/7 Service: An ACT team ensures coverage 24/7 and a live staff member receives calls during afterhours.

Consumer involvement: The people served are involved in decision making about their treatment, and have avenues to take part in program development, implementation, hiring of staff, evaluation and improvement activities.

An ACT team consists of:

- Team Leader (Clinical supervisor)
- Medication prescriber (Psychiatrists, NP, PA)
- Registered Nurses
- Peer Specialist
- Licensed practitioners of the Healing Arts
- Personal Service Coordinators
- Co-occurring Disorder Specialist
- Employment Specialist
- Administrative Support

Role of lead mental health professional (team lead).

- The lead mental health professional is responsible for the supervision of the development of the comprehensive assessment, treatment planning, and delivering services.
- They are mid-level managers responsible for the running of the ACT program.
- Having administrative responsibilities such as hiring, preparing administrative reports, and ensuring that policies and procedures are developed and followed.
- Will also provide direct services to consumers up to 50% of the time.

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**Note: See "Role Descriptions" at the end of this packet for additional team member role descriptions.*

Individual Treatment Team (ITT)

The team within the team. Each consumer has a broad range of goals and service needs. In order to accommodate each individual need, the ACT team members will form Individual Treatment Teams based upon the consumers' unique needs and preferences. These teams are organized based upon the individual's treatment plan.

How to select an Individual Treatment Team (ITT) for consumers.

- Within one week after a new consumer has been admitted into an ACT team. The team leader will assign staff that will be responsible for establishing a relationship with the consumer and provide continuous and integrated services.
- ITT are responsible for:
    - Assessing consumers' status and needs.
    - Initiating the treatment planning process with consumers and families.
    - Providing the majority of consumers' treatment and support services.

Key members of the ITT

- Primary case manager: A mental health professional who coordinates and monitors the activities of the ITT.
    - Primary responsibility to write the treatment plan.
    - Provides individual supportive therapy and illness management education.
    - Ensures immediate revisions to the treatment plan as consumers' needs change.
    - Advocates for consumers' rights and preferences.
- Back up case manager: Also a mental health professional that can be a Licensed Practitioner of the Healing arts, or an MHRS such as; a Personal Service Coordinator, Peer Specialist, Substance Abuse Specialist, and Employment Specialist. Shares tasks related to coordinating care and is responsible for performing them when the primary case manager is absent.
- Psychiatrist (Medical Prescriber): Performs duties that are regularly coordinated and collaborated with the ITT.
- Registered Nurse: Arranges and coordinates consumers' medical care with community medical providers. Nurses may carry out some physical assessments and treatment; however, their primary responsibilities are psychiatric, not medical.
- Other team members: Team members selected to best match consumers' needs and interests. Other team members can include; a Peer specialist, an Employment Specialist, a Substance Abuse Specialist, and a Personal Services Coordinator.
- Weekly Schedule: During the treatment plan development for a consumer and after an ITT is formed, the team is responsible with setting up a weekly schedule specific to the consumer's treatment needs. The weekly schedule can be a mix of phone calls and face to face check-ins from their ITT members within the community per the consumer's preference. The ITT can make adjustments to the weekly schedule as needed to best accommodate the consumer's needs and preferences.

Alameda ACT Review Guide

- *Sample Weekly Consumer Schedule:*

STAFF	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
ACT team Case manager	AM: phone call check in around preparing breakfast			1PM: Weekly Grocery shopping. Meet at home and walk to local store.			8AM: Weekly laundry. Life skills instruction Meet at home
ACT team LPHA			10AM Morning therapy session				
ACT team Employment Specialist					10AM: Meet at coffee shop to apply to jobs		

Daily Team Meeting:

Just before the team's daily meeting, a designated team member checks the *Weekly consumer Schedule* for each consumer that the team serves. The team member enters each scheduled activity for the day in the appropriate time slot. If a particular team member is scheduled to carry out an activity that person's initials are entered next to the activity.

Next, the person who drafts the *Daily Team Schedule* checks for appointments that are not part of the regular activities on the *Weekly Consumer Schedules.* These might be appointments to apply for benefits, follow up on a job lead, or look at an apartment that has become available, activities that the team provides support for, but which do not recur. These are also entered on the *Daily Team Schedule* in the appropriate time slot. If a particular team member should attend the appointment, that person's name is entered next to the activity.

The person who drafts the schedule also checks for crisis situations and consumers who are hospitalized. These are events that the team will respond to, but that are not part of the pre-planned activities or appointments.

The team begins going through its *Communication Log.* A team member calls out each consumer's name. When a name is called, anyone who had contact with that person in the past 24 hours describes the contact, reads their progress note, and talks about the outcome briefly in behavioral terms. By doing this, the team is engaged in a process of continuously adding to the information they learned when doing the comprehensive assessment and timeline and reassessing the effectiveness of the consumer's treatment plan.

During the daily team meeting, if team members report that a consumer is having a difficulty, the team will strategize about how to address the problem if it can be addressed quickly. If the problem is more involved and requires extensive discussion, the team will schedule a separate meeting outside of the daily meeting.

Once all the scheduled activities, special appointments, and any crises response for the current day have been noted, the team will make any changes in the schedule that are needed to ensure that all the things must happen that day are taken care of. For example, as the consumers are discussed, the team may decide that a team member who was initially scheduled to meet with one consumer is needed more urgently to intervene with another. Someone else will have to cover the original appointment.

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Program Meeting should be held 4x a week.

Program Meeting should average 60 minutes and start on time.

Teams should review all members A-Z and then Z-A on alternating days to ensure each member gest equal attention during the program meeting during the week.

Graduation

All ACT consumers are served on a time unlimited basis with fewer than 5% expected to graduate annually. ACT teams should evaluate the consumer's readiness to graduate on an ongoing basis and at minimum addressed in their annual assessment. Team uses explicit criteria for the need to transfer to less intensive services (ACT Graduation Criteria). Transition is gradual and individualized with assured continuity of care and the option to return to the team if needed.

The Fidelity Review:

The fidelity review will be scheduled about a month in advance and typically takes between 1 and 3 days to complete.

The review will consist of:

Team Lead Survey: to be provided to team one month in advance and completed prior to visit. The Team Survey can be found on Pages 11 through 15

- Team interviews
- Daily Team Meeting Observation
- Consumer interviews
- Chart review (10 or 20% of the caseload, whichever is higher).

Dartmouth Assertive Community Treatment Scale (DACTS) for the review ratings. Pages 7 through 9 will list the scale.

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DACTS Item	Rank criteria	Data Sources
H1: Small Caseload client/provider ratio of 10:1	Rank 1: 50 or more:1 ratio Rank 2: 35-49:1 ratio Rank 3: 21-34:1 ratio Rank 4: 11-20:1 ratio Rank 5: 10:1 ratio	Team Survey Staff Interview
H2: Team Approach Provider group functions as a team rather than individual practitioners; clinicians know and work with all clients.	Rank 1: Less than 10% clients with multiple staff face to face contacts in reporting 2 week period. Rank 2: 10-36% clients with multiple staff face to face contacts in reporting 2 week period. Rank 3: 37-63% clients with multiple staff face to face contacts in reporting 2 week period. Rank 4: 64-89% clients with multiple staff face to face contacts in reporting 2 week period. Rank 5: 90% or more clients have face to face contact with >1 member in 2 weeks	Chart Review Log Client Interview Staff Interview
H3: Program Meeting Program meets frequently to plan and review services for each client.	Rank 1: Program service planning for each client occurs at least once/month but less than twice per month. Rank 2: Program service planning for each client occurs at least twice/month but less than once per week. Rank 3: Program service planning for each client occurs at least once/week but less than twice/week. Rank 4: Program service planning for each client occurs at least twice/week but less often than 4 times/week Rank 5: Program meets at least 4 days/week and reviews each client each time, even if only briefly.	Team Observation Team Survey Staff Interview

H4: Practicing Team Leader Supervisor of front line clinicians provides direct services.	Rank 1: Supervisor provides no services. Rank 2: Supervisor provides services on rare occasions as backup. Rank 3: Supervisor provides services routinely as backup, or less than 25% of the time. Rank 4: Supervisor normally provides services between 25% and 50% of the time. Rank 5: Supervisor provides services at least 50% of the time.	Team Survey Team Observation Chart Review Log Team Lead Interview
H5: Continuity of Staffing: Program maintains same staffing over time	Rank 1: Greater than 80% turnover in 2 years Rank 2: 60-80% turnover in 2 years Rank 3: 40-59 % turnover in 2 years Rank 4: 20-39% turnover in 2 years Rank 5: Less than 20% turnover in 2 years	Team Survey Staff Interview
H6: Staff capacity program operations at full staffing	Rank 1: ACT team has operated at less than 50% of staff in the past 12 months Rank 2: 50-64% Rank 3: 65-79% Rank 4: Program has operated at 80-94% in the past 12 months Rank 5: Program has operated at 95% or more of full staffing in the past 12 months	Team Survey

H7: Psychiatrist on Staff there is at least one full time psychiatrist per 100 clients assigned to work with the program	Rank 1: ACT team for 100 clients has less than .10 FTE regular Psychiatrist/Psychiatric prescriber Rank 2: 0.10 – 0.39 FTE per 100 clients	Team Survey Team Lead Interview

	Rank 3: 0.40-0.69 FTE per 100 clients Rank 4: Program for 100 clients has .70 - .99 FTE per 100 clients Rank 5: At least one full time psychiatrist is assigned directly to a 100 client program	Client Interview
H8: Nurse on Staff: There are at least two full time nurses assigned to work with 100 client program.	Rank 1: Act team for 100 clients has less than 0.20 FTE regular nurse. Rank 2: 0.20 – 0.79 FTE per 100 clients Rank 3: 0.80 -1.39 FTE per 100 clients Rank 4: 1.4 to 1.99 FTE per 100 clients Rank 5: two full time nurses or more are members of a 100 client program.	Team Survey Client Interview
H9: Co-occurring disorders specialist on staff a 100 client program includes at least two staff members with 1 year of training or clinical experience in co-occurring disorders treatment.	Rank 1: ACT team has less than 0.20 FTE Co-occurring disorders specialist per 100 clients Rank 2: 0.20 -0.79 FTE per 100 clients Rank 3: 0.80 – 1.39 FTE per 100 clients Rank 4: 1.4 to 1.99 per 100 clients Rank 5: Two FTEs or more with 1 year S/A training or supervised S/A experience	Team Survey
H10: Employment Specialist on Staff The program includes at least two staff members with 1 year training/experience in employment and educational services and support.	Rank 1: Act team has less than 0.20 FTE Employment specialist per 100 clients. Rank 2: 0.20 – 0.79 FTE per 100 clients Rank 3: 0.80 – 1.39 FTE per 100 clients Rank 4: 1.4 -1.99 FTE per 100 clients Rank 5: Two FTEs or more with 1 year voc rehab training or supervised VR experience.	Team Survey

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H11: Program Size program is sufficient absolute size to provide consistently the necessary staffing diversity and coverage	Rank 1: Act team has fewer than 2.5 FTE staff Rank 2: 2.5 -4.9 FTE Rank 3: 5.0 – 7.4 Rank 4: Program has 7.5 – 9.9 FTE staff Rank 5: Program has at least 10 FTE Staff.	Team Survey
O1: Explicit Admission Criteria Program has clearly identified mission to serve a particular population and has and uses measurable and operationally defined criteria to screen out inappropriate referrals.	Rank 1: Act team has no set criteria and takes all types of cases as determined outside the ACT team Rank 2: ACT team has a generally defined mission but the admission process is dominated by organizational convenience. Rank 3: Act team makes an effort to seek and select a defined set of clients but accepts most referrals. Rank 4: Program typically actively seeks and screens referrals carefully but occasionally bows to organizational pressure. Rank 5: The program actively recruits a defined population and all cases comply with explicit admission criteria.	Chart Review Log Team Lead Interview
O2: Intake Rate program takes clients in at a low rate to maintain stable service environment.	Rank 1: Highest monthly intake rate in the last 6 months = greater than 15 clients/month. Rank 2: 13-15 Rank 3: 10-12 Rank 4 Highest monthly intake rate in the last 6 months is 7 to 9. Rank 5: Highest monthly intake rate in the last 6 months is no greater than 6 clients per month.	Team Survey

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O3: Full responsibility for treatment services in addition to case management, program directly provides psychiatric services, counseling/psychotherapy, housing support, integrated treatment for co-occurring disorders, employment/rehabilitative services.	Rank 1: Act team provides no more than case management services. Rank 2: Act team provides one of the five additional services and refers externally for others. Rank 3: Act team provides two of the five additional services and refers externally for others. Rank 4: Program provides three or four of five additional services and refers externally for others. Rank 5: Program provides all five of these services to clients.	Team observation Team lead interview Chart review Log Client interview
O4: Responsibility for Crisis Services Program has 24 hour responsibility for covering psychiatric crises	Rank 1: Act team has no responsibility for handling crises after hours. Rank 2: Emergency service has Act team generated protocol for ACT clients. Rank 3: Act team is available by telephone, predominantly in consulting role. Rank 4: Program provides emergency service backup, e.g program is called, makes decision about need for direct program involvement. Rank 5: Program provides 24 hour coverage.	Team Survey Team lead Interview
O5: Responsibility for Hospital Admissions Program is involved in hospital admissions	Rank 1: Act team has involvement in fewer than 5% decisions to hospitalize. Rank 2: ACT team is involved in 5 – 34% of admissions. Rank 3: Act team is involved in 35 – 64% of admissions. Rank 4: team is involved in 65 – 94% of admissions Rank 5: Team is involved in 95% or more admissions	Team Survey Team Lead Interview Staff Interview
O6: Responsibility for hospital discharge planning	Rank 1: Act team has involvement in fewer than 5% of hospital discharges. Rank 2: Act team has involvement in 5-34% of hospital discharges Rank 3: Act team is involved with 35-64% of hospital discharges Rank 4: 65-94% of program client discharges are planned jointly with the program	Team Survey Team Lead Interview Staff Interview

	Rank 5: 95% or more discharges are planned jointly with the program	
O7: Time unlimited services (Graduation rate) Program rarely closes cases but remains the point of contact for all clients as needed.	Rank 1: More than 90% of clients are discharged within 1 year. Rank 2: From 38-90% of clients are discharged within 1 year. Rank 3: From 18-37% of clients are discharged within 1 year. Rank 4: 5-17% of clients are expected to be discharged within 1 year Rank 5: All clients are served on a time unlimited basis, with fewer than 5% expected to graduate annually.	Team Survey
S1: Community Based Services Program works to monitor status, develop community living skills in the community rather than the office	Rank 1: Less than 20% of face to face contacts I community. Rank 2: 20 -39% Rank 3: 40-59% Rank 4: 60-79% face to face in the community Rank 5: 80% of total face to face contacts in the community.	Chart Review Log Client interview
S2: No dropout policy Retains high percentage of consumers	Rank 1: Less than 50% of the caseload is retained over a 12 month period. Rank 2: 50-64% Rank 3: 65-79% Rank 4: 80-94% of caseload is retained over a 12 month period Rank 5: 95% or more of the caseload is retained over a 12 month period	Team Survey

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S3: Assertive Engagement Mechanisms as part of assuring engagement, program uses street outreach, as well as legal mechanisms (e.g probation/parole, OP commitment) as indicated and as available.	Rank 1: Act Team passive in recruitment and re-engagement; almost never uses street outreach legal mechanisms. Rank 2: ACT tea makes initial attempts to engage but generally focuses efforts on most motivated clients. Rank 3: ACT team attempts outreach and uses legal mechanisms only as convenient. Rank 4: Program usually has plan for engagement and uses most of the mechanisms that are available Rank 5: Program demonstrates consistently well thought-out strategies and uses street outreach and legal mechanisms whenever appropriate.	Team Survey Team Lead Interview Daily Team Meeting Observation Client interview
S4: Intensity of service High total amount of service time as needed	Rank 1: Average of less than 15 min/week or less of face to face contact per client. Rank 2: 15-49 Minutes/week Rank 3: 50-84 minutes/week Rank 4: 85-119 minutes / week average of face to face contact per client Rank 5: Average of 2 hours/week or more of face to face contact per client	Chart Review Log
S5: Frequency of Contact High number of service contacts as needed	Rank 1: Average of less than 1 face to face contact/ week or fewer per client. Rank 2: 1.0 – 1.99 / week. Rank 3: 2.00 to 2.99 Rank 4: 3.00 – 3.99 face to face contacts per week Rank 5: average of 4 or more face to face contacts per week per client	Chart Review Log
S6: Work with informal support system with or without client present, program provides support and skills for client's support network: family, landlords, employers	Rank 1: Less than 0.5 contact per month per client with support system. Rank 2: 0.50 – 0.99 contact per month per client with support system in the community. Rank 3: 1.00 – 1.99 contact per month per client with support system in the community. Rank 4: 2-3.99 contacts per months per client with support system in the community	Chart Review Log Client Interview Staff Interview

	Rank 5: four or more contacts per month per client with support system in the community	
S7: Individualized substance abuse Treatment	Rank 1: No direct individualized substance abuse treatment is provided by the team. Rank 2: The team variably addresses SA concerns with clients; no formal individualized SA treatment provided. Rank 3: While the team integrates some substance abuse treatment into regular client contact, they provide no formal, individualized SA treatment. Rank 4: Some formal individualized SA treatment is offered; clients with substance use disorders spend less than 24 minutes/week in such treatment Rank 5: Clients with substance use disorders spend, on average, 24 minutes/week or more in formal substance abuse treatment.	Chart Review Log
S8: Co-occurring disorder treatment groups	Rank 1: Fewer than 5% of the clients with substance use disorders attend at least one substance abuse treatment group meeting during a month. Rank 2: 5-19% Rank 3: 20-34% Rank 4: 35-49% of clients with substance use disorders attend at least one substance abuse treatment group meeting during a month. Rank 5: 50% or more of the clients with substance use disorders attend at least one substance abuse treatment group meeting during a month.	Client Interview Team Lead Interview Chart review log
S9: dual disorders Model	Rank 1: ACT team fully based on traditional model; confrontation; mandated abstinence; higher power etc. Rank 2: ACT team uses primarily traditional model: E.g., refers to AA; uses inpatient detox & rehabilitation; recognizes need for motivation of clients in denial or who don't fit AA. Rank 3: Act team uses mixed model: e.g., DD principles in treatment plans; refers clients to motivation groups; uses hospitalization for rehab; refers to AA, NA.	Team lead interview

	Rank 4: ACT team uses primarily DD model: e.g., DD principles in treatment plans; motivation and active treatment groups rarely hospitalizes for rehab. Or detox except for medical necessity refers out some s/a treatment. Rank 5: ACT Team fully based in DD treatment principles with treatment provided by ACT team staff.	
S10: Role of consumers on team	Rank 1: Consumers have no involvement in service provision in relation to the ACT team. Rank 2: Consumers fill consumer specific service roles with respect to ACT team. (e.g., self-help). Rank 3: Consumers work part time in case management roles with reduced responsibilities. Rank 4: Consumers work full time in case management roles with reduced responsibilities. Rank 5: Consumers employed full time as ACT team members (E.g case managers) with full professional status.	Team Survey Client Interview

ACT TEAM SURVEY: (To be completed by Team Lead) *Note: Items in [ ] represent the DACTS Items

Team Name:	Click here to enter text.				
Team leader	Click here to enter text.	Year of Team Start up	Click here to enter text.	Today's Date	Click here to enter text.

Please answer each question about your ACT team as best as you can.

ACT TEAM STAFFING

[H1. H3, H7, H8, H9, H10, H11, S10]

Please list staff that are currently working and staff that have left the team within the last 2 years. (Or from when the program started for newer teams).

Staff Name	Position	FTE *(1.0 = 40 hours worked per week)*	Date of Hire	End Date if applicable	Daily Team Meetings per week.	More than 90 on leave prior to review yes / no?
Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.
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Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.	Click here to enter text.

1. How many consumers are served by the team?	Click here to enter text.
For reviewer: (# of clients presently served / (#FTE staff)	
(B) How many times per week do you have a Daily Team Meeting? [H3]	Click here to enter text.
(C) Do you review all the consumers during each team meeting?	Click here to enter Yes or No
(1) If no, how many days per week do you cover all consumers?	Click here to enter text.
(D) How many months or years of supervised experience does your Co-Occurring Disorders Specialist have? (List for each specialist)	Click here to enter text.
(E) How many months or years of supervised experience does your Employment Specialist have? (List for each specialist)	Click here to enter text.
2. Do you (Team Leader) provide services to clients? [H4]	Click here to enter Yes or No
(A) How many hours per week is devoted to direct services?	Click here to enter text.
3. How many positions does your team currently have? [H5]	Click here to enter text.
For reviewer: If team is younger than two years. Use the following formula: (# staff who worked on the team in the last 2 years) – (total # of positions)/Total number of positions X 12 / 24 (for # of months team has been in existence if less than 24 months)	Click here to enter text.

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Example: There were 20 staff workers who occupied the 9 line positions at West over 24 months, compared with 7 staff workers for 5 line positions at South over 23 months. The "annual turnover rate" was 61.1% for West verses 20.9% for South *WEST: [(20-9)/9 x 12/24] = 61.1%* *South: [(7-5)/5 x 12/23] = 20.9*	

4. Please list all ACT Team positions and when they were opened. Please list the number of months that they were vacant within the last 12 months for each position. Even if they are currently filled.

Table 2. ACT Staff Vacancies

Position	Date Opened	Total of Months vacant	Currently held by:
Position Name	Click here to enter text.	Click here to enter text.	Click here to enter text.
Position Name	Click here to enter text.	Click here to enter text.	Click here to enter text.
Position Name	Click here to enter text.	Click here to enter text.	Click here to enter text.
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Table 2. ACT Staff Vacancies

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Position Name	Click here to enter text.	Click here to enter text.	Click here to enter text.
Position Name	Click here to enter text.	Click here to enter text.	Click here to enter text.
Position Name	Click here to enter text.	Click here to enter text.	Click here to enter text.
Position Name	Click here to enter text.	Click here to enter text.	Click here to enter text.

For reviewer: To calculate staff capacity % use following formula:

100 – [100*{total months of vacancies/{Total # staff positions x 12 months}]

To calculate total months: Total number of days position was vacant / 30 days = months of vacancies

5. How many clients did your team intake per month for the last six months? [O2]

Last six months from fidelity review	Number of intakes
Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.

Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.
For Reviewer: Check and cross reference with intake logs	
6. What 24 hour emergency services are available for ACT clients? [O4]	Click here to enter text.
Can you provide a call log? If yes, please attach a copy.	Click here to enter text.
(A) Which ACT team members are responsible for managing the ACT team's Emergency Services?	
Team Member	Role
Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.
Please Describe your staffing and scheduling patterns:	
Click here to enter text.	

7. Please list the last 10 hospital admissions (PES, Inpatient & Medical Hospitals MHS 140). [05, 06]

*Involvement in Admission and Discharge is defined has having a face to face service during the date of admission or discharge.

Client identifier	Date of Admission	Team involved in appropriate admission? Enter yes or no	Team member name/role	Team involved with hospital for discharge planning?
Click here to enter text.	Click here to enter text.	Click here to enter Yes or No	Click here to enter text.	Click here to enter text.

Click here to enter text.	Click here to enter text.	Click here to enter Yes or No	Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.	Click here to enter Yes or No	Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.	Click here to enter Yes or No	Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.	Click here to enter Yes or No	Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.	Click here to enter Yes or No	Click here to enter text.	Click here to enter text.
Click here to enter text.	Click here to enter text.	Click here to enter Yes or No	Click here to enter text.	Click here to enter text.
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8. Does your team use a level or step-down system for clients who no longer required intensive services? [07]	Click here to enter Yes or No
(A) If yes, please describe the step down criteria below:	
Click here to enter text.	

(B) Please provide a list of the consumers that were discharged from your ACT program within the last 12 months. [O7, S2]

Consumer identifier	Date Discharged	Consumer discharged due to moving out of the team's service area?	*If consumer moved out of service area, was a referral made to ACT services?	Was the consumer closed due to an extended inpatient hospitalization? Group home, nursing home and jail?	Was the consumer closed due to moving to a lower level of outpatient care?	Case closed due to Whereabouts unknown?	Case closed due to death?
Click here to enter text.	Click here to enter text.	Click here to enter Yes or No	Click here to enter Yes or No	Click here to enter Yes or No	Click here to enter Yes or No	Click here to enter Yes or No	Click here to enter Yes or No
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Alameda ACT Review Guide

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For Reviewer:

(Total # of ACT clients served by the team over the past 12 months) - (# of clients discharged, dropped, moved without referral) /(total # of ACT clients served by the team over the past 12 months) X 100

9. Do you have a formal written Assertive Engagement Strategy for consumers that are: 1) Unengaged, 2) tentatively engaged, talking with staff but not interested in services, 3) missing or otherwise unable to be located, or 4) not responding to attempts to contact?	Click here to enter Yes or No
(A) If yes, please describe [S3]	Click here to enter text.

Chart Review Log (Client Contacts Full sample, randomly select 10 clients). [H2, O1, O3, S1, S4, S5, S6]

Team Name:			Reviewer Name:		Selected 4 week period for Review:	
Unique Client ID:			Psychiatric Diagnoses:		Average # of Minutes / week	
Date & # minutes seen	Face to Face? Yes or No	Minutes Face to Face	Face to Face Contact in the community?	Team Member and Role	Natural Support contact?	Briefly note content and quality of contact. Include contact with natural supports (persons not paid to support client such as family, landlord, shelter staff, employer or other key person).
Week 1 totals:		Total community f2f		Total Natural Support		Weekly Average F2F contacts:
Date & # minutes seen	Face to Face? Yes or No	Minutes Face to Face	Face to Face Contact in the community?	Team Member and Role	Natural Support contact?	Briefly note content and quality of contact. Include contact with natural supports (persons not paid to support client such as family, landlord, shelter staff, employer or other key person).
Week 2totals:		Total community f2f		Total Natural Support		Weekly Average F2F contacts:
Date & # minutes seen	Face to Face? Yes or No	Minutes Face to Face	Face to Face Contact in the community?	Team Member and Role	Natural Support contact?	Briefly note content and quality of contact. Include contact with natural supports (persons not paid to support client such as family, landlord, shelter staff, employer or other key person).

Alameda ACT Review Guide

Week 3 totals:		Total community f2f		Total Natural Support		Weekly Average F2F contacts:
Date & # minutes seen	Face to Face? Yes or No	Minutes Face to Face	Face to Face Contact in the community?	Team Member and Role	Natural Support contact?	Briefly note content and quality of contact. Include contact with natural supports (persons not paid to support client such as family, landlord, shelter staff, employer or other key person).
Week 4 totals:		Total community f2f		Total Natural Support		Weekly Average F2F contacts:

ROLE DESCRIPTIONS:

TEAM LEADER

The ACT team leader serves in three overlapping roles according to three functions within the team: (1) Administrative, (2) Supervisory, and (3) Clinical.

Administrative Role:

- Directs day to day team operations
- Available to facilitate the day's operations in a supportive manner to both the team and consumers
- Schedules staff work hours to assure full coverage
- Leads daily team meetings and other weekly clinical and administrative meetings
- Leads staff recruitment, interviewing, hiring, orientation, and performance planning
- Assist in compiling and reporting contract deliverables

Supervisory Role:

Provides weekly group and/or individual supervision to other ACT team members (excluding the psychiatric care provider/prescriber). Per ACT fidelity standards, clinical supervision typically includes any of the following activities, as long as it is at least 20 minutes in duration (impromptu or scheduled):

- Case based consultation
- Field mentoring
- Review of clinical documentation and tools
- Didactic teaching/training

Clinical Role:

Provides direct services approximately 20 hours a week. Per ACT fidelity standards, the Team Lead directs clinical services that include:

- Face to face or phone service provision with consumers and/or natural supports
- Treatment planning with consumer and/or natural supports present
- Screening and assessment

ADMINSTRATIVE SUPPORT

The Administrative Support provides administrative support to the team. Key responsibilities can include:

- Data entry for Medi-Cal billing
- Managing phones and faxes and mail
- Coordinate office supplies and track client expenditures

- Verify Medi-Cal eligibility
- Manage office environment

PSYCHIATRIC CARE PROVIDER/ MEDICATION PRESCRIBER

The psychiatric prescriber serves as the medical director for the team. Key responsibilities can include:

- Medication monitoring
- Participates in treatment planning
- One day per week to provide services in the community
- Coordination and consultation with outside medical and psychiatric providers
- Delivers brief therapy
- Provides education to consumers, with medication decisions largely based on shared decision-making paradigm
- Is aware of non-psychiatric medical conditions and medications
- Communicates with inpatient team when consumers are hospitalized
- Educates non-medical staff by providing psychiatric/medical cross-training (e.g., an overview of psychotropic medications, anticipated results and possible side effects; medical issues facing current consumers and what to look for/do if problems are exacerbated)
- Collaborates with team nurses in assessing physical health and coordinating medical and psychiatric treatment

REGISTERED NURSE(S)

Registered nurses are full members of the team and may provide the following:

- Conduct home and field visits
- Participate in treatment planning and the daily team meetings
- Administer needed medications
- Serve to educate the team about important medication issues
- Coordinate care with outside medical providers, hospitals, pharmacies, labs and other health related service providers
- Engage in health prevention, and education activities
- Educate other team members to help them monitor psychiatric symptoms and medication side effects
- When consumers are in agreement, develop strategies that maximize the taking of medications as prescribed

EMPLOYMENT SPECIALIST

Employment Specialists should be available for modeling skills and consultation, cross training to other staff on the team to help them develop Supported Employment approaches, attending all program meetings during work days,

attending treatment planning meetings and Individual Treatment Team meetings with consumers who have employment goals.

- Engagement
- Vocational assessment
- Job development
- Pre-employment services
- Acts as a liaison with employers
- Educations employers regarding inclusive workforce practices and tax incentives
- Job placement (including going back to school, classes)
- Job Coaching & Follow-along supports (including supports in academic setting)
- Benefits counseling
- Support employment
- Honoring and exercising core principles of the Individual Placement and Support model of Supported Employment

PEER SPECIALIST

- Uses their lived experience to help guide treatment and be an active voice for recovery
- Coaching and consultation to consumers to promote recovery and self-direction.
- Facilitating wellness management and recovery strategies (examples; Wellness Recovery Action Plans (WRAP), Illness Management and Recovery (IMR), and other wellness management strategies.
- Participate in all team activities' (treatment planning, chart notes), and has equivalent professional status as other team members.
- Modeling skills for and providing consultation to fellow team members
- Provide cross training to other team members and recovery principals and strategies

LICENSED PRACTIONER OF THE HEALING ARTS

- May take on a higher caseload as "primary"
- Takes the lead in providing psychotherapy
    - Typically empirically-based treatment following a Cognitive Behavioral Therapy (CBT) approach (e.g., CBT for psychosis).
- May take the lead in providing and/or cross-training the rest of the team in psychiatric rehabilitation services/skills training:
    - These services focus on targeted skills training in the areas of community living, which includes skills needed to maintain independent living (e.g., shopping, cooking, cleaning, budgeting, and transportation) and socialization (e.g., enhancing social and/or romantic relationships, recreational and leisure pursuits that contribute to community integration).
    - Psychiatric rehabilitation should address functional deficits as well as the lack of necessary resources, all of which are identified through the assessment process.
    - As such, deliberate and consistent skills training which typically includes staff demonstration, consumer practice/role-plays, and staff feedback, as well as ongoing prompting and cueing for learned skills in more generalized settings.

PERSONAL SERVICE COORDINATOR (PSC)

- May have a higher caseload
- Provides both case management and psychiatric rehabilitation services
- Case management services may include: social and recreational, housing, finances, entitlement and resource acquisition, self-care, and housekeeping tasks; advocates on consumers' behalf, and assists in acquiring resources.
- May take the lead in providing and/or cross-training the rest of the team in psychiatric rehabilitation services/skills training:
    - These services focus on targeted skills training in the areas of community living, which includes skills needed to maintain independent living (e.g., shopping, cooking, cleaning, budgeting, and transportation) and socialization (e.g., enhancing social and/or romantic relationships, recreational and leisure pursuits that contribute to community integration).
    - Psychiatric rehabilitation should address functional deficits as well as the lack of necessary resources, all of which are identified through the assessment process.
    - As such, deliberate and consistent skills training which typically includes staff demonstration, consumer practice/role-plays, and staff feedback, as well as ongoing prompting and cueing for learned skills in more generalized settings.

PEI Participant Satisfaction and Pre-Post Health Assessment Surveys

ACBH used an electronic survey in the calendar year 2023 to assess participant satisfaction across the PEI program portfolio. The optional Participant Satisfaction Survey was offered to all Underserved Ethnic and Language Program (UELP)[1] participants who had received four or more services (including preventive counseling, community events, workshops, support groups, and prevention visits) from February to June 2023, and to all PEI program participants who received services between February and June 2023. 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.

UELP participants receive the Health Assessment Pre-Survey at the start of services. They complete a post-survey when their program participation ends. While the PEI Participant Survey measures satisfaction as a snapshot in time, the Health Assessment measures change over time for participants because of their exposure to UELP programming. In 2022, providers requested to extend the survey from several months to year-round to increase the number of completed post-surveys from individuals who participate in services for an extended period.

PEI contracted providers ACBH staff collaborated in a workgroup to design the survey and the implementation process in 2020. 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.

Following the survey period across calendar years 2021 and 2022, ACBH staff invited representative providers to re-convene the survey workgroup to evaluate the efficacy of the process, to update and clarify survey questions, and to understand the value-add of surveying for staff and their agencies. The workgroup is currently meeting. Its recommendations and insights will directly inform the survey process and outcomes in 2024.

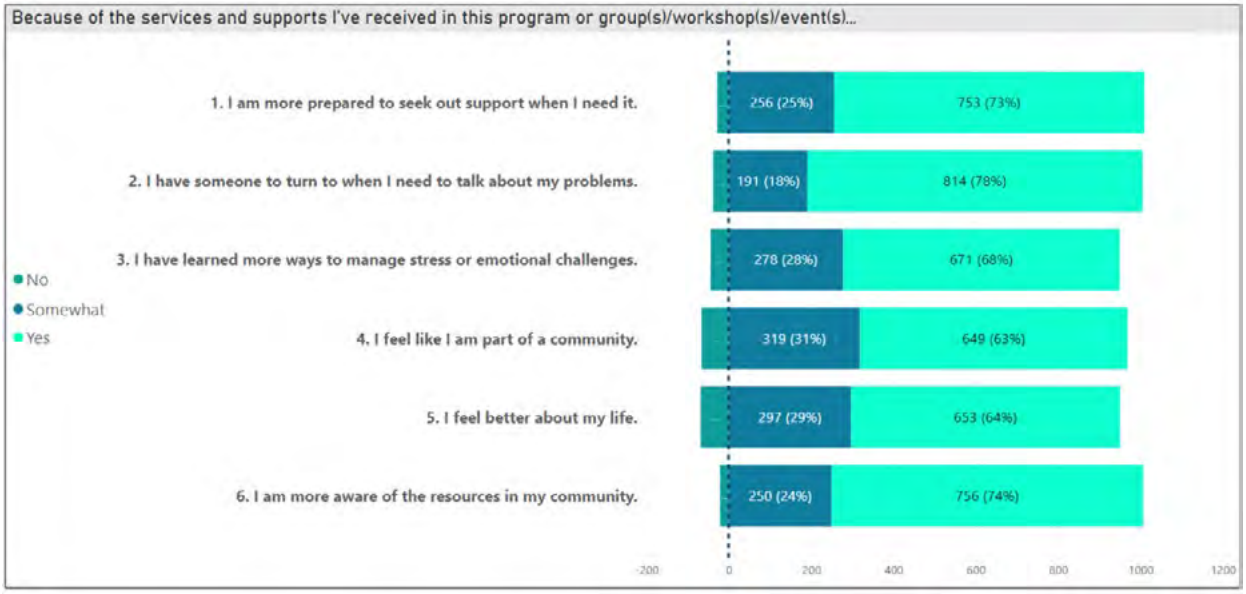
Providers collected 1,552 Participant Satisfaction surveys during the 2023 assessment period. Providers collected 173 completed UELP Pre/Post Health Assessment surveys during the 2023

[1] 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.

assessment period.

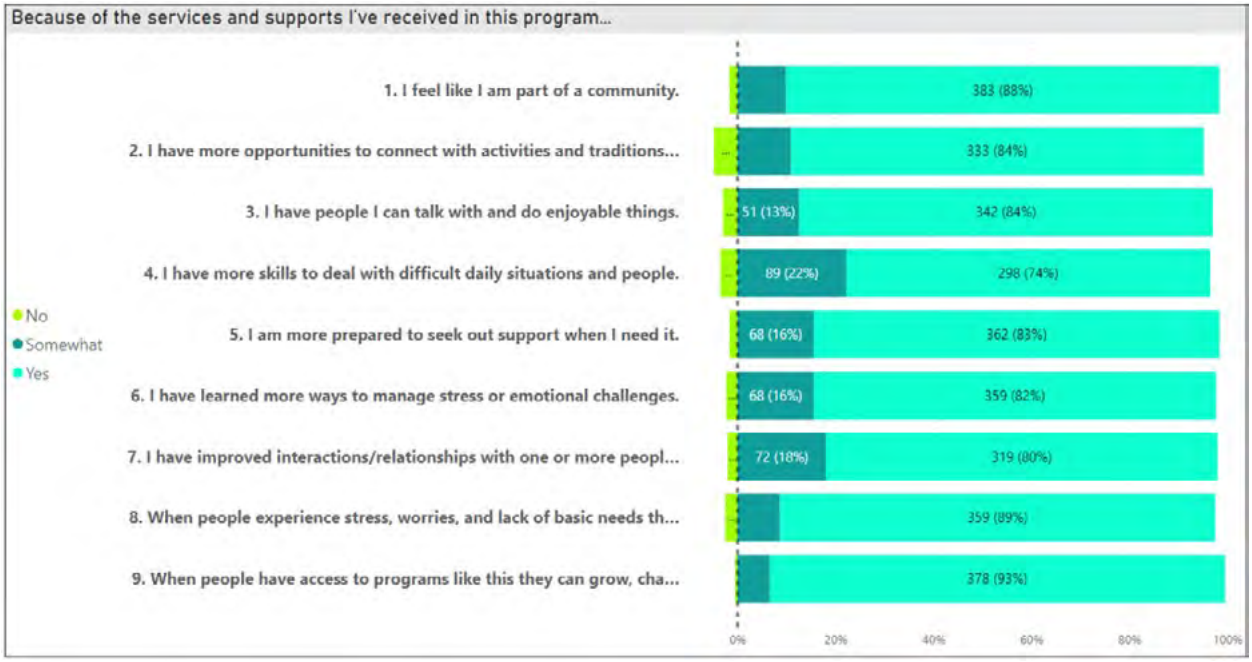
Data from both surveys is represented below:

PEI Participant Satisfaction Survey Results



Statement	# No	% No	# Somewhat	% Somewhat	# Yes	% Yes
1. I am more prepared to seek out support when I need it.	28	3%	256	25%	753	73%
2. I have someone to turn to when I need to talk about my problems.	38	4%	191	18%	814	78%
3. I have learned more ways to manage stress or emotional challenges.	44	4%	278	28%	671	68%
4. I feel like I am part of a community.	66	6%	319	31%	649	63%
5. I feel better about my life.	68	7%	297	29%	653	64%
6. I am more aware of the resources in my community.	21	2%	250	24%	756	74%

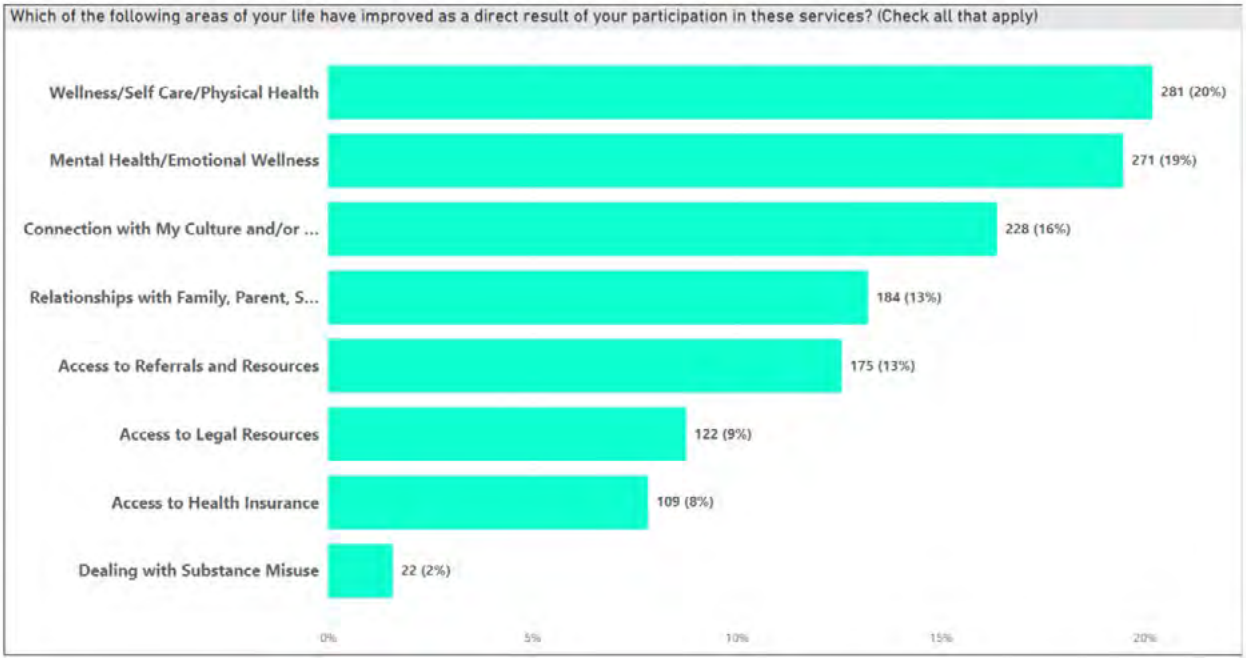
UELP Participant Satisfaction Survey



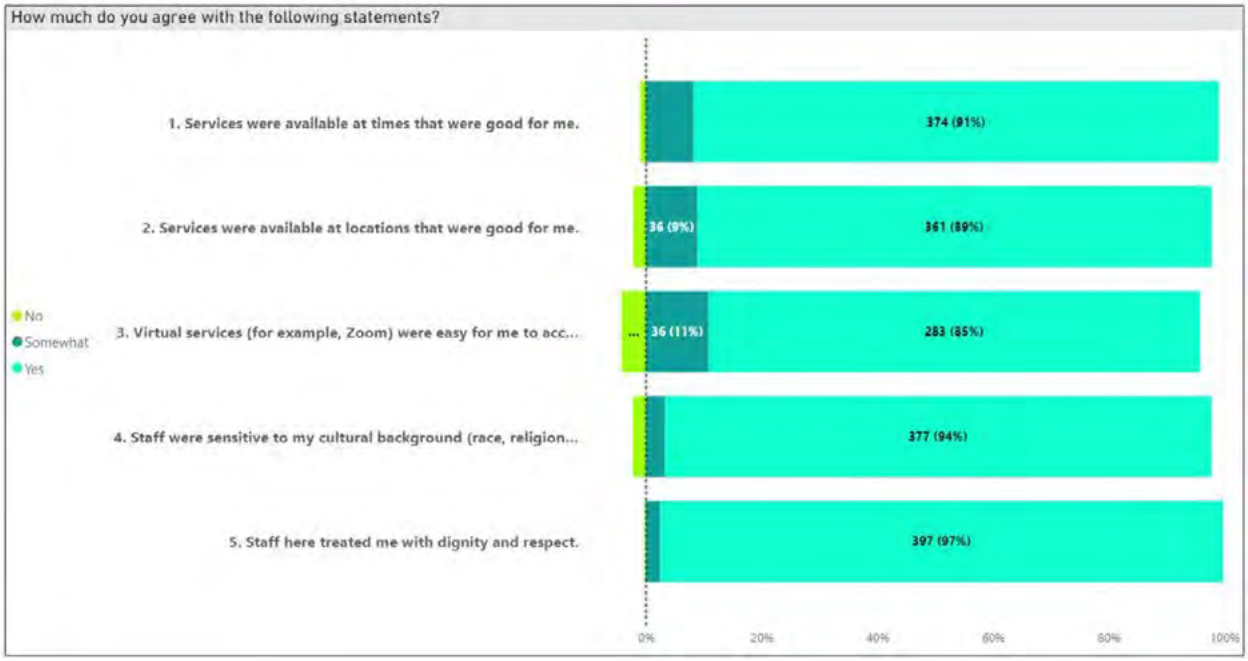
Question	% No	% Somewhat	% Yes
1. I feel like I am part of a community.	1.62%	9.93%	88.45%
2. I have more opportunities to connect with activities and traditions from my culture.	4.81%	10.89%	84.30%
3. I have people I can talk with and do enjoyable things.	2.96%	12.59%	84.44%
4. I have more skills to deal with difficult daily situations and people.	3.49%	22.19%	74.31%
5. I am more prepared to seek out support when I need it.	1.60%	15.56%	82.84%
6. I have learned more ways to manage stress or emotional challenges.	2.29%	15.56%	82.15%
7. I have improved interactions/relationships with one or more people in my family.	2.01%	18.05%	79.95%
8. When people experience stress, worries, and lack of basic needs their mental health or emotional wellness is affected.	2.48%	8.66%	88.86%
9. When people have access to programs like this they can grow, change, and improve their emotional wellness and mental health.	0.49%	6.63%	92.87%

Appendix

UELP Participant Satisfaction Survey

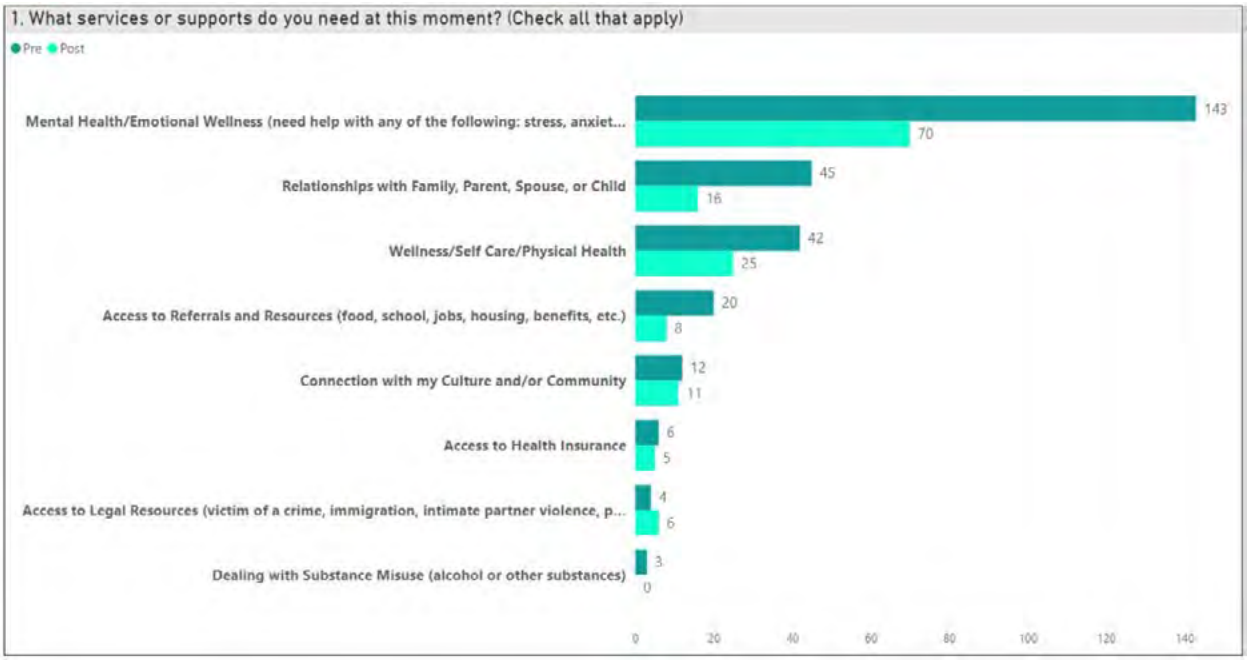


Improvements	% Respondents
Wellness/Self Care/Physical Health	20%
Mental Health/Emotional Wellness	19%
Connection with My Culture and/or Community	16%
Relationships with Family, Parent, Spouse, or Child	13%
Access to Referrals and Resources	13%
Access to Legal Resources	9%
Access to Health Insurance	8%
Dealing with Substance Misuse	2%
Total	**100%**



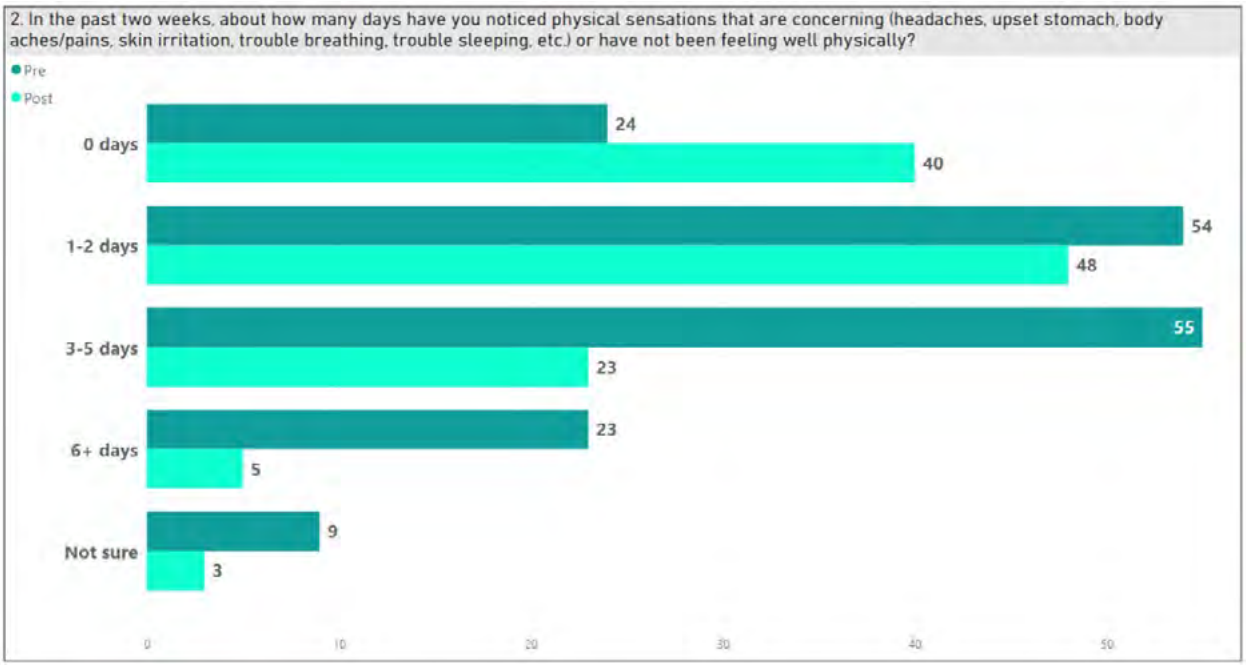
Statement	No	Somewhat	Yes
1. Services were available at times that were good for me.	0.97%	8.25%	90.78%
2. Services were available at locations that were good for me.	2.22%	8.87%	88.92%
3. Virtual services (for example, Zoom) were easy for me to access.	4.20%	10.81%	84.98%
4. Staff were sensitive to my cultural background (race, religion, language, etc.).	2.26%	3.26%	94.49%
5. Staff here treated me with dignity and respect.	0.25%	2.45%	97.30%

Health Assessment Survey Results (Across all UELP Programs)

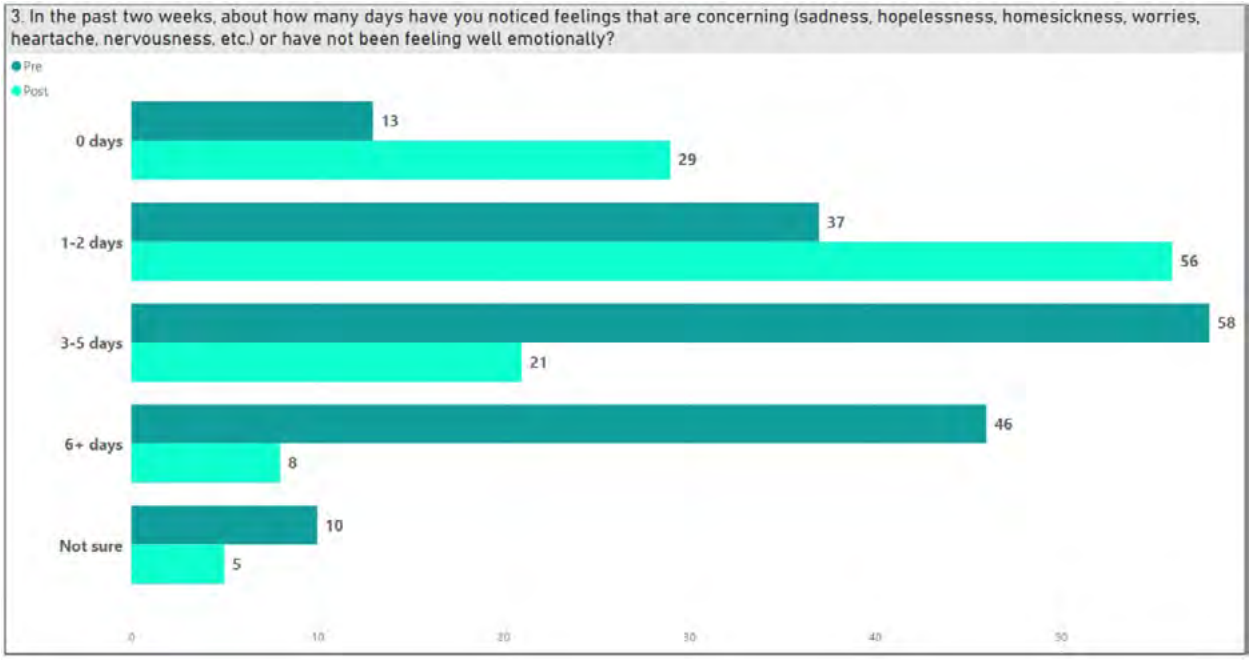


1. What services or supports do you need at this moment? (Check all that apply)

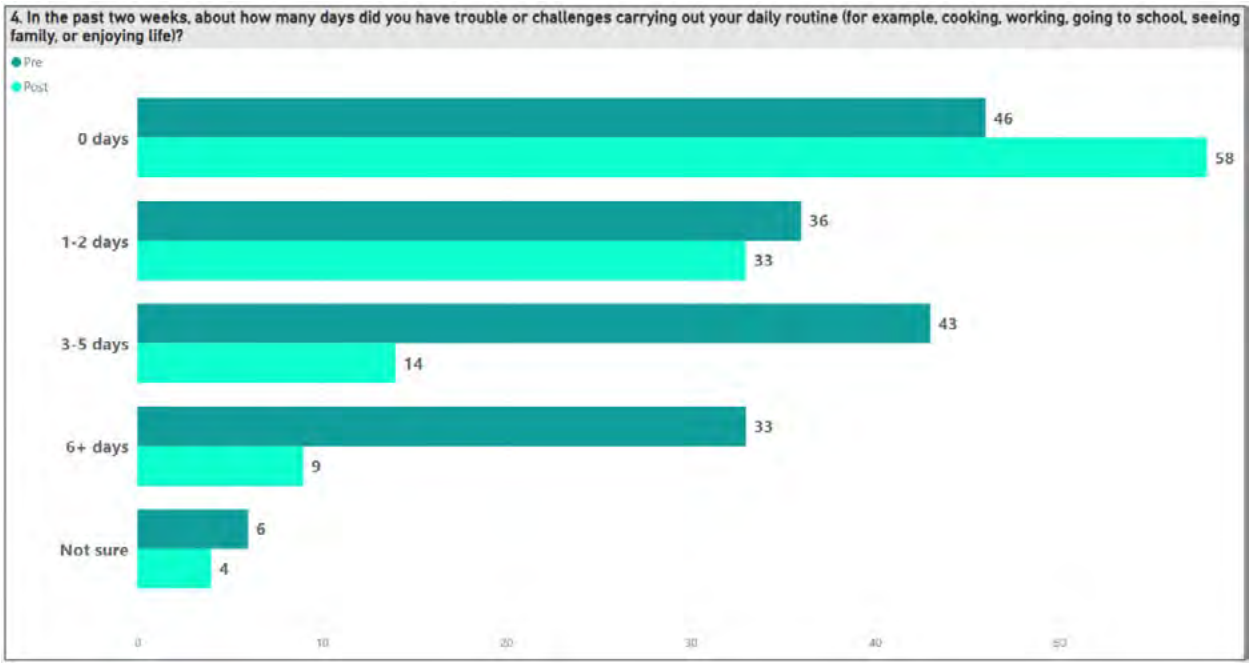
Question	Pre	Post
Mental Health/Emotional Wellness (need help with any of the following: stress, anxiety, depression, self-harm, grief, fear, etc.)	143	70
Relationships with Family, Parent, Spouse, or Child	45	16
Wellness/Self Care/Physical Health	42	25
Access to Referrals and Resources (food, school, jobs, housing, benefits, etc.)	20	8
Connection with my Culture and/or Community	12	11
Access to Health Insurance	6	5
Access to Legal Resources (victim of a crime, immigration, intimate partner violence, probation, etc.)	4	6
Dealing with Substance Misuse (alcohol or other substances)	3	0



2. In the past two weeks, about how many days have you noticed physical sensations that are concerning (headaches, upset stomach, body aches/pains, skin irritation, trouble breathing, trouble sleeping, etc.) or have not been feeling well physically?	Post	Pre
0 days	40	24
1-2 days	48	54
3-5 days	23	55
6+ days	5	23
Not sure	3	9



3. In the past two weeks, about how many days have you noticed feelings that are concerning (sadness, hopelessness, homesickness, worries, heartache, nervousness, etc.) or have not been feeling well emotionally?	Post	Pre	Total
0 days	29	13	**42**
1-2 days	56	37	**93**
3-5 days	21	58	**79**
6+ days	8	46	**54**
Not sure	5	10	**15**



4. In the past two weeks, about how many days did you have trouble or challenges carrying out your daily routine (for example, cooking, working, going to school, seeing family, or enjoying life)?	Post	Pre
0 days	58	46
1-2 days	33	36
3-5 days	14	43
6+ days	9	33
Not sure	4	6

Prevention and Early Intervention | *"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 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.

[1] Proposition 63: Mental Health Services Act 2004
[2] MHSOAC PEI Fact Sheet, December 2017

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), 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

[3] MHSOAC Memo, January 30, 2020

Prevention and Early Intervention Strategies and Priorities[4]

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.

[4] 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-BL SKY 6-AHS 6-CERI 7-AFGHAN 8-NAHC		1C-JFCS		1B-CHSC	
EARLY PSYCHOSIS & MOOD DISORDERS						
	6-AHS 6-CERI	17B-REACH			1B-CHSC	
YOUTH OUTREACH & ENGAGEMENT						
	6-AHS 6-CERI 6-BACH 6-RAMS 7-AFGHAN 7-FAJ 7-HUME 8-NAHC 19-DHTI 1D LA FAM 20A-BRL 20F-RJOY 20E-TRI CIT 20E-PEERSAA 28-HHREC TAY	17A-YU 17B-REACH 24-ROOTS SP	22-MENTOR	4-PEERS-ECC	1B-CHSC	12 CSS-Text 12 CSS-Ed
CULTURE AND LINGUISTIC						
	5-LA CLIN 6-AHS 6-CERI 6-BACH 6-RAMS 6-KCCEB 7-AFGHAN 7-FAJ 7-IRC 7-HUME 8-NAHC 10-PTR 19-DHTI 1D-LA FAM 20A-BRL 20B-BMS 20C-MHAAC 20F-RJOY 20E-TRI CIT 20E-PEERSAA 26-HHREC 10 27-HHREC		1C-JFCS 20C-MHAAC 22-PC TA 28-HHREC TAY	4-PEERS-ECC		
OLDER ADULTS						
	6-BACH 6-RAMS 7-AFGHAN 7-FAJ 7-HUME 8-NAHC 19-DHTI 20E-TRI CIT 20E-PEERS AA	3-GART	22 PC-OLDER OUT 22 PC-MENTOR	4-PEERS ECC		
EARLY IDENTIFICATION						
	1A-BL SKY 5-LA CLIN 6-AHS 6-CERI 6-BACH 6-RAMS 6-KCCEB 7-AFGHAN 7-FAJ 7-IRC 7-HUME 8-NAHC 10-PTR 19-DHTI 20F-RJOY	17A-YU 17B-REACH	1C-JFCS 22 PC-MENTOR		1B-CHSC	12 CSS-Text 12 CSS-Ed 12 CSS-Clinic

% 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%**

PEI Participant Satisfaction and Pre-Post Health Assessment Surveys

ACBH used electronic surveys in 2023 to assess participant satisfaction across the PEI program portfolio. The optional Participant Satisfaction Survey was offered to all Underserved Ethnic and Language Program (UELP)[5] participants who had received four or more services (including preventive counseling, community events, workshops, support groups, and prevention visits) from February to June 2023, and to all PEI program participants who received any service between February and June 2023. The 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 from contracted provider staff to complete paper surveys.

UELP participants additionally receive the Health Assessment Pre-Survey at the start of services. They complete a post-survey when their program participation ends. While the Participant Survey measures satisfaction as a snapshot in time, the Health Assessment measures change over time as a result of participant's exposure to UELP programming. In 2022, providers requested to extend the survey from several months to year-round to increase the number of completed post-surveys from individuals who participate in services for an extended period.

PEI contracted provider volunteers and ACBH staff collaborated in a workgroup to plan the survey launch and implementation process in 2020. 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.

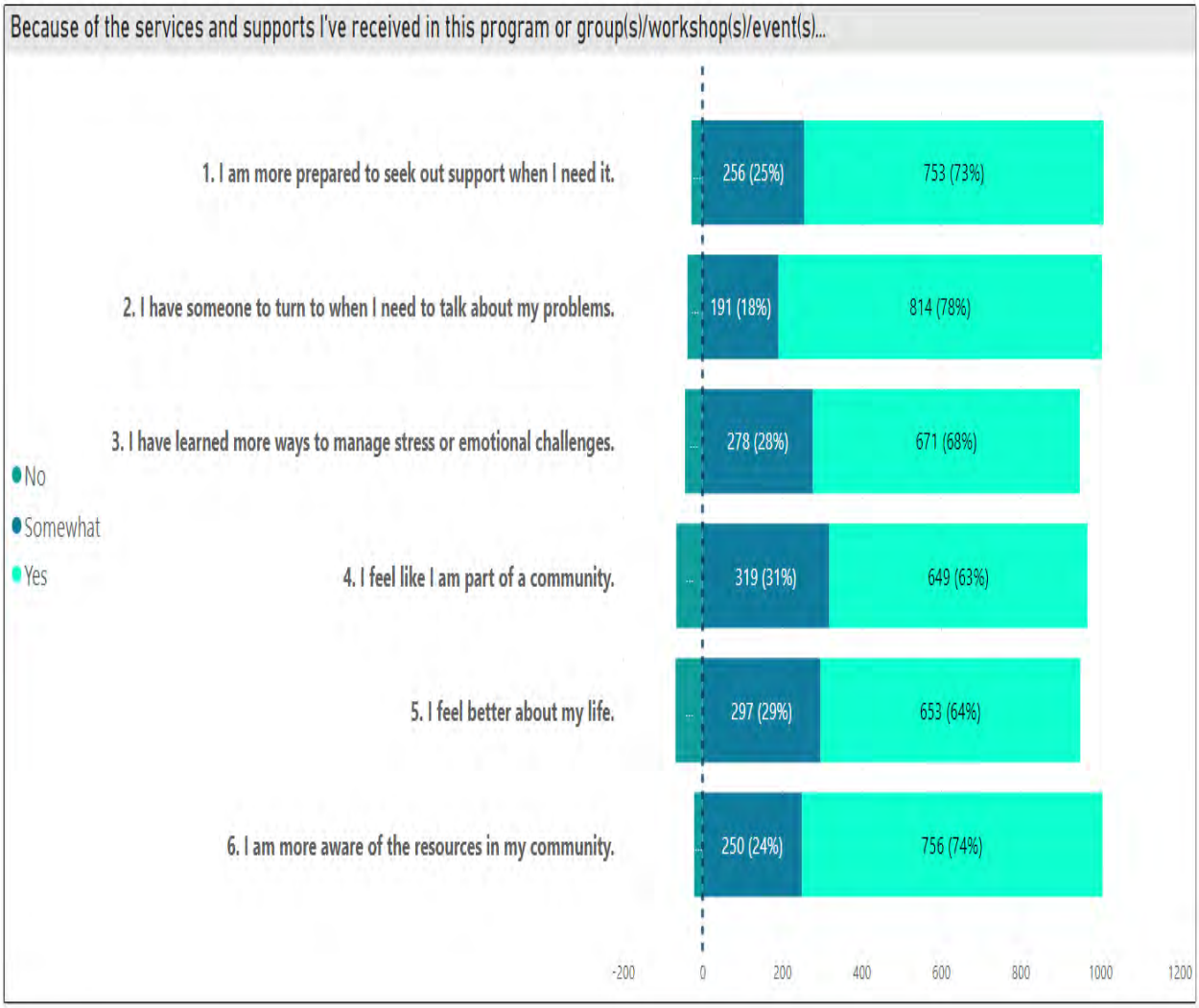
Finally, ACBH coordinated with providers to translate the survey into the various languages representing the diverse communities that receive PEI services: Chinese, Korean, Farsi, Dari, Pashto, Tigrinya, Amharic, French, Arabic, Cambodian, Mein, Vietnamese, Burmese, Spanish, Tagalog, Fijian, Tongan, Urdu, Hindi, and Punjabi.

Following the survey periods across calendar years 2021 and 2022, ACBH staff invited representative providers to re-convene the survey workgroup to evaluate the efficacy of the process to date, to update and clarify survey questions, and to understand the value-add of surveying for staff and their agencies. The workgroup is currently meeting, and its recommendations and insights will directly inform the survey process and outcomes in 2024.

Providers collected 1552 Participant Satisfaction surveys during the 2023 assessment period. Providers collected 173 completed pre-post Health Assessment surveys during the 2023 assessment period. Outcome data from the Participant Satisfaction and from the Health Assessment surveys appears below (please see the full PEI Report in the Appendix for additional survey data):

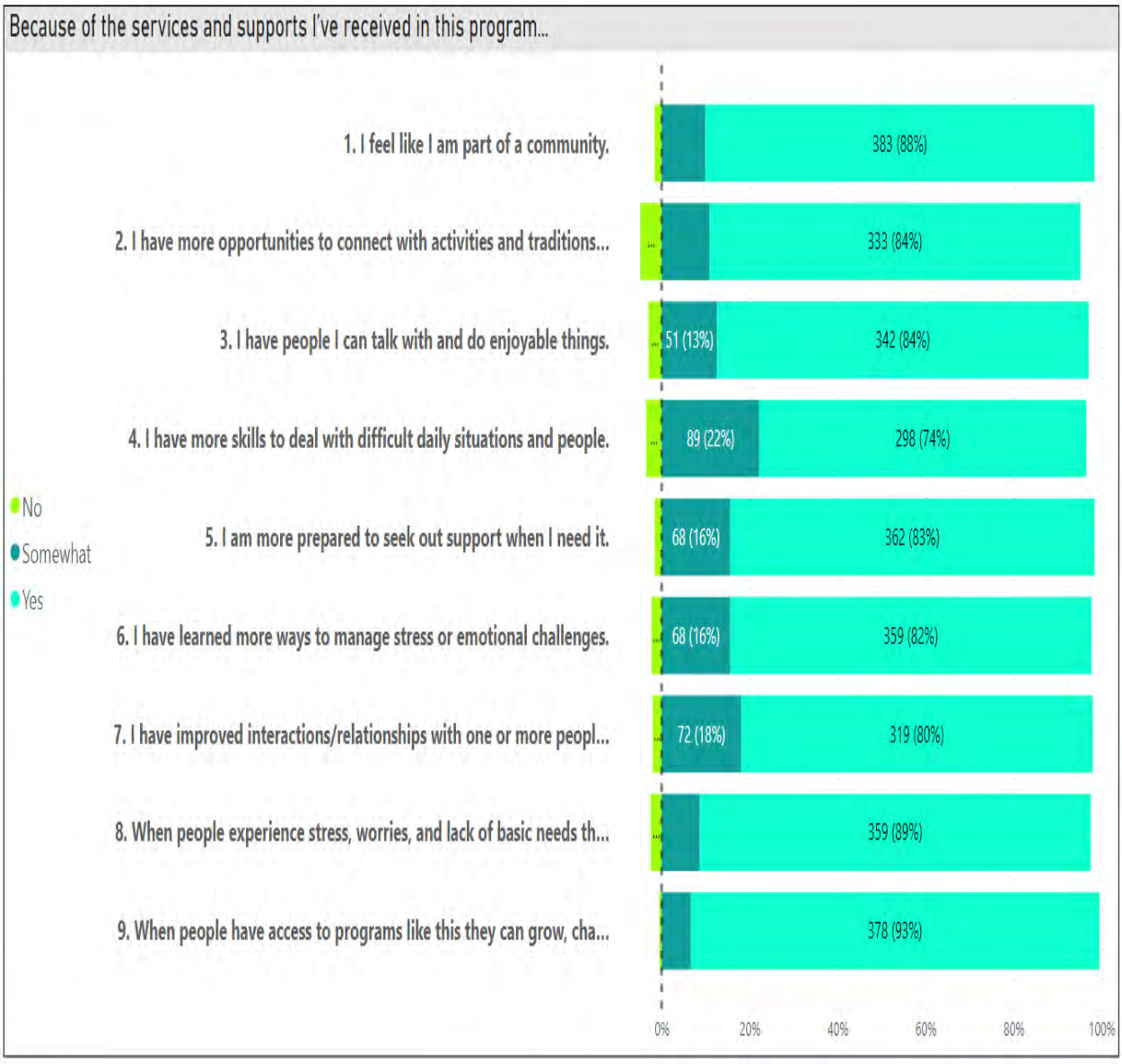
[5] UELP is a subgroup within the PEI portfolio with a specific evidence/community-based, community informed model and program requirements around fidelity. Due to UELP's programmatic and service delivery standardization and evaluation processes, these programs implemented a longer survey. The results are listed separately.

PEI Participant Satisfaction Survey Results



Participant Satisfaction survey data indicates that PEI (non-UELP) programs significantly support participants to have someone to talk to about problems (78%). Programs further support participants to be more aware of community-based support resources (74%) and to be prepared to seek needed support (73%). More moderate percentages of participants have learned more ways to manage stress and challenges (68%), to feel better about their lives (64%), and to feel like a part of community (63%).

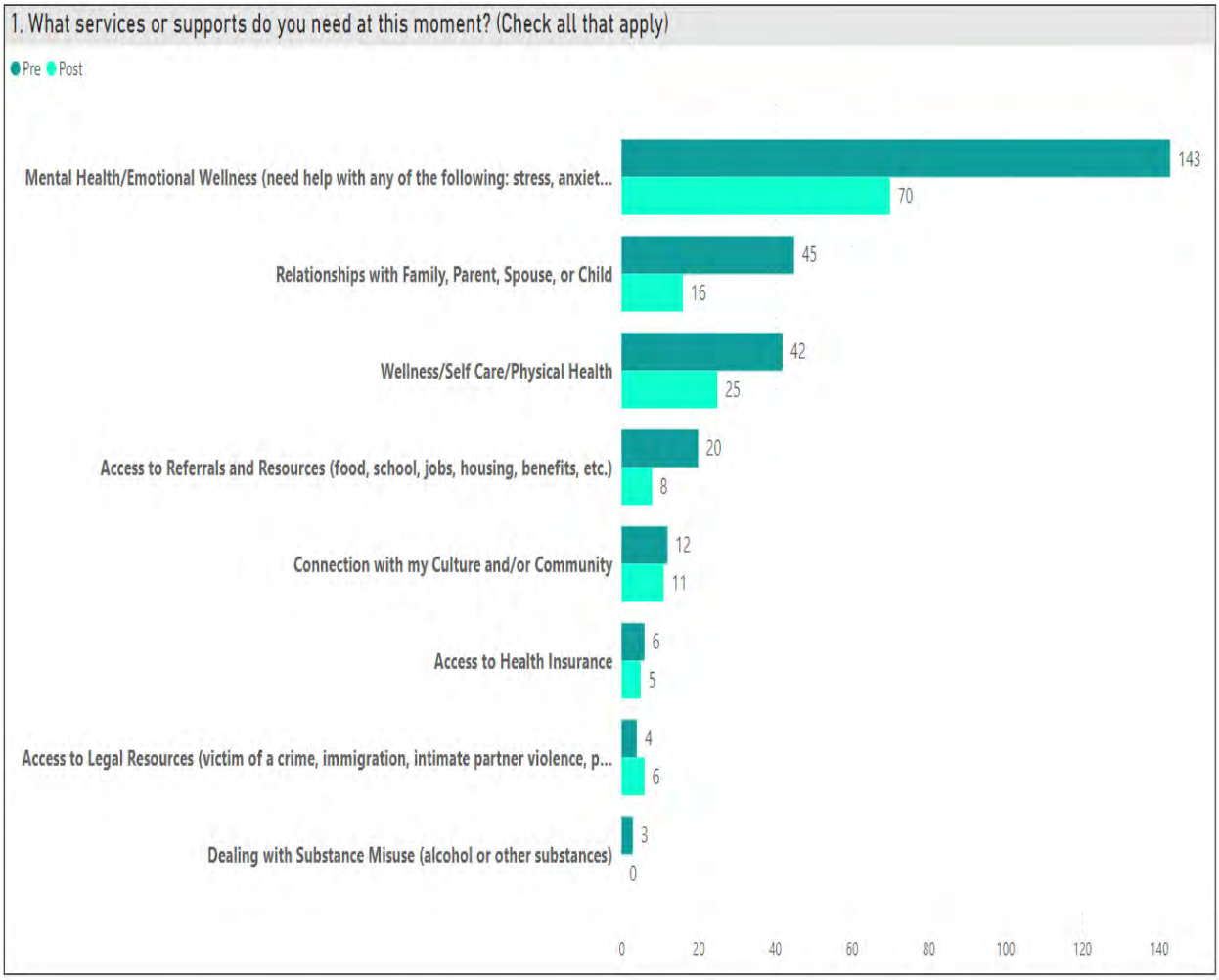
UELP Participant Satisfaction Survey



UELP program participants report a high level of understanding of the impact of stress and worry on mental wellness (88%) and a very high level of understanding about how UELP programs can improve wellness and mental health (92%). Additionally, these programs significantly support participants to feel like they are part of community (88%) and to connect more with traditions and culture (84%). The UELP model centers and deeply values ethnicity and language as the primary channel to reach, to build relationships with, and to serve participants. These programs also show significant outcomes in helping participants to feel more prepared to seek help (82%) and to manage stress and challenges (82%).

Strengths across PEI and UELP programs include support for participants to seek help when they need it and to have people in their lives they can turn to, providing key protective factors for mental wellbeing. Growth opportunities for these programs include increasing support for participants to manage stress and challenges, to feel like part of community, and to feel better overall about life.

UELP Pre/Post Health Assessment Survey



UELP Pre/Post Health Assessment survey data indicates that participant's **need for mental health and emotional wellness services and support was reduced** by almost 49% (pre = 143/post = 70) after receiving services. Significant reductions in needs as a result of receiving services are also shown in other areas, including a 35% reduction in needs for services related to relationships with family, parent, spouse, or child (pre = 45/post = 16); a 59% reduction in needs for services related to overall wellness and health (pre = 42/post = 25), and a 40% reduction in needs for services related to access to referrals and resources (pre = 20/post = 8).

PEI: Prevention

MHSA Program #	PEI 1A
PROVIDER NAME	Blue Skies Mental Wellness Team
PROGRAM NAME	Alameda County Department of Public Health-FHS- MPCAH

Program Outcomes & Impact Data Report FY: 22-23

Program Name:	Blue Skies Mental Wellness Team
Organization:	Alameda County Department of Public Health-FHS- MPCAH
Type of Report:	Annual
PEI Category:	Prevention

Priority Area (place an X next to all that apply):	
X	Childhood Trauma
	Early Psychosis
	Youth/TAY Outreach & Engagement
	Cultural & Linguistic
	Older Adults
X	Early Identification of MH Illness

Outcomes (place an X next to all that apply): Programs focus on <u>reducing</u> the seven negative outcomes that may result from untreated mental illness.	
	Suicide
	Incarceration
	School failure or dropout
	Unemployment
	Prolonged suffering
	Homelessness
	Removal of children from their homes

Box A: <u>Brief</u> program description.

The Blue Skies Mental Wellness Team (BSMWT) is an early intervention and prevention program that provides comprehensive behavioral health services for active participants in Alameda County's Maternal, Paternal, Child and Adolescent Health home visiting programs. Our program is designed to strengthen parent/infant attachment and support parents in adjusting to the emotional changes that can happen before and after childbirth. The BSMWT also provides consultation to Alameda County Maternal, Paternal, Child and Adolescent Health (MPCAH) home visiting programs.

Box B: Number of Individuals served this fiscal year through MHSA funding.	
# of unduplicated individuals served who are at risk of developing a serious mental illness:	114
Number of unduplicated individuals served who show early signs of forming a more severe mental illness:	114
Number of unduplicated individual family members served indirectly by your program:	66
Grand total of unduplicated individuals served:	180

Box C: Demographics of individuals served this fiscal year through MHSA funding:

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	67
Transition Age Youth (16-25 yrs.)	25
Adult (26-59 yrs.)	88
Older Adult (60+ yrs.)	0
Declined to answer	0
Unknown	0
TOTAL	180

SEXUAL ORIENTATION	
Gay/Lesbian	0
Heterosexual/Straight	0
Bisexual	0
Questioning/Unsure	0
Queer	0
Declined to answer	0
Unknown	114
Another group not listed	0
TOTAL	180
If another group is counted, please specify with numbers:	

VETERAN STATUS	
Yes	0
No	0
Declined to answer	0
Unknown	180
TOTAL	180

PRIMARY LANGUAGE	
English	99
Spanish	14
Cantonese	0
Chinese	0
Vietnamese	1
Farsi	0
Arabic	0
Tagalog	0
Declined to answer	0
Unknown	66
Other languages not listed	0
TOTAL	180

CURRENT GENDER IDENTITY	
Female	146
Male	34
Transgender	0
Genderqueer	0
Questioning/unsure of gender identity	0
Declined to answer	0
Unknown	0
Another identity not listed	0
TOTAL	180
If another group is counted, please specify with numbers:	

SEX ASSIGNED AT BIRTH	
Male	146
Female	34
Declined to answer	0
Unknown	0
TOTAL	0
Male	180

DISABILITY STATUS	
Communication Domain	
Vision	3
Hearing/Speech	0
Another type not listed	0
Communication Domain Subtotal	0
Disability Domain	**3**
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	0
Physical/mobility	0
Chronic health condition	0
Disability Subtotal	**0**
None	111
Declined to answer	0
Unknown	66
Another disability not listed	0
TOTAL	180
If another disability is counted, please specify with numbers:	

RACE	
American Indian or Alaska Native	0
Asian	4
Black or African American	73
Native Hawaiian or another Pacific Islander	2
White	0
Other Race	9
Declined to answer	0
Unknown	92
TOTAL	**180**

ETHNICITY/CULTURAL HERITAGE (choose one)	
If Hispanic or Latino, please specify:	
Caribbean	0
Central American	3
Mexican/Mexican American/Chicano	6
Puerto Rican	0
South American	0
Another Hispanic/Latino ethnicity not listed	18
Total Hispanic or Latino	**27**
If Non-Hispanic or Non-Latino, please specify:	
African	0
African American	73
Asian Indian/South Asian	
Cambodian	1
Chinese	
Eastern European	2
European	
Filipino	
Japanese	0
Korean	0
Middle Eastern	0
Vietnamese	1
Other Non-Hispanic or Non-Latino ethnicity not listed	10
Total Non-Hispanic or Non-Latino:	**87**
More than one ethnicity	0
Unknown ethnicity	66
Declined to answer	0
ETHNICITY TOTAL	180
If **another ethnicity** is counted, please specify with numbers:	
If **another race** is counted, please specify with numbers:	

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of.
Nearly 60% of client referrals to Blue Skies identify as African American and 35% identify as Latina. The BSMWT continues to provide culturally congruent care to meet the needs of Blue Skies clients. In addition, from August 2022 - May 2023 two dedicated final year (24-hour a week) master level social work interns (an African American and Bi-lingual/bi-cultural Spanish speaking therapist intern) provided crisis counseling and therapeutic intervention and support to Blue Skies clients. During this reporting period, the BSMWT facilitated 2 mom-to-mom depression groups for 10-weeks with a total 15 participants across both groups. Group participants reported decreased feelings of loneliness and sadness due to establishing connections with other group members along with learning how to manage depressive symptoms during the prenatal period. The group met its goal to help mothers reduce symptoms of depression and stress related symptoms by learning healthy and productive coping strategies so they can deepen their bond with their babies. Here is a case example that illustrates the impact of Blue Skies work and the advantages of meeting with clients in a variety of settings. A Blue Skies clinician worked with a 21-year-old client with a 3-week-old baby. The client was a former foster youth who lacked support and was diagnosed with post-partum depression by her doctor. The client lived alone in a studio apartment and was experiencing a medical issue due to a post-delivery complication. Due to the client's medical issue, she reported she could only receive therapeutic support via a combination of home visits and/or telehealth sessions. By meeting the client where she is at, in her preferred environment, the Blue Skies clinician was able to support the client by providing services such as goal planning to minimize depressive symptoms and strengthening her parenting skills to support the client to raise her baby in nurturing and caring environment.

Box E: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
E.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e., mental health treatment services):	8
E.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):	12
E.3: Types of treatment individuals were referred to (list types below):	
N/A	
E.4: Unduplicated number of individuals who participated in referred program at least one time:	17
G.5: Average duration of untreated mental illness in weeks:	
E.6: Average number of days between referral and first participation in referred treatment program:	7
Box F: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
F.1: Who is/are the underserved target population(s) your program is serving (e.g., TAY, Southeast Asian) (list types below):	
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.	

F.2: Number of paper referrals to an ACBH PEI-funded program:	0
F.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	180
F.4: Average number of days between referral and first participation in referred PEI program:	7
F.5: Describe how your program encouraged access to services and follow through on above referrals:	
N/A	

Box G: 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 Respondents	**N/A**
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):

UELP (Underserved Ethnic Language Populations) 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.

To address its diversity, Alameda County Behavioral Health Care Services (ACBH) has contracted fourteen programs to provide culturally responsive Mental Health PEI services to state-identified underserved populations, including:

- Afghan Coalition
- Asian Health Services
- Bay Area Community Health
- Center for Empowering Immigrants & Refugees
- Diversity in Health Training Institute
- Filipino Advocates for Justice
- International Rescue Committee
- Korean Community Center of the East Bay
- La Familia Counseling Services
- Native American Health Center
- Native American Health Center
- Partnerships for Trauma Recovery
- Portia Bell Hume Center
- Richmond Area Multi-Service, Inc.

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. UELP programs design and deliver services across the following outcomes:

- Forming and Strengthening Identity
  Prevention services enhance self-efficacy.
- Changing Individual Knowledge and Perception of Mental Health Services
  UELP programs are meant to raise awareness and understanding of mental health services and, in turn, decrease internalized stigma.

- Building Community and Its Wellness
  UELP providers continue to create opportunities for clients to build new friendships and support systems within their programs.

- Connecting Individual and Family with Their Culture
  UELP services aim to bolster the connection clients have with their culture by utilizing their cultural norms as a bridge to provide services, including using traditional practices, celebrations, and validations in program activities.

- Improving Access to Services and Resources
  Monolingual or LEP (Limited English Proficiency) populations may experience challenges of navigating the behavioral health care system and accessing services or resources, particularly when they are in need or in crisis. This is extremely important because barriers to access can lead to increased stress, anxiety, isolation, depression, and other mental health concerns.

- Transforming Mental Health Services
  UELP service agencies are determined to provide transformative mental health services. The idea is to move away from the "one size fits all" approach to mental health, emphasizing the use of culturally congruent mental health methods and sensitivities.

- Increase Workforce and Leadership Development
  This outcome is an emerging area of support for mental wellness as the connections between stable employment and mental wellness continue to be emphasized and appreciated by providers and program participants alike.

PROVIDER NAME La Familia Counseling Services

Data Report not available

MHSA Program #	UELP 5
PROVIDER NAME	La Clinica de la Raza
PROGRAM NAME	Cultura y Bienestar

Program Outcomes & Impact Data Report FY: 22-23

Program Name:	Cultura y Bienestar
Organization:	La Clinica de La Raza
Type of Report:	Annual
PEI Category:	Prevention

Priority Area (place an X next to all that apply):

	Childhood Trauma
	Early Psychosis
	Youth/TAY Outreach & Engagement
x	Cultural & Linguistic
	Older Adults
x	Early Identification of MH Illness

Outcomes (place an X next to all that apply): Programs focus on <u>reducing</u> the seven negative outcomes that may result from untreated mental illness.

	Suicide
	Incarceration
x	School failure or dropout
x	Unemployment
x	Prolonged suffering
	Homelessness
	Removal of children from their homes

Box A: <u>Brief</u> program description.

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. Services include support groups, traditional healing workshops, psychoeducational workshops, and up to six one-on-one prevention sessions. Services are in offered in Spanish, English, and Mam and are free to community.

Box B: Number of Individuals served this fiscal year through MHSA funding.

# of unduplicated individuals served who are at risk of developing a serious mental illness:	
Number of unduplicated individuals 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:	

Box C: Demographics of individuals served this fiscal year through MHSA funding:

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	2489
Transition Age Youth (16-25 yrs.)	1314
Adult (26-59 yrs.)	7283
Older Adult (60+ yrs.)	3341
Declined to answer	
Unknown	2142
TOTAL	16,569

SEXUAL ORIENTATION	
Gay/Lesbian	54
Heterosexual/Straight	5476
Bisexual	4
Questioning/Unsure	
Queer	
Declined to answer	
Unknown	10,609
Another group not listed	426
TOTAL	16,569
If another group is counted, please specify with numbers:	

VETERAN STATUS	
Yes	32
No	3,896
Declined to answer	
Unknown	12,641
TOTAL	16,569

PRIMARY LANGUAGE	
English	2,678
Spanish	13,580
Cantonese	
Chinese	
Vietnamese	
Farsi	
Arabic	
Tagalog	
Declined to answer	
Unknown	
Other languages not listed	311

CURRENT GENDER IDENTITY	
Female	11,700
Male	3,207
Transgender	1
Genderqueer	

Questioning/unsure of gender identity	10	TOTAL	
Declined to answer			
Unknown	1,651		
Another identity not listed			
TOTAL	16,569		

SEX ASSIGNED AT BIRTH		**ETHNICITY/CULTURAL HERITAGE (choose one)**	
Male		**If Hispanic or Latino, please specify:**	
Female		Caribbean	
Declined to answer		Central American	
Unknown		Mexican/Mexican American/Chicano	

TOTAL		Puerto Rican	
Male		South American	
		Another Hispanic/Latino ethnicity not listed	
DISABILITY STATUS		**Total Hispanic or Latino**	13,634

Communication Domain		**If Non-Hispanic or Non-Latino, please specify:**	
Vision	3	African	
Hearing/Speech	4	African American	
Another type not listed		Asian Indian/South Asian	
Communication Domain Subtotal		Cambodian	
Disability Domain		Chinese	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)		Eastern European	
		European	
		Filipino	
Physical/mobility	7	Japanese	
Chronic health condition	648	Korean	
Disability Subtotal		Middle Eastern	
None		Vietnamese	
Declined to answer		Other Non-Hispanic or Non-Latino ethnicity not listed	
Unknown		**Total Non-Hispanic or Non-Latino:**	
Another disability not listed	1	More than one ethnicity	
TOTAL	663	Unknown ethnicity	
		Declined to answer	
If another disability is counted, please specify with numbers:		ETHNICITY TOTAL	
		If **another ethnicity** is counted, please specify with numbers:	
RACE			
American Indian or Alaska Native		If **another race** is counted, please specify with numbers:	
Asian			

Black or African American	98	
Latino	13,364	
Native Hawaiian or another Pacific Islander	5	
White	224	
Other Race	1,423	
Declined to answer		
Unknown	1,185	
TOTAL	16,569	

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of.

One exciting part of this year was to see our team grow with the addition of two Mental Health Specialists and three new Health Educators across different sites. We also hosted four BA-level interns throughout the year at the La Clinica site. With increased capacity, we were able to continue providing services with an increase in psychoeducational workshops, support groups, and outreach. This year we also emphasized training for staff in topics such as drumming circle facilitation. Our participants expressed their satisfaction and appreciation of our services and educators through client satisfaction surveys and focus groups.

Box E: For programs that refer individuals with severe mental illness, please provide information for the categories below:

E.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):	35
E.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e., mental health treatment services):	20
E.3: Types of treatment individuals were referred to (list types below):	
Child Protective Services, Domestic Violence counseling/support group, PTSD treatment, legal	
E.4: Unduplicated number of individuals who participated in referred program at least one time:	20
G.5: Average duration of untreated mental illness in weeks:	N/A
E.6: Average number of days between referral and first participation in referred treatment program:	20

Box F: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:

F.1: Who is/are the underserved target population(s) your program is serving (e.g., TAY, Southeast Asian) (list types below):	
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.	
F.2: Number of paper referrals to an ACBH PEI-funded program:	500
F.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	235
F.4: Average number of days between referral and first participation in referred PEI program:	10
F.5: Describe how your program encouraged access to services and follow through on above referrals: When making referrals to other agencies, educators facilitate warm hand-offs and follow up to ensure participants have been linked to services.	

Box G: 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 Respondents	
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	AHS SMH Prevention

Program Outcomes & Impact Data Report FY: 22-23

Program Name:	AHS SMH Prevention
Organization:	Asian Health Services
Type of Report:	Annual
PEI Category:	Prevention

Priority Area (place an X next to all that apply):	
x	Childhood Trauma
x	Early Psychosis
x	Youth/TAY Outreach & Engagement
x	Cultural & Linguistic
x	Older Adults
x	Early Identification of MH Illness

Outcomes (place an X next to all that apply): Programs focus on <u>reducing</u> the seven negative outcomes that may result from untreated mental illness.	
x	Suicide
	Incarceration
x	School failure or dropout
	Unemployment
x	Prolonged suffering
	Homelessness
x	Removal of children from their homes

Box A: **<u>Brief</u>** program description.

Asian Health Services Specialty Mental Health (AHS SMH) Prevention Program serves East Asian language community residents in Alameda's North County seeking mental health support. Services include community outreach, workshops, individual and community consultations, preventative counseling, and support groups. Services provided are free. Our services are supported by the Mental Health Services Act (MHSA) Alameda County Behavioral Health.

Box B: Number of Individuals served this fiscal year through MHSA funding.

# of unduplicated individuals served who are at risk of developing a serious mental illness:	
Number of unduplicated individuals 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:	

Box C: Demographics of individuals served this fiscal year through MHSA funding:

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	1,105
Transition Age Youth (16-25 yrs.)	147
Adult (26-59 yrs.)	1,833
Older Adult (60+ yrs.)	476
Declined to answer	
Unknown	405
TOTAL	3,966

SEXUAL ORIENTATION	
Gay/Lesbian	1
Heterosexual/Straight	712
Bisexual	3
Questioning/Unsure	
Queer	1
Declined to answer	
Unknown	3,248
Another group not listed	1
TOTAL	3,966
If another group is counted, please specify with numbers:	

VETERAN STATUS	
Yes	2
No	989
Declined to answer	
Unknown	2,975
TOTAL	3,966

CURRENT GENDER IDENTITY	
Female	2,519
Male	1,089
Transgender	1
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	357
Another identity not listed	
TOTAL	3,966
If another group is counted, please specify with numbers:	

PRIMARY LANGUAGE	
English	1,693
Spanish	
Cantonese	1,723
Chinese	
Vietnamese	6
Farsi	
Arabic	
Tagalog	
Declined to answer	
Unknown	
Other languages not listed	544
TOTAL	

SEX ASSIGNED AT BIRTH	
Male	
Female	
Declined to answer	
Unknown	
TOTAL	

ETHNITICY/CULTURAL HERITAGE (choose one)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	
Mexican/Mexican American/Chicano	
Puerto Rican	

		Another Hispanic/Latino ethnicity not listed	
DISABILITY STATUS		**Total Hispanic or Latino**	
Communication Domain		**If Non-Hispanic or Non-Latino, please specify:**	
Vision		African	
Hearing/Speech		African American	
Another type not listed	1	Asian Indian/South Asian	3,753
Communication Domain Subtotal		Cambodian	
Disability Domain		Chinese	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)		Eastern European	
		European	
		Filipino	
Physical/mobility	50	Japanese	2
Chronic health condition	1	Korean	
Disability Subtotal		Middle Eastern	
None		Vietnamese	4
Declined to answer		Other Non-Hispanic or Non-Latino ethnicity not listed	19
Unknown		**Total Non-Hispanic or Non-Latino:**	
Another disability not listed		More than one ethnicity	
TOTAL	52	Unknown ethnicity	
If another disability is counted, please specify with numbers:		Declined to answer	
		ETHNICITY TOTAL	3,778
		If **another ethnicity** is counted, please specify with numbers:	
RACE			
American Indian or Alaska Native		If **another race** is counted, please specify with numbers:	
Asian	3,753		
Black or African American			
Native Hawaiian or another Pacific Islander			
White	159		
Other Race	1		
Declined to answer			
Unknown	32		
TOTAL	3,966		

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of.	
CPS referred our mental health programs, to a family of four children in need of care. The youngest child, a two-year-old, was supported by a Prevention Program counselor. The counselor provided a thorough assessment, including direct observation and detailed information gathering. The counselor collaborated with our internal Postdoctoral Fellow to seek a psychological assessment for development concerns. Our postdoc provided the service in language and explained the detailed report to the monolingual-speaking guardians. This evaluation helped our counselor to clarify client needs, build trust with the family, and successfully link to the Regional Center for early intervention care. We had two clinical interns and one trainee that provided counseling services to eight additional clients that totaled seventy-nine direct hours during this fiscal year. We also leveraged our outreach efforts on social media and public media platforms that generated positive engagement.	
Box E: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
E.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
E.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
E.3: Types of treatment individuals were referred to (list types below):	
Psychological Testing; Regional Center; Stabilization OP Clinic; BH; SMH Treatment Program; Kaiser OP, AHS ACCESS	
E.4: Unduplicated number of individuals who participated in referred program at least one time:	7
G.5: Average duration of untreated mental illness in weeks:	n/a
E.6: Average number of days between referral and first participation in referred treatment program:	12
Box F: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
F.1: Who is/are the underserved target population(s) your program is serving (e.g., TAY, Southeast Asian) (list types below):	
East Asian	
F.2: Number of paper referrals to an ACBH PEI-funded program:	50
F.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	36
F.4: Average number of days between referral and first participation in referred PEI program:	17
F.5: Describe how your program encouraged access to services and follow through on above referrals: By using more outreach contacts for checking in and early opening paperwork	

Box G: **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 Respondents	
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 Parents Support Group for 12 weekly sessions in 3 series	78 parents
Virtual Youth Empowering Group in 7 weekly sessions	33 youths
Virtual Mental Health Psychoeducational group with Patient Leadership Council in 3 sessions	30 consumers
Virtual 7 workshops	33 parents
Virtual M2B workshops in 2 sessions	21 expectancy mothers
Virtual workshops and events 12 times	207 general community members
In-person tabling events in 2 times	55 general community members
In-person events at AHS clinics at 3 times	77 general community members
In-person events at senior centers 2 times	124 seniors
In-person tabling at the city street fair	365 general community members
In-person tabling at a community center	20 general community members
YouTube Viewers	752 general viewers
Flyers and Infographics postings on AHS WeChat	2183 for all Likes, Viewers, WOW, and SHARE
Flyers and Infographics postings on AHS Facebook	36 for all Likes and SHARE
Postings on the AHS IG account	84 for all Likes
Postings on the AHS LinkedIn	24 for all Likes and Comments
Postings via internal and external emails	539 email recipients with community leaders, schools, providers, and leaders
Airing 4 Mental Health Episodes at Skylink TV and Website	1124 viewers and 2 Comments

MHSA Program #	**PEI 6 Outreach, Education & Consultation (East-Asian)**
PROVIDER NAME	**Bay Area Community Health**
PROGRAM NAME	**Arise: Asian Wellness Project**

Program Outcomes & Impact Data Report FY: 22 - 23

Program Name:	**Arise: Asian Wellness Project**
Organization:	**Bay Area Community Health**
Type of Report:	Annual
PEI Category:	Prevention

Priority Area (place an X next to all that apply):	
	Childhood Trauma
	Early Psychosis
X	Youth/TAY Outreach & Engagement
X	Cultural & Linguistic
X	Older Adults
X	Early Identification of MH Illness

Outcomes (place an X next to all that apply): Programs focus on <u>reducing</u> the seven negative outcomes that may result from untreated mental illness.	
X	Suicide
	Incarceration
X	School failure or dropout
	Unemployment
	Prolonged suffering
	Homelessness
	Removal of children from their homes

Box A: <u>Brief</u> program description.

Arise: Asian Wellness Project functions as a program focused on Mental Health Prevention and Early Intervention. Our primary goal is to enhance emotional and mental well-being through educational initiatives and advisory services. We offer cost-free workshops, individualized preventative counseling, support groups, and communal gatherings designed for individuals of all ages, including youth, adults, and families belonging to the East Asian Community residing in Southern Alameda County. Furthermore, we aid participants in accessing care and resources by facilitating connections.

Box B: Number of Individuals served this fiscal year through MHSA funding.	
# of unduplicated individuals served who are at risk of developing a serious mental illness:	
Number of unduplicated individuals 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:	

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.)	
Adult (26-59 yrs.)	
Older Adult (60+ yrs.)	21
Declined to answer	
Unknown	
TOTAL	33

SEXUAL ORIENTATION	
Gay/Lesbian	
Heterosexual/Straight	33
Bisexual	
Questioning/Unsure	
Queer	
Declined to answer	
Unknown	
Another group not listed	
TOTAL	33
If another group is counted, please specify with numbers:	

VETERAN STATUS	
Yes	
No	33
Declined to answer	
Unknown	
TOTAL	33

PRIMARY LANGUAGE	
English	20
Spanish	
Cantonese	
Chinese	4
Vietnamese	
Farsi	
Arabic	
Tagalog	
Declined to answer	
Unknown	
Other languages not listed	9
TOTAL	33

CURRENT GENDER IDENTITY	
Female	25
Male	8
Transgender	
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	
Another identity not listed	
TOTAL	33
If another group is counted, please specify with numbers:	

SEX ASSIGNED AT BIRTH	
Male	8
Female	25
Declined to answer	
Unknown	
TOTAL	33
Male	
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	33
Declined to answer	
Unknown	
Another disability not listed	
TOTAL	33
If another disability is counted, please specify with numbers:	

ETHNITICY/CULTURAL HERITAGE (choose one)	
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	**n/a**
If Non-Hispanic or Non-Latino, please specify:	
African	
African American	
Asian Indian/South Asian	
Cambodian	
Chinese	4
Eastern European	
European	
Filipino	
Japanese	
Korean	29
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	
ETHNICITY TOTAL	33
If **another ethnicity** is counted, please specify with numbers:	

RACE		
American Indian or Alaska Native		If **another race** is counted, please specify with numbers:
Asian	33	
Black or African American		
Native Hawaiian or another Pacific Islander		
White		
Other Race		
Declined to answer		
Unknown		
TOTAL	33	

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of.
This year, the Arise team achieved remarkable partnerships with a nearby senior center to organize community events effectively. We offered valuable assistance and encouragement to seniors and their family members, resulting in increased participation in groups, workshops, and events. Additionally, a noteworthy achievement was our successful shift back to conducting in-person activities, groups, and events for young mom's groups and their families. Among the Korean community members, there was a young single mother. Through our workshops and preventative visits, she was able to overcome her challenging times. Her emotional and mental progress has been significant compared to other members, and I heard that she is in an active lead role in her church club. She expressed gratitude and satisfaction with our program services.

Box E: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
E.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
E.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
E.3: Types of treatment individuals were referred to (list types below):	
n/a	
E.4: Unduplicated number of individuals who participated in referred program at least one time:	2
G.5: Average duration of untreated mental illness in weeks:	2
E.6: Average number of days between referral and first participation in referred treatment program:	10
Box F: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
F.1: Who is/are the underserved target population(s) your program is serving (e.g., TAY, Southeast Asian) (list types below):	

East Asians (Chinese, Korean, Japanese) in South Alameda County; all ages (we have clients range from 14 - 85)	
F.2: Number of paper referrals to an ACBH PEI-funded program:	0
F.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	3
F.4: Average number of days between referral and first participation in referred PEI program:	10
F.5: Describe how your program encouraged access to services and follow through on above referrals:	

Box G: 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 Respondents	**719**
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):
Christmas Festival: Agewell Senior Center	*Approx 200 Senior Community members*
Local Senior Center	*20 Senior Community members*
Lunar New Year: Local High School	*Approx 400 total: high school students, teachers at school, parents*
Dragon Boat Festival	*60 Community members*
Fremont Library	*9 librarians*
Online Zoom forum	*Approx 30 Community Health Centers' Staff*

MHSA Program #	01F31
PROVIDER NAME	Center for Empowering Refugee and Immigrants
PROGRAM NAME	ROYA

Program Outcomes & Impact Data Report FY: 22-23

Program Name:	ROYA
Organization:	CERI
Type of Report:	Annual
PEI Category:	PEI-UELP

Priority Area (place an X next to all that apply):	
	Childhood Trauma
	Early Psychosis
	Youth/TAY Outreach & Engagement
x	Cultural & Linguistic
	Older Adults
	Early Identification of MH Illness

Outcomes (place an X next to all that apply): Programs focus on <u>reducing</u> the seven negative outcomes that may result from untreated mental illness.	
x	Suicide
x	Incarceration
x	School failure or dropout
x	Unemployment
x	Prolonged suffering
x	Homelessness
x	Removal of children from their homes

Box A: <u>Brief</u> program description.

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.	
# of unduplicated individuals served who are at risk of developing a serious mental illness:	
Number of unduplicated individuals 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:	

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.)	36
Adult (26-59 yrs.)	366
Older Adult (60+ yrs.)	236
Declined to answer	
Unknown	223
TOTAL	875

SEXUAL ORIENTATION	
Gay/Lesbian	20
Heterosexual/Straight	453
Bisexual	
Questioning/Unsure	
Queer	3
Declined to answer	
Unknown	399
Another group not listed	
TOTAL	875
If another group is counted, please specify with numbers:	

VETERAN STATUS	
Yes	
No	452
Declined to answer	
Unknown	423
TOTAL	875

PRIMARY LANGUAGE	
English	69
Spanish	
Cantonese	
Chinese	
Vietnamese	67
Farsi	
Arabic	
Tagalog	
Declined to answer	
Unknown	
Other languages not listed	739
TOTAL	875

CURRENT GENDER IDENTITY	
Female	463
Male	195
Transgender	1
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	215
Another identity not listed	1
TOTAL	875
If another group is counted, please specify with numbers:	

SEX ASSIGNED AT BIRTH	
Male	
Female	
Declined to answer	
Unknown	
TOTAL	
Male	
DISABILITY STATUS	
Communication Domain	
Vision	2
Hearing/Speech	
Another type not listed	
Communication Domain Subtotal	
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	
Physical/mobility	54
Chronic health condition	2
Disability Subtotal	
None	
Declined to answer	
Unknown	
Another disability not listed	13
TOTAL	375
If another disability is counted, please specify with numbers:	
RACE	
American Indian or Alaska Native	
Asian	864
Black or African American	
Native Hawaiian or another Pacific Islander	
White	6
Other Race	5

ETHNITICY/CULTURAL HERITAGE (choose one)	
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	864
Cambodian	
Chinese	
Eastern European	
European	
Filipino	
Japanese	
Korean	
Middle Eastern	
Vietnamese	
Other Non-Hispanic or Non-Latino ethnicity not listed	6
Total Non-Hispanic or Non-Latino:	
More than one ethnicity	
Unknown ethnicity	5
Declined to answer	
ETHNICITY TOTAL	875
If **another ethnicity** is counted, please specify with numbers:	
If **another race** is counted, please specify with numbers:	

Declined to answer		
Unknown		
TOTAL	875	

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of.

Our organization has experienced various accomplishments and success over this past year that reflect the hard work of our staff, generosity of our donors and funders, and the resilience of our community members. We have seen major expansions in our youth program, doubling the number of youth and increasing services to three days a week for both our groups and individual needs. Our additional youth programs included the spring break camp and the summer camp, which was created in response to a need for youth engagement during the summer due to various barriers preventing the youth from spending their summer months outdoors and in community. This 6-week long program has a total of about 60 youth, who have spent the majority of their time outdoors being active, diving into creative art projects, appreciating and connecting with nature, and immersing themselves into their culture.

This year we have also expanded services and celebratory cultural events for our southeast asian communities. Our Vietnamese services have expanded to the south bay through a counseling group run by one of our amazing staff members, Cam-mi. Our services for the Burmese community almost doubled with the assistance of our Outreach worker Min. Additionally, we had the privilege of celebrating southeast Asian refugee and immigrant communities through actively getting involved in several cultural celebration fairs. CERI transported 300 community members, which included many of our elders, with buses to the Presidio in San Francisco to enjoy the festivities surrounding the Boun Pchoum Ben. Our organization was also very grateful to have a blessing ceremony for the Khmer new year led by Monks at the grand opening of CERI's new space.

The opening of a new location was a very big milestone for CERI this past year, allowing for the necessary space to support all the growth that our organization has already made and future growth that we hope to make. This new space addresses multiple needs including enough space to accommodate our increasing numbers of community members and staff, as well increasing our proximity to safe outdoor spaces for our community members to enjoy. Our increased staff and community numbers is an accomplishment of itself, resulting from UELP funding that allowed for leverage other funding to increase staffing and services by increasing staff numbers, CERI was eligible for more grants which were used to create more programs that used the UELP model to provide services for the Afghan community members.

At CERI, the growth and healing of our community members is the most telling reflection of our success as an organization. One particularly inspiring example is a multi-generation family composed of a grandmother, a mother, and two sons, who have been beloved members of our community for many years. The grandmother herself is a survivor of the Cambodian genocide and has a lot of trauma from this event which has resulted in symptoms such as intrusive thoughts, PTSD, flashbacks, and anxiety. She has been receiving services from CERI including our yoga group, women's support group, and one on one counseling services. The mother has suffered from serious substance and alcohol abuse issues, which she has had trouble addressing and has felt a lot of shame around. Both of the son's ages 16 and 18 are in our youth programs.

The eldest son attends public school in Oakland, and in addition to the difficulties with navigating handling his mother's substance abuse issues, does not have a positive male role model in his life. When we first met him he had a lot of insecurities, and was very self conscious.

Since joining CERI's community, he has been involved in our youth programs, as well as one on one counseling services. He has been such a big support in our youth programs and stepped into leadership roles in environmental and social justice issues. He participated in a stipend internship for our youth program where he showcased his strong youth leadership skills by engaging the kids and setting a good example for them. He also has helped bring more youth into the program by bringing friends of his own. Now, he has shown immense growth in confidence and engagement with his future. He is the first generation in his family to graduate high school this year, and he plans on going to CSLA in the fall. In addition to our services, CERI has supported him with building his resume, buying books for college, and purchasing the essentials for housing when he moves.

Through his involvement in the CERI community his mother was able to finally receive one on one and group counseling. She has been sober for the past 4-5 months after only receiving 8 months of services. She has shown less shame around her issues by openly discussing them within the community and being more social in general. CERI has also helped her get employment at IHSS (in home health services) which has allowed the family to have more financial autonomy and support. The struggles and healing journey of this family are the essence of CERI's mission to create a space that nurtures intergenerational and culturally sensitive healing for our immigrant and refugee communities.

Box E: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
E.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):	
E.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):	
E.3: Types of treatment individuals were referred to (list types below):	
E.4: Unduplicated number of individuals who participated in referred program at least one time:	
G.5: Average duration of untreated mental illness in weeks:	
E.6: Average number of days between referral and first participation in referred treatment program:	
Box F: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
F.1: Who is/are the underserved target population(s) your program is serving (e.g., TAY, Southeast Asian) (list types below):	
Southeast Asian, refugees and immigrants, underserved ethnic language population, TAY, elderly, families, formerly incarcerated/systems impacted, houseless.	
F.2: Number of paper referrals to an ACBH PEI-funded program:	0
F.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	0
F.4: Average number of days between referral and first participation in referred PEI program:	0

F.5: Describe how your program encouraged access to services and follow through on above referrals:

With all CERI clients referred to other services, we make calls together with the clients, in the client's preferred language. We work with the new service provider to ensure that the clients' needs are met linguistically and culturally. We make follow-up calls to both the clients and the provider.

Box G: 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 Respondents	
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):
Church	**2 Veterans, 1 police officer, 1 author, 1 FBI agent, 2 council members**
State of CA bldg. SF	**10 MSW Graduate students, 5 Clinicians, 20 Mental Health workers, 5 Doctors**
Bystander Intervention Training	**100 Mental health workers**
Non-Profit	**ACDV Collab – 10 Mental Health Workers, 2 Trainers**
Non-Profit	**Trauma Training -10 Mental health workers, 25 Outreach workers, 5 Interpreters**
Non-Profit	**Mental Health First Aid Training - 20 Mental Health workers, 3 Interpreters**

MHSA Program #: 01RZ1
PROVIDER NAME: Korean Community Center of the East Bay (KCCEB)
PROGRAM NAME: Asian Community Wellness Program

Program Outcomes & Impact Data Report FY: 22 -23

Program Name:	Asian Community Wellness Program
Organization:	Korean Community Member of the East Bay (KCCEB)
Type of Report:	PEI Annual Report
PEI Category:	Cultural and Linguistic

Priority Area (place an X next to all that apply):	
	Childhood Trauma
	Early Psychosis
	Youth/TAY Outreach & Engagement
x	Cultural & Linguistic
	Older Adults
	Early Identification of MH Illness

Outcomes (place an X next to all that apply): Programs focus on <u>reducing</u> the seven negative outcomes that may result from untreated mental illness.	
x	Suicide
	Incarceration
x	School failure or dropout
	Unemployment
x	Prolonged suffering
	Homelessness
x	Removal of children from their homes

Box A: <u>Brief</u> program description.

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.	
# of unduplicated individuals served who are at risk of developing a serious mental illness:	
Number of unduplicated individuals 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:	

Box C: Demographics of individuals served this fiscal year through MHSA funding:

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	208
Transition Age Youth (16-25 yrs.)	120
Adult (26-59 yrs.)	578
Older Adult (60+ yrs.)	1,375
Declined to answer	
Unknown	215
TOTAL	2,496

SEXUAL ORIENTATION	
Gay/Lesbian	24
Heterosexual/Straight	299
Bisexual	19
Questioning/Unsure	2
Queer	5
Declined to answer	
Unknown	2,142
Another group not listed	5
TOTAL	2,496
If another group is counted, please specify with numbers:	

VETERAN STATUS	
Yes	6
No	235
Declined to answer	2,255
Unknown	
TOTAL	2,496

CURRENT GENDER IDENTITY	
Female	1,382
Male	658
Transgender	2
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	439
Another identity not listed	15
TOTAL	2,496
If another group is counted, please specify with numbers:	

PRIMARY LANGUAGE	
English	531
Spanish	87
Cantonese	807
Chinese	156
Vietnamese	43
Farsi	29
Arabic	
Tagalog	
Declined to answer	
Unknown	
Other languages not listed	843
TOTAL	

SEX ASSIGNED AT BIRTH	
Male	
Female	
Declined to answer	
Unknown	
TOTAL	
Male	
DISABILITY STATUS	
Communication Domain	
Vision	
Hearing/Speech	
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	
None	
Declined to answer	
Unknown	
Another disability not listed	46
TOTAL	48
If another disability is counted, please specify with numbers:	
RACE	
American Indian or Alaska Native	
Asian	
Black or African American	
Native Hawaiian or another Pacific Islander	
White	
Other Race	

ETHNITICY/CULTURAL HERITAGE (choose one)	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	
Mexican/Mexican American/Chicano	
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed	106
Total Hispanic or Latino	
If Non-Hispanic or Non-Latino, please specify:	
African	
African American	50
Asian Indian/South Asian	1,705
Cambodian	
Chinese	
Eastern European	
European	
Filipino	
Japanese	
Korean	
Middle Eastern	
Vietnamese	
Other Non-Hispanic or Non-Latino ethnicity not listed	107
Total Non-Hispanic or Non-Latino:	
More than one ethnicity	329
Unknown ethnicity	283
Declined to answer	
ETHNICITY TOTAL	2,496
If **another ethnicity** is counted, please specify with numbers:	
If **another race** is counted, please specify with numbers:	

Declined to answer		
Unknown		
TOTAL		

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of.

1. Through KCCEB community wellness outreach and education, we have continued to expand our partnership with school-based partners and have ongoing requests for school partnerships for preventive counseling. This fiscal year, we have expanded our partnership to three schools in Hayward, thus reaching out to South Alameda County to engage a large Chinese Cantonese/Mandarin speaking children, youth, and families. Through this partnership, we have surpassed our PEI preventive counseling deliverable with additional waiting lists for individual counseling services. We also have expanded services to provide couple and family counseling to API families due to limited resources in the community.

2. Success Case Study: Xi is a PEI immigrant Chinese speaking client. He is very traditional with chronically ill children which impacted his family in complex ways. He was involved in the medical system receiving "western medical treatment," has a multidisciplinary team of medical and family mental health providers, and Children and Family Services, which is viewed as a Western definition of parenting and conflict resolution. However, the service was not able to meet his cultural and linguistic needs, leading to feel more isolated and worsening his mental health symptoms. He initially was referred by CFS but became engaged in our services due to language and cultural barriers. After receiving counseling services from our bilingual and bicultural Wellness Counselor, he ultimately felt less isolated working with a provider who spoke his language, understood his culture and nuances, and validated the conflict between American values of individuality, definition of wellness/stabilization vs Chinese values of collectivism and family hierarchy that contributed to internal household conflicts and stress. Though this wellness support, he has learned coping skills to manage his family stress and conflict and founds ways to manage his own stress.

3. KCCEB had proactively responded to the API Hate and discrimination in the community, especially supporting API elders who were mostly targeted in the community. We developed a 4-week curriculum series focused on street smart safety and self-defense classes to Chinese and Korean elders at senior housing facilities this past fiscal year. The 6 weeks class series engaged elders to practice preventive measures to ensure their safety in their neighborhood, discussed signs and symptoms of traumas and vicarious traumas, educated them to report hate crimes, explored ways to advocate safety in the community by uplifting their stories to policy makers, and seeking mental health support as needed. This educational class and wellness support group was important in creating a safe space for elders to share their concerns and talk about vicarious trauma. Seniors were particularly interested in making a change and sharing their stories to decision-makers. We created a Tree of Life project where seniors wrote on fabric leaves responses to these questions: *To have a safe community we need to; To have a healthy community we need to…*We hope to engage seniors in sharing their stories in the future with our partner Oakland Asian Cultural Center.

Box E: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
E.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
E.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
E.3: Types of treatment individuals were referred to (list types below):	
n/a	
E.4: Unduplicated number of individuals who participated in referred program at least one time:	10
G.5: Average duration of untreated mental illness in weeks:	6
E.6: Average number of days between referral and first participation in referred treatment program:	0
Box F: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
F.1: Who is/are the underserved target population(s) your program is serving (e.g., TAY, Southeast Asian) (list types below):	
1) East Asian Community: Chinese, Korean, Japanese, Mongolian, E. Indian (children, youth, TAY, family, adult, and older adults) 2) Southeast Asian: Vietnamese, Khmer, Mien (youth & Tay) 3) Pacific Islanders: Filipino (youth & TAY) 4) Other BIPOC: E. Indian, Latinx, African Americans/Black, Mix Race (youth & Tay)	

F.2: Number of paper referrals to an ACBH PEI-funded program:	98
F.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	61
F.4: Average number of days between referral and first participation in referred PEI program:	2-5 days

F.5: Describe how your program encouraged access to services and follow through on above referrals:

KCCEB Wellness Counselors will follow up on referral with a short timeframe (2-5 days) and perform wellness check through prevention visits. During the prevention visits, our bilingual/bicultural Wellness Counselors perform wellness checks with the clients to build rapport, understand their needs, provide psychoeducation, and engage in empathic listening to make sure the client is being heard, understood, supported, and safe. We provide mental health education in a culturally responsive manner and encourage the clients to reach out to the Wellness Counselor to ensure that the clients have access to support. Often, the Wellness Counselors provided 4-6 prevention visits to engage the clients to make them feel more comfortable and ready to access mental health services. In addition, the Wellness Counselors would meet the clients at home, virtual, school, and phone to reduce geographic barriers. Engagement to build rapport and encouragement to access mental health services is provide in their preferred language: English, Cantonese, Mandarin, Korean, Khmer, etc. to reduce additional linguistic barriers. Once the clients need higher care for treatment services, our Wellness Counselors provided case management service to the clients through linkages and navigation. Our Wellness Counselors will assist client to contact the treatment program for initial appointment and screening, be with the clients when needed to complete the clinical screening, and scheduling of first therapy session for support. Once the clients received their first or second therapy session in the treatment program, the Wellness Counselors performed wellness checks again to check their progress in the treatment program and quality of services before terminating with their client. This process is to ensure that client can receive a smooth and seamless continuation of higher care in the treatment program.

Box G: 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 Respondents	
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):
Cultural & Wellness Events (7): social & wellness trips, cultural festivals, covid-19 health/vaccine, and Trauma informed mental health conference @ KCCEB office, school, senior housing, and field	community members and leaders, children, youth, TAY, families and adults and older adults, CBO staff
MH Workshops (38): Understand MH, leadership, mental health stigma, safety street smart, emotional wellness, healthy communication,	community members and leaders, youth, TAY and adults and older adults

stress management, MH access support, Digital Literacy to promote social support @ office, school, specific community center, and CBO partners' center	
MH Trainings (10): accessing culturally responsive resources, cultural and holistic healing, MH & COVID @ cultural community space, office, and school.	community based professionals (school-based staff, community-based worker staff, caregivers)
Mental Health Consultation (9): MH among youth, access MH Tx, MH Stigma in API comm, MH ref & svc @ school, home, office, and phone	CBO's professionals (school-based staff, community-based worker staff, caregivers, CPS workers) and family members
Newsletters(7): Selfcare, COVID, cultural/sexual ID & pride, caregivers support, mental health and wellness, healthy boundary	general community members and CBO's professionals
Tabling/Distributing materials (10): community resources and mental health services @school, community festivals and resource fairs, and API cultural events	API & other BIPOC community members and leaders, children, youth, TAY and adults and older adults
Wellness Support Group (5): TaiJi for wellness, Safety Street Smart (Chinese & Korean), Jikimee Leadership & Wellness Group (Cohort 1 & 2), Youth Wellness support @ senior housing facilities, office, and school	Korean and Chinese elders, community members, API immigrant/refugees, and East Asian Youth and other API/BIPOC youth
PV Home Visits (60): MH screening, referral, help-seeking encouragement, psycho-ed, and community resource support @ school, phone, virtual, office, and home	community members and leaders, children, youth, TAY and adults and older adults

MHSA Program #	01R91
PROVIDER NAME	RICHMOND AREA MULTI-SERVICES, INC.
PROGRAM NAME	PACIFIC ISLANDER WELLNESS INITIATIVE

Program Outcomes & Impact Data Report FY: 22-23

Program Name:	PACIFIC ISLANDER WELLNESS INITIATIVE
Organization:	RICHMOND AREA MULTI-SERVICES, INC.
Type of Report:	ANNUAL REPORT
PEI Category:	UELP

Priority Area (place an X next to all that apply):	
	Childhood Trauma
	Early Psychosis
X	Youth/TAY Outreach & Engagement
X	Cultural & Linguistic
X	Older Adults
X	Early Identification of MH Illness

Outcomes (place an X next to all that apply): Programs focus on <u>reducing</u> the seven negative outcomes that may result from untreated mental illness.	
	Suicide
	Incarceration
	School failure or dropout
	Unemployment
	Prolonged suffering
	Homelessness
	Removal of children from their homes

Box A: <u>Brief</u> program description.

Pacific Islander Wellness Initiative (PIWI) is a prevention and early intervention mental health program of RAMS in collaboration with long-standing and trusted Pacific Islander community-based organizations. PIWI provides culturally responsive and in-language preventive counseling, psycho-education, mental health consultation, and outreach and engagement services, including navigation, translation, and interpretation assistance to Pacific Islander residents of Alameda County.

Box B: Number of Individuals served this fiscal year through MHSA funding.	
# of unduplicated individuals served who are at risk of developing a serious mental illness:	62
Number of unduplicated individuals 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:	

Box C: Demographics of individuals served this fiscal year through MHSA funding:

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	304
Transition Age Youth (16-25 yrs.)	401
Adult (26-59 yrs.)	778
Older Adult (60+ yrs.)	171
Declined to answer	
Unknown	146
TOTAL	1,800

SEXUAL ORIENTATION	
Gay/Lesbian	81
Heterosexual/Straight	1,091
Bisexual	
Questioning/Unsure	
Queer	
Declined to answer	
Unknown	622
Another group not listed	
TOTAL	1,800
If another group is counted, please specify with numbers:	

VETERAN STATUS	
Yes	10
No	1,506
Declined to answer	
Unknown	284
TOTAL	1,800

PRIMARY LANGUAGE	
English	1,060
Spanish	74
Cantonese	
Chinese	5
Vietnamese	
Farsi	
Arabic	
Tagalog	
Declined to answer	
Unknown	
Other languages not listed	661
TOTAL	1,800

CURRENT GENDER IDENTITY	
Female	880
Male	
Transgender	
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	272
Another identity not listed	
TOTAL	1,800
If another group is counted, please specify with numbers:	

SEX ASSIGNED AT BIRTH	
Male	
Female	
Declined to answer	
Unknown	
TOTAL	
Male	
DISABILITY STATUS	
Communication Domain	
Vision	
Hearing/Speech	10
Another type not listed	
Communication Domain Subtotal	
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	
Physical/mobility	20
Chronic health condition	
Disability Subtotal	
None	
Declined to answer	
Unknown	
Another disability not listed	10
TOTAL	40
If another disability is counted, please specify with numbers:	
RACE	
American Indian or Alaska Native	
Asian	149
Black or African American	42
Native Hawaiian or another Pacific Islander	
White	20
Other Race	1,552

ETHNITICY/CULTURAL HERITAGE (choose one)	
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	**99**
If Non-Hispanic or Non-Latino, please specify:	
African	
African American	42
Asian Indian/South Asian	149
Cambodian	
Chinese	
Eastern European	
European	
Filipino	
Japanese	
Korean	
Middle Eastern	
Vietnamese	
Other Non-Hispanic or Non-Latino ethnicity not listed	1389
Total Non-Hispanic or Non-Latino:	
More than one ethnicity	84
Unknown ethnicity	37
Declined to answer	
ETHNICITY TOTAL	1,800
If **another ethnicity** is counted, please specify with numbers:	
If **another race** is counted, please specify with numbers:	

Declined to answer	
Unknown	37
TOTAL	1,800

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of.

PIWI successfully met 100% of its objectives. Our program provided:
20 in-person home visits
73 prevention visits
19 hosted/co-hosted community events reaching 1,173 people
81 clients screened and assessed (RAMS internal objective)
62 unduplicated clients received preventive counseling
43 promotional materials created and shared widely reaching 21,468 people
4 mental health consultations reaching 54 people
12 psycho-education workshops reaching 183 people
13 Talanoa4Wellness (support groups) reaching 220 people
9 referrals and successful linkages
4 cultural-based educational workshops reaching 152 people
Case study: Male Samoan self-referred for individual therapy due anxiety, anger, and stress. He sought support to set boundaries due to his many responsibilities as a graduate student, youth leader, lay pastor, and so forth. He also experienced spells of dizziness and scored 3 or more items from PTSD screen. Client was set for weekly sessions and two sessions were completed. The case was closed because the client died from gun violence. Staff outreached to the family to offer services and support.

Box E: For programs that refer individuals with severe mental illness, please provide information for the categories below:

E.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):	79
E.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

E.3: Types of treatment individuals were referred to (list types below):

Preventive counseling, specialty mental health services; long term counseling services; higher level case management

E.4: Unduplicated number of individuals who participated in referred program at least one time:	66
E.5: Average duration of untreated mental illness in weeks:	16
E.6: Average number of days between referral and first participation in referred treatment program:	9

Box F: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:

F.1: Who is/are the underserved target population(s) your program is serving (e.g., TAY, Southeast Asian) (list types below):	
Pacific Islanders (Samoans, Tongans, Hawaiians, Palauans, Chomorros), Youth, TAY, parents, children, seniors	
F.2: Number of paper referrals to an ACBH PEI-funded program:	81
F.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	66
F.4: Average number of days between referral and first participation in referred PEI program:	9
F.5: Describe how your program encouraged access to services and follow through on above referrals:	
PIWI staff engages in deep outreach and engagement activities in Pacific Islander churches, groups, schools, individuals, and other providers to enhance awareness of PIWI services. PIWI staff hold dual roles as working professionals and also as community members who care deeply about responding and supporting the mental health of their community. Once staff are aware of a death, crisis, trouble in the community, we reach out to the family with the death, crisis, and trouble to lend our support by offering our services and resources. All staff work as a team to support the clients seeking PIWI services.	

Box G: 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 Respondents	
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 = 3; COST specialists: 3; Parents: 5; Counselors: 5; Teachers: 5
Churches	Pastors: 14; youth leaders: 10
Cultural affinity groups	Kumu instructor: 2; Parents: 5
Colleges	Advisors: 3; Peers: 4
Community events	Event planners: 5

MHSA Program #	PEI 7 Outreach, Education & Consultation
PROVIDER NAME	Afghan Coalition
PROGRAM NAME	Afghan Wellness Project

Program Outcomes & Impact Data Report FY: 22-23

Program Name:	Afghan Wellness Project
Organization:	Afghan Coalition
Type of Report:	Year End Report
PEI Category:	UELP

Priority Area (place an X next to all that apply):	
x	Childhood Trauma
	Early Psychosis
x	Youth/TAY Outreach & Engagement
x	Cultural & Linguistic
	Older Adults
x	Early Identification of MH Illness

Outcomes (place an X next to all that apply): Programs focus on <u>reducing</u> the seven negative outcomes that may result from untreated mental illness.	
x	Suicide
	Incarceration
x	School failure or dropout
x	Unemployment
x	Prolonged suffering
X	Homelessness
X	Removal of children from their homes

Box A: **<u>Brief</u>** program description.

Project is designed to provide culturally sensitive prevention and early intervention mental health services and increase access to mental health treatment for Afghans living in Alameda County. The program design is informed by direct services the agency has delivered since 1996, including the interaction and case management of 400-500 unduplicated individuals per year (most of whom are Afghan); recent research, both quantitative and qualitative conducted in the Afghan community; and culturally appropriate strategies recommended by local community groups and leaders

Box B: Number of Individuals served this fiscal year through MHSA funding.	
# of unduplicated individuals served who are at risk of developing a serious mental illness:	
Number of unduplicated individuals 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:	

Box C: Demographics of individuals served this fiscal year through MHSA funding:			
AGE CATEGORIES		**SEXUAL ORIENTATION**	
Children/Youth (0-15 yrs.)	1,011	Gay/Lesbian	6
Transition Age Youth (16-25 yrs.)	480	Heterosexual/Straight	3,782
Adult (26-59 yrs.)	3,707	Bisexual	
Older Adult (60+ yrs.)	231	Questioning/Unsure	
Declined to answer		Queer	5
Unknown	82	Declined to answer	
TOTAL	5,511	Unknown	1,718
		Another group not listed	
		TOTAL	5,511
		If another group is counted, please specify with numbers:	
VETERAN STATUS		**PRIMARY LANGUAGE**	
Yes	0	English	445
No	1,585	Spanish	
Declined to answer		Cantonese	
Unknown	3,926	Chinese	
TOTAL	5,511	Vietnamese	
		Farsi	1,647
CURRENT GENDER IDENTITY		Arabic	
Female	3,631	Tagalog	
Male	1,880	Declined to answer	
Transgender		Unknown	
Genderqueer		Other languages not listed	3,419
Questioning/unsure of gender identity		TOTAL	5,511
Declined to answer			
Unknown			
Another identity not listed			
TOTAL	5,511		
If another group is counted, please specify with numbers:			

SEX ASSIGNED AT BIRTH		**ETHNITICY/CULTURAL HERITAGE (choose one)**	
Male		**If Hispanic or Latino, please specify:**	
Female		Caribbean	
Declined to answer		Central American	

Unknown		Mexican/Mexican American/Chicano	
TOTAL		Puerto Rican	
Male		South American	
		Another Hispanic/Latino ethnicity not listed	
DISABILITY STATUS		**Total Hispanic or Latino**	**32**
Communication Domain		**If Non-Hispanic or Non-Latino, please specify:**	
Vision	1	African	
Hearing/Speech		African American	6
Another type not listed		Asian Indian/South Asian	5,106
Communication Domain Subtotal		Cambodian	
Disability Domain		Chinese	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)		Eastern European	
		European	
		Filipino	
Physical/mobility	1	Japanese	
Chronic health condition	37	Korean	
Disability Subtotal		Middle Eastern	
None		Vietnamese	
Declined to answer		Other Non-Hispanic or Non-Latino ethnicity not listed	9
Unknown		**Total Non-Hispanic or Non-Latino:**	
Another disability not listed	376	More than one ethnicity	
TOTAL	415	Unknown ethnicity	358
		Declined to answer	
		ETHNICITY TOTAL	5,511
If another disability is counted, please specify with numbers:		If **another ethnicity** is counted, please specify with numbers:	
RACE			
American Indian or Alaska Native		If **another race** is counted, please specify with numbers:	
Asian	5,106		
Black or African American	6		
Native Hawaiian or another Pacific Islander			
White	5		
Other Race	36		
Declined to answer			
Unknown	358		
TOTAL	5,511		

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of.
One major success of this year was the agency's ability to provide much needed education to clients and to community providers regarding the importance of mental health and the impacts of trauma and abuse on overall health and wellness. The agency participated and held many groups aimed at providing education about the importance of mental health. The agency also facilitated groups with schools and community providers and provided cultural sensitivity training regarding the complexities of supporting the Afghan community, in particular the women and children. A success story that we are proud of involves a young Afghan woman who fled Afghanistan during the Taliban takeover in August 2021. She left everything and everyone behind in Afghanistan. She arrived, alone, to a completely foreign country; she did not know the language, the customs, and the culture of this new world she landed on. She had no one here to support her, comfort her or help her; however, this young lady, like many Afghan women, was resilient, strong and hardworking. She managed to find resources and connected with our agency. Within months she found a job and a room to rent, enrolled in English classes and passed her driving permit test. She was connected with a mental health counselor and started working on learning healthy coping skills to manage symptoms of depression and anxiety. She continues to work on improving her mental health and learning healthy ways to manage her emotions. She has maintained her job and her housing and is looking to take the driving test soon and eventually purchase a car. This young lady did all the work, but having the network of support that our agency provided empowered and motivated her to not give up.

Box E: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
E.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e., mental health treatment services):	8
E.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
E.3: Types of treatment individuals were referred to (list types below) Intense individual psychotherapy, Medical Evaluation, Psychiatrist referral for medical evaluation, Senior Case Management Support, Hospitals, and ACCESS	
E.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:	2
E.6: Average number of days between referral and first participation in referred treatment program:	10

Box F: **For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:**	
F.1: Who is/are the underserved target population(s) your program is serving (e.g., TAY, Southeast Asian) (list types below) Refugees, Immigrants, and new arrival Afghans. Afghan youth	
F.2: Number of paper referrals to an ACBH PEI-funded program:	3
F.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	2
F.4: Average number of days between referral and first participation in referred PEI program:	7
F.5: Describe how your program encouraged access to services and follow through on above referrals: Our agency provides much needed education to the Afghan community around mental health and resources that are available to them. This includes understanding what mental health is, what symptoms are, the importance of self-care and how to get connected to treatment. Outreach Workers check in with community members to confirm that clients have been connected to services	

Box G: **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 Respondents	
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):
School –HUSD Community without Boarders- Quarterly	**15 -Teachers, 35 Parents at school facility**
School- HUSD – Cultural Competency Training	**15 –Teachers and school professionals**
School-FUSD- Girl's Support group-bi-weekly	**1 Teacher, 1- School Counselor at school**
Parenting Class Zoom Workshop	**26- Parents, 1-Mental Health Specialist**
Aging Well Center-Cultural Event -Monthly	**1-Teacher, 5 Outreach Workers average at Community Center 200 unduplicated parents**
Community Kitchen – Men's Support Groups	**2- Outreach Workers –Community facility**
4 - Consortium Meetings for Service Providers & Community Leaders over Zoom	**Service Providers/Community Leaders per meeting** **1st – 87** **2nd- 120** **3rd—67** **4tth - 55**
School-HUSD – Monthly Meetings/Zoom	**1- Family Engagement Specialist , 1-Newcomer**

	Services Coordinator, 1- Teacher
Central Park Fremont –Eid Festival	**120 – Parents, 5 Outreach Workers at community park**
Community Sports Complex – Soccer Youth Club	**1-Outreach Worker, 20 Parents**

MHSA Program #	PEI 7 Outreach, Education & Consultation (Afghan)- International Rescue Committee
PROVIDER NAME	International Rescue Committee
PROGRAM NAME	Afghan Path Towards Wellness

Program Outcomes & Impact Data Report FY: 22-23

Program Name:	Afghan Path Towards Wellness
Organization:	International Rescue Committee
Type of Report:	Annual
PEI Category:	Prevention

Priority Area (place an X next to all that apply):	
	Childhood Trauma
	Early Psychosis
	Youth/TAY Outreach & Engagement
x	Cultural & Linguistic
	Older Adults
x	Early Identification of MH Illness

Outcomes (place an X next to all that apply): Programs focus on <u>reducing</u> the seven negative outcomes that may result from untreated mental illness.	
x	Suicide
	Incarceration
	School failure or dropout
x	Unemployment
x	Prolonged suffering
x	Homelessness
	Removal of children from their homes

Box A: <u>Brief</u> program description.

Afghan Path Towards Wellness (APTW): Providing wellness and psychosocial support services to the Afghan community of North Alameda County. Primary services include preventative counseling, psychosocial and educational workshops, community events, socials support groups, wellness assessments, and community provider and leader training.

Box B: Number of Individuals served this fiscal year through MHSA funding.	
# of unduplicated individuals served who are at risk of developing a serious mental illness:	
Number of unduplicated individuals 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:	

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.)	154
Adult (26-59 yrs.)	361
Older Adult (60+ yrs.)	37
Declined to answer	449
Unknown	
TOTAL	1,001

SEXUAL ORIENTATION	
Gay/Lesbian	21
Heterosexual/Straight	686
Bisexual	
Questioning/Unsure	
Queer	
Declined to answer	
Unknown	294
Another group not listed	
TOTAL	1,001

If another group is counted, please specify with numbers:

VETERAN STATUS	
Yes	
No	493
Declined to answer	
Unknown	508
TOTAL	1,001

CURRENT GENDER IDENTITY	
Female	694
Male	39
Transgender	
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	268
Another identity not listed	
TOTAL	1,001

PRIMARY LANGUAGE	
English	
Spanish	
Cantonese	
Chinese	
Vietnamese	
Farsi	4
Arabic	
Tagalog	
Declined to answer	
Unknown	
Other languages not listed	997
TOTAL	1,001

SEX ASSIGNED AT BIRTH	
Male	
Female	
Declined to answer	
Unknown	
TOTAL	
Male	
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	731
Declined to answer	
Unknown	270
Another disability not listed	
TOTAL	1,001
If another disability is counted, please specify with numbers:	
RACE	
American Indian or Alaska Native	
Asian	1,001
Black or African American	
Native Hawaiian or another Pacific Islander	
White	
Other Race	

ETHNITICY/CULTURAL HERITAGE (choose one)	
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	1,001
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	
ETHNICITY TOTAL	1,001
If **another ethnicity** is counted, please specify with numbers:	
If **another race** is counted, please specify with numbers:	

Declined to answer		
Unknown		
TOTAL	1,001	

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of.
One event that our team is particularly proud of was an in-person community event taking place at our office to talk to families about stress management and then we walked around Lake Merritt together. It was great to see both parents and children interacting with stress management activities. We partnered with Casa Ubuntu who brought in a guest speaker to speak on stress management as well. We also strengthened our collaboration with our internal Resettlement and Placement Cultural Orientation Programming to support new Afghan arrivals faster.

Box E: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
E.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
E.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
E.3: Types of treatment individuals were referred to (list types below):	
Clients were referred to both short term and long-term therapy at community based clinics and behavioral health programs at their local hospitals.	
E.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:	16
E.6: Average number of days between referral and first participation in referred treatment program:	30
Box F: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
F.1: Who is/are the underserved target population(s) your program is serving (e.g., TAY, Southeast Asian) (list types below):	
Afghans	
F.2: Number of paper referrals to an ACBH PEI-funded program:	3
F.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	3
F.4: Average number of days between referral and first participation in referred PEI program:	30
F.5: Describe how your program encouraged access to services and follow through on above referrals: The APTW strategies for successful linkage to other PEI programs revolve around one-on-one coaching on resources, and education around myths of the risks of seeking mental health support. If a client is willing to be referred to another PEI program, the APTW offers to support with transportation, registration, and other logistical stressors that can be barriers. The APTW team also follows up directly with the PEI provider to ensure a smooth transition.	

Box G: 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 Respondents	
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	Filipino Advocates for Justice
PROGRAM NAME	Filipino Community Wellness Program

Program Outcomes & Impact Data Report FY: 22-23

Program Name:	Filipino Community Wellness Program
Organization:	Filipino Advocates for Justice
Type of Report:	Annual
PEI Category:	Prevention

Priority Area (place an X next to all that apply):	
	Childhood Trauma
	Early Psychosis
X	Youth/TAY Outreach & Engagement
X	Cultural & Linguistic
X	Older Adults
	Early Identification of MH Illness

Outcomes (place an X next to all that apply): Programs focus on reducing the seven negative outcomes that may result from untreated mental illness.	
	Suicide
	Incarceration
X	School failure or dropout
	Unemployment
X	Prolonged suffering
	Homelessness
	Removal of children from their homes

Box A: Brief program description.
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.	
# of unduplicated individuals served who are at risk of developing a serious mental illness:	
Number of unduplicated individuals 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:	

Box C: Demographics of individuals served this fiscal year through MHSA funding:

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	32
Transition Age Youth (16-25 yrs.)	272
Adult (26-59 yrs.)	175
Older Adult (60+ yrs.)	85
Declined to answer	
Unknown	
TOTAL	564

SEXUAL ORIENTATION	
Gay/Lesbian	1
Heterosexual/Straight	177
Bisexual	
Questioning/Unsure	
Queer	98
Declined to answer	
Unknown	288
Another group not listed	
TOTAL	564
If another group is counted, please specify with numbers:	

VETERAN STATUS	
Yes	
No	
Declined to answer	
Unknown	564
TOTAL	564

CURRENT GENDER IDENTITY	
Female	352
Male	135
Transgender	4
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	2
Another identity not listed	71
TOTAL	564

PRIMARY LANGUAGE	
English	437
Spanish	
Cantonese	
Chinese	
Vietnamese	
Farsi	
Arabic	
Tagalog	
Declined to answer	
Unknown	
Other languages not listed	127
TOTAL	564

SEX ASSIGNED AT BIRTH	
Male	
Female	
Declined to answer	
Unknown	
TOTAL	
Male	
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	564
Another disability not listed	
TOTAL	564
If another disability is counted, please specify with numbers:	
RACE	
American Indian or Alaska Native	
Asian	494
Black or African American	2
Native Hawaiian or another Pacific Islander	
White	9
Other Race	31

ETHNITICY/CULTURAL HERITAGE (choose one)	
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	**15**
If Non-Hispanic or Non-Latino, please specify:	
African	
African American	2
Asian Indian/South Asian	494
Cambodian	
Chinese	
Eastern European	
European	
Filipino	
Japanese	
Korean	
Middle Eastern	
Vietnamese	
Other Non-Hispanic or Non-Latino ethnicity not listed	9
Total Non-Hispanic or Non-Latino:	
More than one ethnicity	16
Unknown ethnicity	28
Declined to answer	
ETHNICITY TOTAL	564
If **another ethnicity** is counted, please specify with numbers:	
If **another race** is counted, please specify with numbers:	

Declined to answer	
Unknown	28
TOTAL	564

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of.

High School aged youth destigmatizing accessing mental health services were very well received. Program was particularly responsive to needs of young women of color and gender non-conforming youth.

For TAY, continued growth and collaboration with local community colleges such as Chabot College and Ohlone College by offering LGBTQIA+ support group services & resources to community college students achieving a regular in-person turnout.

Practicing focus group type feedback workshops to allow TAY participants to develop leadership and critical thinking skills to help improve the development of future TAY wellness curriculum.

Elder program participants continued to attend the workshop using Zoom despite age and lack of technology knowledge. They were particularly responsive to workshops on building resilience in challenging times and emotional wellness.

SUCCESS STORY: Our most steady reoccurring youth from last year applied and became an intern. They became a driving force in mental wellness and gender rights/empowerment topics. Progressively got more and more comfortable in the space as a leader and vocal advocate. Has characterized the program and peers as their safe space and secondary family, where they are able to express themselves and identity freely.

SUCCESS STORY: One elder participant was struggling with an adult son with ASD. Though she was reluctant to seek counseling, she became so grateful that she had a safe space and peer support of other elders to share how she felt. Today she is happier and continues to attend our program

Box E: For programs that refer individuals with severe mental illness, please provide information for the categories below:

E.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
E.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
E.3: Types of treatment individuals were referred to (list types below):	
E.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
E.6: Average number of days between referral and first participation in referred treatment	NA

program:	
Box F: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
F.1: Who is/are the underserved target population(s) your program is serving (e.g., TAY, Southeast Asian) (list types below):	
Filipino and other AAPI youth, TAY and adult, including immigrants and LGBTQ.	
F.2: Number of paper referrals to an ACBH PEI-funded program:	0
F.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	16
F.4: Average number of days between referral and first participation in referred PEI program:	7
F.5: Describe how your program encouraged access to services and follow through on above referrals: Received referrals from school COST teams and direct/word of mouth referrals from students and greater FAJ/Filipino American community.	

Box G: 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 Respondents	
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):
Virtual/Telehealth	Youth, TAY, LGBTQ+, Elder Caregivers.
Social media	Community-at-large.

MHSA Program #	PEI 7 Outreach, Education, Consultation (So. Asian) The Hume Center
PROVIDER NAME	The Hume Center (Portia Bell Hume Behavioral Health & Training Center
PROGRAM NAME	South Asian Community Health Promotion Services Program

Program Outcomes & Impact Data Report FY: 22-23

Program Name:	South Asian Community Health Promotion Services
Organization:	The Hume Center
Type of Report:	Annual Report
PEI Category:	UELP (Prevention)
Priority Area (place an X next to all that apply):	
x	Childhood Trauma
	Early Psychosis

X	Youth/TAY Outreach & Engagement
X	Cultural & Linguistic
	Older Adults
X	Early Identification of MH Illness

Outcomes (place an X next to all that apply): Programs focus on <u>reducing</u> the seven negative outcomes that may result from untreated mental illness.

X	Suicide
	Incarceration
X	School failure or dropout
X	Unemployment
X	Prolonged suffering
	Homelessness
X	Removal of children from their homes

Box A: <u>Brief</u> program description.

When life becomes too overwhelming, that result can bring changes in how an individual thinks, feels and acts. The South Asian program provide specialized prevention and early intervention (PEI) services to the South Asian population to participants across the lifespan. We are the main provider in Alameda County for this population, currently serving Afghanis, Bangladeshis, Bhutanese, Asian Indians including Fiji Islanders, Iranians, Maldivians, Nepalese, Pakistanis, and Sri Lankans. We provide these services in the clinic, home visits, in schools, in the community (community centers, religious establishments, etc.) and through telehealth. To meet the linguistic needs of the population services are provided in English, Hindi, Punjabi, Urdu, Farsi, Dari, Gujarati, Marathi, Tamil, and Nepali. These short-term culturally sensitive and language specific services offer support aimed at developing knowledge and skills to work through life challenges effectively. The program also breaks stigmas of mental health through outreach, education, and consultation. Our prevention strategies re-frame mental health and behavioral health care from a pathological perspective to a strength-based, normative, developmental assets focus. Working with immigrants and refugees we understand that they often come from collectivistic cultures, and so we adapt our services so that we are addressing collective wellness, rather than just focusing on individuals within the community. We understand that immigrant and refugee communities rely on their families and community for supporting times of distress. Family, community, and religion are a huge part of building resilience for those that we work with. We adjust our approaches to include these protective factors as
a part of our work. When we work with immigrant and refugee communities, we incorporate these holistic, cultural and religious forms of healing into our services to help build rapport, break stigmas around mental health and increase participation. (Examples: Yoga workshops, Badminton and Soccer groups, Prayer; Meditation). We offer family education and consultation to help educate and increase awareness for families struggling with loved ones with a mental health disorder. We also offer family focused trauma informed care to help address domestic/family violence, immigration trauma and acculturation stress. Our work is focused on strengthening relationships within families and communities. (Offering parent/child workshops, offering community gatherings, engaging families in play through art and games).

The goal of the program is to help community members build resilience which can contribute to the prevention of mental health disorders.

Box B: Number of Individuals served this fiscal year through MHSA funding.	
# of unduplicated individuals served who are at risk of developing a serious mental illness:	
Number of unduplicated individuals 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:	

Box C: Demographics of individuals served this fiscal year through MHSA funding:

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	376
Transition Age Youth (16-25 yrs.)	378
Adult (26-59 yrs.)	3,362
Older Adult (60+ yrs.)	321
Declined to answer	
Unknown	
TOTAL	4,437

SEXUAL ORIENTATION	
Gay/Lesbian	2
Heterosexual/Straight	1,800
Bisexual	4
Questioning/Unsure	1
Queer	8
Declined to answer	
Unknown	2,621
Another group not listed	1
TOTAL	4,437
If another group is counted, please specify with numbers:	

VETERAN STATUS	
Yes	2
No	2,166
Declined to answer	
Unknown	2,269
TOTAL	4,437

CURRENT GENDER IDENTITY	
Female	1,765
Male	2,532
Transgender	
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	134
Another identity not listed	6
TOTAL	4,437

PRIMARY LANGUAGE	
English	2,393
Spanish	
Cantonese	
Chinese	
Vietnamese	
Farsi	159
Arabic	
Tagalog	
Declined to answer	
Unknown	
Other languages not listed	1,876
TOTAL	4,437

SEX ASSIGNED AT BIRTH	
Male	
Female	
Declined to answer	
Unknown	
TOTAL	
Male	
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	2
Chronic health condition	1
Disability Subtotal	
None	
Declined to answer	
Unknown	
Another disability not listed	8
TOTAL	11
If another disability is counted, please specify with numbers:	
RACE	
American Indian or Alaska Native	7
Asian	3,118
Black or African American	53
Native Hawaiian or another Pacific Islander	126
White	275
Other Race	310

ETHNITICY/CULTURAL HERITAGE (choose one)	
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	**50**
If Non-Hispanic or Non-Latino, please specify:	
African	
African American	53
Asian Indian/South Asian	3,118
Cambodian	
Chinese	
Eastern European	
European	
Filipino	
Japanese	
Korean	
Middle Eastern	
Vietnamese	
Other Non-Hispanic or Non-Latino ethnicity not listed	665
Total Non-Hispanic or Non-Latino:	
More than one ethnicity	3
Unknown ethnicity	548
Declined to answer	
ETHNICITY TOTAL	4,437
If **another ethnicity** is counted, please specify with numbers:	
If **another race** is counted, please specify with numbers:	

Declined to answer		
Unknown	548	
TOTAL	4,437	

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of.

Our biggest success and accomplishment this year has been the ability to go back to being in person as a community. Many of our participants have asked to engage in services at our clinic or out in the community. We have adopted more of a hybrid model of services delivery, where we continue to do telehealth with those hard-to-reach community members. Telehealth has continued to help the participants maintain anonymity and minimize other barriers to services. We were able to bring back our Farsi support group in-person but most of our other groups and workshops have remained on Zoom to align with participant's preferences.

We have noticed that the community is rebuilding its resilience and tapping into spiritual/cultural/religious healing practices more often now that the COVID protocols are lifting.
We have increased our visibility out in the community this year by attending many in-person events. We have participated in more than 20 tabling events and have also established a regular presence at a local farmer's market once a month.

One of our biggest accomplishments this year was a collaboration we made with a local South Asian Domestic Violence Agency. We were able to work closely with DV advocates in creating a support workshop for survivors of DV & IPV. Two of our mental health clinicians co-facilitated a 6-week group, focusing on cycle of abuse, emotions, rebuilding community, dealing with identity, anxiety/grief and loss, parenting and moving forward. Participants in the workshop were able to build community with other participants and shared that they appreciated the safe, non-judgmental space to talk about what it means to be a survivor and how can one move forward. From that collaboration we were also able to establish strong relationships with DV advocates who now feel more confident in making referrals to our program for prevention visits and preventative counseling sessions.

Box E: For programs that refer individuals with severe mental illness, please provide information for the categories below:

E.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
E.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):	36
E.3: Types of treatment individuals were referred to (list types below):	
Kaiser, Palo Alto Medical Foundation, Company employee assistance programs, school/college counselors, faith leaders, spiritual healers	
E.4: Unduplicated number of individuals who participated in referred program at least one time:	N/a
G.5: Average duration of untreated mental illness in weeks:	N/a
E.6: Average number of days between referral and first participation in referred treatment program:	N/a

Box F: **For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:**	
F.1: Who is/are the underserved target population(s) your program is serving (e.g., TAY, Southeast Asian) (list types below): This program serves individuals from the unserved and underserved South Asian community, more specifically those from India, Pakistan, Bhutan, Nepal, Sri Lanka, Bangladesh, Maldives, Fiji, Afghanistan and Burma.	
South Asians (India, Pakistan, Nepal, Bhutan, Bangladesh, Sri Lanka, Maldives, Afghanistan)	
F.2: Number of paper referrals to an ACBH PEI-funded program:	8
F.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	4
F.4: Average number of days between referral and first participation in referred PEI program:	N/a
F.5: Describe how your program encouraged access to services and follow through on above referrals:	

Box G: **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 Respondents	
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	20+ counselors, 6+ social workers, 6+ principals, nurses, resource officers, district staff, family partner
Colleges & Universities	professors, administration, counselors, staff, unlimited students & community members
Local CBO's	DV advocates, MH providers, Docs, nurses, social workers, peer/resource spec., first responders, volunteers
Community/Faith Leaders	100+ leaders in Nepalese, Bhutanese, Punjabi, Persian, Pakistani, Indian, Fijian community
Community Centers & Senior Centers	Unlimited Community Members
South Asian Businesses (Restaurants, Grocery Stores, etc.)	Unlimited Community Members
Religious Places of Worship	Unlimited Community Members
Hospitals	Doctors, nurses, admin, social workers, community specialists, volunteers, students
Libraries	Librarians, Staff, Parents, Children, Community Members
Academic Conferences	Professors, Students (Grad, College, HS, K-12),

	Parents, Peers, MH providers, Social Workers, Lawyers, Councilmembers, Senators
Listening Sessions	ACBH staff, State of California Staff, Unlimited CBO's, Community members, etc.

MHSA Program #: 81112

Provider Name: Native American Health Center, INC.

Program Name: Native American Health Center

Program Outcomes & Impact: PEI Data Report

Fiscal Year:	22-23	
Type of Report:	Annual	
PEI Category:	Early Intervention	
Priority Area (X placed 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: Program Description (character limit 500).

We provide an integrated approach that incorporates evidence-based practices, culturally responsive programming, & training on mental health to address the unique challenges of our NA/AN community. We work to increase our community's access to mental health services, healthy lifestyle opportunities, & to stay connected through the diverse services & resources offered. We strive to create lasting positive change & improve the overall well-being for our Youth, Elders, & community.

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):	
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:	

Box C: Demographics of individuals served during this fiscal year through MHSA funding.

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	899
Transition Age Youth (16-25 yrs.)	398
Adult (26-59 yrs.)	445
Older Adult (60+ yrs.)	651
Declined to answer	
Unknown	
TOTAL	**2,393**

VETERAN STATUS	
Yes	15
No	1,345
Declined to answer	
Unknown	1,033
TOTAL	**2,393**

SEX ASSIGNED AT BIRTH	
Female	
Male	
Declined to answer	
Unknown	
TOTAL	**0**

CURRENT GENDER IDENTITY	
Female	1,416
Male	929
Transgender	
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	48
Another identity not listed (see below)	
TOTAL	**2,393**

If another gender identity is counted, please specify:

SEXUAL ORIENTATION	
Gay/Lesbian	9
Heterosexual/Straight	544
Bisexual	
Questioning/Unsure	
Queer	
Declined to answer	

DISABILITY STATUS	
Communication Domain	
Vision	2
Hearing/Speech	7
Another type not listed	
Communication Domain Subtotal	
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	
Physical/mobility	337
Chronic health condition	
Disability Domain Subtotal	**0**
None	
Declined to answer	
Unknown	
Another disability not listed (see below)	
TOTAL	**346**

If another disability is counted, please specify:

PRIMARY LANGUAGE	
English	2,344
Spanish	42
Cantonese	
Mandarin	

Unknown	1,840
Another orientation not listed (see below)	
TOTAL	**2,393**

If another sexual orientation is counted, please specify:

Vietnamese	
Farsi	
Arabic	
Tagalog	
Declined to answer	
Unknown	
Another language not listed (see below)	7
TOTAL	**2,393**

If another language is counted, please specify:

Box C Continued: Demographics of individuals served during this fiscal year through MHSA funding.

RACE	
American Indian or Alaska Native	1,347
Asian	
Black or African American	161
Native Hawaiian or Other Pacific Islander	
White	16
Declined to answer	
Another Race not listed (see below)	854
Unknown	15
TOTAL	**2,393**

If another race is counted, please specify:

ETHNICITY/CULTURAL HERITIAGE	
If Hispanic or Latino, please specify:	
Caribbean	
Central American	
Mexican/Mexican American/Chicano	
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed (see below)	
Total Hispanic or Latino	**789**
If Non-Hispanic or Non-Latino, please specify:	
African	
African American	161
Asian Indian/South Asian	
Cambodian	
Chinese	
Eastern European	
European	
Filipino	

Japanese	
Korean	
Middle Eastern	
Vietnamese	
Another Non-Hispanic/Latino ethnicity not listed (see below)	1,428
Total Non-Hispanic or Non-Latino	**0**
More than one ethnicity	
Unknown Ethnicity	15
Declined to answer	
ETHNICITY TOTAL	**2,393**

If another ethnicity is counted, please specify:

Box D: Program successes/accomplishments of the past year with one example or case study that the agency is particularly proud of. (character limit 1,000)

The program successes/accomplishments from this past year that we are particularly proud of was our ability to hit the ground running when we went back to being able to hold in person activities. We found that offering a hybrid version of our program works best. Virtual was a wonderful way to reach out to those with transportation issues & time constraints. We believe the continued use of virtual platforms works & that utilizing when necessary is cost & time effective. Going back to in-person has been so healing for both our participants & staff. Being able to see faces & share time was missed by all. Staff did their best to make sure our youth, elders & community felt cared for & thought of. We plan to continue the Food Security Project & the parts of the program that are needed & that are successful. the positive part of COVID was that it taught us to be kinder, to have patience & to have more compassion with participants as well as each other.

Box E: Program challenges of the past year and how the agency mitigated the challenges. (character limit 1,000)

Due to us being a clinic, we had to follow more stringent guidelines for safety. When other agencies got to reopen at full capacity, we continued to adhere to the same restrictions as hospitals. To mitigate our situation, we held groups with a small number of attendees outside and continued to wear masks. Once we were able to restart our in-house programming and up our capacity with our youth & adults, we felt a sense of relief. Our Youth Summer Program has been amazing and exciting, our youth have had a wonderful Summer. We held a lovely spring event for our Elders at a park and have opened our Cedar Center to hold beading, art, & other groups. Staff have really worked hard to make sure our participants and clients were well taken care of during the last year. We are looking forward to this next year & what we will be able to do with our community.

Box F: Program lessons learned of the past year. (character limit 1,000)

We learned that our community has a tremendous amount of resiliency & together we can get through anything. 1. That we need to maintain and continue the Food Security Project, families and elders have conveyed the cost of food is a stressor the supplementary help we provide help. 2. Grief continues to play a big role in our community with the loss of 4 of our elders. We learned our programs hold a special place for our community & we need to expand services to address issues as they arise.3. Going back to normal takes time, working together to rebuild has been difficult however, we have built stronger bonds with our youth, families, & Elders. They've had to trust us and allow us closer in the last few years. When we drop off our care packages or food boxes we see where they live, this takes a lot on their behalf, so we have to always be aware of how we navigate through our visits & interactions carefully.

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):	
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):	
G.3: Types of treatment individuals were referred to (list types) (250-character limit):	care coordination and Recipe 4 Health
G.4: Unduplicated number of individuals who participated in referred program at least one time:	88
G.5: Average duration of untreated mental illness in weeks:	
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, 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):	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.
H.2: Number of paper referrals to an ACBH PEI-funded program:	46
H.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	117
H.4: Average number of days between referral and first participation in referred PEI program:	7

H.5: Describe how your program encouraged access to services and follow through on above referrals (250 Characters):	

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.)***

TOTAL 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 10 Outreach, Education and Consultation (African)
PROVIDER NAME	Partnerships for Trauma Recovery
PROGRAM NAME	African Communities Program

Program Outcomes & Impact Data Report FY: 22-23

Program Name:	African Communities Program
Organization:	Partnerships for Trauma Recovery
Type of Report:	Annual
PEI Category:	Prevention

Priority Area (place an X next to all that apply):

	Childhood Trauma
	Early Psychosis
	Youth/TAY Outreach & Engagement
X	Cultural & Linguistic
	Older Adults
	Early Identification of MH Illness

Outcomes (place an X next to all that apply): Programs focus on reducing the seven negative outcomes that may result from untreated mental illness.

X	Suicide
	Incarceration
	School failure or dropout
X	Unemployment
X	Prolonged suffering
X	Homelessness
	Removal of children from their homes

Box A: **Brief** program description.

Partnerships for Trauma Recovery (PTR) offers culturally sensitive, trauma-informed, and linguistically accessible PEI services, coupled with community-based healing, to marginalized communities of forcibly displaced youth, women, men, and families from various African countries. While primarily centered in North and South Alameda County, PTR's reach extends beyond these areas. Driven by a steadfast commitment to technical excellence, PTR ensures the delivery of inclusive and comprehensive behavioral health care, as well as short-term, solution-focused psycho-social and case management support for individuals who have experienced violence and persecution in their countries of origin.

Box B: Number of Individuals served this fiscal year through MHSA funding.

# of unduplicated individuals served who are at risk of developing a serious mental illness:	
Number of unduplicated individuals 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:	

Box C: Demographics of individuals served this fiscal year through MHSA funding:

AGE CATEGORIES		SEXUAL ORIENTATION	
Children/Youth (0-15 yrs.)	88	Gay/Lesbian	
Transition Age Youth (16-25 yrs.)	228	Heterosexual/Straight	767
Adult (26-59 yrs.)	1,135	Bisexual	
Older Adult (60+ yrs.)	124	Questioning/Unsure	
Declined to answer		Queer	
Unknown	1	Declined to answer	
TOTAL	1,576	Unknown	809
		Another group not listed	
		TOTAL	1,576
		If another group is counted, please specify with numbers:	

VETERAN STATUS	PRIMARY LANGUAGE

Yes	40
No	751
Declined to answer	
Unknown	785
TOTAL	1,576

CURRENT GENDER IDENTITY	
Female	806
Male	751
Transgender	
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	19
Another identity not listed	
TOTAL	1,576
If another group is counted, please specify with numbers:	

English	704
Spanish	
Cantonese	
Chinese	
Vietnamese	
Farsi	
Arabic	
Tagalog	
Declined to answer	
Unknown	
Other languages not listed	870
TOTAL	1,576

SEX ASSIGNED AT BIRTH	
Male	
Female	
Declined to answer	
Unknown	
TOTAL	
Male	

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	3
Chronic health condition	
Disability Subtotal	

ETHNITICY/CULTURAL HERITAGE (choose one)	
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	**1**
If Non-Hispanic or Non-Latino, please specify:	
African	
African American	1,540
Asian Indian/South Asian	1
Cambodian	
Chinese	
Eastern European	
European	
Filipino	
Japanese	
Korean	
Middle Eastern	

None		Vietnamese	
Declined to answer		Other Non-Hispanic or Non-Latino ethnicity not listed	34
Unknown		**Total Non-Hispanic or Non-Latino:**	
Another disability not listed	5	More than one ethnicity	
TOTAL	8	Unknown ethnicity	
If another disability is counted, please specify with numbers:		Declined to answer	
		ETHNICITY TOTAL	1,576
		If **another ethnicity** is counted, please specify with numbers:	
RACE			
American Indian or Alaska Native		If **another race** is counted, please specify with numbers:	
Asian			
Black or African American	1,540		
Native Hawaiian or another Pacific Islander			
White	18		
Other Race	17		
Declined to answer			
Unknown			
TOTAL	1,576		

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of.

PTR's African Communities Program made significant strides, impacting a total of 1578 community members. They provided counseling to 32 registered clients on Insyst, excluding 15 who opted not to register, and engaged African immigrants in various activities, including 12 psycho-educational workshops, 3 educational workshops, 3 support groups, 7 community events, and 11 mental health consultations. The program also conducted prevention visits for 102 potential clients, offering a maximum of six sessions, and distributed program materials through 3 listservs.

The major accomplishments of the program revolved around creating a more culturally responsive approach to care, fostering space for collective healing, and ensuring accessibility to psychology and mental health information. This involved considering the cultural context from which community members came and aligning interventions and supportive services with their beliefs and practices. This approach enabled community members to heal within their own cultural framework, empowering them with choices and support to address trauma both individually and collectively.

Additionally, PTR designed events that catered to the mental health needs of those who might be hesitant to directly engage in clinically therapeutic spaces. The Decolonizing Healing Series of educational workshop, and Afro-soccer wellness events were among the activities incorporated during the year to promote community-based healing. These efforts aimed to destigmatize seeking help and create opportunities for healing in culturally relevant and accessible ways.

The main ongoing challenge for PTR was entering personal client information into the InSyst system, with 15 clients choosing not to consent to registration. Most PTR's clients are asylum seekers, facing uncertain immigration status and a history of trauma, making them apprehensive about sharing personal and identifiable information such as date of birth, full name, and social security number. This concern causes significant stress and anxiety for these clients.

In response to this issue, PTR took proactive steps by creating a unique consent form, a helpful tip-sheet, and a user-friendly referral form specifically designed for UELP clients. These documents clearly outline the information shared in InSyst and the level of protection guaranteed by Alameda County to address clients' fears and provide reassurance.

Despite this challenge, PTR made considerable progress by conducting prevention visits for 102 potential clients and offering mental health consultations to 113 community members. These positive outcomes are promising indicators of PTR's ability to expand the number of clients benefiting from PEI counseling services.

Box E: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
E.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):	32
E.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
E.3: Types of treatment individuals were referred to (list types below):	
In the PTR ACP, the mental health specialist played a crucial role in facilitating internal referrals for long-term individual and group psychotherapy, as well as case management, connecting clients with our skilled staff clinicians and case workers. This process always prioritized obtaining the informed consent of clients or their caregivers. Furthermore, the program provided opportunities for diagnosis and assessment of mental, emotional, and behavioral disorders through our Pro Bono psychiatrists.	
E.4: Unduplicated number of individuals who participated in referred program at least one time:	32
G.5: Average duration of untreated mental illness in weeks:	4 weeks
E.6: Average number of days between referral and first participation in referred treatment program:	7 days

Box F: **For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:**	
F.1: Who is/are the underserved target population(s) your program is serving (e.g., TAY, Southeast Asian) (list types below):	
African refugees, asylum-seekers, and immigrants in general who reside in North and South Alameda County and beyond.	
F.2: Number of paper referrals to an ACBH PEI-funded program:	0
F.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	32
F.4: Average number of days between referral and first participation in referred PEI program:	7 days
F.5: Describe how your program encouraged access to services and follow through on above referrals: The ACP Coordinators took initiative in organizing a diverse array of linguistically accessible and culturally appropriate outreach events, aiming to promote community health-seeking behavior and enhance access to mental health services. These events encompassed prevention visits, case management sessions, mental health consultations, outreach events, and psycho-educational workshops. To effectively address mental health stigmatization, the coordinators actively collaborated with influential figures and role models within the community. Furthermore, the program embraced community-based healing interventions, embracing healing through various means, including sports, art, drumming, and partnerships with community-based organizations (CBOs). Additionally, insightful panel discussions were incorporated to enrich the healing process. These strategies proved to be invaluable in fostering a positive start to healing and overall well-being within the community.	

Box G: **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 Respondents	
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 sessions	377 general community members and 27 community leaders through psycho-educational workshops
Phone calls and in-person meetings	104 potential clients through prevention visits, 27 community leaders, 7 youth from school
social media (Facebook, Instagram)	328 likes
WhatsApp Group	African Student Association, Rwandan, Ethiopian, Eritrean, Ivory Coast, and Liberian Community Associations
Senior centers	55 Ethiopian and Eritrean senior and elderly communities

MHSA Program #:	**PEI 19 Outreach, Education, & Consultation (Middle-Eastern)-DHTI**
Provider Name:	**Diversity in Health Training Institute's Sidra Program**
Program Name:	**PEI for UELP**

Program Outcomes & Impact: PEI Data Report

Fiscal Year:	22-23	
Type of Report:	Annual	
PEI Category:		
Priority Area (X placed 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: Program Description (character limit 500).

Sidra Community Wellness Program (SIDRA) launched in July 2019. The purpose of SIDRA is to promote healing, wellness, and mental health among Middle Eastern and North African communities in Alameda County. We offer preventive counseling, support groups, educational and cultural workshops, community events, and referrals and linkages to promote and support community wellness. We also offer consultations to local organizations.

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):	38
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:	30
Grand total of unduplicated individuals served:	

Box C: Demographics of individuals served during this fiscal year through MHSA funding.

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	9
Transition Age Youth (16-25 yrs.)	29
Adult (26-59 yrs.)	
Older Adult (60+ yrs.)	
Declined to answer	
Unknown	
TOTAL	**38**

VETERAN STATUS	
Yes	
No	
Declined to answer	
Unknown	
TOTAL	**0**

SEX ASSIGNED AT BIRTH	
Female	17
Male	21
Declined to answer	
Unknown	
TOTAL	**38**

CURRENT GENDER IDENTITY	
Female	17
Male	21
Transgender	
Genderqueer	
Questioning/unsure of gender identity	
Declined to answer	
Unknown	
Another identity not listed (see below)	
TOTAL	**38**

If another gender identity 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 Domain Subtotal	**0**
None	
Declined to answer	
Unknown	
Another disability not listed (see below)	
TOTAL	**0**

If another disability is counted, please specify:

SEXUAL ORIENTATION	
Gay/Lesbian	
Heterosexual/Straight	
Bisexual	
Questioning/Unsure	
Queer	
Declined to answer	
Unknown	38

PRIMARY LANGUAGE	
English	
Spanish	
Cantonese	
Mandarin	
Vietnamese	

Another orientation not listed (see below)	
TOTAL	**38**

If another sexual orientation is counted, please specify:

Farsi	27
Arabic	11
Tagalog	
Declined to answer	
Unknown	
Another language not listed (see below)	
TOTAL	**38**

If another language is counted, please specify:

American Indian or Alaska Native	
Asian	
Black or African American	
Native Hawaiian or Other Pacific Islander	
White	
Declined to answer	
Another Race not listed (see below)	
Unknown	
TOTAL	**0**

If another race is counted, please specify:

If Hispanic or Latino, please specify:	
Caribbean	
Central American	
Mexican/Mexican American/Chicano	
Puerto Rican	
South American	
Another Hispanic/Latino ethnicity not listed (see below)	
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	38
Vietnamese	

Another Non-Hispanic/Latino ethnicity not listed (see below)	
Total Non-Hispanic or Non-Latino	**38**
More than one ethnicity	
Unknown Ethnicity	
Declined to answer	
ETHNICITY TOTAL	**38**

If another ethnicity is counted, please specify:

Box D: Program successes/accomplishments of the past year with one example or case study that the agency is particularly proud of. (character limit 1,000)

The team's greatest accomplishment this year has been developing a process for getting hard-to-reach clients connected with mental health services. In most initial encounters, clients are not interested in sharing their challenges. In many MENA cultures, talking about your problems with others is seen as shameful. However, the Sidra team has found a way to connect clients with support. A great example of this is a student who was referred to the program by the school for behavioral issues. The student met with the Sidra team but refused therapy. Sidra staff stayed in contact with the student and invited him to workshops and cultural events. After building rapport with the mental health specialist (MHS) at these events, the student reached out about receiving therapy. The MHS provides preventative counseling, while other team members offer case management services to his family to address underlying stressors. We have enrolled 37 preventative counseling clients in the same way.

Box E: Program challenges of the past year and how the agency mitigated the challenges. (character limit 1,000)

One major challenge was navigating translation during workshops and support groups where Arabic and Farsi speaking were together. We addressed this by providing the same workshop topics to Arabic and Farsi speaking students separately so that every student could understand the session. We did this while also providing cultural events to encourage all MENA communities to participate and build community. Another challenge was balancing the number of workshops, support groups, and cultural events. In order to ensure that students did not feel overwhelmed and that there wasn't excessive overlap of topics and resource-sharing, we began to coordinate with the school's Community Manager. An ongoing challenge that our community is impacted by is the stigma around mental health. We have found creative ways to address this by offering low-stress, interactive events with Sidra staff so that students can begin to build rapport and ease into the therapeutic process when needed.

Box F: Program lessons learned of the past year. (character limit 1,000)

As a team, we have learned how to continue growing and improving our services. We have learned that the best way for us to address the mental health needs within the community is by allowing people to move at their own pace. We cannot pressure people into accessing mental health services, but with time clients trust that we are serving them with the best intentions. We have also learned that not every student will benefit equally from individual counseling, workshops, or support groups. For this reason, our team is offering a range of activities so students are exposed to a number of protective factors. These protective factors include cultural events that offer a sense of belonging, staff who are welcoming and offer emotional and concrete support, and educational opportunities for their own self-development. We have also learned how collaborating with other organizations can improve our impact and reach. We plan to continue building partnerships to expand our programs.

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):	N/A
G.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e. mental health treatment services):	24
G.3: Types of treatment individuals were referred to (list types) (250 character limit):	mental health providers that provide long-term care
G.4: Unduplicated number of individuals who participated in referred program at least one time:	10
G.5: Average duration of untreated mental illness in weeks:	N/A
G.6: . Average number of days between referral and first participation in referred treatment program:	30

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):	Middle Eastern and North African communities, Arabic speaking communities, mothers and grandmothers, youth, transitional age youth, older adults, women, men
H.2: Number of paper referrals to an ACBH PEI-funded program:	10
H.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	4
H.4: Average number of days between referral and first participation in referred PEI program:	30

H.5: Describe how your program encouraged access to services and follow through on above referrals (250 Characters):	We introduced the program/provider to the client, and made the initial phone call to get them in contact. Once the client and provider were connected, staff reached out to client on weekly basis to track progress and maintained communication with provider when needed.

Box I: For <u>Outreach, Suicide Prevention, and Stigma Reduction</u> programs, information for unduplicated potential responders (i.e., those who are in a position to identify early signs of potentially severe mental illness provide support, and or refer individuals who need treatment) reached. ***(Note: For Prevention, Early Intervention, Access & Linkage programs, this section is optional.)***

TOTAL NUMBER OF RESPONDERS:	
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):
School - UC Davis Field Trip - Exploring College Life for Oakland International High School Students	*15 students, 3 Sidra staff*
Back to School Event	*40 students, 15 school staff, 4 Sidra staff*
Chai Hour with Sidra	*10 Parents*
Persian New Year Event	*30 students, 10 school staff*
Cultural Event Workshop at DHTI Office	*10 parents*
Afghan Kite Celebration at Park (Oakland)	*5 families (30 people), 3 Sidra staff*
Afghan Kite Celebration at Park (Fremont)	*6 families (30 people), 3 Sidra staff*
Self-Care for Afghan Girls Workshop at DHTI Office	*12 youth*
Managing Stress Workshop at School	*24 students*
Healthy Relationships Workshop Series at School	*20 students*

New Years Resolution Workshop	*15 students*
Applying for Grants & Scholarships Workshop at School	*20 students*
Exercise & Wellbeing Workshop at school	*20 students*
Building Habits Workshop at school	*15 students*

PEI: Access and Linkage

MHSA Program #	PEI 1B
PROVIDER NAME	Center for Healthy Schools and Communities
PROGRAM NAME	School-based Mental Health Access & Linkage in Elementary, Middle & High School

Program Outcomes & Impact Data Report FY: 22-23

Program Name:	School-based Mental Health Access & Linkage in Elementary, Middle & High School
Organization:	Center for Healthy Schools and Communities
Type of Report:	Annual
PEI Category:	Access and Linkage

Priority Area (place an X next to all that apply):	
X	Childhood Trauma
X	Early Psychosis
X	Youth/TAY Outreach & Engagement
	Cultural & Linguistic
	Older Adults
X	Early Identification of MH Illness

Outcomes (place an X next to all that apply): Programs focus on <u>reducing</u> the seven negative outcomes that may result from untreated mental illness.	
X	Suicide
X	Incarceration
X	School failure or dropout
	Unemployment
X	Prolonged suffering
X	Homelessness
X	Removal of children from their homes

Box A: <u>Brief</u> program description.

Coordination of Services Team (COST) is a strategy used to integrate behavioral health and other health care supports for students through a referral and triage process. A universal referral system is used by

teachers and staff to flag students who need support. School staff and service providers collaborate to determine the best intervention or support service for referred students. PEI funds aid in the implementation of COST in 292 schools across 14 school districts in Alameda County.

Box B: Number of Individuals served this fiscal year through MHSA funding.	
# of unduplicated individuals served who are at risk of developing a serious mental illness:	5078
Number of unduplicated individuals served who show early signs of forming a more severe mental illness:	5484
Number of unduplicated individual family members served indirectly by your program:	0
Grand total of unduplicated individuals served:	

Box C: Demographics of individuals served this fiscal year through MHSA funding:

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	14630
Transition Age Youth (16-25 yrs.)	6605
Adult (26-59 yrs.)	0
Older Adult (60+ yrs.)	0
Declined to answer	0
Unknown	0
TOTAL	**21235**

SEXUAL ORIENTATION	
Gay/Lesbian	18
Heterosexual/Straight	519
Bisexual	2
Questioning/Unsure	9
Queer	4
Declined to answer	27
Unknown	6934
Another group not listed	4
TOTAL	**7517**
If another group is counted, please specify with numbers:	

VETERAN STATUS	
Yes	0
No	0
Declined to answer	0
Unknown	0
TOTAL	**0**

CURRENT GENDER IDENTITY	
Female	3807
Male	4216
Transgender	15
Genderqueer	4
Questioning/unsure of gender identity	8
Declined to answer	3
Unknown	4293
Another identity not listed	28
TOTAL	**12374**
If another group is counted, please specify with	

PRIMARY LANGUAGE	
English	9903
Spanish	5182
Cantonese	425
Chinese	165
Vietnamese	104
Farsi	116
Arabic	135
Tagalog	114
Declined to answer	93
Unknown	1189
Other languages not listed	666
TOTAL	**18092**

numbers:

SEX ASSIGNED AT BIRTH	
Male	6693
Female	6252
Declined to answer	29
Unknown	1055
TOTAL	**14029**

DISABILITY STATUS	
Communication Domain	
Vision	43
Hearing/Speech	115
Another type not listed	0
Communication Domain Subtotal	**158**
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	282
Physical/mobility	2
Chronic health condition	39
Disability Subtotal	**323**
None	5689
Declined to answer	4952
Unknown	0
Another disability not listed	928
TOTAL	**12050**

If another disability is counted, please specify with numbers:

RACE	
American Indian or Alaska Native	231
Asian	1902
Black or African American	3126
Native Hawaiian or another Pacific	302

ETHNITICY/CULTURAL HERITAGE (choose one)	
If Hispanic or Latino, please specify:	
Caribbean	5
Central American	86
Mexican/Mexican American/Chicano	521
Puerto Rican	6
South American	17
Another Hispanic/Latino ethnicity not listed	260
Total Hispanic or Latino	**895**
If Non-Hispanic or Non-Latino, please specify:	
African	40
African American	836
Asian Indian/South Asian	530
Cambodian	17
Chinese	167
Eastern European	7
European	16
Filipino	337
Japanese	18
Korean	12
Middle Eastern	64
Vietnamese	91
Other Non-Hispanic or Non-Latino ethnicity not listed	179
Total Non-Hispanic or Non-Latino:	**2314**
More than one ethnicity	319
Unknown ethnicity	6741
Declined to answer	710
ETHNICITY TOTAL	**10979**

If **another ethnicity** is counted, please specify with numbers:

If **another race** is counted, please specify with numbers: Hispanic or Latino- 8197 More than one race- 1118

Islander	
White	2704
Other Race	0
Declined to answer	366
Unknown	2209
TOTAL	**20155**

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of.
Through COST, 8883 students across 292 schools and 14 school districts in Alameda County were referred and linked to behavioral health services and supports. While schools continue to see an increased need in Tier 2 & 3 behavioral health services, there was a shortage of on-site and community-based therapists leading to long waitlists for students. In response, many school districts utilized short-term COVID relief funds to strengthen Tier 1 supports and diversify behavioral service support through wellness centers and through non-clinical, mental health and case management staff. School districts also strengthened COST infrastructure by updating COST tracking and referral processes and improved collaboration among schools, community-based organizations and families. Two school districts reported providing continual counseling and wrap around supports to students and families who were Mckiney-Vento status and saw drastic improvements in academics and behavioral health.

Box E: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
E.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):	2974
E.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e., mental health treatment services):	N/A
E.3: Types of treatment individuals were referred to (list types below):	
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.	
E.4: Unduplicated number of individuals who participated in referred program at least one time:	2974
G.5: Average duration of untreated mental illness in weeks:	N/A
E.6: Average number of days between referral and first participation in referred treatment program:	N/A
Box F: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
F.1: Who is/are the underserved target population(s) your program is serving (e.g., TAY, Southeast Asian) (list types below):	
Transitional-aged youth, foster youth, LGBTQ-identifying youth, boys and young men of color, unaccompanied immigrant youth, food and shelter insecure youth and families, and English as a second language youth.	
F.2: Number of paper referrals to an ACBH PEI-funded program:	N/A

F.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	N/A
F.4: Average number of days between referral and first participation in referred PEI program:	N/A

F.5: Describe how your program encouraged access to services and follow through on above referrals:

Strategies that increase access and follow through include partnerships with family outreach workers, community based agencies, information sharing through family workshops and professional Learning sessions for staff, and building relationships with students.

Box G: 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 Respondents	N/A
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):

MHSA Program #	PEI 1C
PROVIDER NAME	JFCS-EB Juliana Ybarra, PsyD
PROGRAM NAME	Early Childhood Mental Health Consultation

Program Outcomes & Impact Data Report FY: 22-23

Program Name:	Early Childhood Mental Health Consultation
Organization:	Jewish Family & Community Services – East Bay
Type of Report:	Annual
PEI Category:	Access and Linkage

Priority Area (place an X next to all that apply):

X	Childhood Trauma
	Early Psychosis
	Youth/TAY Outreach & Engagement
	Cultural & Linguistic
	Older Adults
X	Early Identification of MH Illness

Outcomes (place an X next to all that apply): Programs focus on reducing the seven negative outcomes that may result from untreated mental illness.

	Suicide

	Incarceration
	School failure or dropout
	Unemployment
	Prolonged suffering
	Homelessness
	Removal of children from their homes

Box A: **Brief** program description.
Early Childhood Mental Health Consultation is an intervention that promotes the social, emotional, and behavioral health of children in ECE Programs. Consultants help build the capacity of families, staff, programs, and systems to increase understanding of children's behavior to prevent, identify, and reduce, the impact of 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.	
# of unduplicated individuals served who are at risk of developing a serious mental illness:	0
Number of unduplicated individuals served who show early signs of forming a more severe mental illness:	0
Number of unduplicated individual family members served indirectly by your program:	15
Grand total of unduplicated individuals served:	15

Box C: Demographics of individuals served this fiscal year through MHSA funding:

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	15
Transition Age Youth (16-25 yrs.)	0
Adult (26-59 yrs.)	0
Older Adult (60+ yrs.)	0
Declined to answer	0
Unknown	0
TOTAL	**15**

SEXUAL ORIENTATION	
Gay/Lesbian	0
Heterosexual/Straight	0
Bisexual	0
Questioning/Unsure	0
Queer	0
Declined to answer	0
Unknown	15
Another group not listed	0
TOTAL	**15**
If another group is counted, please specify with numbers:	

VETERAN STATUS	
Yes	0
No	15
Declined to answer	0
Unknown	0
TOTAL	**15**

PRIMARY LANGUAGE	
English	11
Spanish	0
Cantonese	2
Chinese	0
Vietnamese	0
Farsi	0
Arabic	0
Tagalog	0

CURRENT GENDER IDENTITY	
Female	7

Male	8	Declined to answer	0
Transgender	0	Unknown	2
Genderqueer	0	Other languages not listed	0
Questioning/unsure of gender identity	0	**TOTAL**	**15**
Declined to answer	0		
Unknown	0		
Another identity not listed	0		
TOTAL	**15**		
If another group is counted, please specify with numbers:			

SEX ASSIGNED AT BIRTH		**ETHNITICY/CULTURAL HERITAGE (choose one)**	
Male	7	**If Hispanic or Latino, please specify:**	
Female	8	Caribbean	0
Declined to answer	0	Central American	0
Unknown	0	Mexican/Mexican American/Chicano	4
TOTAL	**15**	Puerto Rican	0
		South American	0
		Another Hispanic/Latino ethnicity not listed	0
DISABILITY STATUS		**Total Hispanic or Latino**	**8**
Communication Domain		**If Non-Hispanic or Non-Latino, please specify:**	
Vision	0	African	2
Hearing/Speech	2	African American	3
Another type not listed	0	Asian Indian/South Asian	0
Communication Domain Subtotal	**2**	Cambodian	0
Disability Domain		Chinese	2
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	1	Eastern European	0
		European	0
		Filipino	0
Physical/mobility	0	Japanese	0
Chronic health condition	0	Korean	0
Disability Subtotal	**1**	Middle Eastern	0
None	0	Vietnamese	0
Declined to answer	0	Other Non-Hispanic or Non-Latino ethnicity not listed	0
Unknown	12	**Total Non-Hispanic or Non-Latino:**	**7**
Another disability not listed	0	More than one ethnicity	0
TOTAL	**15**	Unknown ethnicity	0
If another disability is counted, please specify with numbers:		Declined to answer	0
		ETHNICITY TOTAL	**15**

		If **another ethnicity** is counted, please specify with numbers:
RACE		
American Indian or Alaska Native	0	If **another race** is counted, please specify with numbers:
Asian	2	
Black or African American	5	
Native Hawaiian or another Pacific Islander	0	
White	0	
Other Race	5	
Declined to answer	0	
Unknown	0	
TOTAL	**15**	

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of.
School staff experienced multiple losses on professional and personal levels. Clinicians were able to support teachers and kids through these losses and build resiliency. Classrooms came out of the difficult time feeling supported and resilient.

Box E: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
E.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e., mental health treatment services):	N/A
E.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e., mental health treatment services):	N/A
E.3: Types of treatment individuals were referred to (list types below):	
N/A	
E.4: Unduplicated number of individuals who participated in referred program at least one time:	N/A
G.5: Average duration of untreated mental illness in weeks:	N/A
E.6: Average number of days between referral and first participation in referred treatment program:	N/A
Box F: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
F.1: Who is/are the underserved target population(s) your program is serving (e.g., TAY, Southeast Asian) (list types below):	
N/A	
F.2: Number of paper referrals to an ACBH PEI-funded program:	N/A
F.3: Unduplicated number of individuals who participated in referred PEI-program at least	N/A

one time:	
F.4: Average number of days between referral and first participation in referred PEI program:	N/A
F.5: Describe how your program encouraged access to services and follow through on above referrals:	
N/A	

Box G: 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 Respondents	**N/A**
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):

MHSA Program #	PEI 3
PROVIDER NAME	GART/ACBH
PROGRAM NAME	Geriatric Assessment & Response Team

Program Outcomes & Impact Data Report FY: 22-23

Program Name:	Geriatric Assessment & Response Team (GART)
Organization:	ACBH
Type of Report:	Annual
PEI Category:	Prevention, Early Intervention, Outreach, Access & Linkage

Priority Area (place an X next to all that apply):	
	Childhood Trauma
	Early Psychosis
	Youth/TAY Outreach & Engagement
	Cultural & Linguistic
X	Older Adults
	Early Identification of MH Illness

Outcomes (place an X next to all that apply): Programs focus on reducing the seven negative outcomes that may result from untreated mental illness.	
X	Suicide
X	Incarceration
	School failure or dropout
	Unemployment
X	Prolonged suffering

X	Homelessness
	Removal of children from their homes

Box A: **Brief** program description.
The Geriatric Assessment and Response Team (GART) program is a brief therapeutic treatment and case management service for older adults aged 55+ in Alameda County. GART screens and evaluates older adults for behavioral health care needs and provides age-appropriate interventions. The program's goals are to maintain independence, offer an alternative to hospitalization, promote consumer recovery, provide culturally competent services, and integrate care approaches. GART aims to empower older adults, enhance their wellness, and improve their quality of life through linkage to best matched care.

Box B: Number of Individuals served this fiscal year through MHSA funding.	
# of unduplicated individuals served who are at risk of developing a serious mental illness:	133
Number of unduplicated individuals served who show early signs of forming a more severe mental illness:	133
Number of unduplicated individual family members served indirectly by your program:	N/A
Grand total of unduplicated individuals served:	133

Box C: Demographics of individuals served this fiscal year through MHSA funding:

AGE CATEGORIES		**SEXUAL ORIENTATION**	
Children/Youth (0-15 yrs.)	0	Gay/Lesbian	2
Transition Age Youth (16-25 yrs.)	0	Heterosexual/Straight	27
Adult (26-59 yrs.)	42	Bisexual	0
Older Adult (60+ yrs.)	93	Questioning/Unsure	0
Declined to answer	0	Queer	0
Unknown	0	Declined to answer	1
TOTAL	**135**	Unknown	76
		Another group not listed	27
		TOTAL	**133**
		If another group is counted, please specify with numbers:	

VETERAN STATUS		**PRIMARY LANGUAGE**	
Yes	0	English	123
No	8	Spanish	4
Declined to answer	7	Cantonese	2
Unknown	118	Chinese	3
TOTAL	**133**	Vietnamese	1
		Farsi	0
CURRENT GENDER IDENTITY		Arabic	0
Female	76	Tagalog	0
Male	57	Declined to answer	0
Transgender	0	Unknown	0

Genderqueer	0	Other languages not listed	0
Questioning/unsure of gender identity	0	**TOTAL**	**133**
Declined to answer	0		
Unknown	0		
Another identity not listed	0		
TOTAL	**133**		
If another group is counted, please specify with numbers:			

SEX ASSIGNED AT BIRTH		**ETHNITICY/CULTURAL HERITAGE (choose one)**	
Male	48	**If Hispanic or Latino, please specify:**	
Female	55	Caribbean	0
Declined to answer	3	Central American	0
Unknown	27	Mexican/Mexican American/Chicano	1
TOTAL	**133**	Puerto Rican	0
		South American	0
		Another Hispanic/Latino ethnicity not listed	9
DISABILITY STATUS		**Total Hispanic or Latino**	**10**
Communication Domain		**If Non-Hispanic or Non-Latino, please specify:**	
Vision	2	African	0
Hearing/Speech	0	African American	54
Another type not listed	0	Asian Indian/South Asian	0
Communication Domain Subtotal	**2**	Cambodian	0
Disability Domain		Chinese	2
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	0	Eastern European	0
		European	56
		Filipino	0
Physical/mobility	9	Japanese	0
Chronic health condition	0	Korean	0
Disability Subtotal	**9**	Middle Eastern	0
None	87	Vietnamese	2
Declined to answer	0	Other Non-Hispanic or Non-Latino ethnicity not listed	4
Unknown	35	**Total Non-Hispanic or Non-Latino:**	**116**
Another disability not listed	0	More than one ethnicity	0
TOTAL	**133**	Unknown ethnicity	0
		Declined to answer	5
		ETHNICITY TOTAL	**133**
If another disability is counted, please specify with numbers:		If **another ethnicity** is counted, please specify with numbers:	

RACE		
American Indian or Alaska Native	1	If **another race** is counted, please specify with numbers:
Asian	6	
Black or African American	54	
Native Hawaiian or another Pacific Islander	1	
White	56	
Other Race	5	
Declined to answer	N/A	
Unknown	0	
TOTAL	**133**	

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of.
One specific case study stands out as a success story that we are particularly proud of. The client, a 58-year-old cis-gendered female of Mexican descent, came to the GART program with a complex set of challenges. She had a history of significant mental health issues, including a diagnosis of Bipolar II. Her struggles with attachment issues, unstable relationships, and a history of evictions had a profound impact on her well-being and the well-being of her elderly parents. The client's behaviors triggered fear and concern in her parents, leading to multiple 911 calls to law enforcement. Upon entering the GART program, the client received comprehensive and tailored support to address her presenting problems. Our clinician, dedicated to building a strong therapeutic alliance, worked diligently to establish trust with the client. Collaborating closely with the client's parents, the clinician addressed their co-dependent behaviors and facilitated their participation in codependency meetings. Involving the family system was vital in creating a supportive environment for the client's progress. Because of the comprehensive care provided by the GART program, the client achieved remarkable progress. Her parents now feel safer with her, as evidenced by the decrease in emergency calls to the police. The client is actively working towards building confidence in gaining employment, demonstrating an increased sense of self-worth and prospects. This case study exemplifies the GART program's ability to create lasting positive changes in the lives of clients and their families. It showcases our dedication to providing personalized care, building trust, and addressing specific challenges. The remarkable progress achieved through our services underscores the effectiveness of our approach and our commitment to improving the well-being of those we serve.

Box E: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
E.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):	82

E.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e., mental health treatment services):	N/A
E.3: Types of treatment individuals were referred to (list types below):	
Mental Health Services: Case Management, Counseling, Medication Clinic (prescribing and managing psychiatric medications) and Psychiatric Hospitalization, **Dental Services:** Dentists (oral health care) and **General Medical Services:** Primary Care Physician (general medical care)	
E.4: Unduplicated number of individuals who participated in referred program at least one time:	659
G.5: Average duration of untreated mental illness in weeks:	N/A
E.6: Average number of days between referral and first participation in referred treatment program:	N/A
Box F: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
F.1: Who is/are the underserved target population(s) your program is serving (e.g., TAY, Southeast Asian) (list types below):	
Geriatric Population ages 55+.	
F.2: Number of paper referrals to an ACBH PEI-funded program:	0
F.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	N/A
F.4: Average number of days between referral and first participation in referred PEI program:	N/A
F.5: Describe how your program encouraged access to services and follow through on above referrals:	
GART program aims to encourage access to services and ensure that clients follow through on the referrals they receive through: **Referral Assistance:** Based on the individualized assessments, GART provides informed and appropriate referrals to various services and resources that can cater to the specific needs of elderly clients. These referrals may include medical professionals, social services, housing assistance, caregiver support, mental health services, psychiatric hospitalizations, and more. **Appointment Coordination:** Recognizing that setting appointments can be overwhelming for some elderly individuals, GART assists clients in scheduling their appointments with the referred service providers. By doing so, the program ensures that clients have a smooth and convenient experience in accessing the services they require. **Follow-Up Support:** GART doesn't stop at making referrals and appointments; the team also engages in active follow-up with clients. They contact the clients to ensure they attended their appointments and received the necessary services. This follow-up process is essential in providing additional support and addressing any potential issues that may arise during the service utilization process.	

Box G: 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 Respondents	**2789**
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):
Shattuck Neighborhood Crime Prevention Council	10 Community Business Members
City of Albany: Social & Economic Justice Commission (SEJC)	25 appointed and elected officials, community members, providers
Seneca Center	100 Providers
Oakland Vet Center	7 case managers and supervisor
Aureum Counseling & Consulting	10 counseling staff members
Del Norte Crisis Servicies Panel	10 Crisis Services Panel
Youth & Family Services Bureau	15 clinicians, law enforcement, social workers
988 Alameda County Conference	300 law enforcement, fire, mental health and SUD providers, consumers, family /caregivers, elected officials, medical providers, EMS
MHAB Adult Committee	25 Adult Committee members
Tri-Valley Coordinated Entry	12 Tri-Valley Coordinated Entry members
Korean Community Center of the East Bay	6 clinical interns and staff
SBBH Provider Meeting	10 Providers
CHCN Coordinators: Crisis Services Presentation	4 housing providers
Lavamae	23 community members
John George Psychiatric Emergency Hospital patients (In person)	2048 John George Psychiatric Emergency Patients
John George Psychiatric Emergency Hospital patients (phone)	184 John George Psychiatric Emergency Patients

PEI: Stigma and Discrimination Reduction Programs

MHSA Program #	PEI 4
PROVIDER NAME	Peers Envisioning and Engaging in Recovery Services (PEERS)
PROGRAM NAME	Stigma & Discrimination Reduction Campaign- “Everyone Counts”

Program Outcomes & Impact Data Report FY: 22-23

Program Name:	Stigma & Discrimination Reduction Campaign- “Everyone Counts”
Organization:	Peers Envisioning and Engaging in Recovery Services (PEERS)
Type of Report:	Annual
PEI Category:	Stigma and Discrimination Reduction

Priority Area (place an X next to all that apply):

	Childhood Trauma

	Early Psychosis
X	Youth/TAY Outreach & Engagement
X	Cultural & Linguistic
X	Older Adults
	Early Identification of MH Illness

Outcomes (place an X next to all that apply): Programs focus on <u>reducing</u> the seven negative outcomes that may result from untreated mental illness.

X	Suicide
	Incarceration
	School failure or dropout
	Unemployment
X	Prolonged suffering
	Homelessness
	Removal of children from their homes

Box A: **<u>Brief</u>** program description.

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 (TAY Wellness, Black Wellness and Resilience, Buried in Treasures, and Special Messages groups), Outreach (speakers' bureau, Asian American ECC--including action team and 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.

# of unduplicated individuals served who are at risk of developing a serious mental illness:	349
Number of unduplicated individuals 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:	349

Box C: Demographics of individuals served this fiscal year through MHSA funding:

AGE CATEGORIES		SEXUAL ORIENTATION	
Children/Youth (0-15 yrs.)	1	Gay/Lesbian	5
Transition Age Youth (16-25 yrs.)	17	Heterosexual/Straight	27
Adult (26-59 yrs.)	21	Bisexual	3
Older Adult (60+ yrs.)	16	Questioning/Unsure	0
Declined to answer	294	Queer	2
Unknown	0	Declined to answer	4
TOTAL	**349**	Unknown	308
		Another group not listed	0
		TOTAL	**349**
		If another group is counted, please specify with numbers:	

VETERAN STATUS	
Yes	2
No	33
Declined to answer	314
Unknown	0
TOTAL	**349**

CURRENT GENDER IDENTITY	
Female	51
Male	13
Transgender	1
Genderqueer	0
Questioning/unsure of gender identity	0
Declined to answer	281
Unknown	0
Another identity not listed	3
TOTAL	**349**
If another group is counted, please specify with numbers: Nonbinary (3)	

PRIMARY LANGUAGE	
English	36
Spanish	5
Cantonese	0
Chinese	0
Vietnamese	1
Farsi	0
Arabic	0
Tagalog	5
Declined to answer	296
Unknown	0
Other languages not listed	6
TOTAL	**349**

SEX ASSIGNED AT BIRTH	
Male	0
Female	0
Declined to answer	0
Unknown	349
TOTAL	**349**

DISABILITY STATUS	
Communication Domain	
Vision	0
Hearing/Speech	0
Another type not listed	0
Communication Domain Subtotal	**0**
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	0
Physical/mobility	2
Chronic health condition	0
Disability Subtotal	**2**

ETHNITICY/CULTURAL HERITAGE (choose one)	
If Hispanic or Latino, please specify:	
Caribbean	1
Central American	0
Mexican/Mexican American/Chicano	2
Puerto Rican	0
South American	0
Another Hispanic/Latino ethnicity not listed	1
Total Hispanic or Latino	**4**
If Non-Hispanic or Non-Latino, please specify:	
African	0
African American	5
Asian Indian/South Asian	4
Cambodian	0
Chinese	0
Eastern European	1
European	0
Filipino	2
Japanese	0
Korean	0
Middle Eastern	0

None	14	Vietnamese	0
Declined to answer	332	Other Non-Hispanic or Non-Latino ethnicity not listed	15
Unknown	0	**Total Non-Hispanic or Non-Latino:**	**27**
Another disability not listed	11	More than one ethnicity	1
TOTAL	**349**	Unknown ethnicity	0
		Declined to answer	317
		ETHNICITY TOTAL	**349**
If another disability is counted, please specify with numbers: Mental illness (11)		If **another ethnicity** is counted, please specify with numbers: Indigenous (1), K'iche' (1), Moore (1), White (1)	
RACE			
American Indian or Alaska Native	2	If **another race** is counted, please specify with numbers: Multiple (e.g. Black/Korean, Latinx/Asian) (2), Latino (6), Other	
Asian	10		
Black or African American	32		
Native Hawaiian or another Pacific Islander	0		
White	5		
Other Race	20		
Declined to answer	280		
Unknown	0		
TOTAL	**349**		

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of.

Two major accomplishments this year were our successful effort to support our staff through the process of certification as Medi-Cal Peer Support Specialist. Every member of the PEERS staff who was eligible for the CalMHSA Medi-Cal Peer Support Specialist Grandparenting Process achieved certification – a total of 10 staff. Additionally, among staff not eligible for the Grandparenting Process, one staff member completed initial certification and two others are in the process. This is an essential step toward our goal of becoming certified to bill Medi-Cal for the peer support services we provide.

Highlights from the second year of our Asian American Everyone Counts Campaign, HOPE – Healing from Our Past and Expectations included a lively and engaging AAPI Mental Health and Wellness Jam, which drew a multi-generational group of more than 50 participants. The event, a collaboration with the Oakland Asian Cultural Center, focused on celebrating Asian joy while learning new wellness tools and exploring community mental health resources. Another highlight was a well-attended provider training in June.

Comments from HOPE participants include:

I love connecting to the others in the group!

Everyone was honest and vulnerable. *I liked how we talked about our stigmas and things I haven't talked to a lot of people about, yet the group share was helpful to learn about everyone's family's immigration histories.* *Internalized stigma, intersectionality of mental health, learned more about our peers :)*

Box E: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
E.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e., mental health treatment services):	N/A
E.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e., mental health treatment services):	N/A
E.3: Types of treatment individuals were referred to (list types below):	
N/A	
E.4: Unduplicated number of individuals who participated in referred program at least one time:	N/A
G.5: Average duration of untreated mental illness in weeks:	N/A
E.6: Average number of days between referral and first participation in referred treatment program:	N/A
Box F: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
F.1: Who is/are the underserved target population(s) your program is serving (e.g., TAY, Southeast Asian) (list types below):	
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).	
F.2: Number of paper referrals to an ACBH PEI-funded program:	N/A
F.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	N/A
F.4: Average number of days between referral and first participation in referred PEI program:	N/A
F.5: Describe how your program encouraged access to services and follow through on above referrals:	
We referred many participants to multiple PEERS programs, but none of these constituted paper referrals for appointments.	

Box G: 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 Respondents	**1,131**
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):
Dia De Los Muertos Festival	500 community members, primarily Latinx
Hayward High Community Resource Expo	130 high school students
Oakland Pride	100 community members, primarily LGBTQ+
Alliance for Girls Conference	86 girls and girl-serving providers
Oakland PrideFest	66 community members, primarily LGBTQ+
NAMI Walks Your Way	63 community members, primarily family members and people with lived experience
Chabot College Accessibility Awareness Day	28 community college students
African American Family Conference	60 community members, primarily African American family members
Prayer & Unity Community Celebration	59 community members, primarily East Oakland residents
Arroyo High School Health and Wellness Spring Event	35 high school students
Project Eden/Lambda Youth Project Pride Prom	30 LGBTQ+ youth

PEI Suicide Prevention

MHSA Program #	PEI 12
PROVIDER NAME	Crisis Support Services of Alameda County
PROGRAM NAME	Text Line Program

Program Outcomes & Impact Data Report FY: 22-23

Program Name:	Text Line Program
Organization:	Crisis Support Services of Alameda County
Type of Report:	Annual
PEI Category:	Suicide Prevention

Priority Area (place an X next to all that apply):

	Childhood Trauma
	Early Psychosis
X	Youth/TAY Outreach & Engagement
	Cultural & Linguistic
	Older Adults
X	Early Identification of MH Illness

Outcomes (place an X next to all that apply): Programs focus on <u>reducing</u> the seven negative outcomes that may result from untreated mental illness.

X	Suicide
	Incarceration
	School failure or dropout
	Unemployment

	Prolonged suffering
	Homelessness
	Removal of children from their homes

Box A: **Brief** program description.
The program provides brief crisis intervention and emotional support to individuals via chat/text/sms modality with emphasis on school aged youth and TAY.

Box B: Number of Individuals served this fiscal year through MHSA funding.	
# of unduplicated individuals served who are at risk of developing a serious mental illness:	0
Number of unduplicated individuals 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:	1464

Box C: Demographics of individuals served this fiscal year through MHSA funding:

AGE CATEGORIES		SEXUAL ORIENTATION	
Children/Youth (0-15 yrs.)	267	Gay/Lesbian	3
Transition Age Youth (16-25 yrs.)	428	Heterosexual/Straight	11
Adult (26-59 yrs.)	342	Bisexual	9
Older Adult (60+ yrs.)	25	Questioning/Unsure	2
Declined to answer	0	Queer	30
Unknown	434	Declined to answer	0
TOTAL	**1496**	Unknown	1912
		Another group not listed	0
		TOTAL	**1967**
		If another group is counted, please specify with numbers:	

VETERAN STATUS		PRIMARY LANGUAGE	
Yes	4	English	764
No	1	Spanish	2
Declined to answer	0	Cantonese	0
Unknown	1530	Chinese	0
TOTAL	**1535**	Vietnamese	0
		Farsi	0
CURRENT GENDER IDENTITY		Arabic	0
Female	778	Tagalog	0
Male	319	Declined to answer	0
Transgender	2	Unknown	0
Genderqueer	23	Other languages not listed	1
Questioning/unsure of gender identity	2	TOTAL	**767**
Declined to answer	0		
Unknown	1534		

Another identity not listed	0
TOTAL	**2658**
If another group is counted, please specify with numbers:	

SEX ASSIGNED AT BIRTH	
Male	10
Female	46
Declined to answer	0
Unknown	491
TOTAL	**547**

DISABILITY STATUS	
Communication Domain	0
Vision	0
Hearing/Speech	0
Another type not listed	0
Communication Domain Subtotal	0
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	0
Physical/mobility	5
Chronic health condition	
Disability Subtotal	5
None	762
Declined to answer	0
Unknown	0
Another disability not listed	0
TOTAL	**767**
If another disability is counted, please specify with numbers:	

ETHNITICY/CULTURAL HERITAGE (choose one)	
If Hispanic or Latino, please specify:	
Caribbean	0
Central American	0
Mexican/Mexican American/Chicano	1
Puerto Rican	0
South American	0
Another Hispanic/Latino ethnicity not listed	0
Total Hispanic or Latino	**1**
If Non-Hispanic or Non-Latino, please specify:	
African	1
African American	0
Asian Indian/South Asian	0
Cambodian	0
Chinese	0
Eastern European	0
European	0
Filipino	0
Japanese	0
Korean	0
Middle Eastern	0
Vietnamese	0
Other Non-Hispanic or Non-Latino ethnicity not listed	0
Total Non-Hispanic or Non-Latino:	**1**
More than one ethnicity	0
Unknown ethnicity	1398
Declined to answer	0
ETHNICITY TOTAL	**1400**
If **another ethnicity** is counted, please specify with numbers:	

RACE		
American Indian or Alaska Native	0	If **another race** is counted, please specify with

		numbers: Multiple race
Asian	2	
Black or African American	136	
Native Hawaiian or another Pacific Islander	0	
White	3	
Other Race	3	
Declined to answer	0	
Unknown	1827	
TOTAL	**1971**	

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of.
We experienced tremendous growth in text volume this year from taking 1352 text contacts to 3370 text contacts. This is an increase of 149.26% from the year prior. In addition, the number of texters presenting with medium to high risk for suicide increased by 167% from the prior year. We created a position for a Text Line Program Manager to oversee and assist the Text Line Coordinator with recruiting volunteers and hiring text line staff as we expand. There has been nearly a 150% increase in the number of text sessions from extending our local text line hours and 988 Lifeline Chat and Text hours, from 7 hours daily to at least 16 hours daily, there is an increase of 78.97% on concerns of social issues. To meet the infrastructure requirements of this growth in our program services, we hired 12 more staff and recruited 5 volunteers.

Box E: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
E.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e., mental health treatment services):	N/A
E.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e., mental health treatment services):	N/A
E.3: Types of treatment individuals were referred to (list types below):	
N/A	
E.4: Unduplicated number of individuals who participated in referred program at least one time:	N/A
G.5: Average duration of untreated mental illness in weeks:	N/A
E.6: Average number of days between referral and first participation in referred treatment program:	N/A
Box F: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
F.1: Who is/are the underserved target population(s) your program is serving (e.g., TAY, Southeast Asian) (list types below): 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).	
N/A	
F.2: Number of paper referrals to an ACBH PEI-funded program:	N/A
F.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	N/A
F.4: Average number of days between referral and first participation in referred PEI program:	N/A
F.5: Describe how your program encouraged access to services and follow through on above referrals:	
Medium to high-risk clients are rated a 3 or above by counselor to be at risk of suicide. We offer an outreach text or call session to confirm if the texter completed the referral. We also refer anyone of a suicide risk of 3 or above to our Lifeline Follow-Up Program.	

Box G: 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 Respondents	**21**
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	21 text line counselors

MHSA Program #	PEI 12
PROVIDER NAME	Crisis Support Services of Alameda County
PROGRAM NAME	Community Education Program

Program Outcomes & Impact Data Report FY: 22-23

Program Name:	Community Education Program
Organization:	Crisis Support Services of Alameda County
Type of Report:	Annual
PEI Category:	Suicide Prevention

Priority Area (place an X next to all that apply):

	Childhood Trauma
	Early Psychosis
X	Youth/TAY Outreach & Engagement
	Cultural & Linguistic
	Older Adults
X	Early Identification of MH Illness

Outcomes (place an X next to all that apply): Programs focus on reducing the seven negative

outcomes that may result from untreated mental illness.	
X	Suicide
	Incarceration
	School failure or dropout
	Unemployment
X	Prolonged suffering
	Homelessness
	Removal of children from their homes

Box A: **Brief** program description.

The goal of our Community Education Program is to raise awareness that suicide is a public health issue and that our community is a natural safety net for those that are vulnerable to suicide risk. Providing education & 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.

# of unduplicated individuals served who are at risk of developing a serious mental illness:	14546
Number of unduplicated individuals served who show early signs of forming a more severe mental illness:	0
Number of unduplicated individual family members served indirectly by your program:	17
Grand total of unduplicated individuals served:	14563

Box C: Demographics of individuals served this fiscal year through MHSA funding:

AGE CATEGORIES		SEXUAL ORIENTATION	
Children/Youth (0-15 yrs.)	1703	Gay/Lesbian	45
Transition Age Youth (16-25 yrs.)	51	Heterosexual/Straight	1296
Adult (26-59 yrs.)	38	Bisexual	138
Older Adult (60+ yrs.)	5	Questioning/Unsure	70
Declined to answer	0	Queer	31
Unknown	12766	Declined to answer	78
TOTAL	**14563**	Unknown	12833
		Another group not listed	72
		TOTAL	**14563**
		If another group is counted, please specify with numbers:	

VETERAN STATUS		PRIMARY LANGUAGE	
Yes	0	English	45
No	47	Spanish	3
Declined to answer	2	Cantonese	0
Unknown	14514	Chinese	0
TOTAL	**14563**	Vietnamese	0
		Farsi	0

CURRENT GENDER IDENTITY	
Female	749
Male	902
Transgender	26
Genderqueer	46
Questioning/unsure of gender identity	24
Declined to answer	28
Unknown	12787
Another identity not listed	1
TOTAL	**14563**
If another group is counted, please specify with numbers: 1 person added: Agender, Voidgender, Cassgender	

Arabic	0
Tagalog	0
Declined to answer	0
Unknown	14514
Other languages not listed	1
TOTAL	**14563**

SEX ASSIGNED AT BIRTH	
Male	7
Female	42
Declined to answer	0
Unknown	14514
TOTAL	**14563**

DISABILITY STATUS	
Communication Domain	0
Vision	0
Hearing/Speech	0
Another type not listed	0
Communication Domain Subtotal	**0**
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	0
Physical/mobility	0
Chronic health condition	
Disability Subtotal	**0**
None	0
Declined to answer	0
Unknown	14563
Another disability not listed	0
TOTAL	**14563**

ETHNITICY/CULTURAL HERITAGE (choose one)	
If Hispanic or Latino, please specify:	
Caribbean	8
Central American	27
Mexican/Mexican American/Chicano	288
Puerto Rican	24
South American	16
Another Hispanic/Latino ethnicity not listed	2
Total Hispanic or Latino	**365**
If Non-Hispanic or Non-Latino, please specify:	
African	11
African American	110
Asian Indian/South Asian	246
Cambodian	16
Chinese	145
Eastern European	28
European	158
Filipino	66
Japanese	17
Korean	28
Middle Eastern	37
Vietnamese	23
Other Non-Hispanic or Non-Latino ethnicity not listed	10
Total Non-Hispanic or Non-Latino:	**895**
More than one ethnicity	182
Unknown ethnicity	13066

If another disability is counted, please specify with numbers:		Declined to answer	55
		ETHNICITY TOTAL	**14563**
RACE		If **another ethnicity** is counted, please specify with numbers: 8 (Jewish, East Indian/African American, Taiwanese, American Samoa, Pueblo	
American Indian or Alaska Native	0	If **another race** is counted, please specify with numbers: 285 (biracial, multiracial)	
Asian	513		
Black or African American	143		
Native Hawaiian or another Pacific Islander	16		
White	418		
Other Race	248		
Declined to answer	49		
Unknown	13176		
TOTAL	**14563**		

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of.
1 - Hiring a TFL Bilingual (Spanish) Health Educator: We're pleased to finally be able to meet a need to provide our TFL youth curriculum in Spanish to middle schools and high schools. Our bilingual colleague did a great job translating our youth curriculum and were able roll it out to several classrooms this past school year after an initial outreach. They had also translated our TFL resource wallet card as well. 2 - Updated and revised TFL resource wallet card for students: Our TFL youth program did an amazing job updating our resource card for students. The card now reflects our new services which included reaching out through 988, expanded English language hours on our Textline and the addition of Spanish language hours - also on our Textline. 3 - Expanding Bilingual Spanish services: Towards the end of this past school year, we were able to hire a Bilingual (Spanish) Community Education Trainer who's focus will include a targeted outreach to Spanish speaking parents, guardians, and caregivers. Being able to provide youth suicide prevention workshops in Spanish to this group also meets a need in our school communities. In addition, we are also looking forward to hiring an additional TFL Bilingual Health Educator to expand our capacity to outreach and provide the youth curriculum to Spanish speaking youth in classrooms. These efforts are in alignment with our commitment to our Justice, Equity, Diversity, and Inclusion statement.

Box E: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
E.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e., mental health treatment services):	N/A
E.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e., mental health treatment services):	N/A
E.3: Types of treatment individuals were referred to (list types below):	
N/A	

E.4: Unduplicated number of individuals who participated in referred program at least one time:	N/A
G.5: Average duration of untreated mental illness in weeks:	N/A
E.6: Average number of days between referral and first participation in referred treatment program:	N/A
Box F: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
F.1: Who is/are the underserved target population(s) your program is serving (e.g., TAY, Southeast Asian) (list types below):	
N/A	
F.2: Number of paper referrals to an ACBH PEI-funded program:	N/A
F.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	N/A
F.4: Average number of days between referral and first participation in referred PEI program:	N/A
F.5: Describe how your program encouraged access to services and follow through on above referrals:	
N/A	

Box G: 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 Respondents	**12,189**
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	10,066 youth 169 Teachers 193 School Mental health staff 17 parents, guardians, or caregivers
Law Enforcement Settings	67 Dispatchers 252 LE Officers
College settings	235 college students and faculty
Correctional Settings	195 civilian staff 84 MH professionals
Places of faith	14 community members of faith
Healthcare settings	305 medical providers 39 integrated behavioral health staff
Health Fairs	553 community members

MHSA Program # PEI 12

PROVIDER NAME	Crisis Support Services of Alameda County
PROGRAM NAME	Trauma Informed Counseling (Clinical Department)

Program Outcomes & Impact Data Report FY: 22-23

Program Name:	Trauma Informed Counseling (Clinical Department)
Organization:	Crisis Support Services of Alameda County
Type of Report:	Annual
PEI Category:	Suicide Prevention

Priority Area (place an X next to all that apply):	
	Childhood Trauma
	Early Psychosis
	Youth/TAY Outreach & Engagement
	Cultural & Linguistic
X	Older Adults
X	Early Identification of MH Illness

Outcomes (place an X next to all that apply): Programs focus on <u>reducing</u> the seven negative outcomes that may result from untreated mental illness.	
X	Suicide
	Incarceration
X	School failure or dropout
X	Unemployment
X	Prolonged suffering
X	Homelessness
	Removal of children from their homes

Box A: **<u>Brief</u>** program description.

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 at 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 this fiscal year through MHSA funding.	
# of unduplicated individuals served who are at risk of developing a serious mental illness:	0
Number of unduplicated individuals 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:	0

Box C: Demographics of individuals served this fiscal year through MHSA funding:

AGE CATEGORIES		**SEXUAL ORIENTATION**	
Children/Youth (0-15 yrs.)	31	Gay/Lesbian	6

Transition Age Youth (16-25 yrs.)	15
Adult (26-59 yrs.)	22
Older Adult (60+ yrs.)	49
Declined to answer	0
Unknown	67
TOTAL	**184**

Heterosexual/Straight	80
Bisexual	6
Questioning/Unsure	4
Queer	4
Declined to answer	15
Unknown	73
Another group not listed	0
TOTAL	**184**
If another group is counted, please specify with numbers:	

VETERAN STATUS	
Yes	1
No	101
Declined to answer	0
Unknown	72
TOTAL	**184**

PRIMARY LANGUAGE	
English	109
Spanish	5
Cantonese	1
Chinese	0
Vietnamese	0
Farsi	0
Arabic	0
Tagalog	1
Declined to answer	0
Unknown	66
Other languages not listed	2
TOTAL	**184**

CURRENT GENDER IDENTITY	
Female	90
Male	34
Transgender	4
Genderqueer	0
Questioning/unsure of gender identity	1
Declined to answer	2
Unknown	51
Another identity not listed	2
TOTAL	**184**
If another group is counted, please specify with numbers:	

SEX ASSIGNED AT BIRTH	
Male	0
Female	0
Declined to answer	0
Unknown	184
TOTAL	**184**
DISABILITY STATUS	
Communication Domain	
Vision	6

ETHNITICY/CULTURAL HERITAGE (choose one)	
If Hispanic or Latino, please specify:	
Caribbean	0
Central American	0
Mexican/Mexican American/Chicano	0
Puerto Rican	0
South American	0
Another Hispanic/Latino ethnicity not listed	0
Total Hispanic or Latino	**0**
If Non-Hispanic or Non-Latino, please specify:	
African	38

Hearing/Speech	6	African American	0
Another type not listed	0	Asian Indian/South Asian	0
Communication Domain Subtotal	**12**	Cambodian	0
Disability Domain		Chinese	0
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	3	Eastern European	33
		European	0
		Filipino	0
Physical/mobility	13	Japanese	0
Chronic health condition	5	Korean	0
Disability Subtotal	**21**	Middle Eastern	0
None	49	Vietnamese	0
Declined to answer	1	Other Non-Hispanic or Non-Latino ethnicity not listed	0
Unknown	101	**Total Non-Hispanic or Non-Latino:**	**71**
Another disability not listed		More than one ethnicity	8
TOTAL	**184**	Unknown ethnicity	105
		Declined to answer	0
		ETHNICITY TOTAL	**184**
If another disability is counted, please specify with numbers:		If **another ethnicity** is counted, please specify with numbers:	
RACE			
American Indian or Alaska Native	2	If **another race** is counted, please specify with numbers:	
Asian	9		
Black or African American	38		
Native Hawaiian or another Pacific Islander	0		
White	33		
Other Race	0		
Declined to answer	0		
Unknown	102		
TOTAL	**184**		

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of.

Drop-In Grief Group Success Story: The Redefining Suicide Prevention series brought creativity and reflection by engaging unique communities in conversation about suicide and care.

The drop-in grief group "Tending Your Grief" is a collaboration that grew out of one of the "People Just Want to Be Seen" conversations with the Oakland Public Library this past spring. This group was one of the most unique groups I've ever facilitated because of the many different types of loss that people were experiencing. We welcomed grief from death loss, infant loss, health loss from chronic illness,

friend loss, grandparent loss, home loss, parent loss, anticipatory grief of a grandparent, and relationship loss from family estrangement. We welcomed a family who brought their 6-year-old son because of a lack of childcare and we also welcomed a CSS crisis line community member. There was so much diversity in cultural identities and grief identities and it was astonishing to see people find connection and compassion for each other in their grief process. From the group evaluations, members found the group a helpful time of connection: "I loved the space we had to talk about personal experiences; hearing other people's stories was very healing in many ways". Members have also requested another iteration of the group which we are developing for fall.

Box E: **For programs that refer individuals with severe mental illness, please provide information for the categories below:**	
E.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e., mental health treatment services):	N/A
E.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e., mental health treatment services):	N/A
E.3: Types of treatment individuals were referred to (list types below):	
N/A	
E.4: Unduplicated number of individuals who participated in referred program at least one time:	N/A
G.5: Average duration of untreated mental illness in weeks:	N/A
E.6: Average number of days between referral and first participation in referred treatment program:	N/A
Box F: **For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:**	
F.1: Who is/are the underserved target population(s) your program is serving (e.g., TAY, Southeast Asian) (list types below):	
N/A	
F.2: Number of paper referrals to an ACBH PEI-funded program:	N/A
F.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	N/A
F.4: Average number of days between referral and first participation in referred PEI program:	N/A
F.5: Describe how your program encouraged access to services and follow through on above referrals:	
N/A	

Box G: **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 Respondents	**N/A**
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):
Schools, outpatient, in-home, library	**mental health interns**

PEI Early Intervention

MHSA Program #	PEI 17B
PROVIDER NAME	Santi Soumpholphakdy
PROGRAM NAME	REACH Ashland Youth Center

Program Outcomes & Impact Data Report FY: 22-23

Program Name:	REACH Ashland Youth Center
Organization:	HCSA-CHSC
Type of Report:	Annual
PEI Category:	Prevention Early Intervention

Priority Area (place an X next to all that apply):	
	Childhood Trauma
X	Early Psychosis
X	Youth/TAY Outreach & Engagement
	Cultural & Linguistic
	Older Adults
X	Early Identification of MH Illness

Outcomes (place an X next to all that apply): Programs focus on <u>reducing</u> the seven negative outcomes that may result from untreated mental illness.	
	Suicide
	Incarceration
	School failure or dropout
	Unemployment
	Prolonged suffering
	Homelessness
	Removal of children from their homes

Box A: <u>Brief</u> program description.
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 provide recreation, education, arts, career and health and wellness activities and services. 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.	
# of unduplicated individuals served who are at risk of developing a serious mental illness:	41
Number of unduplicated individuals served who show early signs of forming a more severe mental illness:	92
Number of unduplicated individual family members served indirectly by your program:	89
Grand total of unduplicated individuals served:	222

Box C: Demographics of individuals served this fiscal year through MHSA funding:

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	64
Transition Age Youth (16-25 yrs.)	67
Adult (26-59 yrs.)	0
Older Adult (60+ yrs.)	0
Declined to answer	0
Unknown	2
TOTAL	**133**

SEXUAL ORIENTATION	
Gay/Lesbian	0
Heterosexual/Straight	0
Bisexual	0
Questioning/Unsure	0
Queer	0
Declined to answer	0
Unknown	133
Another group not listed	0
TOTAL	**133**
If another group is counted, please specify with numbers:	

VETERAN STATUS	
Yes	0
No	0
Declined to answer	0
Unknown	133
TOTAL	**133**

PRIMARY LANGUAGE	
English	70
Spanish	33
Cantonese	0
Chinese	0
Vietnamese	0
Farsi	0
Arabic	0
Tagalog	0
Declined to answer	0
Unknown	29
Other languages not listed	1
TOTAL	**133**

CURRENT GENDER IDENTITY	
Female	70
Male	56
Transgender	1
Genderqueer	1
Questioning/unsure of gender identity	0
Declined to answer	3
Unknown	2
Another identity not listed	0
TOTAL	**133**
If another group is counted, please specify with	

numbers:

SEX ASSIGNED AT BIRTH	
Male	0
Female	0
Declined to answer	0
Unknown	133
TOTAL	**133**

DISABILITY STATUS	
Communication Domain	
Vision	0
Hearing/Speech	0
Another type not listed	0
Communication Domain Subtotal	**0**
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	0
Physical/mobility	0
Chronic health condition	0
Disability Subtotal	**0**
None	0
Declined to answer	0
Unknown	133
Another disability not listed	0
TOTAL	**133**

If another disability is counted, please specify with numbers:

RACE	
American Indian or Alaska Native	4
Asian	1
Black or African American	35
Native Hawaiian or another Pacific Islander	1
White	6
Other Race	67

ETHNITICY/CULTURAL HERITAGE (choose one)	
If Hispanic or Latino, please specify:	
Caribbean	0
Central American	12
Mexican/Mexican American/Chicano	42
Puerto Rican	3
South American	1
Another Hispanic/Latino ethnicity not listed	0
Total Hispanic or Latino	**58**
If Non-Hispanic or Non-Latino, please specify:	
African	19
African American	0
Asian Indian/South Asian	1
Cambodian	1
Chinese	0
Eastern European	0
European	
Filipino	
Japanese	1
Korean	0
Middle Eastern	0
Vietnamese	0
Other Non-Hispanic or Non-Latino ethnicity not listed	2
Total Non-Hispanic or Non-Latino:	**24**
More than one ethnicity	3
Unknown ethnicity	42
Declined to answer	6
ETHNICITY TOTAL	**133**

If **another ethnicity** is counted, please specify with numbers: 2 Other Non-Hispanic or Non-Latino ethnicity (unspecified)

If **another race** is counted, please specify with numbers:

- 56 Latino/a/x
- 3 Multiracial
- 6 Other (unspecified) with unknown ethnicities
- 2 Other (unspecified with Other non-Hispanic ethnicities

Declined to answer	5	
Unknown	14	
TOTAL	**133**	

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of.
This last fiscal year we were able to continue to work with Alameda County Office of Education, Opportunity Academy program, a high school diploma program. The program assists high school students who were struggling in the traditional school setting to access additional supports services at REACH and to obtain their high school diploma. Last year school year 7 students graduated. 1 worked closely with the Health and Wellness team members. He was referred through our COST (referral) process because of his anxiety and depression. He was connected to one of our clinical case managers who met with him weekly for therapy and worked closely with teachers and the youth's family. The youth also became involved and joined the REACH Program Planning Program and is currently working with our career and employment services program.

Box E: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
E.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e., mental health treatment services):	N/A
E.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e., mental health treatment services):	N/A
E.3: Types of treatment individuals were referred to (list types below):	
N/A	
E.4: Unduplicated number of individuals who participated in referred program at least one time:	N/A
G.5: Average duration of untreated mental illness in weeks:	N/A
E.6: Average number of days between referral and first participation in referred treatment program:	N/A
Box F: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
F.1: Who is/are the underserved target population(s) your program is serving (e.g., TAY, Southeast Asian) (list types below):	
N/A	
F.2: Number of paper referrals to an ACBH PEI-funded program:	N/A
F.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	N/A
F.4: Average number of days between referral and first participation in referred PEI program:	N/A
F.5: Describe how your program encouraged access to services and follow through on above referrals:	
N/A	

Box G: 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 Respondents	**N/A**
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):

PEI: Outreach

MHSA Program #	PEI 20A
PROVIDER NAME	Beats Rhymes and Life Inc.
PROGRAM NAME	Beats Rhymes and Life Inc. "Prevention Pathways Program"

Program Outcomes & Impact Data Report FY: 22-23

Program Name:	Beats Rhymes and Life Inc. "Prevention Pathways Program"
Organization:	Beats Rhymes and Life Inc.
Type of Report:	Annual
PEI Category:	Outreach

Priority Area (place an X next to all that apply):	
	Childhood Trauma
	Early Psychosis
	Youth/TAY Outreach & Engagement
X	Cultural & Linguistic
	Older Adults
	Early Identification of MH Illness

Outcomes (place an X next to all that apply): Programs focus on <u>reducing</u> the seven negative outcomes that may result from untreated mental illness.	
	Suicide
	Incarceration
	School failure or dropout
	Unemployment
	Prolonged suffering
	Homelessness
	Removal of children from their homes

Box A: <u>Brief</u> program description.
Beats Rhymes & Life, Inc. uses the influence of Hip Hop as a catalyst for change and Development. Our

curriculum combines youth culture with self-psychology, group work and narrative therapy. Our Interventions include 1:1 individual therapy, therapeutic activity groups, mental health awareness presentations, Life skills workshops and work force training for young adults.

Box B: Number of Individuals served this fiscal year through MHSA funding.	
# of unduplicated individuals served who are at risk of developing a serious mental illness:	234
Number of unduplicated individuals 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:	234

Box C: Demographics of individuals served this fiscal year through MHSA funding:

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	8
Transition Age Youth (16-25 yrs.)	65
Adult (26-59 yrs.)	0
Older Adult (60+ yrs.)	0
Declined to answer	161
Unknown	0
TOTAL	**234**

SEXUAL ORIENTATION	
Gay/Lesbian	2
Heterosexual/Straight	24
Bisexual	12
Questioning/Unsure	4
Queer	3
Declined to answer	2
Unknown	0
Another group not listed	187
TOTAL	**234**
If another group is counted, please specify with numbers:	

VETERAN STATUS	
Yes	1
No	50
Declined to answer	183
Unknown	0
TOTAL	**234**

PRIMARY LANGUAGE	
English	47
Spanish	7
Cantonese	0
Chinese	0
Vietnamese	0
Farsi	0
Arabic	0
Tagalog	0
Declined to answer	180
Unknown	0
Other languages not listed	0
TOTAL	**234**

CURRENT GENDER IDENTITY	
Female	26
Male	20
Transgender	0
Genderqueer	4
Questioning/unsure of gender identity	1
Declined to answer	0
Unknown	0
Another identity not listed	183
TOTAL	**234**
If another group is counted, please specify with	

numbers:

SEX ASSIGNED AT BIRTH	
Male	26
Female	20
Declined to answer	1
Unknown	187
TOTAL	**234**

DISABILITY STATUS	
Communication Domain	
Vision	5
Hearing/Speech	0
Another type not listed	7
Communication Domain Subtotal	**12**
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	3
Physical/mobility	0
Chronic health condition	0
Disability Subtotal	**3**
None	34
Declined to answer	183
Unknown	2
Another disability not listed	0
TOTAL	**234**

If another disability is counted, please specify with numbers:

RACE	
American Indian or Alaska Native	0
Asian	3
Black or African American	34
Native Hawaiian or another Pacific Islander	1

ETHNITICY/CULTURAL HERITAGE (choose one)	
If Hispanic or Latino, please specify:	
Caribbean	0
Central American	0
Mexican/Mexican American/Chicano	4
Puerto Rican	0
South American	0
Another Hispanic/Latino ethnicity not listed	0
Total Hispanic or Latino	**4**
If Non-Hispanic or Non-Latino, please specify:	
African	0
African American	34
Asian Indian/South Asian	2
Cambodian	0
Chinese	0
Eastern European	0
European	0
Filipino	1
Japanese	0
Korean	0
Middle Eastern	0
Vietnamese	0
Other Non-Hispanic or Non-Latino ethnicity not listed	0
Total Non-Hispanic or Non-Latino:	**37**
More than one ethnicity	11
Unknown ethnicity	0
Declined to answer	182
ETHNICITY TOTAL	**234**

If **another ethnicity** is counted, please specify with numbers:

If **another race** is counted, please specify with numbers:

White	2
Other Race	0
Declined to answer	181
Unknown	13
TOTAL	**234**

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of.
We had less unique youth than planned but had more youth in long term services which led to more treatment of youth who needed long term care. Here we saw 61 TAY in long term services when we were meant to see 35.

Box E: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
E.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e., mental health treatment services):	N/A
E.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e., mental health treatment services):	N/A
E.3: Types of treatment individuals were referred to (list types below):	
N/A	
E.4: Unduplicated number of individuals who participated in referred program at least one time:	N/A
G.5: Average duration of untreated mental illness in weeks:	N/A
E.6: Average number of days between referral and first participation in referred treatment program:	N/A
Box F: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
F.1: Who is/are the underserved target population(s) your program is serving (e.g., TAY, Southeast Asian) (list types below):	
African Americans	
F.2: Number of paper referrals to an ACBH PEI-funded program:	N/A
F.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	N/A
F.4: Average number of days between referral and first participation in referred PEI program:	N/A
F.5: Describe how your program encouraged access to services and follow through on above referrals:	
Intensive and strategic outreach that scaffolds into services.	

Box G: 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 Respondents	**N/A**
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):
Oakland High School	Students staff counselors and teachers
Oakland School for the Arts	Students staff counselors and teachers
Youth Empowerment 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
Berkely College Underground Scholars Initiative	Students staff counselors and teachers
Latitude High School	Students staff counselors and teachers
First Place for the Youth	Students staff counselors and teachers
Westcoast Clinic	Students staff counselors and teachers
OUSD Credit Academic Recovery	Students staff counselors and teachers
UCSF Oakland Childrens 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, Inc.
PROGRAM NAME	Black Men Speak

Program Outcomes & Impact Data Report FY: 22-23

Program Name:	Black Men Speak, Inc.
Organization:	Black Men Speak
Type of Report:	Annual
PEI Category:	Outreach

Priority Area (place an X next to all that apply):

	Childhood Trauma
	Early Psychosis
	Youth/TAY Outreach & Engagement
X	Cultural & Linguistic
	Older Adults
	Early Identification of MH Illness

Outcomes (place an X next to all that apply): Programs focus on <u>reducing</u> the seven negative outcomes that may result from untreated mental illness.

X	Suicide
X	Incarceration
	School failure or dropout
X	Unemployment
	Prolonged suffering
X	Homelessness
	Removal of children from their homes

Box A: **Brief** program description.

Black Men Speak is a speaker's bureau that aims to reduce stigma and discrimination against people with mental health experiences by empowering African American Men and Women to share their personal stories of hope and recovery and our community.

Box B: Number of Individuals served this fiscal year through MHSA funding.

# of unduplicated individuals served who are at risk of developing a serious mental illness:	N/A
Number of unduplicated individuals served who show early signs of forming a more severe mental illness:	N/A
Number of unduplicated individual family members served indirectly by your program:	N/A
Grand total of unduplicated individuals served:	N/A

Box C: Demographics of individuals served this fiscal year through MHSA funding:

AGE CATEGORIES		SEXUAL ORIENTATION	
Children/Youth (0-15 yrs.)	500	Gay/Lesbian	0
Transition Age Youth (16-25 yrs.)	0	Heterosexual/Straight	0
Adult (26-59 yrs.)	2687	Bisexual	0
Older Adult (60+ yrs.)	2470	Questioning/Unsure	0
Declined to answer	886	Queer	0
Unknown	1538	Declined to answer	0
TOTAL	**8081**	Unknown	8081
		Another group not listed	0
		TOTAL	**8081**
		If another group is counted, please specify with numbers:	

VETERAN STATUS		PRIMARY LANGUAGE	
Yes	0	English	6244
No	0	Spanish	1025
Declined to answer	0	Cantonese	0
Unknown	8081	Chinese	464
TOTAL	**8081**	Vietnamese	58
		Farsi	0

CURRENT GENDER IDENTITY		Arabic	0

Female	3549	Tagalog	0
Male	3033	Declined to answer	0
Transgender	0	Unknown	290
Genderqueer	0	Other languages not listed	0
Questioning/unsure of gender identity	0	**TOTAL**	**8081**
Declined to answer	437		
Unknown	1062		
Another identity not listed	0		
TOTAL	**8081**		
If another group is counted, please specify with numbers:			

SEX ASSIGNED AT BIRTH		**ETHNITICY/CULTURAL HERITAGE (choose one)**	
Male	3537	**If Hispanic or Latino, please specify:**	
Female	3020	Caribbean	157
Declined to answer	638	Central American	0
Unknown	886	Mexican/Mexican American/Chicano	1370
TOTAL	**8081**	Puerto Rican	135
		South American	0
		Another Hispanic/Latino ethnicity not listed	0
DISABILITY STATUS		**Total Hispanic or Latino**	**1662**
Communication Domain		**If Non-Hispanic or Non-Latino, please specify:**	
Vision	0	African	508
Hearing/Speech	0	African American	3675
Another type not listed	0	Asian Indian/South Asian	1065
Communication Domain Subtotal	**0**	Cambodian	0
Disability Domain		Chinese	464
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	0	Eastern European	0
		European	0
		Filipino	651
Physical/mobility	0	Japanese	0
Chronic health condition	0	Korean	0
Disability Subtotal	**0**	Middle Eastern	0
None	0	Vietnamese	0
Declined to answer	0	Other Non-Hispanic or Non-Latino ethnicity not listed	0
Unknown	8081	**Total Non-Hispanic or Non-Latino:**	**5899**
Another disability not listed	0	More than one ethnicity	0
TOTAL	**8081**	Unknown ethnicity	520

If another disability is counted, please specify with numbers:		Declined to answer	0
		ETHNICITY TOTAL	**8081**
		If **another ethnicity** is counted, please specify with numbers:	
RACE			
American Indian or Alaska Native	750	If **another race** is counted, please specify with numbers:	
Asian	1065		
Black or African American	3875		
Native Hawaiian or another Pacific Islander	0		
White	1250		
Other Race	0		
Declined to answer	1141		
Unknown	0		
TOTAL	**8081**		

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of.
We have many successes and accomplishments this quarter. We have a new financial person in place to ensure our goals are met and our finances continue to be tracked and our bills paid on time. We also have a person in place who organizes and runs our Digital Literacy classes in English and Spanish. Our director is involved with the Crisis and Intervention training for law enforcement Officers which will directly impact on our community partnerships. He is also very active in letting the community know that we are present and active by sitting on several boards and BMS participation in many live events. We look forward to our next fiscal year filled with growth and outreach and many more successes.

Box E: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
E.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e., mental health treatment services):	N/A
E.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e., mental health treatment services):	N/A
E.3: Types of treatment individuals were referred to (list types below):	
N/A	
E.4: Unduplicated number of individuals who participated in referred program at least one time:	N/A
G.5: Average duration of untreated mental illness in weeks:	N/A
E.6: Average number of days between referral and first participation in referred treatment program:	N/A
Box F: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	

F.1: Who is/are the underserved target population(s) your program is serving (e.g., TAY, Southeast Asian) (list types below):	
N/A	
F.2: Number of paper referrals to an ACBH PEI-funded program:	N/A
F.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	N/A
F.4: Average number of days between referral and first participation in referred PEI program:	N/A
F.5: Describe how your program encouraged access to services and follow through on above referrals:	
N/A	

Box G: 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 Respondents	**N/A**
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):

MHSA Program #	PEI 20C
PROVIDER NAME	Mental Health Association of Alameda County (MHAAC)
PROGRAM NAME	African American Family Outreach Project

Program Outcomes & Impact Data Report FY: 22-23

Program Name:	African American Family Outreach Project
Organization:	Mental Health Association of Alameda County (MHAAC)
Type of Report:	Annual
PEI Category:	Outreach

Priority Area (place an X next to all that apply):

	Childhood Trauma
	Early Psychosis
	Youth/TAY Outreach & Engagement
X	Cultural & Linguistic
	Older Adults
	Early Identification of MH Illness

Outcomes (place an X next to all that apply): Programs focus on reducing the seven negative outcomes that may result from untreated mental illness.	
	Suicide
	Incarceration
	School failure or dropout
	Unemployment
	Prolonged suffering
	Homelessness
	Removal of children from their homes

Box A: Brief program description.
MHAAC provides virtual and in-person workshops, evening events and a warmline for African American families. These culturally sensitive events provide professional and peer support to help family members care for their loved ones living with mental illness. Family members receive information about mental health, specific mental health disorders, information about services available in Alameda County, and information on the importance of self-care as a means of stress reduction.

Box B: Number of Individuals served this fiscal year through MHSA funding.	
# of unduplicated individuals served who are at risk of developing a serious mental illness:	0
Number of unduplicated individuals served who show early signs of forming a more severe mental illness:	0
Number of unduplicated individual family members served indirectly by your program:	51
Grand total of unduplicated individuals served:	51

Box C: Demographics of individuals served this fiscal year through MHSA funding:

AGE CATEGORIES		SEXUAL ORIENTATION	
Children/Youth (0-15 yrs.)	0	Gay/Lesbian	0
Transition Age Youth (16-25 yrs.)	1	Heterosexual/Straight	0
Adult (26-59 yrs.)	20	Bisexual	0
Older Adult (60+ yrs.)	28	Questioning/Unsure	0
Declined to answer	0	Queer	0
Unknown	2	Declined to answer	0
TOTAL	**51**	Unknown	51
		Another group not listed	0
		TOTAL	**51**
		If another group is counted, please specify with numbers:	

VETERAN STATUS		PRIMARY LANGUAGE	
Yes	0	English	51
No	0	Spanish	0
Declined to answer	0	Cantonese	0
Unknown	51	Chinese	0
TOTAL	**51**	Vietnamese	0

CURRENT GENDER IDENTITY	
Female	46
Male	4
Transgender	0
Genderqueer	0
Questioning/unsure of gender identity	0
Declined to answer	1
Unknown	0
Another identity not listed	0
TOTAL	**51**
If another group is counted, please specify with numbers:	

Farsi	0
Arabic	0
Tagalog	0
Declined to answer	0
Unknown	0
Other languages not listed	0
TOTAL	**51**

SEX ASSIGNED AT BIRTH	
Male	0
Female	0
Declined to answer	0
Unknown	51
TOTAL	**51**

DISABILITY STATUS	
Communication Domain	
Vision	0
Hearing/Speech	0
Another type not listed	0
Communication Domain Subtotal	**0**
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	0
Physical/mobility	0
Chronic health condition	0
Disability Subtotal	**0**
None	0
Declined to answer	0
Unknown	51
Another disability not listed	0
TOTAL	**51**

ETHNICITY/CULTURAL HERITAGE (choose one)	
If Hispanic or Latino, please specify:	
Caribbean	0
Central American	1
Mexican/Mexican American/Chicano	0
Puerto Rican	0
South American	0
Another Hispanic/Latino ethnicity not listed	0
Total Hispanic or Latino	**1**
If Non-Hispanic or Non-Latino, please specify:	
African	1
African American	44
Asian Indian/South Asian	0
Cambodian	0
Chinese	0
Eastern European	0
European	2
Filipino	1
Japanese	0
Korean	0
Middle Eastern	0
Vietnamese	0
Other Non-Hispanic or Non-Latino ethnicity not listed	0
Total Non-Hispanic or Non-Latino:	**48**
More than one ethnicity	0
Unknown ethnicity	1

If another disability is counted, please specify with numbers:		Declined to answer	1
		ETHNICITY TOTAL	**51**
		If **another ethnicity** is counted, please specify with numbers:	
RACE			
American Indian or Alaska Native	1	If **another race** is counted, please specify with numbers: Multi-racial	
Asian	0		
Black or African American	43		
Native Hawaiian or another Pacific Islander	0		
White	5		
Other Race	2		
Declined to answer	0		
Unknown	0		
TOTAL	**51**		

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of.
From July to December 2023, AAFOP orchestrated three highly successful outreach workshops and Zoom and in person, with a remarkable 100% of participant evaluation survey responses ranking the workshops as a perfect 10 out of 10. The presenters received glowing reviews, with an average of 100% of respondents finding them accessible and skillfully responsive to questions. Equally impressive, 98% of respondents rated both the registration process and the overall workshop experience as 9 or above out of 10, signifying exceptional satisfaction. Beyond participant praise, the program excelled in garnering valuable community feedback, which not only informed the selection of presenters but was also shared with ACBH, further enhancing the workshops' impact and effectiveness.

Box E: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
E.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e., mental health treatment services):	N/A
E.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e., mental health treatment services):	N/A
E.3: Types of treatment individuals were referred to (list types below):	
N/A	
E.4: Unduplicated number of individuals who participated in referred program at least one time:	N/A
G.5: Average duration of untreated mental illness in weeks:	N/A
E.6: Average number of days between referral and first participation in referred treatment program:	N/A

Box F: **For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:**	
F.1: Who is/are the underserved target population(s) your program is serving (e.g., TAY, Southeast Asian) (list types below):	
N/A	
F.2: Number of paper referrals to an ACBH PEI-funded program:	N/A
F.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	N/A
F.4: Average number of days between referral and first participation in referred PEI program:	N/A
F.5: Describe how your program encouraged access to services and follow through on above referrals:	
N/A	

Box G: **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 Respondents	**32**
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 February 4, 2023	AAFOP Director; 3 Presenters; AAFOP Supervisor; 4 Volunteers
Zoom Workshop April 22, 2023	Executive Director; AAFOP Director; 2 Presenters; 4 Volunteers
Zoom Workshop June 17, 2023	Executive Director; AAFOP Director; 4 Presenters; 4 Volunteers; 5 MHAAC employees (FERC/Grievance)

MHSA Program #	PEI 20E
PROVIDER NAME	Tri Cities Community Development Center
PROGRAM NAME	Mental Health Friendly Communities

Program Outcomes & Impact Data Report FY: 22-23

Program Name:	Mental Health Friendly Communities
Organization:	Tri Cities Community Development Center
Type of Report:	Annual
PEI Category:	Outreach

Priority Area (place an X next to all that apply):	
	Childhood Trauma
	Early Psychosis
X	Youth/TAY Outreach & Engagement
X	Cultural & Linguistic
X	Older Adults
X	Early Identification of MH Illness

Outcomes (place an X next to all that apply): Programs focus on reducing the seven negative outcomes that may result from untreated mental illness.	
	Suicide
	Incarceration
	School failure or dropout
	Unemployment
	Prolonged suffering
	Homelessness
	Removal of children from their homes

Box A: **Brief** program description.

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.

# of unduplicated individuals served who are at risk of developing a serious mental illness:	95
Number of unduplicated individuals served who show early signs of forming a more severe mental illness:	20
Number of unduplicated individual family members served indirectly by your program:	420
Grand total of unduplicated individuals served:	535

Box C: Demographics of individuals served this fiscal year through MHSA funding:

AGE CATEGORIES		SEXUAL ORIENTATION	
Children/Youth (0-15 yrs.)	18	Gay/Lesbian	4
Transition Age Youth (16-25 yrs.)	42	Heterosexual/Straight	210
Adult (26-59 yrs.)	188	Bisexual	0
Older Adult (60+ yrs.)	177	Questioning/Unsure	0
Declined to answer	0	Queer	0
Unknown	0	Declined to answer	50
TOTAL	**425**	Unknown	51

Another group not listed	0
TOTAL	**264**
If another group is counted, please specify with numbers:	

VETERAN STATUS	
Yes	43
No	0
Declined to answer	0
Unknown	0
TOTAL	**43**

CURRENT GENDER IDENTITY	
Female	182
Male	157
Transgender	0
Genderqueer	0
Questioning/unsure of gender identity	0
Declined to answer	0
Unknown	0
Another identity not listed	0
TOTAL	**339**
If another group is counted, please specify with numbers:	

PRIMARY LANGUAGE	
English	392
Spanish	0
Cantonese	0
Chinese	0
Vietnamese	0
Farsi	0
Arabic	0
Tagalog	0
Declined to answer	0
Unknown	0
Other languages not listed	0
TOTAL	**392**

SEX ASSIGNED AT BIRTH	
Male	162
Female	133
Declined to answer	163
Unknown	0
TOTAL	**453**

DISABILITY STATUS	
Communication Domain	
Vision	0
Hearing/Speech	2
Another type not listed	0
Communication Domain Subtotal	**2**
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental,	0

ETHNICITY/CULTURAL HERITAGE (choose one)	
If Hispanic or Latino, please specify:	
Caribbean	1
Central American	0
Mexican/Mexican American/Chicano	14
Puerto Rican	0
South American	0
Another Hispanic/Latino ethnicity not listed	0
Total Hispanic or Latino	**15**
If Non-Hispanic or Non-Latino, please specify:	
African	11
African American	345
Asian Indian/South Asian	0
Cambodian	0
Chinese	0
Eastern European	0
European	0

dementia, etc.)		Filipino	0
Physical/mobility	7	Japanese	0
Chronic health condition	40	Korean	0
Disability Subtotal	**47**	Middle Eastern	0
None	0	Vietnamese	0
Declined to answer	0	Other Non-Hispanic or Non-Latino ethnicity not listed	0
Unknown	0	**Total Non-Hispanic or Non-Latino:**	**356**
Another disability not listed	0	More than one ethnicity	0
TOTAL	**49**	Unknown ethnicity	0
If another disability is counted, please specify with numbers:		Declined to answer	0
		ETHNICITY TOTAL	**371**
		If **another ethnicity** is counted, please specify with numbers:	
RACE			
American Indian or Alaska Native	0	If **another race** is counted, please specify with numbers:	
Asian	0		
Black or African American	380		
Native Hawaiian or another Pacific Islander	0		
White	3		
Other Race	9		
Declined to answer	0		
Unknown	0		
TOTAL	**392**		

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of.
We sponsored a webinar for our Mental Health Friendly Congregations in Q1 & 3 addressing suicide awareness for African American TAY and how to provide a safe place for support, transparency, inclusion within our faith communities. Pastors, mental health ministries and congregational leaders participated in our "I'm A Winner" curriculum to better serve our youth. We also hosted a Mental Wellness Fireside Virtual Chat in Q2 focusing on Seasonal Affective Disorder partnering with our MHFC Congregations and their Mental Wellness Ministries to provide resources and support for congregants and their families.

Box E: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
E.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e., mental health treatment services):	N/A

E.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e., mental health treatment services):	N/A
E.3: Types of treatment individuals were referred to (list types below):	
N/A	
E.4: Unduplicated number of individuals who participated in referred program at least one time:	N/A
G.5: Average duration of untreated mental illness in weeks:	N/A
E.6: Average number of days between referral and first participation in referred treatment program:	N/A
Box F: **For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:**	
F.1: Who is/are the underserved target population(s) your program is serving (e.g., TAY, Southeast Asian) (list types below):	
N/A	
F.2: Number of paper referrals to an ACBH PEI-funded program:	N/A
F.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	N/A
F.4: Average number of days between referral and first participation in referred PEI program:	N/A
F.5: Describe how your program encouraged access to services and follow through on above referrals:	
N/A	

Box G: **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 Respondents	**192**
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	**27 Pastors, 37 Deacons, 33 Ministers, 83 Teachers & Children, Youth, TAY and Adult ministry leaders**
Congregational Mental Wellness Teams	**12 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	African American Mental Wellness and Spirituality Campaign (Hope & Faith)

Program Outcomes & Impact Data Report FY: 22-23

Program Name:	African American Mental Wellness and Spirituality Campaign (Hope & Faith)
Organization:	Peers Envisioning and Engaging in Recovery Services (PEERS)
Type of Report:	Annual
PEI Category:	Outreach

Priority Area (place an X next to all that apply):	
	Childhood Trauma
	Early Psychosis
X	Youth/TAY Outreach & Engagement
X	Cultural & Linguistic
X	Older Adults
X	Early Identification of MH Illness

Outcomes (place an X next to all that apply): Programs focus on <u>reducing</u> the seven negative outcomes that may result from untreated mental illness.	
X	Suicide
	Incarceration
	School failure or dropout
	Unemployment
X	Prolonged suffering
	Homelessness
	Removal of children from their homes

Box A: **<u>Brief</u>** program description.

The Hope & Faith African American Mental Wellness and Spirituality Campaign comprises unique mini-campaigns, each hosted by a faith and spiritual/healing-based community. Each campaign includes an educational presentation or orientation and a stigma reduction support group hosted by the faith community. The Hope & Faith Campaign is informed by an advisory board that includes representatives from the faith and spiritual/healing-based communities.

Box B: Number of Individuals served this fiscal year through MHSA funding.	
# of unduplicated individuals served who are at risk of developing a serious mental illness:	167
Number of unduplicated individuals 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:	167

Box C: Demographics of individuals served this fiscal year through MHSA funding:			
AGE CATEGORIES		**SEXUAL ORIENTATION**	
Children/Youth (0-15 yrs.)	1	Gay/Lesbian	2
Transition Age Youth (16-25 yrs.)	5	Heterosexual/Straight	14
Adult (26-59 yrs.)	28	Bisexual	0
Older Adult (60+ yrs.)	8	Questioning/Unsure	0
Declined to answer	125	Queer	0
Unknown	0	Declined to answer	151
TOTAL	**167**	Unknown	0
		Another group not listed	0
		TOTAL	**167**
		If another group is counted, please specify with numbers:	
VETERAN STATUS		**PRIMARY LANGUAGE**	
Yes	1	English	21
No	15	Spanish	0
Declined to answer	151	Cantonese	0
Unknown	0	Chinese	0
TOTAL	**167**	Vietnamese	0
		Farsi	0
CURRENT GENDER IDENTITY		Arabic	0
Female	29	Tagalog	1
Male	17	Declined to answer	145
Transgender	0	Unknown	0
Genderqueer	0	Other languages not listed	0
Questioning/unsure of gender identity	0	TOTAL	**167**
Declined to answer	121		
Unknown	0		
Another identity not listed	0		
TOTAL	**167**		
If another group is counted, please specify with numbers:			

SEX ASSIGNED AT BIRTH		**ETHNITICY/CULTURAL HERITAGE (choose one)**	
Male	0	**If Hispanic or Latino, please specify:**	
Female	0	Caribbean	1
Declined to answer	0	Central American	0
Unknown	167	Mexican/Mexican American/Chicano	0
TOTAL	**167**	Puerto Rican	0
		South American	0
		Another Hispanic/Latino ethnicity not listed	0

DISABILITY STATUS		Total Hispanic or Latino	1
Communication Domain		**If Non-Hispanic or Non-Latino, please specify:**	
Vision	0	African	1
Hearing/Speech	0	African American	4
Another type not listed	0	Asian Indian/South Asian	0
Communication Domain Subtotal	**0**	Cambodian	1
Disability Domain		Chinese	0
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	1	Eastern European	0
		European	
		Filipino	
Physical/mobility	1	Japanese	0
Chronic health condition	1	Korean	0
Disability Subtotal	**3**	Middle Eastern	0
None	11	Vietnamese	0
Declined to answer	152	Other Non-Hispanic or Non-Latino ethnicity not listed	0
Unknown	0	**Total Non-Hispanic or Non-Latino:**	**0**
Another disability not listed	1	More than one ethnicity	7
TOTAL	**167**	Unknown ethnicity	0
If another disability is counted, please specify with numbers: PTSD/Anxiety (1)		Declined to answer	152
		ETHNICITY TOTAL	**167**
		If **another ethnicity** is counted, please specify with numbers:	
RACE			
American Indian or Alaska Native	0	If **another race** is counted, please specify with numbers: Latino (2), African American/Filipino (3), African American/Latino (1), Black/Cambodian (1), Multiracial/Mixed (2)	
Asian	3		
Black or African American	35		
Native Hawaiian or another Pacific Islander	0		
White	1		
Other Race	9		
Declined to answer	119		
Unknown	0		
TOTAL	**167**		

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of.
PEERS was pleased to have forged partnerships with the following African American churches for 2022-23: • **Christian Community Church of California (Oakland)**: average of 15 participants per session, met in person. • **Memorial Tabernacle Church (Oakland)**: average of 10 participants per session. • **House of Restoration (Oakland)**: average of nine participants per session. • **Brothers and Sisters in Christ Ministry (San Leandro)**: This church participated in the program for the first time. The Rev. Wanda Johnson, who also is the mother of Oscar Grant, first became involved with PEERS through the Day of Prayer several years ago. The support group was in person and averaged 19 participants per session. Comments from participants in the anti-stigma support groups included: *I truly loved the lesson today. It taught me not to think negative about myself.* *Internal stigma can cause me to feel depressed* *It's okay to face a struggle. Call on God. It's normal to have these emotions.* *[I learned to] show compassion for those with mental illness* *[I learned to] talk openly about mental health* *We are not alone.* *I love how deep and real we got.* *I was able to be honest about what I'm going through* *I was given a safe space to speak my truth*

Box E: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
E.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
E.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
E.3: Types of treatment individuals were referred to (list types below):	
N/A	
E.4: Unduplicated number of individuals who participated in referred program at least one time:	N/A
G.5: Average duration of untreated mental illness in weeks:	N/A
E.6: Average number of days between referral and first participation in referred treatment program:	N/A
Box F: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
F.1: Who is/are the underserved target population(s) your program is serving (e.g., TAY, Southeast Asian) (list types below):	
African American members of faith and spiritual/healing communities.	
F.2: Number of paper referrals to an ACBH PEI-funded program:	0
F.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	N/A

F.4: Average number of days between referral and first participation in referred PEI program:	N/A

F.5: Describe how your program encouraged access to services and follow through on above referrals:

We invest heavily in creating warm, open, supportive relationships with participants and our partners at each church and use those relationships to facilitate referrals. Equipping the leaders at each church with access to local mental health resources is a key part of our strategy. However, none of the referrals we made were on paper.

Box G: 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 Respondents	**126**
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	**67 members of primarily African American churches**
Prayer & Unity Community Celebration	**59 community members, primarily East Oakland residents**

MHSA Program #	PEI 20D
PROVIDER NAME	Restorative Justice for Oakland Youth
PROGRAM NAME	Africentric Healing Circles

Program Outcomes & Impact Data Report FY: 22-23

Program Name:	Africentric Healing Circles
Organization:	Restorative Justice for Oakland Youth
Type of Report:	Annual
PEI Category:	Outreach

Priority Area (place an X next to all that apply):

	Childhood Trauma
	Early Psychosis
X	Youth/TAY Outreach & Engagement
	Cultural & Linguistic
	Older Adults
	Early Identification of MH Illness

Outcomes (place an X next to all that apply): Programs focus on reducing the seven negative outcomes that may result from untreated mental illness.	
X	Suicide
X	Incarceration
X	School failure or dropout
X	Unemployment
X	Prolonged suffering
X	Homelessness
X	Removal of children from their homes

Box A: Brief program description.
The RJOY African American Healing Circles Program provides culturally responsive mental health support to individuals in Alameda County. The affinity groups draw on indigenous and Africentric healing practices in combination with the ACBH MHSA Prevention and Early Intervention (PEI) plan. The Circles explore community, celebration, joy, grief, fatherhood, mental health, and systemic conditions that impact program participants.

Box B: Number of Individuals served this fiscal year through MHSA funding.	
# of unduplicated individuals served who are at risk of developing a serious mental illness:	31
Number of unduplicated individuals served who show early signs of forming a more severe mental illness:	1
Number of unduplicated individual family members served indirectly by your program:	40
Grand total of unduplicated individuals served:	72

Box C: Demographics of individuals served this fiscal year through MHSA funding:

AGE CATEGORIES		SEXUAL ORIENTATION	
Children/Youth (0-15 yrs.)	25	Gay/Lesbian	7
Transition Age Youth (16-25 yrs.)	34	Heterosexual/Straight	68
Adult (26-59 yrs.)	65	Bisexual	5
Older Adult (60+ yrs.)	23	Questioning/Unsure	1
Declined to answer	0	Queer	3
Unknown	875	Declined to answer	69
TOTAL	**1022**	Unknown	870
		Another group not listed	0
		TOTAL	**1022**
		If another group is counted, please specify with numbers:	

VETERAN STATUS		PRIMARY LANGUAGE	
Yes	0	English	146
No	0	Spanish	2
Declined to answer	0	Cantonese	0
Unknown	1022	Chinese	0
TOTAL	**1022**	Vietnamese	0

CURRENT GENDER IDENTITY	
Female	66
Male	84
Transgender	0
Genderqueer	0
Questioning/unsure of gender identity	0
Declined to answer	0
Unknown	869
Another identity not listed	3
TOTAL	**1022**
If another group is counted, please specify with numbers: Non-binary	

Farsi	0
Arabic	2
Tagalog	0
Declined to answer	0
Unknown	870
Other languages not listed	2
TOTAL	**1022**

SEX ASSIGNED AT BIRTH	
Male	84
Female	66
Declined to answer	3
Unknown	869
TOTAL	**1022**
DISABILITY STATUS	
Communication Domain	
Vision	1
Hearing/Speech	2
Another type not listed	0
Communication Domain Subtotal	**1**
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	0
Physical/mobility	0
Chronic health condition	0
Disability Subtotal	**0**
None	4
Declined to answer	149
Unknown	869
Another disability not listed	0
TOTAL	**1022**

ETHNICITY/CULTURAL HERITAGE (choose one)	
If Hispanic or Latino, please specify:	
Caribbean	0
Central American	0
Mexican/Mexican American/Chicano	8
Puerto Rican	0
South American	0
Another Hispanic/Latino ethnicity not listed	0
Total Hispanic or Latino	**8**
If Non-Hispanic or Non-Latino, please specify:	
African	0
African American	126
Asian Indian/South Asian	1
Cambodian	0
Chinese	0
Eastern European	0
European	0
Filipino	0
Japanese	0
Korean	0
Middle Eastern	2
Vietnamese	0
Other Non-Hispanic or Non-Latino ethnicity not listed	0
Total Non-Hispanic or Non-Latino:	**129**
More than one ethnicity	3
Unknown ethnicity	882

If another disability is counted, please specify with numbers:		Declined to answer	0
		ETHNICITY TOTAL	**1022**
		If **another ethnicity** is counted, please specify with numbers:	
RACE			
American Indian or Alaska Native	2	If **another race** is counted, please specify with numbers: Hispanic/Latino- 8	
Asian	27		
Black or African American	822		
Native Hawaiian or another Pacific Islander	2		
White	100		
Other Race	55		
Declined to answer	0		
Unknown	14		
TOTAL	**1022**		

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of.
We sponsored a webinar for our Mental Health Friendly Congregations in Q1 & 3 addressing suicide awareness for African American TAY and how to provide a safe place for support, transparency, inclusion within our faith communities. Pastors, mental health ministries, and congregational leaders participated in our "I'm A Winner" curriculum to better serve our youth. We also hosted a Mental Wellness Fireside Virtual Chat in Q2 focusing on Seasonal Affective Disorder partnering with our MHFC Congregations and their Mental Wellness Ministries to provide resources and support for congregants and their families.

Box E: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
E.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
E.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
E.3: Types of treatment individuals were referred to (list types below):	
Mental Health Counseling, Education, Employment and Housing	
E.4: Unduplicated number of individuals who participated in referred program at least one time:	6
G.5: Average duration of untreated mental illness in weeks:	2
E.6: Average number of days between referral and first participation in referred treatment program:	5
Box F: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	

F.1: Who is/are the underserved target population(s) your program is serving (e.g., TAY, Southeast Asian) (list types below):	
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). The healing circles predominantly serve individuals and families of African Descent, but all are welcome to participate. We provide services and support for a range of people from different demographics with reference to age, gender, socio-economic status, gender, and sexuality. In addition, we provide community spaces for marginalized identities such as trans people and adolescent youth.	
F.2: Number of paper referrals to an ACBH PEI-funded program:	1
F.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	1
F.4: Average number of days between referral and first participation in referred PEI program:	7
F.5: Describe how your program encouraged access to services and follow through on above referrals:	
Circle keepers frequently advise participants about multiple referral opportunities and how participants can access services. Announcements are given at the beginning and end of the Circle. Staff also share information through email reminders. Furthermore, social media is used as a medium to share updates and resources. Circle Keepers continue to conduct wellness calls to determine interest and need for referrals in addition to discussions on mental health and wellness during Circle.	

Box G: 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 Respondents	**N/A**
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):

MHSA Program #	PEI 22
PROVIDER NAME	Pacific Center for Human Growth
PROGRAM NAME	LGBTQ Services – Older And Out

Program Outcomes & Impact Data Report FY: 22-23

Program Name:	Older and Out
Organization:	Pacific Center for Human Growth
Type of Report:	Annual
PEI Category:	Early Intervention - LGBTQ Services

Priority Area (place an X next to all that apply):	
	Childhood Trauma
	Early Psychosis
	Youth/TAY Outreach & Engagement
	Cultural & Linguistic
X	Older Adults
	Early Identification of MH Illness

Outcomes (place an X next to all that apply): Programs focus on reducing the seven negative outcomes that may result from untreated mental illness.	
	Suicide
	Incarceration
	School failure or dropout
	Unemployment
	Prolonged suffering
	Homelessness
	Removal of children from their homes

Box A: **Brief** program description.

The Older & Out program offers free, drop-in therapy groups for LGBTQIA+ adults over the age of 60. Pacific Center partners with senior centers around Alameda County, as well as the Oakland LGBTQ Center, to provide various Older & Out service locations. 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.

# of unduplicated individuals served who are at risk of developing a serious mental illness:	46
Number of unduplicated individuals 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:	46

Box C: Demographics of individuals served this fiscal year through MHSA funding:

AGE CATEGORIES		SEXUAL ORIENTATION	
Children/Youth (0-15 yrs.)	0	Gay/Lesbian	32
Transition Age Youth (16-25 yrs.)	0	Heterosexual/Straight	0
Adult (26-59 yrs.)	4	Bisexual	3
Older Adult (60+ yrs.)	38	Questioning/Unsure	1
Declined to answer	4	Queer	4
Unknown	0	Declined to answer	1
TOTAL	**46**	Unknown	0
		Another group not listed	5
		TOTAL	**46**
		If another group is counted, please specify with	

VETERAN STATUS	
Yes	1
No	21
Declined to answer	24
Unknown	0
TOTAL	**46**

CURRENT GENDER IDENTITY	
Female	18
Male	19
Transgender	0
Genderqueer	1
Questioning/unsure of gender identity	0
Declined to answer	1
Unknown	0
Another identity not listed	7
TOTAL	**46**
If another group is counted, please specify with numbers:	

numbers:	
PRIMARY LANGUAGE	
English	41
Spanish	0
Cantonese	0
Chinese	0
Vietnamese	0
Farsi	0
Arabic	0
Tagalog	0
Declined to answer	4
Unknown	0
Other languages not listed	1
TOTAL	**46**

SEX ASSIGNED AT BIRTH	
Male	0
Female	0
Declined to answer	46
Unknown	0
TOTAL	**46**
DISABILITY STATUS	
Communication Domain	
Vision	0
Hearing/Speech	0
Another type not listed	0
Communication Domain Subtotal	**0**
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	3
Physical/mobility	3
Chronic health condition	1

ETHNITICY/CULTURAL HERITAGE (choose one)	
If Hispanic or Latino, please specify:	
Caribbean	0
Central American	0
Mexican/Mexican American/Chicano	0
Puerto Rican	0
South American	0
Another Hispanic/Latino ethnicity not listed	8
Total Hispanic or Latino	**8**
If Non-Hispanic or Non-Latino, please specify:	
African	0
African American	0
Asian Indian/South Asian	0
Cambodian	0
Chinese	1
Eastern European	2
European	0
Filipino	1
Japanese	1
Korean	0

Disability Subtotal	**7**	Middle Eastern	0
None	27	Vietnamese	0
Declined to answer	5	Other Non-Hispanic or Non-Latino ethnicity not listed	2
Unknown	0	**Total Non-Hispanic or Non-Latino:**	**0**
Another disability not listed	7	More than one ethnicity	3
TOTAL	**46**	Unknown ethnicity	6
If another disability is counted, please specify with numbers:		Declined to answer	30
		ETHNICITY TOTAL	**46**
		If **another ethnicity** is counted, please specify with numbers:	
RACE			
American Indian or Alaska Native	0	If **another race** is counted, please specify with numbers:	
Asian	3		
Black or African American	3		
Native Hawaiian or another Pacific Islander	0		
White	31		
Other Race	1		
Declined to answer	4		
Unknown	4		
TOTAL	**46**		

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of.

Older & Out has continued to operate with three therapy groups, meeting the needs of many community members, many who return for multiple sessions There have been no interruptions to service offerings. We ran five 9-week sessions per group and offered 1:1 contact on the week break in between sessions. Intakes are conducted over Zoom by the clinician facilitating each group.

At the start of the second quarter of this fiscal year, two Older & Out therapy groups moved back to meeting in-person. Immediately, some former members who had been reluctant to meet on Zoom, returned. A few members who had enjoyed Zoom attendance and were unable to attend in-person declined to return.

We continue to offer peer support groups focused on LGBTQIA+ older adults for residents of Dublin, Hayward, Livermore, and San Leandro. The Dublin, Hayward and Livermore groups take place on Zoom. San Leandro is meeting in-person.

Box E: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
E.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e., mental health treatment services):	N/A
E.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e., mental health treatment services):	6
E.3: Types of treatment individuals were referred to (list types below):	
Older adults were referred to Life ElderCare for 1:1 case management	
E.4: Unduplicated number of individuals who participated in referred program at least one time:	N/A
G.5: Average duration of untreated mental illness in weeks:	N/A
E.6: Average number of days between referral and first participation in referred treatment program:	N/A
Box F: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
F.1: Who is/are the underserved target population(s) your program is serving (e.g., TAY, Southeast Asian) (list types below):	
N/A	
F.2: Number of paper referrals to an ACBH PEI-funded program:	N/A
F.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	N/A
F.4: Average number of days between referral and first participation in referred PEI program:	N/A
F.5: Describe how your program encouraged access to services and follow through on above referrals:	
N/A	

Box G: 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 Respondents	**N/A**
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):

MHSA Program #	PEI 22
PROVIDER NAME	Pacific Center for Human Growth
PROGRAM NAME	Peer Mentorship Program

Program Outcomes & Impact Data Report FY: 22-23

Program Name:	Peer Mentorship Program
Organization:	Pacific Center for Human Growth
Type of Report:	Annual Report
PEI Category:	Outreach

Priority Area (place an X next to all that apply):	
	Childhood Trauma
	Early Psychosis
X	Youth/TAY Outreach & Engagement
	Cultural & Linguistic
X	Older Adults
X	Early Identification of MH Illness

Outcomes (place an X next to all that apply): Programs focus on <u>reducing</u> the seven negative outcomes that may result from untreated mental illness.	
	Suicide
	Incarceration
	School failure or dropout
	Unemployment
	Prolonged suffering
	Homelessness
	Removal of children from their homes

Box A: **<u>Brief</u>** program description.

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.	
# of unduplicated individuals served who are at risk of developing a serious mental illness:	261
Number of unduplicated individuals served who show early signs of forming a more severe mental illness:	25
Number of unduplicated individual family members served indirectly by your program:	0
Grand total of unduplicated individuals served:	261

Box C: Demographics of individuals served this fiscal year through MHSA funding:			
AGE CATEGORIES		**SEXUAL ORIENTATION**	
Children/Youth (0-15 yrs.)	0	Gay/Lesbian	53
Transition Age Youth (16-25 yrs.)	33	Heterosexual/Straight	12
Adult (26-59 yrs.)	173	Bisexual	28
Older Adult (60+ yrs.)	49	Questioning/Unsure	11
Declined to answer	6	Queer	27
Unknown	0	Declined to answer	7
TOTAL	**261**	Unknown	0
		Another group not listed	123
		TOTAL	**261**
		If another group is counted, please specify with numbers:	
VETERAN STATUS		**PRIMARY LANGUAGE**	
Yes	11	English	254
No	244	Spanish	3
Declined to answer	6	Cantonese	0
Unknown	0	Chinese	0
TOTAL	**261**	Vietnamese	0
		Farsi	0
CURRENT GENDER IDENTITY		Arabic	0
Female	24	Tagalog	0
Male	40	Declined to answer	4
Transgender	79	Unknown	0
Genderqueer	9	Other languages not listed	0
Questioning/unsure of gender identity	4	**TOTAL**	**261**
Declined to answer	7		
Unknown	0		
Another identity not listed	98		
TOTAL	**261**		
If another group is counted, please specify with numbers:			

SEX ASSIGNED AT BIRTH		**ETHNITICY/CULTURAL HERITAGE (choose one)**	
Male	0	**If Hispanic or Latino, please specify:**	
Female	0	Caribbean	0
Declined to answer	261	Central American	0
Unknown	0	Mexican/Mexican American/Chicano	18
TOTAL	**261**	Puerto Rican	1
		South American	0
		Another Hispanic/Latino ethnicity not listed	14

DISABILITY STATUS		Total Hispanic or Latino	33
Communication Domain		**If Non-Hispanic or Non-Latino, please specify:**	
Vision	0	African	9
Hearing/Speech	2	African American	19
Another type not listed	0	Asian Indian/South Asian	7
Communication Domain Subtotal	**2**	Cambodian	0
Disability Domain		Chinese	13
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	24	Eastern European	10
		European	72
		Filipino	3
Physical/mobility	3	Japanese	0
Chronic health condition	21	Korean	1
Disability Subtotal	**48**	Middle Eastern	8
None	168	Vietnamese	1
Declined to answer	0	Other Non-Hispanic or Non-Latino ethnicity not listed	9
Unknown	0	**Total Non-Hispanic or Non-Latino:**	**152**
Another disability not listed	43	More than one ethnicity	22
TOTAL	**261**	Unknown ethnicity	0
If another disability is counted, please specify with numbers:		Declined to answer	73
		ETHNICITY TOTAL	**280**
		If **another ethnicity** is counted, please specify with numbers:	
RACE			
American Indian or Alaska Native	3	If **another race** is counted, please specify with numbers:	
Asian	29		
Black or African American	19		
Native Hawaiian or another Pacific Islander	0		
White	157		
Other Race	5		
Declined to answer	25		
Unknown	23		
TOTAL	**261**		

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of.
Our peer groups at the Pacific Center have continued to run uninterrupted throughout the year. While most of the groups have continued to run virtually, we anticipate that many will return in-person now that the Pacific Center has secured our new location in downtown Berkeley.

Our primary goal this year was to increase capacity and reduce burnout for our facilitators. To that end, we were able to onboard 16 new facilitators and re-trained an additional 3 facilitators at their request. We were also able to offer a full set of Diversity Equity and Inclusion trainings including one that was co-facilitated by a peer facilitator and our Community Programs Director.

We are happy to report that our peer groups continue to be vital support to the LGBTQIA+ community in this time. This year, 92.39% of our participants reported that the peer support group(s) they attended helped them to feel safe talking about their gender. Also, 88.04% reported that the peer support group(s) they attended helped them to feel safe in talking about their sexuality.

Box E: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
E.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
E.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):	14
E.3: Types of treatment individuals were referred to (list types below):	
Participants were referred to therapy at PC, therapy at external service providers, medical care at external service providers, social services at external service providers, housing support at external service providers, spiritual support at external service providers.	
E.4: Unduplicated number of individuals who participated in referred program at least one time:	N/A
G.5: Average duration of untreated mental illness in weeks:	N/A
E.6: Average number of days between referral and first participation in referred treatment program:	N/A
Box F: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
F.1: Who is/are the underserved target population(s) your program is serving (e.g., TAY, Southeast Asian) (list types below):	
N/A	
F.2: Number of paper referrals to an ACBH PEI-funded program:	N/A
F.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	N/A
F.4: Average number of days between referral and first participation in referred PEI program:	N/A
F.5: Describe how your program encouraged access to services and follow through on above referrals:	
N/A	

Box G: **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 Respondents	**N/A**
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):

MHSA Program #	PEI 22
PROVIDER NAME	Pacific Center for Human Growth
PROGRAM NAME	Training Assistance

Program Outcomes & Impact Data Report FY: 22-23

Program Name:	Training Assistance
Organization:	Pacific Center for Human Growth
Type of Report:	Annual
PEI Category:	Outreach

Priority Area (place an X next to all that apply):	
	Childhood Trauma
	Early Psychosis
	Youth/TAY Outreach & Engagement
X	Cultural & Linguistic
	Older Adults
	Early Identification of MH Illness

Outcomes (place an X next to all that apply): Programs focus on reducing the seven negative outcomes that may result from untreated mental illness.	
	Suicide
	Incarceration
	School failure or dropout
	Unemployment
	Prolonged suffering
	Homelessness
	Removal of children from their homes

Box A: Brief program description.

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 ACBH contracted providers' cultural responsiveness to the LGBTQIA+ community.

Box B: Number of Individuals served this fiscal year through MHSA funding.	
# of unduplicated individuals served who are at risk of developing a serious mental illness:	0
Number of unduplicated individuals 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:	105

Box C: Demographics of individuals served this fiscal year through MHSA funding:

AGE CATEGORIES	
Children/Youth (0-15 yrs.)	3
Transition Age Youth (16-25 yrs.)	19
Adult (26-59 yrs.)	76
Older Adult (60+ yrs.)	7
Declined to answer	0
Unknown	0
TOTAL	**105**

SEXUAL ORIENTATION	
Gay/Lesbian	7
Heterosexual/Straight	54
Bisexual	10
Questioning/Unsure	1
Queer	11
Declined to answer	6
Unknown	0
Another group not listed	16
TOTAL	**105**
If another group is counted, please specify with numbers:	

VETERAN STATUS	
Yes	3
No	99
Declined to answer	3
Unknown	0
TOTAL	**105**

PRIMARY LANGUAGE	
English	101
Spanish	1
Cantonese	0
Chinese	0
Vietnamese	0
Farsi	0
Arabic	0
Tagalog	0
Declined to answer	1
Unknown	0
Other languages not listed	3
TOTAL	**105**

CURRENT GENDER IDENTITY	
Female	65
Male	16
Transgender	2
Genderqueer	3
Questioning/unsure of gender identity	0
Declined to answer	5
Unknown	0
Another identity not listed	14
TOTAL	**105**
If another group is counted, please specify with numbers:	

SEX ASSIGNED AT BIRTH	
Male	0
Female	0
Declined to answer	105
Unknown	0
TOTAL	**105**

DISABILITY STATUS	
Communication Domain	
Vision	0
Hearing/Speech	0
Another type not listed	0
Communication Domain Subtotal	**0**
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	11
Physical/mobility	4
Chronic health condition	7
Disability Subtotal	**22**
None	70
Declined to answer	9
Unknown	0
Another disability not listed	4
TOTAL	**105**

If another disability is counted, please specify with numbers:

RACE	
American Indian or Alaska Native	4
Asian	9
Black or African American	12
Native Hawaiian or another Pacific Islander	2
White	45
Other Race	23

ETHNITICY/CULTURAL HERITAGE (choose one)	
If Hispanic or Latino, please specify:	
Caribbean	1
Central American	3
Mexican/Mexican American/Chicano	6
Puerto Rican	1
South American	1
Another Hispanic/Latino ethnicity not listed	0
Total Hispanic or Latino	**12**
If Non-Hispanic or Non-Latino, please specify:	
African	9
African American	2
Asian Indian/South Asian	0
Cambodian	0
Chinese	1
Eastern European	6
European	18
Filipino	2
Japanese	1
Korean	0
Middle Eastern	0
Vietnamese	0
Other Non-Hispanic or Non-Latino ethnicity not listed	39
Total Non-Hispanic or Non-Latino:	**78**
More than one ethnicity	10
Unknown ethnicity	0
Declined to answer	5
ETHNICITY TOTAL	**105**

If **another ethnicity** is counted, please specify with numbers:

If **another race** is counted, please specify with numbers:

Declined to answer	10
Unknown	0
TOTAL	**105**

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of.
This year we offered a total of 42 trainings for our clinicians and the larger community focused on the mental health and wellness of LGBTQIA+ communities, grounded in cultural humility, and centered in diversity, equity and inclusion. We worked with ten community organizations, offering a total of 25 LGBTQIA+ and cultural humility trainings to enhance the knowledge and skill set of their community workers. Seven of those sessions happened in-person as communities are slowly bringing their programming and services back in-person. Additionally, we were able to work with organizations outside of Alameda County by incorporating a sliding scale fee structure to our training offerings. Finally, we held our 5th annual Mental Health at the Intersections conference as a hybrid model where we received more in-person and virtual participation this year than last.

Box E: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
E.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e., mental health treatment services):	N/A
E.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e., mental health treatment services):	N/A
E.3: Types of treatment individuals were referred to (list types below):	
N/A	
E.4: Unduplicated number of individuals who participated in referred program at least one time:	N/A
G.5: Average duration of untreated mental illness in weeks:	N/A
E.6: Average number of days between referral and first participation in referred treatment program:	N/A
Box F: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
F.1: Who is/are the underserved target population(s) your program is serving (e.g., TAY, Southeast Asian) (list types below):	
N/A	
F.2: Number of paper referrals to an ACBH PEI-funded program:	N/A
F.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	N/A
F.4: Average number of days between referral and first participation in referred PEI program:	N/A
F.5: Describe how your program encouraged access to services and follow through on above referrals:	
N/A	

Box G: **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 Respondents	**N/A**
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):

MHSA Program #	PEI 28
PROVIDER NAME	Roots Community Health Center
PROGRAM NAME	Sobrante Park Community Project

Program Outcomes & Impact Data Report FY: 22-23

Program Name:	Sobrante Park Community Project
Organization:	Roots Community Health Center
Type of Report:	Annual
PEI Category:	Outreach

Priority Area (place an X next to all that apply):	
	Childhood Trauma
	Early Psychosis
	Youth/TAY Outreach & Engagement
	Cultural & Linguistic
	Older Adults
X	Early Identification of MH Illness

Outcomes (place an X next to all that apply): Programs focus on reducing the seven negative outcomes that may result from untreated mental illness.	
	Suicide
	Incarceration
	School failure or dropout
	Unemployment
	Prolonged suffering
	Homelessness
	Removal of children from their homes

Box A: Brief program description.
Roots Community Health Center seeks to address long-standing health inequalities in the Sobrante Park community by partnering with the Sobrante Park Residents 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.	
# of unduplicated individuals served who are at risk of developing a serious mental illness:	0
Number of unduplicated individuals served who show early signs of forming a more severe mental illness:	0
Number of unduplicated individual family members served indirectly by your program:	27
Grand total of unduplicated individuals served:	27

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.)	11
Adult (26-59 yrs.)	0
Older Adult (60+ yrs.)	0
Declined to answer	0
Unknown	16
TOTAL	**27**

SEXUAL ORIENTATION	
Gay/Lesbian	0
Heterosexual/Straight	0
Bisexual	0
Questioning/Unsure	0
Queer	0
Declined to answer	0
Unknown	27
Another group not listed	0
TOTAL	**27**
If another group is counted, please specify with numbers:	

VETERAN STATUS	
Yes	0
No	0
Declined to answer	0
Unknown	27
TOTAL	**27**

PRIMARY LANGUAGE	
English	27
Spanish	0
Cantonese	0
Chinese	0
Vietnamese	0
Farsi	0
Arabic	0
Tagalog	0
Declined to answer	0
Unknown	0
Other languages not listed	0
TOTAL	**27**

CURRENT GENDER IDENTITY	
Female	15
Male	1
Transgender	0
Genderqueer	0
Questioning/unsure of gender identity	0
Declined to answer	0
Unknown	11
Another identity not listed	0
TOTAL	**27**
If another group is counted, please specify with numbers:	

SEX ASSIGNED AT BIRTH	
Male	15
Female	1
Declined to answer	0
Unknown	11
TOTAL	**27**

DISABILITY STATUS	
Communication Domain	
Vision	0
Hearing/Speech	0
Another type not listed	0
Communication Domain Subtotal	**0**
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	0
Physical/mobility	0
Chronic health condition	0
Disability Subtotal	**0**
None	0
Declined to answer	0
Unknown	27
Another disability not listed	0
TOTAL	**27**

If another disability is counted, please specify with numbers:

RACE	
American Indian or Alaska Native	0
Asian	0
Black or African American	16
Native Hawaiian or another Pacific Islander	0
White	0
Other Race	6
Declined to answer	0

ETHNITICY/CULTURAL HERITAGE (choose one)	
If Hispanic or Latino, please specify:	
Caribbean	0
Central American	0
Mexican/Mexican American/Chicano	0
Puerto Rican	0
South American	0
Another Hispanic/Latino ethnicity not listed	6
Total Hispanic or Latino	**6**
If Non-Hispanic or Non-Latino, please specify:	
African	0
African American	14
Asian Indian/South Asian	0
Cambodian	0
Chinese	0
Eastern European	0
European	0
Filipino	0
Japanese	0
Korean	0
Middle Eastern	0
Vietnamese	0
Other Non-Hispanic or Non-Latino ethnicity not listed	0
Total Non-Hispanic or Non-Latino:	**14**
More than one ethnicity	2
Unknown ethnicity	5
Declined to answer	0
ETHNICITY TOTAL	**27**

If **another ethnicity** is counted, please specify with numbers:

If **another race** is counted, please specify with numbers:

Unknown	5
TOTAL	**27**

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of.
Since returning to our in-person pop-up market model in April 2022, we have more than doubled our intake and have become a well-recognized name in the community by providing much needed resources. Our community engagement efforts have resulted in sustainability between our partners to keep the program operating at its optimum performance.

Box E: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
E.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
E.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
E.3: Types of treatment individuals were referred to (list types below):	
Referred clients received weekly 1:1 sessions with mental healthcare provider, or in some cases group therapy depending on the level and kind of treatment determined by clinician.	
E.4: Unduplicated number of individuals who participated in referred program at least one time:	16
G.5: Average duration of untreated mental illness in weeks:	2-4 weeks
E.6: Average number of days between referral and first participation in referred treatment program:	1 week
Box F: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
F.1: Who is/are the underserved target population(s) your program is serving (e.g., TAY, Southeast Asian) (list types below):	
Individuals and families of African-American and Latino/a/x descent who live, go to school, or work in Sobrante Park.	
F.2: Number of paper referrals to an ACBH PEI-funded program:	1
F.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	1
F.4: Average number of days between referral and first participation in referred PEI program:	1 week
F.5: Describe how your program encouraged access to services and follow through on above referrals:	
Through the collaboration with our community partners, Sobrante Park Residents Action Council, Higher Ground and Madison Park Academy Primary community members are referred to Roots for a variety of services. A Roots navigator will then work with that community member to help facilitate matching the appropriate service to meet the need of the client. The Navigator also conducts regular check ins with the client to ensure the efficacy of the service.	

Box G: **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 Respondents	**5**
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):
Roots: 12 Touchless Produce Distributions	5 Roots Staff

MHSA Program #	PEI 26
PROVIDER NAME	HHREC - The Health and Human Resource Education Center
PROGRAM NAME	10x10

Program Outcomes & Impact Data Report FY: 22-23

Program Name:	10x10
Organization:	HHREC - The Health and Human Resource Education Center
Type of Report:	Annual
PEI Category:	Outreach

Priority Area (place an X next to all that apply):	
	Childhood Trauma
	Early Psychosis
	Youth/TAY Outreach & Engagement
	Cultural & Linguistic
X	Older Adults
	Early Identification of MH Illness

Outcomes (place an X next to all that apply): Programs focus on reducing the seven negative outcomes that may result from untreated mental illness.	
	Suicide
	Incarceration
	School failure or dropout
	Unemployment
X	Prolonged suffering
	Homelessness
	Removal of children from their homes

Box A: Brief program description.
Over the next 10 years, Alameda County's 10X10 campaign will promote services, activities and policies, incorporating the 8 dimensions of wellness, that seek to increase the life expectancy of mental health consumers by 10 Years. HHREC coordinates and implements this project for Alameda County Behavioral Health Care Services as part of their Mental Health Services Act funding.

Box B: Number of Individuals served this fiscal year through MHSA funding.	
# of unduplicated individuals served who are at risk of developing a serious mental illness:	23
Number of unduplicated individuals 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:	23

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.)	0
Adult (26-59 yrs.)	10
Older Adult (60+ yrs.)	0
Declined to answer	0
Unknown	9
TOTAL	**34**

SEXUAL ORIENTATION	
Gay/Lesbian	0
Heterosexual/Straight	0
Bisexual	0
Questioning/Unsure	0
Queer	0
Declined to answer	0
Unknown	0
Another group not listed	0
TOTAL	**0**
If another group is counted, please specify with numbers:	

VETERAN STATUS	
Yes	0
No	0
Declined to answer	0
Unknown	0
TOTAL	**0**

CURRENT GENDER IDENTITY	
Female	32
Male	2
Transgender	0
Genderqueer	0
Questioning/unsure of gender identity	0
Declined to answer	0
Unknown	0
Another identity not listed	0
TOTAL	**34**
If another group is counted, please specify with numbers:	

PRIMARY LANGUAGE	
English	27
Spanish	4
Cantonese	0
Chinese	0
Vietnamese	0
Farsi	0
Arabic	0
Tagalog	0
Declined to answer	0
Unknown	0
Other languages not listed	3
TOTAL	**34**

SEX ASSIGNED AT BIRTH	
Male	2
Female	32
Declined to answer	0
Unknown	0
TOTAL	**34**

DISABILITY STATUS	
Communication Domain	
Vision	0
Hearing/Speech	0
Another type not listed	0
Communication Domain Subtotal	**0**
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	0
Physical/mobility	0
Chronic health condition	0
Disability Subtotal	**0**
None	0
Declined to answer	0
Unknown	0
Another disability not listed	0
TOTAL	**0**

If another disability is counted, please specify with numbers:

RACE	
American Indian or Alaska Native	0
Asian	1
Black or African American	17
Native Hawaiian or another Pacific Islander	2
White	4
Other Race	0

ETHNITICY/CULTURAL HERITAGE (choose one)	
If Hispanic or Latino, please specify:	
Caribbean	0
Central American	0
Mexican/Mexican American/Chicano	0
Puerto Rican	0
South American	0
Another Hispanic/Latino ethnicity not listed	7
Total Hispanic or Latino	**7**
If Non-Hispanic or Non-Latino, please specify:	
African	0
African American	0
Asian Indian/South Asian	0
Cambodian	0
Chinese	0
Eastern European	0
European	0
Filipino	0
Japanese	0
Korean	0
Middle Eastern	2
Vietnamese	0
Other Non-Hispanic or Non-Latino ethnicity not listed	0
Total Non-Hispanic or Non-Latino:	**0**
More than one ethnicity	0
Unknown ethnicity	0
Declined to answer	0
ETHNICITY TOTAL	**7**

If **another ethnicity** is counted, please specify with numbers:

If **another race** is counted, please specify with numbers:

Declined to answer	1
Unknown	9
TOTAL	**34**

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of.
HHREC is moving to in person programming. In this transition, we provided in person orientation and graduation for Getfit. We also asked participants what their comfort level was in person. For Getfit programming was via zoom with one on one check in with participants either in person, zoom or by phone. Participants provided feedback regarding their success and enjoyment of the Get Fit class. Get Fit participants have self-reported the following: -Less consumption of alcohol and more movement via Get Fit class and yoga and walking -My health feels good -Increase exercise -I am reading labels a lot more, paying more attention to my daily calorie intake and cutting back on my sodas. -I've learned to make more exercise, walk every day and change my eating habits to better and healthy food -I drink a lot of water I feel great my body I know how to lose my weight

Box E: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
E.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e., mental health treatment services):	N/A
E.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e., mental health treatment services):	N/A
E.3: Types of treatment individuals were referred to (list types below):	
N/A	
E.4: Unduplicated number of individuals who participated in referred program at least one time:	N/A
G.5: Average duration of untreated mental illness in weeks:	N/A
E.6: Average number of days between referral and first participation in referred treatment program:	N/A
Box F: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
F.1: Who is/are the underserved target population(s) your program is serving (e.g., TAY, Southeast Asian) (list types below):	
N/A	
F.2: Number of paper referrals to an ACBH PEI-funded program:	N/A
F.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	N/A
F.4: Average number of days between referral and first participation in referred PEI program:	N/A

F.5: Describe how your program encouraged access to services and follow through on above referrals:
N/A

Box G: 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 Respondents	**12**
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	1 Program Coordinator; 1 Program Manager
Asian Health services	1 Program Specialist
Berkeley Mental Health	1 Consumer Liaison
Downtown TAY	1 Program Manager; 3 TAY interns
Pool of Consumer Champions (POCC)	2 POCC members
Mental Health Association for Chinese Communities	1 CEO/Founder
CALFresh	1 Interim Associate Director
CNAP	N/A

MHSA Program #	PEI 27
PROVIDER NAME	Health and Human Resource and Education Center
PROGRAM NAME	Black Women's Media and Wellness Project

Program Outcomes & Impact Data Report FY: 22-23

Program Name:	Black Women's Media and Wellness Project
Organization:	HHREC- Health and Human Resource Education Center
Type of Report:	Annual
PEI Category:	Prevention/Early Intervention/ Outreach

Priority Area (place an X next to all that apply):	
	Childhood Trauma
	Early Psychosis
	Youth/TAY Outreach & Engagement
X	Cultural & Linguistic
	Older Adults
X	Early Identification of MH Illness

Outcomes (place an X next to all that apply): Programs focus on reducing the seven negative outcomes that may result from untreated mental illness.	
	Suicide
	Incarceration
	School failure or dropout
	Unemployment
X	Prolonged suffering
	Homelessness
	Removal of children from their homes

Box A: **Brief** program description.

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 community resources, developing and promoting 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.

# of unduplicated individuals served who are at risk of developing a serious mental illness:	303
Number of unduplicated individuals 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:	303

Box C: Demographics of individuals served this fiscal year through MHSA funding:

AGE CATEGORIES		SEXUAL ORIENTATION	
Children/Youth (0-15 yrs.)	6	Gay/Lesbian	0
Transition Age Youth (16-25 yrs.)	45	Heterosexual/Straight	0
Adult (26-59 yrs.)	232	Bisexual	0
Older Adult (60+ yrs.)	20	Questioning/Unsure	0
Declined to answer	0	Queer	0
Unknown	0	Declined to answer	0
TOTAL	**303**	Unknown	303
		Another group not listed	0
		TOTAL	**303**
		If another group is counted, please specify with numbers:	

VETERAN STATUS		PRIMARY LANGUAGE	
Yes	0	English	303
No	0	Spanish	0
Declined to answer	0	Cantonese	0
Unknown	303	Chinese	0
TOTAL	**303**	Vietnamese	0

CURRENT GENDER IDENTITY	
Female	250
Male	16
Transgender	0
Genderqueer	0
Questioning/unsure of gender identity	0
Declined to answer	0
Unknown	37
Another identity not listed	0
TOTAL	**303**
If another group is counted, please specify with numbers:	

Farsi	0
Arabic	0
Tagalog	0
Declined to answer	0
Unknown	0
Other languages not listed	0
TOTAL	**303**

SEX ASSIGNED AT BIRTH	
Male	16
Female	250
Declined to answer	0
Unknown	37
TOTAL	**303**
DISABILITY STATUS	
Communication Domain	
Vision	0
Hearing/Speech	0
Another type not listed	0
Communication Domain Subtotal	**0**
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	0
Physical/mobility	0
Chronic health condition	0
Disability Subtotal	**0**
None	0
Declined to answer	0
Unknown	303
Another disability not listed	0
TOTAL	**303**

ETHNICITY/CULTURAL HERITAGE (choose one)	
If Hispanic or Latino, please specify:	
Caribbean	0
Central American	0
Mexican/Mexican American/Chicano	0
Puerto Rican	0
South American	0
Another Hispanic/Latino ethnicity not listed	0
Total Hispanic or Latino	**0**
If Non-Hispanic or Non-Latino, please specify:	
African	0
African American	0
Asian Indian/South Asian	0
Cambodian	0
Chinese	0
Eastern European	0
European	
Filipino	
Japanese	0
Korean	0
Middle Eastern	0
Vietnamese	0
Other Non-Hispanic or Non-Latino ethnicity not listed	0
Total Non-Hispanic or Non-Latino:	**0**
More than one ethnicity	0
Unknown ethnicity	303

If another disability is counted, please specify with numbers:		Declined to answer	0
		ETHNICITY TOTAL	**303**
		If **another ethnicity** is counted, please specify with numbers:	
RACE			
American Indian or Alaska Native	0	If **another race** is counted, please specify with numbers:	
Asian	0		
Black or African American	261		
Native Hawaiian or another Pacific Islander	0		
White	1		
Other Race	0		
Declined to answer	0		
Unknown	41		
TOTAL	**303**		

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of.
The program has been successful at reinstituting in person activities. At the beginning of the fiscal year, our first event was a luncheon and over 60 participants attended. All the attendants were excited to reconnect with the program in person and simply enjoy their time. It was a celebration and included and excellent key speaker whose topic was "Black Girl Magic". We took time to highlight our resilience, acknowledge our past and move full steam ahead toward our future. The program was particularly successful, and we received a lot of positive feedback for weeks to come.

Box E: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
E.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e., mental health treatment services):	N/A
E.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e., mental health treatment services):	N/A
E.3: Types of treatment individuals were referred to (list types below):	
N/A	
E.4: Unduplicated number of individuals who participated in referred program at least one time:	N/A
G.5: Average duration of untreated mental illness in weeks:	N/A
E.6: Average number of days between referral and first participation in referred treatment program:	N/A

Box F: **For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:**	
F.1: Who is/are the underserved target population(s) your program is serving (e.g., TAY, Southeast Asian) (list types below):	
Black women in Alameda County	
F.2: Number of paper referrals to an ACBH PEI-funded program:	N/A
F.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	N/A
F.4: Average number of days between referral and first participation in referred PEI program:	N/A
F.5: Describe how your program encouraged access to services and follow through on above referrals:	
Online magazine is available to program participants that encourages mental health awareness and resources for treatment.	

Box G: **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 Respondents	**499**
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):
Colleges	**40 College Students**
Outreach Events	**359 Community members**
Church	**100 Congregants and church members**

MHSA Program #	PEI 28
PROVIDER NAME	HHREC - The Health and Human Resource Education Center
PROGRAM NAME	Downtown TAY

Program Outcomes & Impact Data Report FY: 22-23

Program Name:	Downtown TAY
Organization:	HHREC - The Health and Human Resource Education Center
Type of Report:	Annual
PEI Category:	Outreach

Priority Area (place an X next to all that apply):	
	Childhood Trauma
	Early Psychosis
X	Youth/TAY Outreach & Engagement
	Cultural & Linguistic
	Older Adults
	Early Identification of MH Illness

Outcomes (place an X next to all that apply): Programs focus on reducing the seven negative outcomes that may result from untreated mental illness.	
X	Suicide
X	Incarceration
X	School failure or dropout
X	Unemployment
	Prolonged suffering
X	Homelessness
	Removal of children from their homes

Box A: **Brief** program description.

Downtown TAY serves as a resource center to support young adults, with emphasis on African American transitional aged youth, to connect to needed resources that include housing, employment, health care, educational development, mental health wellness and introductions to positive uplifting social networks. Through a wealth of peer led and intergenerational programs, we strive to educate, elevate and inspire TAY(16-25).

Box B: Number of Individuals served this fiscal year through MHSA funding.

# of unduplicated individuals served who are at risk of developing a serious mental illness:	0
Number of unduplicated individuals 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:	0

Box C: Demographics of individuals served this fiscal year through MHSA funding:

AGE CATEGORIES		SEXUAL ORIENTATION	
Children/Youth (0-15 yrs.)	0	Gay/Lesbian	0
Transition Age Youth (16-25 yrs.)	287	Heterosexual/Straight	62
Adult (26-59 yrs.)	0	Bisexual	3
Older Adult (60+ yrs.)	0	Questioning/Unsure	1
Declined to answer	0	Queer	0
Unknown	0	Declined to answer	0
TOTAL	**287**	Unknown	221
		Another group not listed	0
		TOTAL	**287**
		If another group is counted, please specify with numbers:	

VETERAN STATUS	
Yes	0
No	0
Declined to answer	0
Unknown	287
TOTAL	**287**

CURRENT GENDER IDENTITY	
Female	144
Male	143
Transgender	0
Genderqueer	0
Questioning/unsure of gender identity	0
Declined to answer	0
Unknown	0
Another identity not listed	0
TOTAL	**287**
If another group is counted, please specify with numbers:	

PRIMARY LANGUAGE	
English	150
Spanish	0
Cantonese	0
Chinese	0
Vietnamese	0
Farsi	0
Arabic	0
Tagalog	0
Declined to answer	0
Unknown	137
Other languages not listed	0
TOTAL	**287**

SEX ASSIGNED AT BIRTH	
Male	144
Female	143
Declined to answer	0
Unknown	0
TOTAL	**287**

DISABILITY STATUS	
Communication Domain	
Vision	0
Hearing/Speech	0
Another type not listed	0
Communication Domain Subtotal	**0**
Disability Domain	
Cognitive (**exclude** mental illness; **include** learning, developmental, dementia, etc.)	0
Physical/mobility	0
Chronic health condition	0
Disability Subtotal	**0**

ETHNITICY/CULTURAL HERITAGE (choose one)	
If Hispanic or Latino, please specify:	
Caribbean	0
Central American	2
Mexican/Mexican American/Chicano	26
Puerto Rican	0
South American	0
Another Hispanic/Latino ethnicity not listed	0
Total Hispanic or Latino	**28**
If Non-Hispanic or Non-Latino, please specify:	
African	0
African American	0
Asian Indian/South Asian	0
Cambodian	0
Chinese	0
Eastern European	0
European	0
Filipino	0
Japanese	0
Korean	0
Middle Eastern	0

None	0	Vietnamese	0
Declined to answer	0	Other Non-Hispanic or Non-Latino ethnicity not listed	0
Unknown	287	**Total Non-Hispanic or Non-Latino:**	**0**
Another disability not listed	0	More than one ethnicity	0
TOTAL	**287**	Unknown ethnicity	259
If another disability is counted, please specify with numbers:		Declined to answer	0
		ETHNICITY TOTAL	**287**
RACE		If **another ethnicity** is counted, please specify with numbers:	
American Indian or Alaska Native	0	If **another race** is counted, please specify with numbers: Mexican(27)	
Asian	10		
Black or African American	53		
Native Hawaiian or another Pacific Islander	0		
White	2		
Other Race	27		
Declined to answer	0		
Unknown	195		
TOTAL	**287**		

Box D: Program successes/accomplishments of the past year with one example or case study of a success the agency is particularly proud of.
Downtown TAY has achieved great success by launching in-person programming that focuses on Health & Wellness workshops. The program has successfully created a vibrant space for young individuals to engage in music, art, and dance classes, promoting creativity, personal growth, and a sense of community. One notable accomplishment is the program's partnership with Dewey Academy, where two cohorts of students actively participated in these workshops. Downtown TAY recognizes the importance of providing opportunities for youth to explore and express themselves through various artistic outlets. Understanding the positive impact that music, art, and dance can have on young individuals' well-being, the program decided to offer workshops that were centered in allowing youth to explore all these creative mediums.

Box E: For programs that refer individuals with severe mental illness, please provide information for the categories below:	
E.1: Unduplicated number of individuals with severe mental illness referred to a higher level of care within ACBH system (i.e., mental health treatment services):	N/A
E.2: Unduplicated number of individuals with severe mental illness referred to a higher level of care outside ACBH system (i.e., mental health treatment services):	N/A
E.3: Types of treatment individuals were referred to (list types below):	

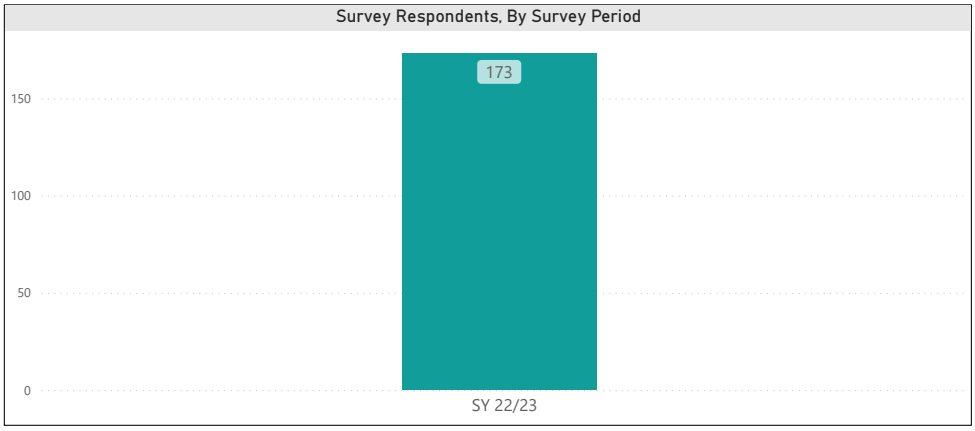
N/A	
E.4: Unduplicated number of individuals who participated in referred program at least one time:	N/A
G.5: Average duration of untreated mental illness in weeks:	N/A
E.6: Average number of days between referral and first participation in referred treatment program:	N/A
Box F: For programs that work to improve timely access to mental health services for underserved populations, please provide information on the categories below:	
F.1: Who is/are the underserved target population(s) your program is serving (e.g., TAY, Southeast Asian) (list types below):	
N/A	
F.2: Number of paper referrals to an ACBH PEI-funded program:	N/A
F.3: Unduplicated number of individuals who participated in referred PEI-program at least one time:	N/A
F.4: Average number of days between referral and first participation in referred PEI program:	N/A
F.5: Describe how your program encouraged access to services and follow through on above referral	
N/A	

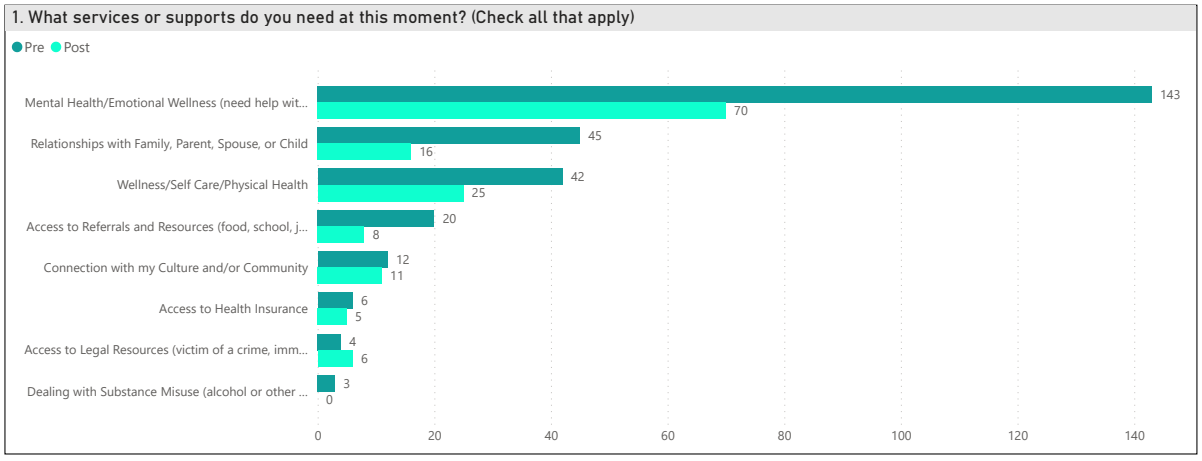
Box G: For Outreach, Suicide Prevention, and Stigma Reduction programs, please provide information for unduplicated potential responders (i.e., those who can identify early signs of potentially severe mental illness provide support, and or refer individuals who need treatment) reached. *(Note: For Prevention, Early Intervention, Access & Linkage programs, this section is optional.)*	
Number of Respondents	**N/A**
Types of settings (e.g., schools, senior centers, churches, etc.) (100 Characters):	Types of responders (e.g., 2 nurses at schools, 15 parents at community centers, 15 teachers at schools, & 1 police officer at a school.) (100 Characters):

Appendix D-5 | PEI & UELP Pre Post Health Assessment

Respondents, Total	Agencies, Total Surveyed	Survey Periods, Total
173	8	1

Agency
- Afghan Coalition
- Asian Health Services
- Center for Empowering R...
- International Rescue Com...
- Korean Community Cente...
- La Clinica/La Familia/Tibur...
- Partnerships for Trauma R...
- Richmond Area Multi-Ser...

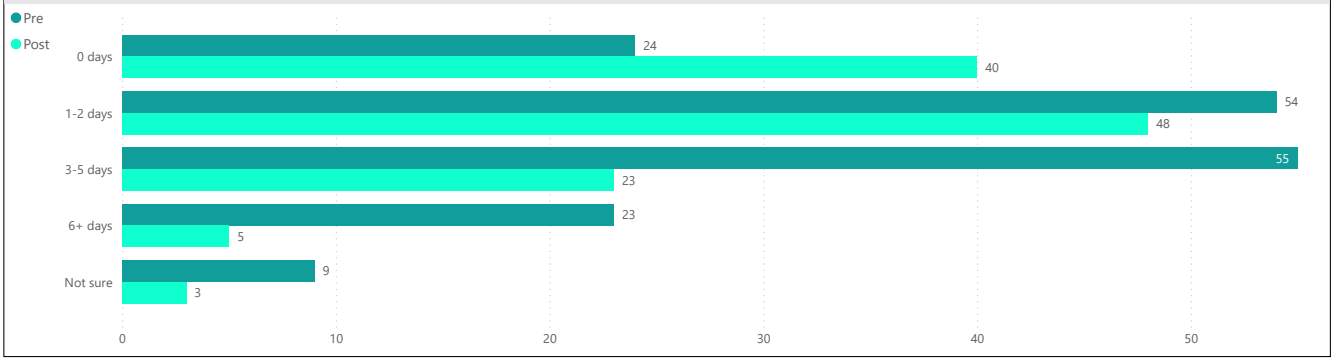




Agency
- Afghan Coalition
- Asian Health Services
- Center for Empowering Refugees and Immigrants (CERI)
- International Rescue Committee/Refugee and Immigrant Transitions
- Korean Community Center for the East Bay
- La Clinica/La Familia/Tiburcio
- Partnerships for Trauma Recovery

Survey Period
- SY 22/23

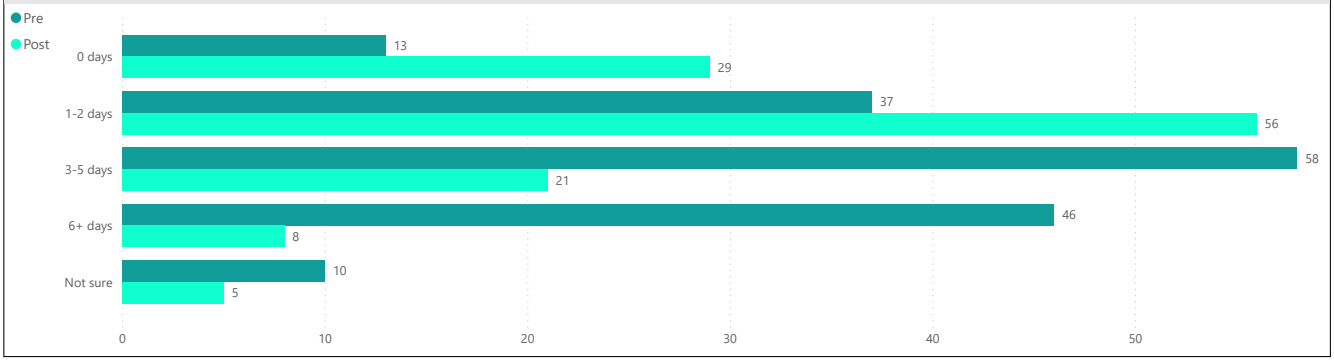
2. In the past two weeks, about how many days have you noticed physical sensations that are concerning (headaches, upset stomach, body aches/pains, skin irritation, trouble breathing, trouble sleeping, etc.) or have not been feeling well physically?



Agency
- Afghan Coalition
- Asian Health Services
- Center for Empowering Refugees and Immigrants (CERI)
- International Rescue Committee/Refugee and Immigrant Transitions
- Korean Community Center for the East Bay
- La Clinica/La Familia/Tiburcio
- Partnerships for Trauma Recovery
- Richmond Area Multi-Services (RAMS)/Taulama

Survey Period
- SY 22/23

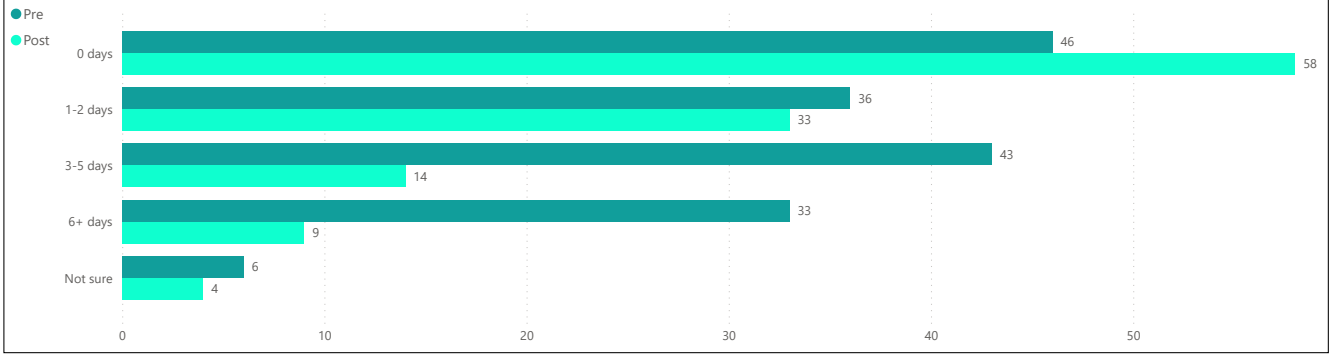
3. In the past two weeks, about how many days have you noticed feelings that are concerning (sadness, hopelessness, homesickness, worries, heartache, nervousness, etc.) or have not been feeling well emotionally?



Agency
- Afghan Coalition
- Asian Health Services
- Center for Empowering Refugees and Immigrants (CERI)
- International Rescue Committee/Refugee and Immigrant Transitions
- Korean Community Center for the East Bay
- La Clinica/La Familia/Tiburcio
- Partnerships for Trauma Recovery
- Richmond Area Multi-Services (RAMS)/Taulama

Survey Period
- SY 22/23

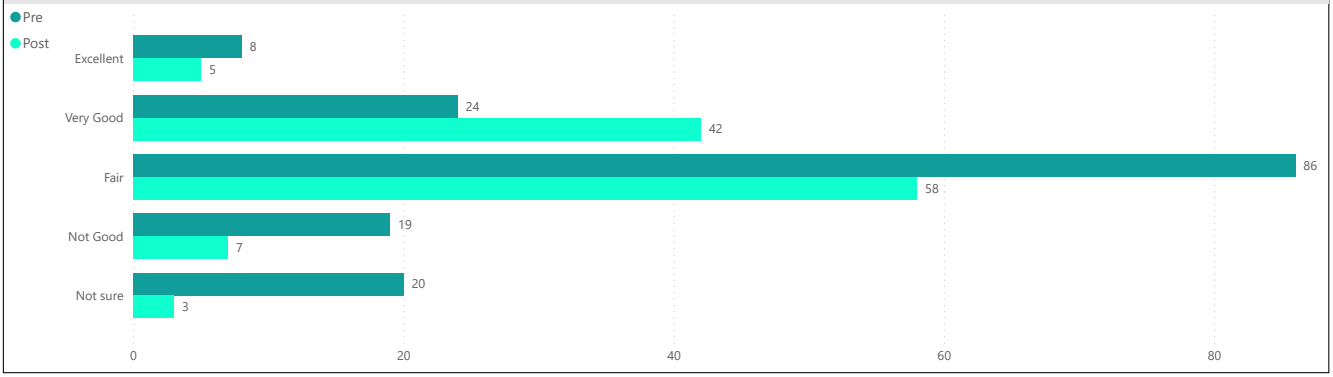
4. In the past two weeks, about how many days did you have trouble or challenges carrying out your daily routine (for example, cooking, working, going to school, seeing family, or enjoying life)?



Agency
- Afghan Coalition
- Asian Health Services
- Center for Empowering Refugees and Immigrants (CERI)
- International Rescue Committee/Refugee and Immigrant Transitions
- Korean Community Center for the East Bay
- La Clinica/La Familia/Tiburcio
- Partnerships for Trauma Recovery
- Richmond Area Multi-Services (RAMS)/Taulama

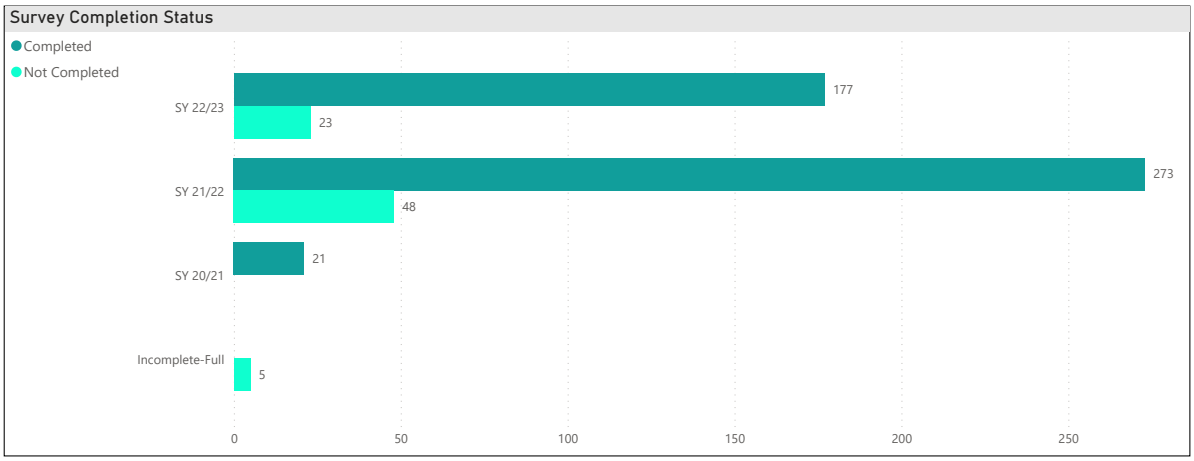
Survey Period
- SY 22/23

5. How would you rate your overall health?



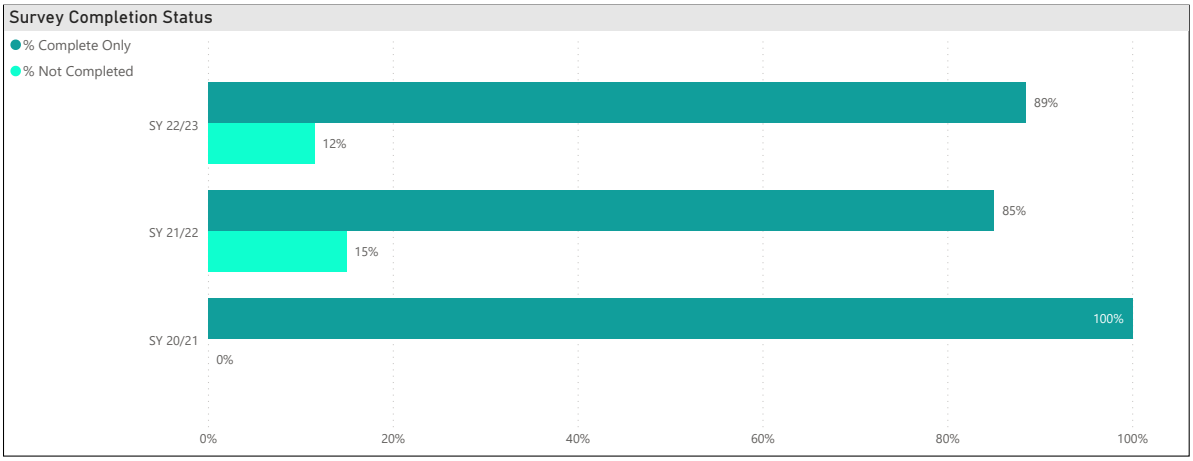
Agency
- Afghan Coalition
- Asian Health Services
- Center for Empowering Refugees and Immigrants (CERI)
- International Rescue Committee/Refugee and Immigrant Transitions
- Korean Community Center for the East Bay
- La Clinica/La Familia/Tiburcio
- Partnerships for Trauma Recovery
- Richmond Area Multi-Services (RAMS)/Taulama

Survey Period
- SY 22/23



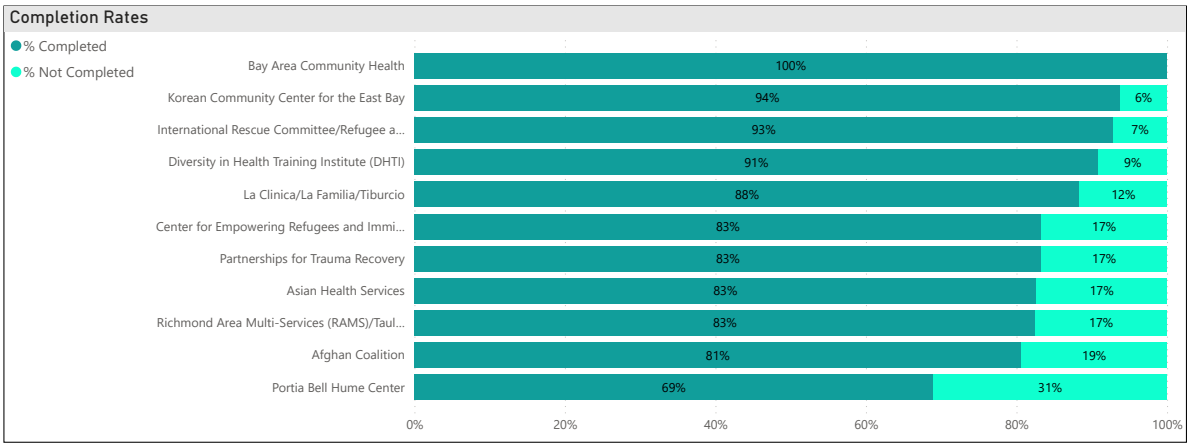
Agency

- [ ] Afghan Coalition
- [ ] Asian Health Services
- [ ] Bay Area Community Health
- [ ] Center for Empowering Refugees and Immigrants (CERI)
- [ ] Diversity in Health Training Institute (DHTI)
- [ ] International Rescue Committee/Refugee and Immigrant Transitions
- [ ] Korean Community Center for the East Bay

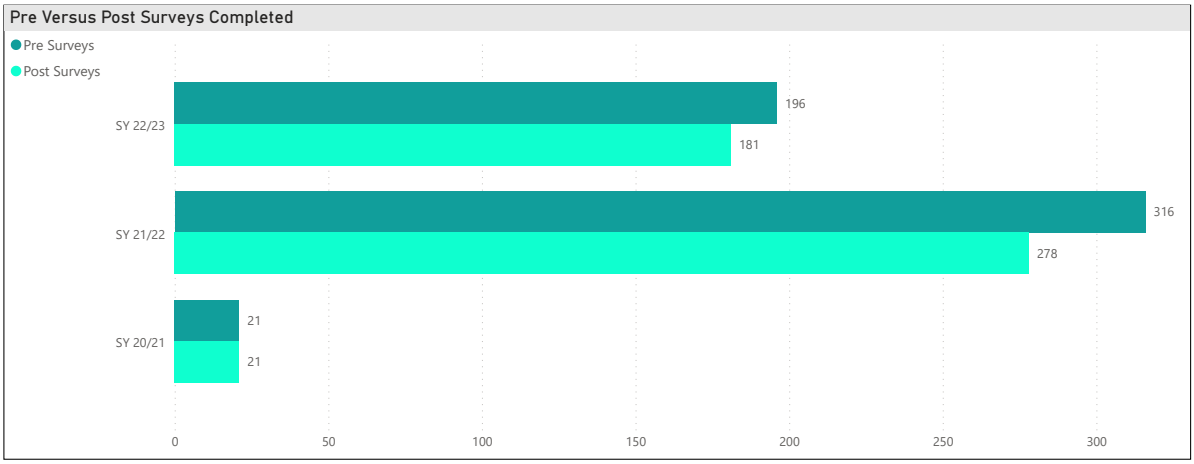


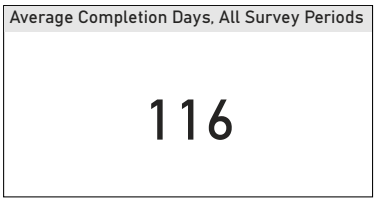
Agency

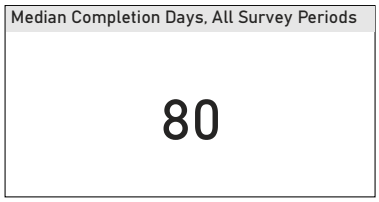
- [ ] Afghan Coalition
- [ ] Asian Health Services
- [ ] Bay Area Community Health
- [ ] Center for Empowering Refugees and Immigrants (CERI)
- [ ] Diversity in Health Training Institute (DHTI)
- [ ] International Rescue Committee/Refugee and Immigrant Transitions
- [ ] Korean Community Center for the East Bay

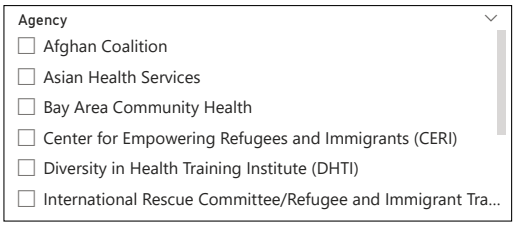


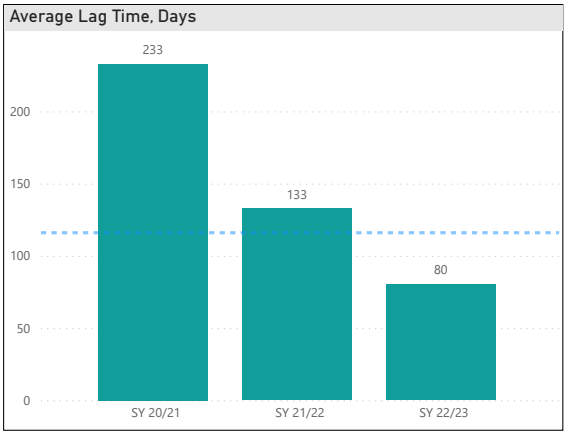
Agency	% Complete Only
Afghan Coalition	81%
Asian Health Services	83%
Bay Area Community Health	100%
Center for Empowering Refugees and Immigrants (CERI)	83%
Diversity in Health Training Institute (DHTI)	91%
International Rescue Committee/Refugee and Immigrant Transitions	93%
Korean Community Center for the East Bay	94%
La Clinica/La Familia/Tiburcio	88%
Partnerships for Trauma Recovery	83%
Portia Bell Hume Center	69%
Richmond Area Multi-Services (RAMS)/Taulama	83%
Total	**86%**

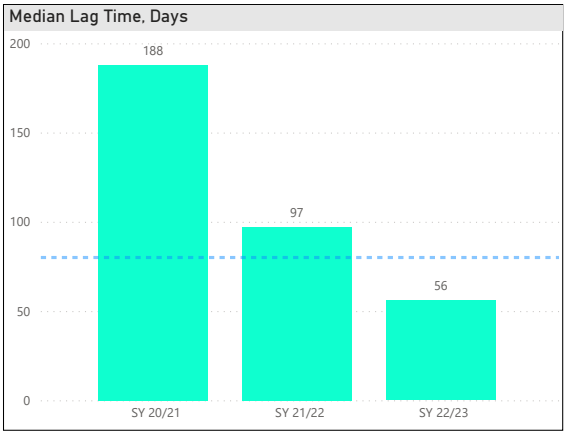


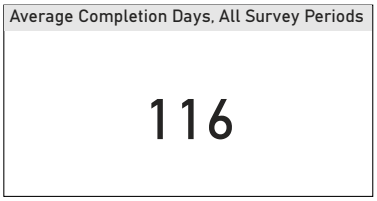

Average Completion Days, All Survey Periods
116

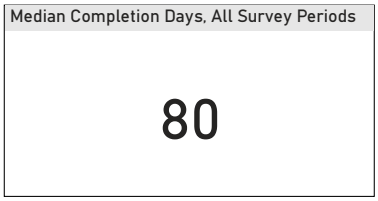

Median Completion Days, All Survey Periods
80

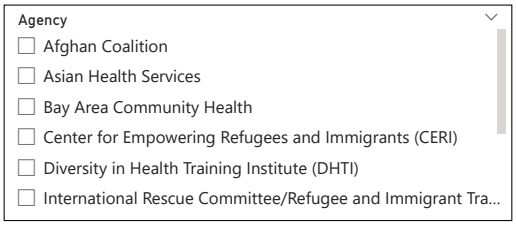

Agency
Afghan Coalition
Asian Health Services
Bay Area Community Health
Center for Empowering Refugees and Immigrants (CERI)
Diversity in Health Training Institute (DHTI)
International Rescue Committee/Refugee and Immigrant Tra...

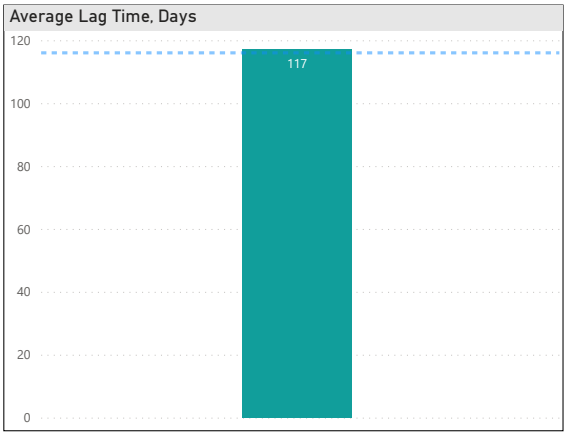

Average Lag Time, Days
233
133
80
200
150
100
50
0
SY 20/21
SY 21/22
SY 22/23

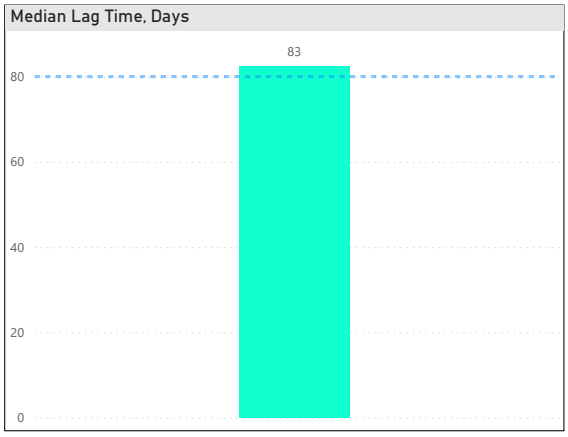

Median Lag Time, Days
188
97
56
200
150
100
50
0
SY 20/21
SY 21/22
SY 22/23

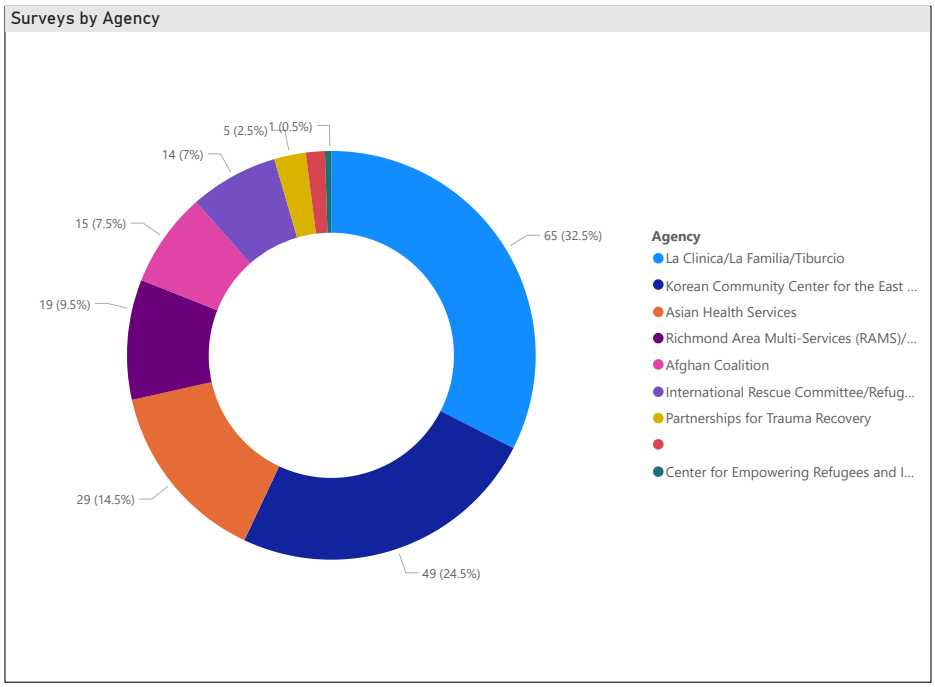

Average Completion Days, All Survey Periods
116

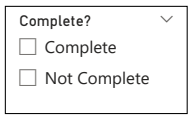

Median Completion Days, All Survey Periods
80

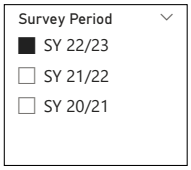

Agency
Afghan Coalition
Asian Health Services
Bay Area Community Health
Center for Empowering Refugees and Immigrants (CERI)
Diversity in Health Training Institute (DHTI)
International Rescue Committee/Refugee and Immigrant Tra...


Average Lag Time, Days
117
120
100
80
60
40
20
0


Median Lag Time, Days
83
80
60
40
20
0

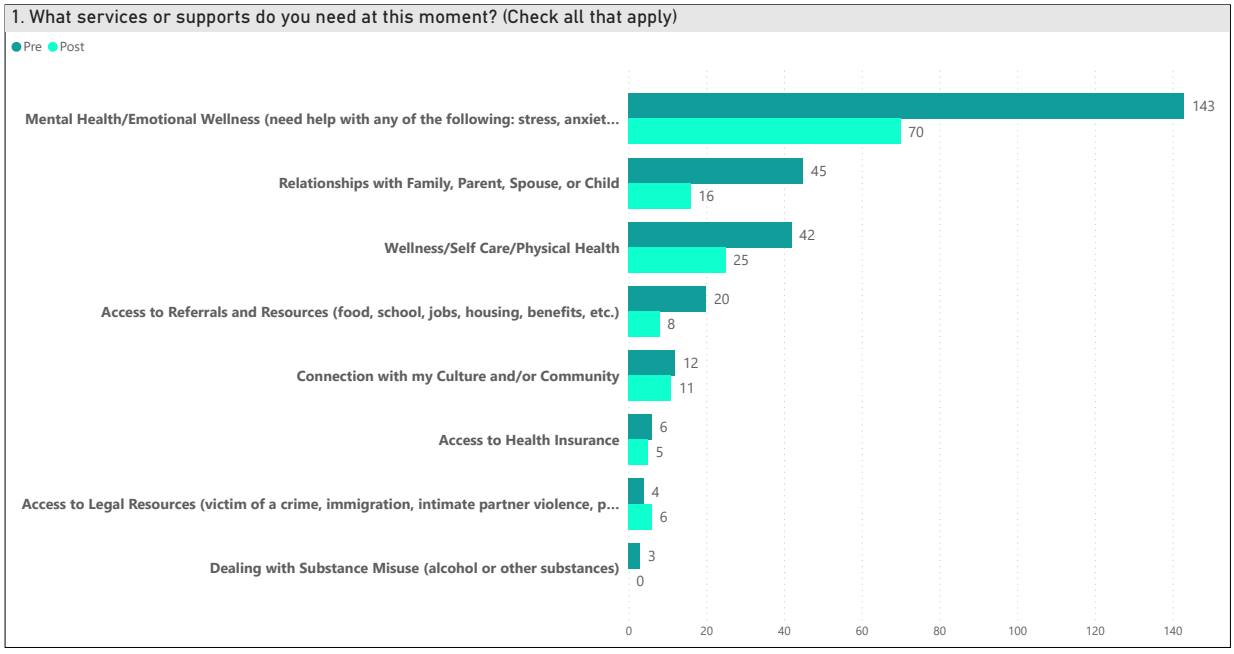

Surveys by Agency
65 (32.5%)
49 (24.5%)
29 (14.5%)
19 (9.5%)
15 (7.5%)
14 (7%)
5 (2.5%)
1 (0.5%)
Agency
La Clinica/La Familia/Tiburcio
Korean Community Center for the East ...
Asian Health Services
Richmond Area Multi-Services (RAMS)/...
Afghan Coalition
International Rescue Committee/Refug...
Partnerships for Trauma Recovery
Center for Empowering Refugees and I...

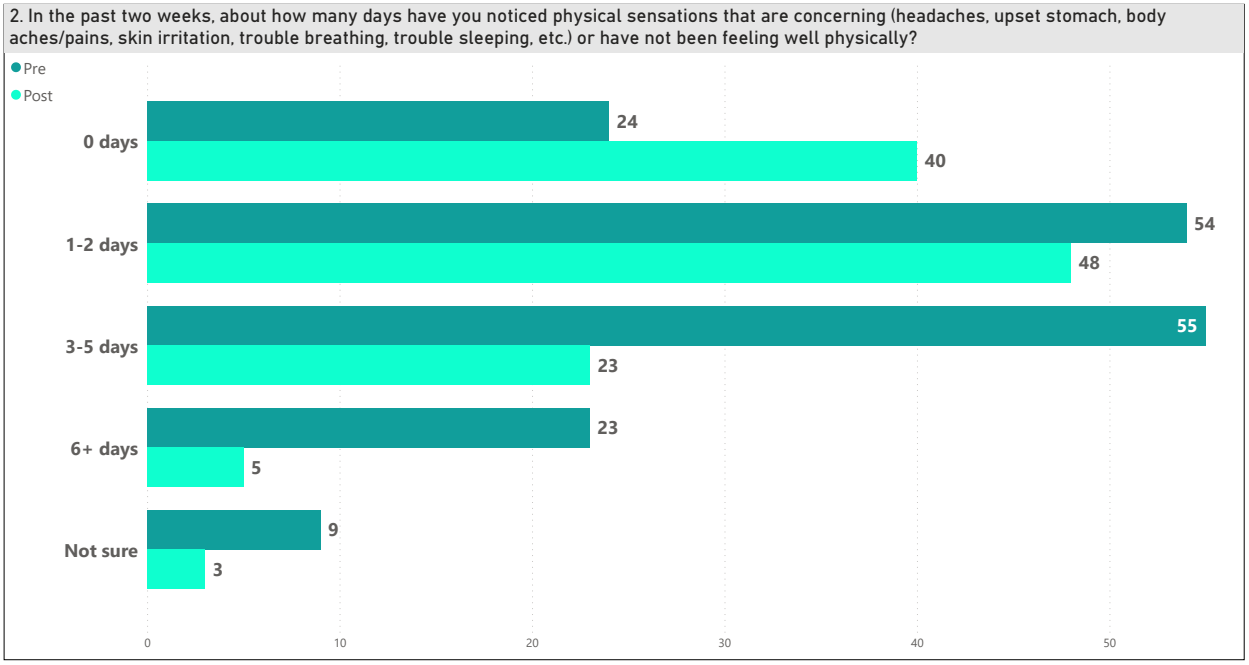

Complete?
Complete
Not Complete


Survey Period
SY 22/23
SY 21/22
SY 20/21

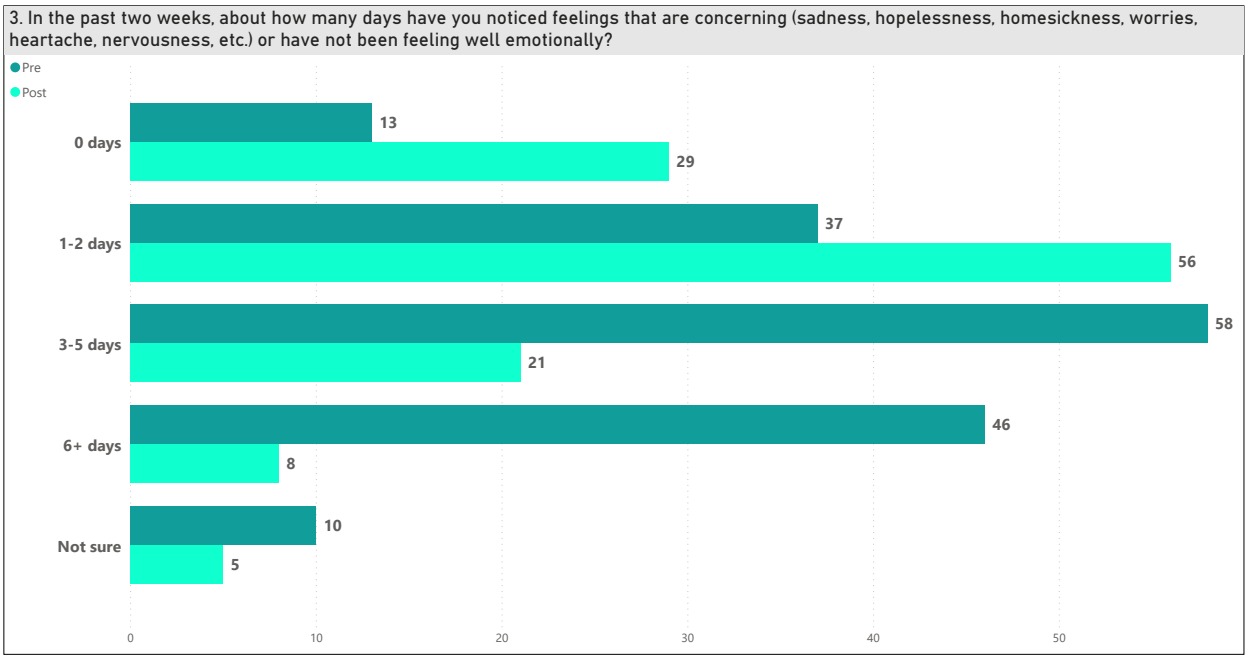
Agency	% Complete
⊞	**100%**
⊟ **Afghan Coalition**	**100%**
Completed	81%
Incomplete- Post not done	16%
Incomplete- Pre not done	3%
⊟ **Asian Health Services**	**100%**
Completed	83%
Incomplete- Post not done	16%
Incomplete- Pre not done	1%
⊟ **Bay Area Community Health**	**100%**
Completed	100%
⊟ **Center for Empowering Refugees and Immigrants (CERI)**	**100%**
Completed	83%
Incomplete- Post not done	17%
⊟ **Diversity in Health Training Institute (DHTI)**	**100%**
Completed	91%
Incomplete- Pre not done	9%
⊟ **International Rescue Committee/Refugee and Immigrant Transitions**	**100%**
Completed	93%
Incomplete- Post not done	5%
Incomplete-Full	2%
⊟ **Korean Community Center for the East Bay**	**100%**
Completed	94%
Incomplete- Post not done	5%
Incomplete- Pre not done	1%
⊟ **La Clinica/La Familia/Tiburcio**	**100%**
Completed	88%
Incomplete- Post not done	10%
Incomplete- Pre not done	1%
Incomplete-Full	1%
⊟ **Partnerships for Trauma Recovery**	**100%**
Completed	83%
Incomplete- Post not done	17%
Total	**100%**

Agency	# Total Respondents	% Complete
⊞	**3**	**100%**
⊟ **Afghan Coalition**	**31**	**100%**
Completed	25	81%
Incomplete- Post not done	5	16%
Incomplete- Pre not done	1	3%
⊟ **Asian Health Services**	**75**	**100%**
Completed	62	83%
Incomplete- Post not done	12	16%
Incomplete- Pre not done	1	1%
⊟ **Bay Area Community Health**	**2**	**100%**
Completed	2	100%
⊟ **Center for Empowering Refugees and Immigrants (CERI)**	**24**	**100%**
Completed	20	83%
Incomplete- Post not done	4	17%
⊟ **Diversity in Health Training Institute (DHTI)**	**11**	**100%**
Completed	10	91%
Incomplete- Pre not done	1	9%
⊟ **International Rescue Committee/Refugee and Immigrant Transitions**	**42**	**100%**
Completed	39	93%
Incomplete- Post not done	2	5%
Incomplete-Full	1	2%
⊟ **Korean Community Center for the East Bay**	**97**	**100%**
Completed	91	94%
Incomplete- Post not done	5	5%
Incomplete- Pre not done	1	1%
⊟ **La Clinica/La Familia/Tiburcio**	**164**	**100%**
Completed	145	88%
Incomplete- Post not done	17	10%
Incomplete- Pre not done	1	1%
Incomplete-Full	1	1%
⊟ **Partnerships for Trauma Recovery**	**6**	**100%**
Completed	5	83%
Incomplete- Post not done	1	17%
Total	**547**	**100%**

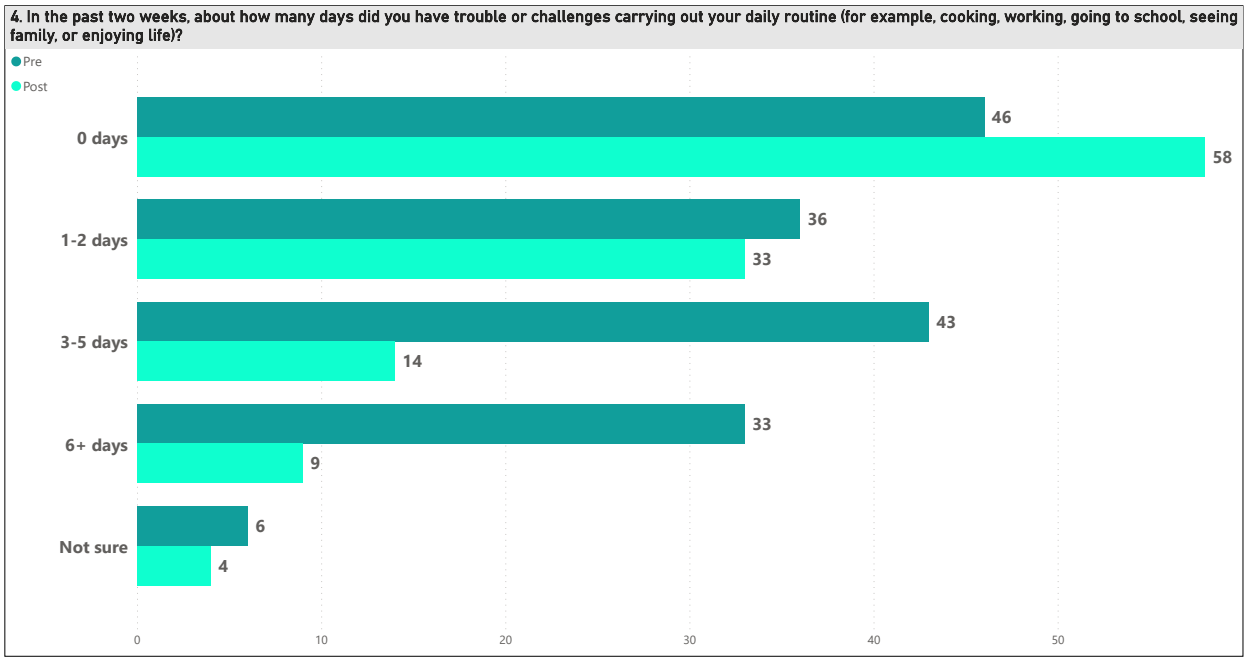




2. In the past two weeks, about how many days have you noticed physical sensations that are concerning (headaches, upset stomach, body aches/pains, skin irritation, trouble breathing, trouble sleeping, etc.) or have not been feeling well physically?
0 days
1-2 days
3-5 days
6+ days
Not sure



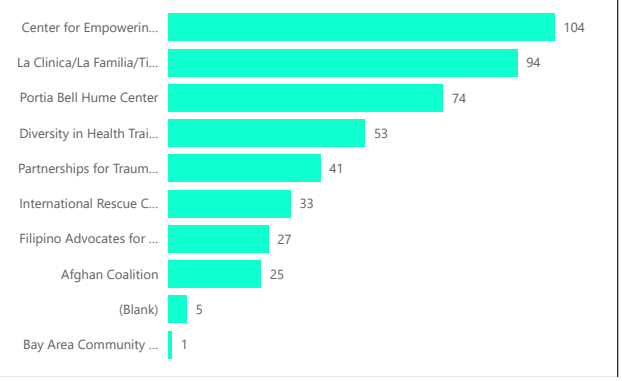
3. In the past two weeks, about how many days have you noticed feelings that are concerning (sadness, hopelessness, homesickness, worries, heartache, nervousness, etc.) or have not been feeling well emotionally?	Post	Pre	Total
0 days	29	13	**42**
1-2 days	56	37	**93**
3-5 days	21	58	**79**
6+ days	8	46	**54**
Not sure	5	10	**15**



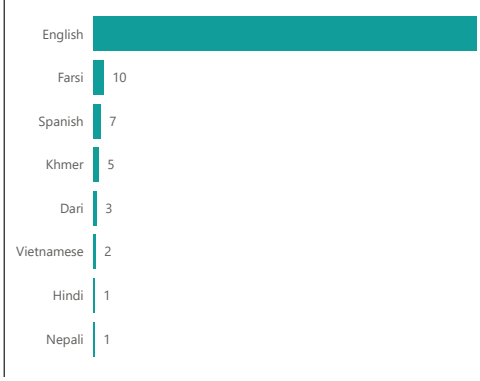
4. In the past two weeks, about how many days did you have trouble or challenges carrying out your daily routine (for example, cooking, working, going to school, seeing family, or enjoying life)?	Post	Pre
0 days	58	46
1-2 days	33	36
3-5 days	14	43
6+ days	9	33
Not sure	4	6

457	10	8
Surveys Collected (Respondent ID's)	Agencies Submitting Surveys	Survey Languages Collected

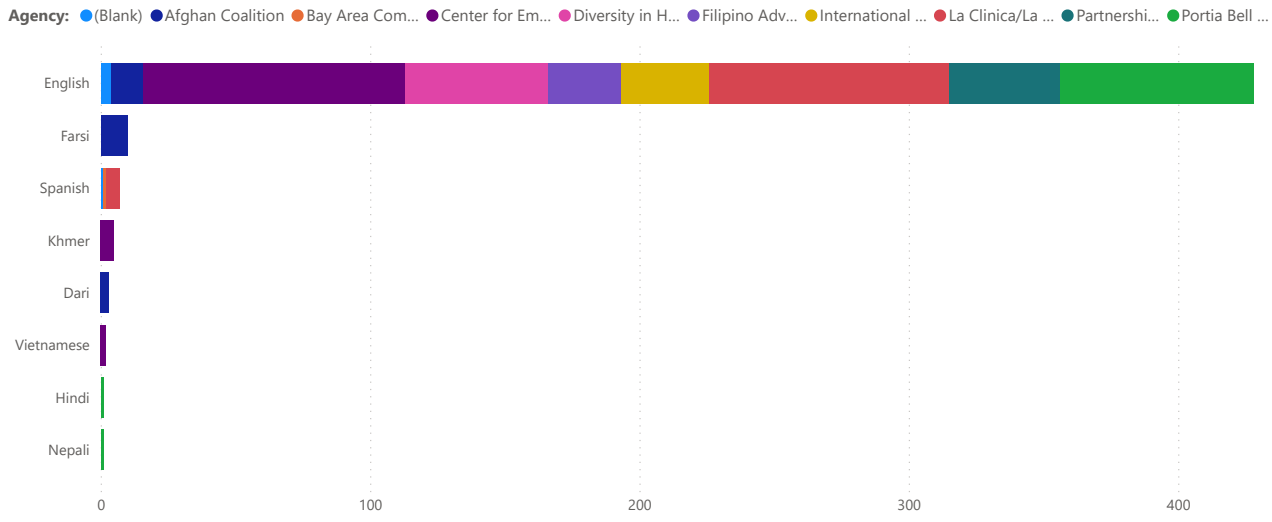
Respondent ID's by Agency



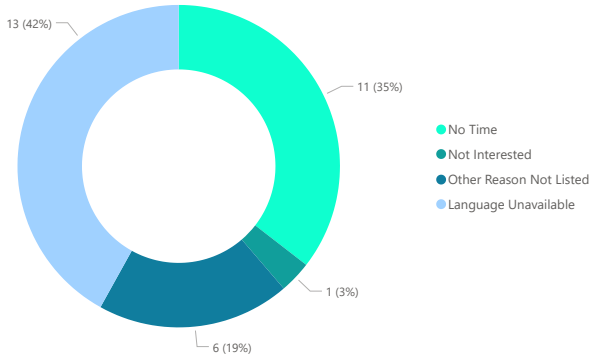
Respondent ID's by Language



Respondent ID's by Language and Agency



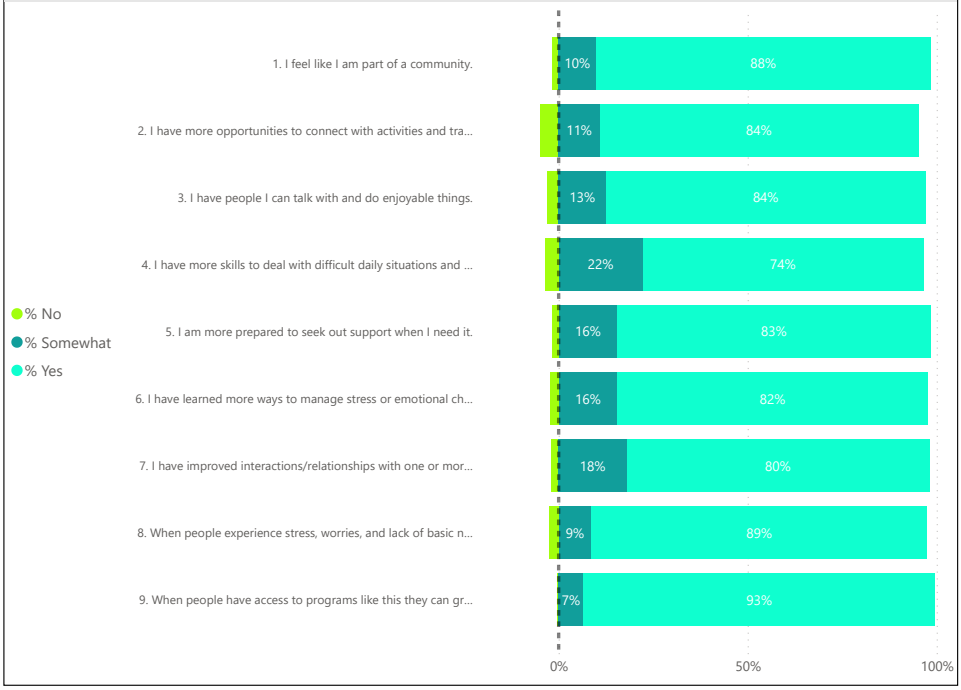
If you cannot complete this survey, please indicate reason:



Language
- (Blank)
- Dari
- English
- Farsi
- Khmer

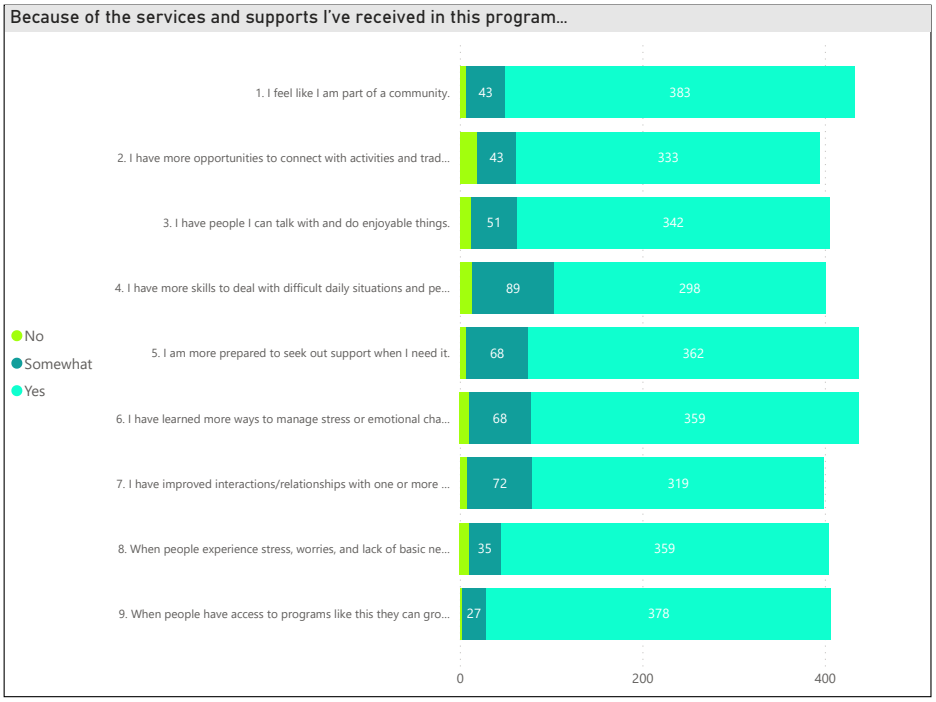
Agency
- (Blank)
- Afghan Coalition
- Center for Empowering Refugees and Immigrants (CERI)
- Diversity in Health Training Institute (DHTI)
- Filipino Advocates for Justice
- International Rescue Committee/Refugee and Immigrant Transitions
- La Clinica/La Familia/Tiburcio
- Partnerships for Trauma Recovery
- Portia Bell Hume Center

Because of the services and supports I've received in this program...

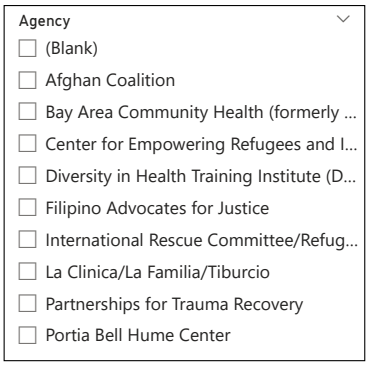


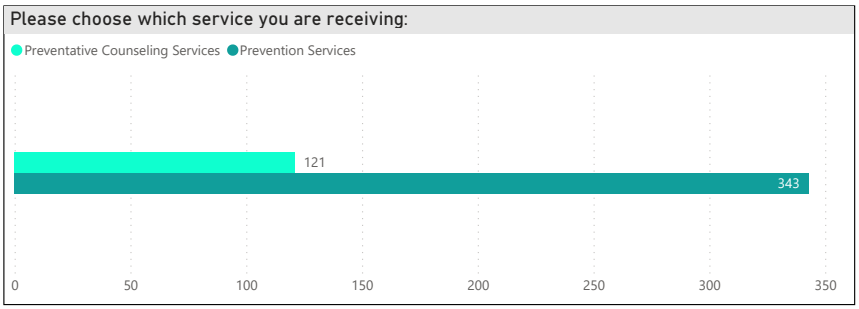
Language
- Dari
- English
- Farsi
- Hindi
- Khmer
- Nepali
- Spanish
- Vietnamese

Agency
- (Blank)
- Afghan Coalition
- Bay Area Community Health (formerly ...
- Center for Empowering Refugees and I...
- Diversity in Health Training Institute (D...
- Filipino Advocates for Justice
- International Rescue Committee/Refug...
- La Clinica/La Familia/Tiburcio
- Partnerships for Trauma Recovery
- Portia Bell Hume Center

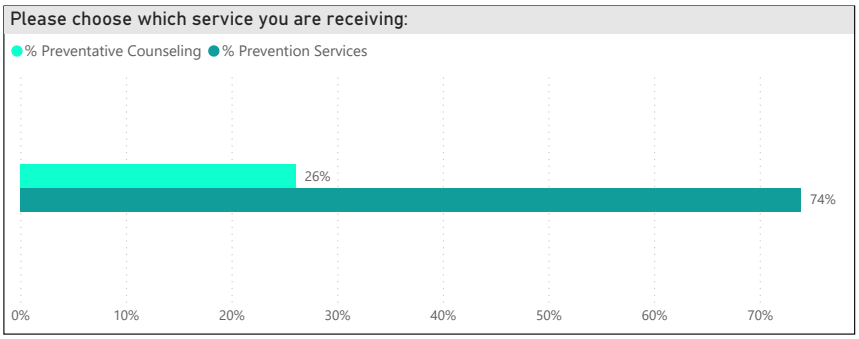

Because of the services and supports I've received in this program...
1. I feel like I am part of a community.
43
383
2. I have more opportunities to connect with activities and trad...
43
333
3. I have people I can talk with and do enjoyable things.
51
342
4. I have more skills to deal with difficult daily situations and pe...
89
298
5. I am more prepared to seek out support when I need it.
68
362
6. I have learned more ways to manage stress or emotional cha...
68
359
7. I have improved interactions/relationships with one or more ...
72
319
8. When people experience stress, worries, and lack of basic ne...
35
359
9. When people have access to programs like this they can gro...
27
378
No
Somewhat
Yes
0
200
400

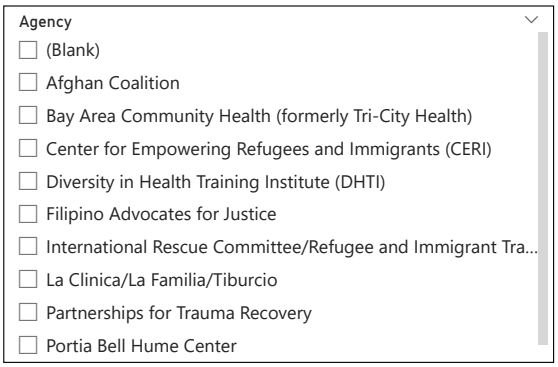

Language
Dari
English
Farsi
Hindi
Khmer
Nepali
Spanish
Vietnamese

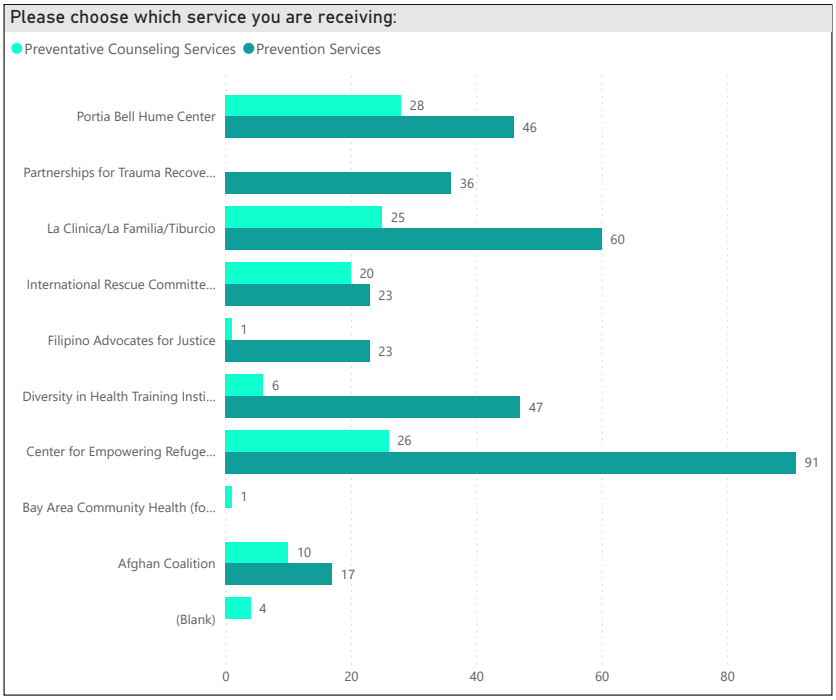

Agency
(Blank)
Afghan Coalition
Bay Area Community Health (formerly ...
Center for Empowering Refugees and I...
Diversity in Health Training Institute (D...
Filipino Advocates for Justice
International Rescue Committee/Refug...
La Clinica/La Familia/Tiburcio
Partnerships for Trauma Recovery
Portia Bell Hume Center


Please choose which service you are receiving:
Preventative Counseling Services
Prevention Services
121
343
0
50
100
150
200
250
300
350

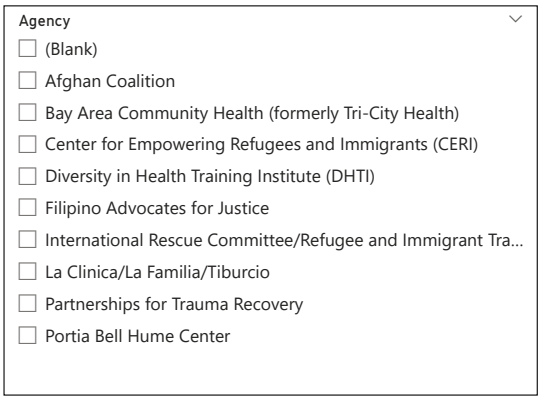

Language
Dari
English
Farsi
Hindi
Khmer
Nepali
Spanish
Vietnamese

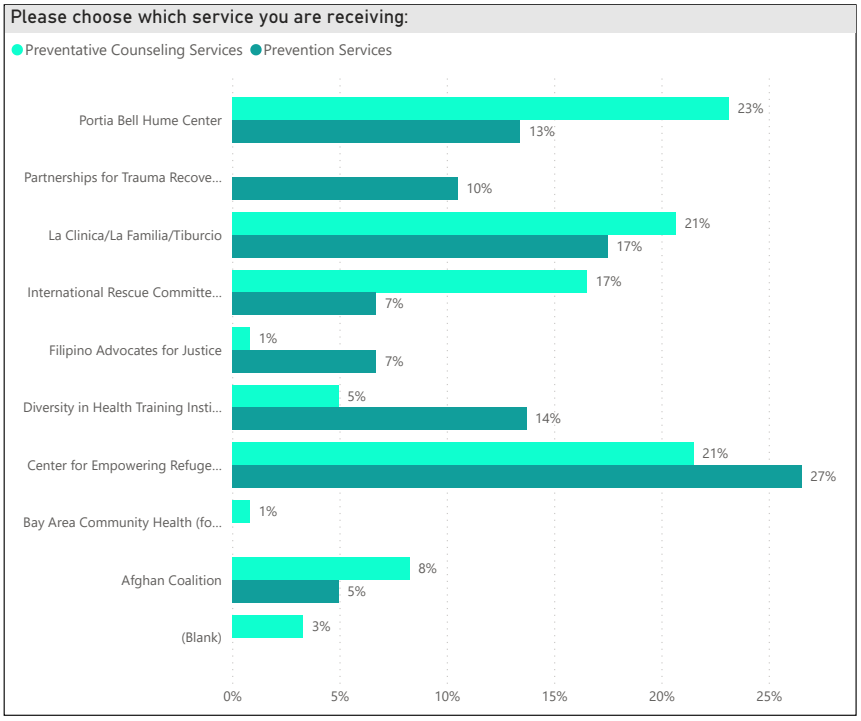

Please choose which service you are receiving:
% Preventative Counseling
% Prevention Services
26%
74%
0%
10%
20%
30%
40%
50%
60%
70%


Agency
(Blank)
Afghan Coalition
Bay Area Community Health (formerly Tri-City Health)
Center for Empowering Refugees and Immigrants (CERI)
Diversity in Health Training Institute (DHTI)
Filipino Advocates for Justice
International Rescue Committee/Refugee and Immigrant Tra...
La Clinica/La Familia/Tiburcio
Partnerships for Trauma Recovery
Portia Bell Hume Center

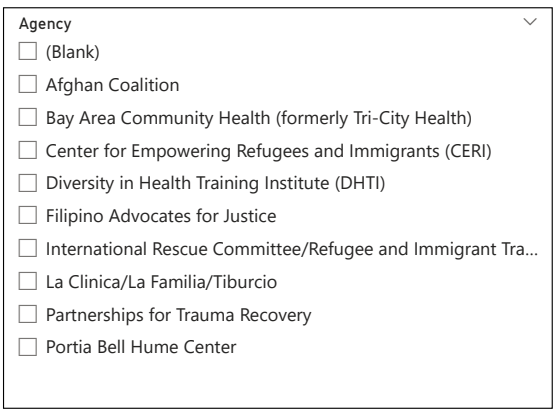

Please choose which service you are receiving:
Preventative Counseling Services
Prevention Services
Portia Bell Hume Center
28
46
Partnerships for Trauma Recove...
36
La Clinica/La Familia/Tiburcio
25
60
International Rescue Committe...
20
23
Filipino Advocates for Justice
1
23
Diversity in Health Training Insti...
6
47
Center for Empowering Refuge...
26
91
Bay Area Community Health (fo...
1
Afghan Coalition
10
17
(Blank)
4
0
20
40
60
80


Language
Dari
English
Farsi
Hindi
Khmer
Nepali
Spanish
Vietnamese


Agency
(Blank)
Afghan Coalition
Bay Area Community Health (formerly Tri-City Health)
Center for Empowering Refugees and Immigrants (CERI)
Diversity in Health Training Institute (DHTI)
Filipino Advocates for Justice
International Rescue Committee/Refugee and Immigrant Tra...
La Clinica/La Familia/Tiburcio
Partnerships for Trauma Recovery
Portia Bell Hume Center


Please choose which service you are receiving:
Preventative Counseling Services
Prevention Services
Portia Bell Hume Center
23%
13%
Partnerships for Trauma Recove...
10%
La Clinica/La Familia/Tiburcio
21%
17%
International Rescue Committe...
17%
7%
Filipino Advocates for Justice
1%
7%
Diversity in Health Training Insti...
5%
14%
Center for Empowering Refuge...
21%
27%
Bay Area Community Health (fo...
1%
Afghan Coalition
8%
5%
(Blank)
3%
0%
5%
10%
15%
20%
25%


Language
Dari
English
Farsi
Hindi
Khmer
Nepali
Spanish
Vietnamese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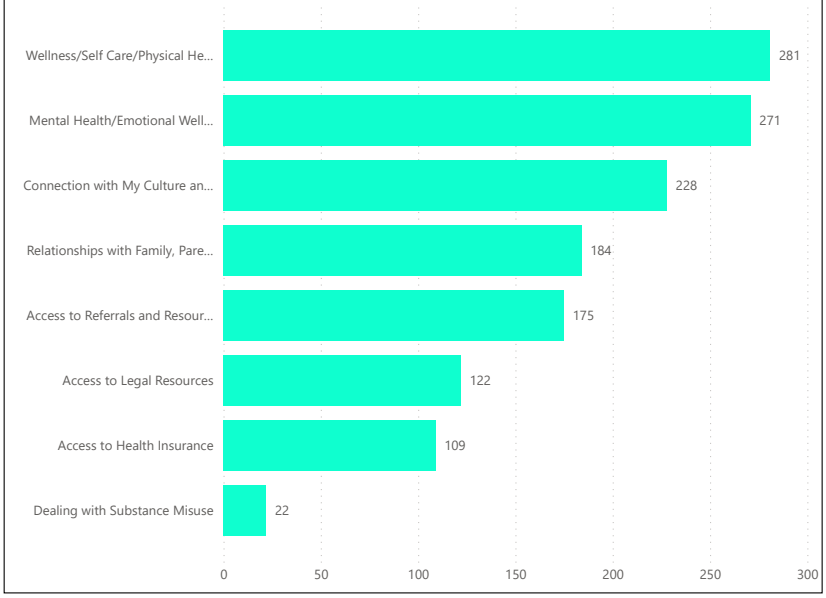
Afghan Coalition
Bay Area Community Health (formerly Tri-City Health)
Center for Empowering Refugees and Immigrants (CERI)
Diversity in Health Training Institute (DHTI)
Filipino Advocates for Justice
International Rescue Committee/Refugee and Immigrant Tra...
La Clinica/La Familia/Tiburcio
Partnerships for Trauma Recovery
Portia Bell Hume Center

Which of the following areas of your life have improved as a direct result of your participation in these services? (Check all that apply)



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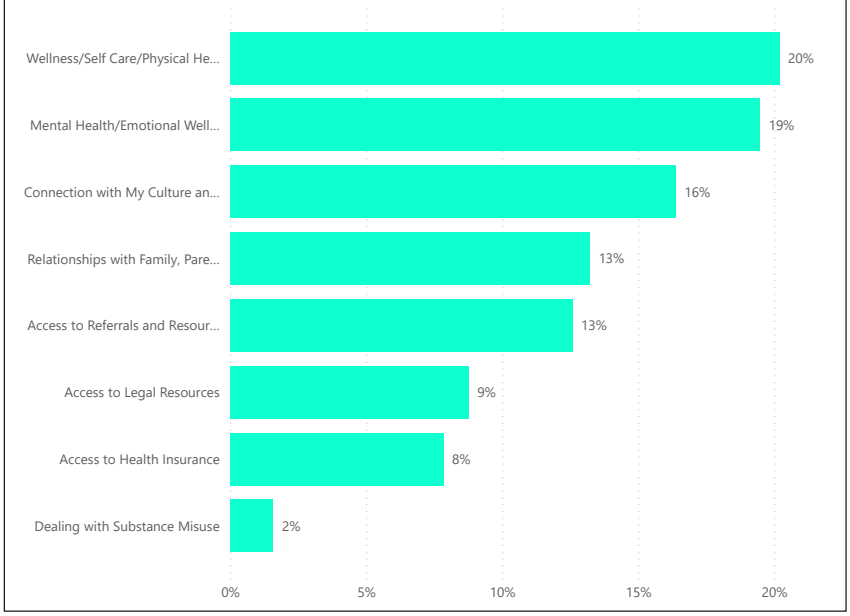
Which of the following areas of your life have improved as a direct result of your participation in these services? (Check all that apply)



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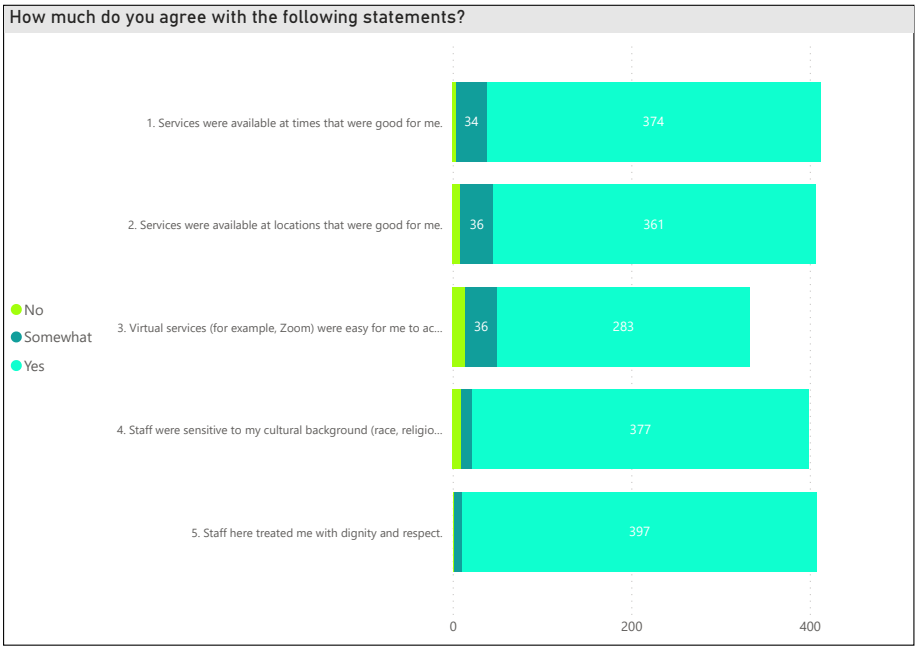

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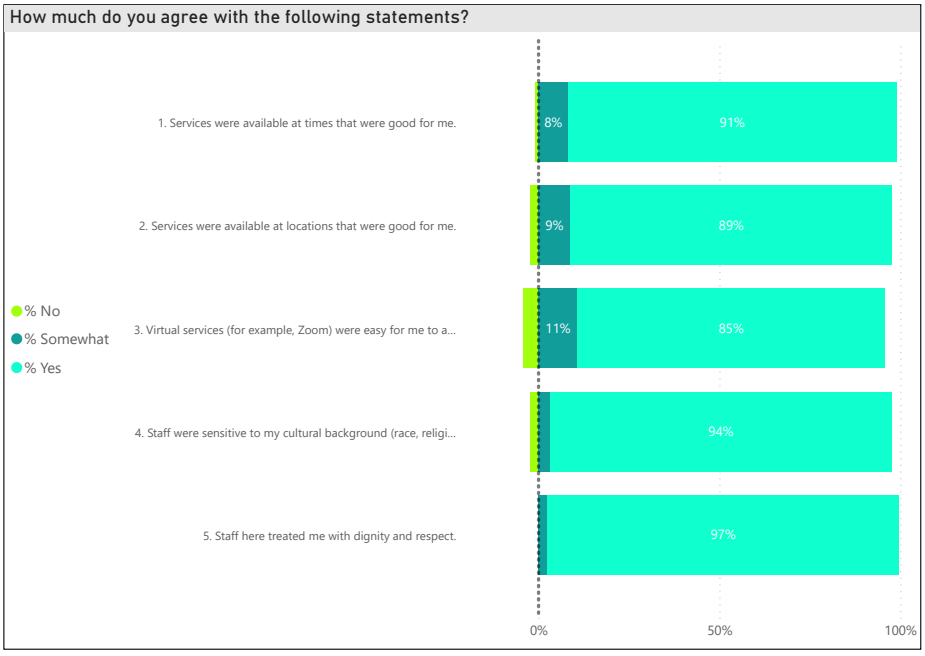

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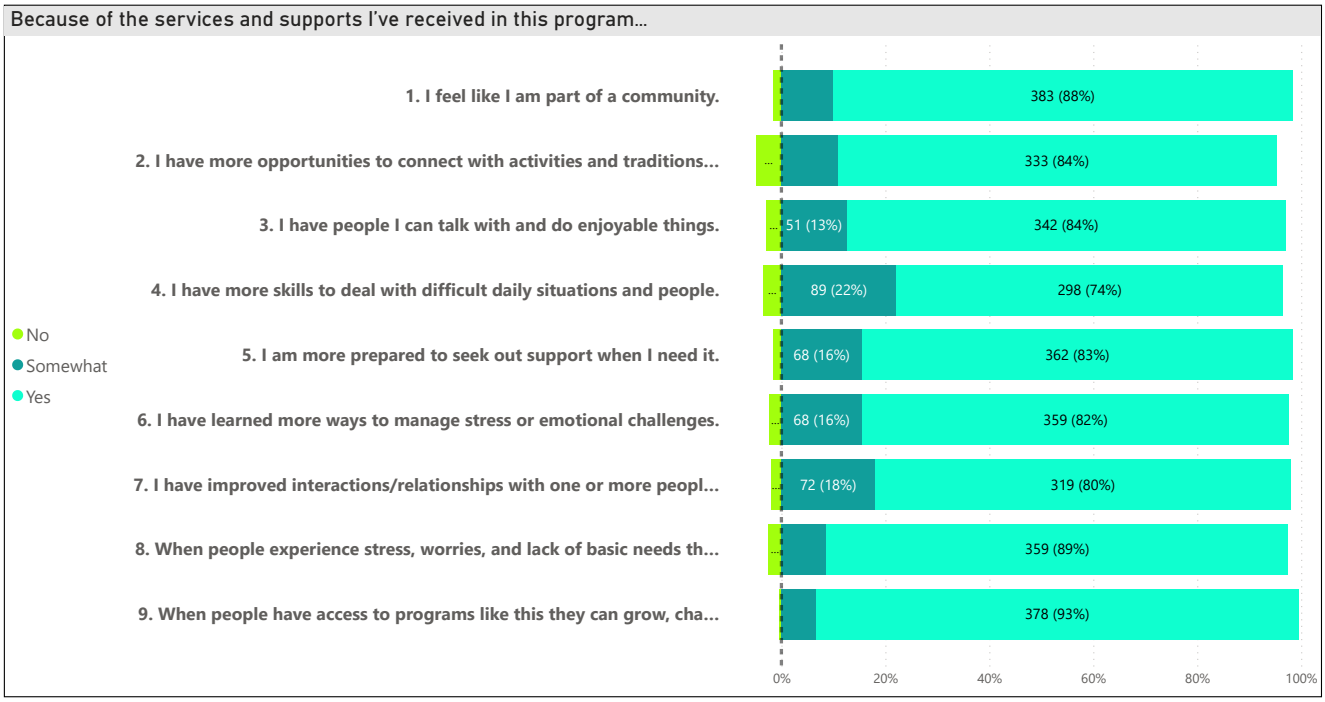
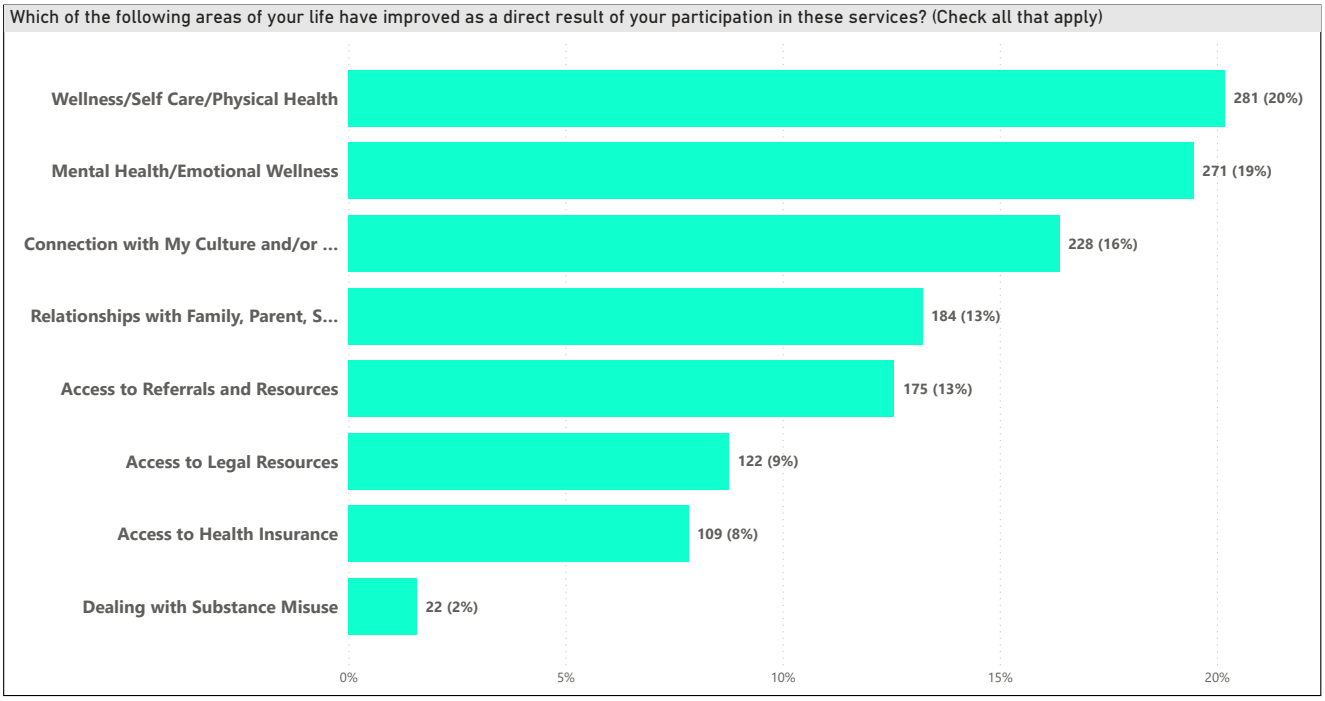
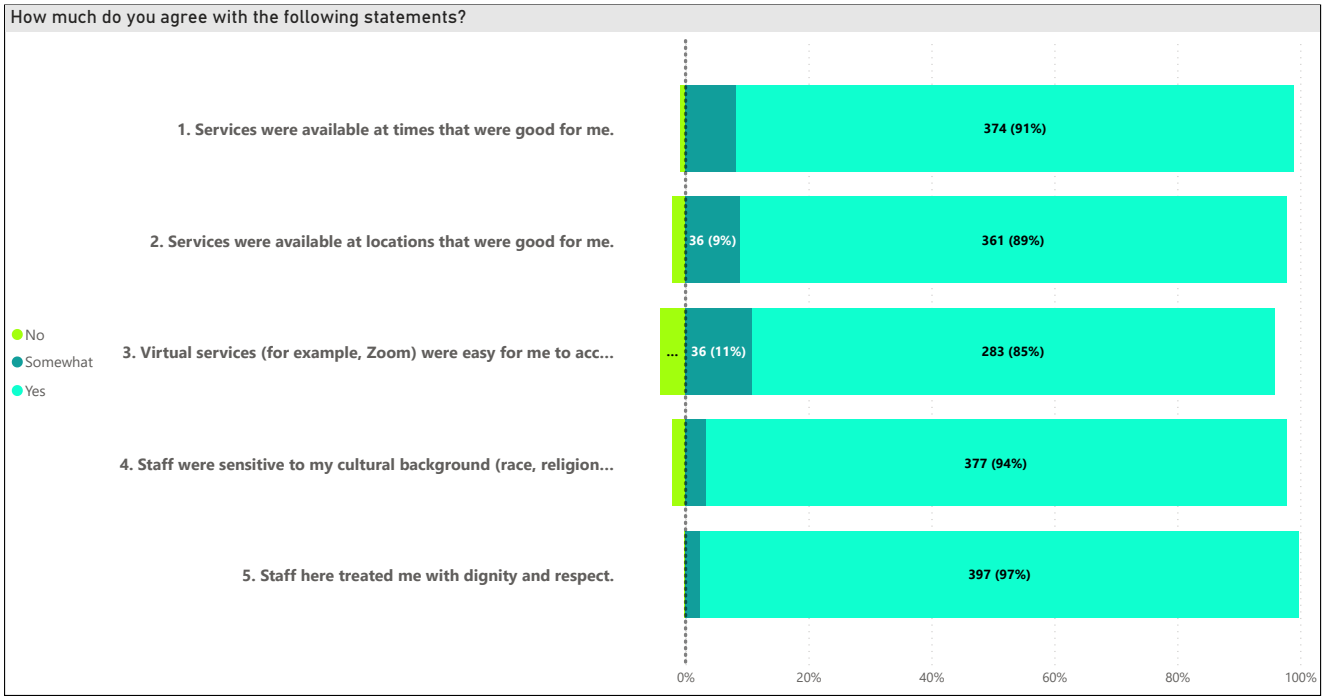


Question	% No	% Somewhat	% Yes
1. I feel like I am part of a community.	1.62%	9.93%	88.45%
2. I have more opportunities to connect with activities and traditions from my culture.	4.81%	10.89%	84.30%
3. I have people I can talk with and do enjoyable things.	2.96%	12.59%	84.44%
4. I have more skills to deal with difficult daily situations and people.	3.49%	22.19%	74.31%
5. I am more prepared to seek out support when I need it.	1.60%	15.56%	82.84%
6. I have learned more ways to manage stress or emotional challenges.	2.29%	15.56%	82.15%
7. I have improved interactions/relationships with one or more people in my family.	2.01%	18.05%	79.95%
8. When people experience stress, worries, and lack of basic needs their mental health or emotional wellness is affected.	2.48%	8.66%	88.86%
9. When people have access to programs like this they can grow, change, and improve their emotional wellness and mental health.	0.49%	6.63%	92.87%



Improvements	% Respondents
Wellness/Self Care/Physical Health	20%
Mental Health/Emotional Wellness	19%
Connection with My Culture and/or Community	16%
Relationships with Family, Parent, Spouse, or Child	13%
Access to Referrals and Resources	13%
Access to Legal Resources	9%
Access to Health Insurance	8%
Dealing with Substance Misuse	2%
Total	**100%**



Statement	No	Somewhat	Yes
1. Services were available at times that were good for me.	0.97%	8.25%	90.78%
2. Services were available at locations that were good for me.	2.22%	8.87%	88.92%
3. Virtual services (for example, Zoom) were easy for me to access.	4.20%	10.81%	84.98%
4. Staff were sensitive to my cultural background (race, religion, language, etc.).	2.26%	3.26%	94.49%
5. Staff here treated me with dignity and respect.	0.25%	2.45%	97.30%

Statement	# No	% No	# Somewhat	% Somewhat	# Yes	% Yes
1. I am more prepared to seek out support when I need it.	28	3%	256	25%	753	73%
2. I have someone to turn to when I need to talk about my problems.	38	4%	191	18%	814	78%
3. I have learned more ways to manage stress or emotional challenges.	44	4%	278	28%	671	68%
4. I feel like I am part of a community.	66	6%	319	31%	649	63%
5. I feel better about my life.	68	7%	297	29%	653	64%
6. I am more aware of the resources in my community.	21	2%	250	24%	756	74%

WELLNESS • RECOVERY • RESILIENCE

PEI Participant Survey
English v2023

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.

*** Agency/Program:**

Date

Month, Day, Year

Date

MM/DD/YYYY

If you **cannot** complete this survey, please indicate reason:

- ◯ No time
- ◯ Refused
- ◯ Not interested
- ◯ Language unavailable
- ◯ Other reason not listed:

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:

Community Health Assessment -

If you **cannot** complete this survey, please indicate reason:

- □ No time
- □ Refused
- □ Not interested
- □ Language unavailable
- □ Other reason not listed

Please help us learn more about you by answering the questions below. Read each one carefully and then check the box that best represents how you feel about the statement. Your participation is voluntary, anonymous, and will not affect your ability to receive services or support.

Agency/Program: _____ **Date:** Month ☐☐ Day ☐☐ Year ☐☐☐☐

1. What services or supports do you need at this moment? (Check all that apply)

- ☐ Mental Health/Emotional Wellness (need help with any of the following: stress, anxiety, depression, self-harm, grief, fear, etc.)
- ☐ Access to Legal Resources (victim of a crime, immigration, intimate partner violence, probation, etc.)
- ☐ Access to Health Insurance
- ☐ Access to Referrals and Resources (food, school, jobs, housing, benefits, etc.)
- ☐ Connection with my Culture and/or Community
- ☐ Relationships with Family, Parent, Spouse, or Child
- ☐ Wellness/Self Care/Physical Health
- ☐ Dealing with Substance Misuse (alcohol or other substances)

Please answer the following questions about your health.	0 days	1-2 days	3-5 days	6+ days	Not sure
2. In the past two weeks, about how many days have you noticed physical sensations that are concerning (headaches, upset stomach, body aches/pains, skin irritation, trouble breathing, trouble sleeping, etc.) or have not been feeling well physically?	☐	☐	☐	☐	☐
3. In the past two weeks, about how many days have you noticed feelings that are concerning (sadness, hopelessness, homesickness, worries, heartache, nervousness, etc.) or have not been feeling well emotionally?	☐	☐	☐	☐	☐
4. In the past two weeks, about how many days did you have trouble or challenges carrying out your daily routine (for example, cooking, working, going to school, seeing family, or enjoying life)?	☐	☐	☐	☐	☐

5. How would you rate your overall health?

☐ Excellent ☐ Very Good ☐ Fair ☐ Not Good ☐ Not sure

If you are comfortable, please say more about why you chose this answer in the space below: (For example, happy, able to do physical activities, eating healthy, thinking about healthier habits, want to do more physical activity, can't focus, lonely, angry, sad, urge to use substances/alcohol, or body aches/pains).

Community Health Assess

If you **cannot** complete this survey, please indicate reason:

□ No time
□ Refused
□ Not interested
□ Language
□ No longer receiving services
□ Other reason not listed _____

Please help us learn more about you by answering the questions below. Read each one carefully and then check the box that best represents how you feel about the statement. Your participation is voluntary, anonymous, and will not affect your ability to receive services or support.

Agency/Program: _____ **Date:** Month ☐☐ Day ☐☐ Year ☐☐☐☐

1. What services or supports do you need at this moment? (Check all that apply)

☐ Mental Health/Emotional Wellness (need help with any of the following: stress, anxiety, depression, self-harm, grief, fear etc.)

☐ Access to Legal Resources (victim of a crime, immigration, intimate partner violence, probation, etc.)

☐ Access to Health Insurance

☐ Access to Referrals and Resources (food, school, jobs, housing, benefits, etc.)

☐ Connection with my Culture and/or Community

Provider Program-Specific / ACBH Staff Information			
Provider Name		Date of Virtual Site Visit (via GoToMeeting)	
Program Name(s)		Site Address	
Site Manager Name / Title		Lead ACBH Staff	☐Kelly Robinson, PEI Coordinator ☐Cheryl Narvaez, PEI Program Specialist
Phone / Fax Number		**Other Provider or ACBH Staff Present (Name/Title)**	
Email Address			

☐

☐ Relationships with Family, Parent, Spouse, or Child

☐ Wellness/Self Care/Physical Health

☐ Dealing with Substance Misuse (alcohol or other substances)

Please answer the following questions about your health.	0 days	1-2 days	3-5 days	6+ days	Not sure
2. In the past two weeks, about how many days have you noticed physical sensations that are concerning (headaches, upset stomach, body aches/pains, skin irritation, trouble breathing, trouble sleeping, etc.) or have not been feeling well physically?	☐	☐	☐	☐	☐
3. In the past two weeks, about how many days have you noticed feelings that are concerning (sadness, hopelessness, homesickness, worries, heartache, nervousness, etc.) or have not been feeling well emotionally?	☐	☐	☐	☐	☐
4. In the past two weeks, about how many days did you have trouble or challenges carrying out your daily routine (for example, cooking, working, going to school, seeing family, or enjoying life)?	☐	☐	☐	☐	☐

5. How would you rate your overall health?

☐ Excellent ☐ Very Good ☐ Fair ☐ Not Good ☐ Not sure

If you are comfortable, please say more about why you chose this answer in the space below: (For example, happy, able to do physical activities, eating healthy, thinking about healthier habits, want to do more physical activity, can't focus, lonely, angry, sad, urge to use substances/alcohol, or body aches/pains, etc.).

6. In your own words, describe three ways you or your life has changed since you have been working with your counselor.

Instructions:

1. Please complete a thorough "self- check" using this Monitoring Tool in lieu of submitting all documents up front as evidence of compliance. In the column named "**Action/Task for Provider**," you will find suggestions on how and what to review in order to be able to confirm (and mark "yes") that your program/agency is in compliance. You may add brief comments/notes in this column as well.
2. For each item, please mark checkbox ☒for **Yes**, **No**, or **N/A**. Do not change or edit this column.
    a. For areas in which you indicate compliance (i.e. mark "Yes"), ACBH will request that a selection of those documents be emailed to us **one week after** the virtual site visit.
    b. In areas where "no" is marked, ACBH staff will provide technical assistance and discuss a timeline for submission of evidence **during** the virtual site visit.
3. Submit this completed checklist to ACBH staff **3 working days prior** to your virtual site visit. **No additional documents** need to be sent at this point.
4. During the virtual site visit, there will be time to highlight your program's accomplishments and challenges.
5. Please feel free to reach out to Cheryl.Narvaez@acgov.org or Kelly.Robinson@acgov.org with any questions about this process.

A. Compliance with required postings and site safety	Yes	No	Action/Task for Provider (Add brief comments/notes below if needed)
1. ACBH grievance posters prominently posted for clients	☐	☐	*If not posted, here is the copy/link to materials (http://www.acbhcs.org/providers/Forms/SUD/Grievance_Appeal_Poster.pdf).*
2. No observable safety or accessibility issues with site	☐	☐	*Review site for any observable safety issues for clients and families (especially young children), i.e., trip hazards, excessive temperatures, exits clearly marked, etc. If there are any concerns, please document, request immediate resolution, and inform ACBH staff of status.*
3. Access to services and reasonable accommodation for people with disabilities	☐	☐	*Conduct a visual inspection, in particular inspections around ADA access, and the status. If ADA issues are identified, provider must address and inform ACBH upon resolution.*
4. Implementation of services and training of staff around culturally and linguistically appropriate services (CLAS)	☐	☐	*Review documents that confirm dates of CLAS Standards trainings that staff have attended as evidence. May include additional evidence of CLAS implementation beyond training.*

B. Evidence of required data collection	Yes	No	N/A	Action/Task for Provider (Add brief comments/notes below if needed)
1. Registration/sign-in kiosk, sign-in sheets, other data collection protocols in place/being used to document program activities and collect demographic data	☐	☐		*Review copy of blank sign in or intake sheet with demographic information asked of participants as evidence.*
2. **<u>For UELP providers and other Early Intervention Programs only</u>:** Procedures regarding InSyst, Clinicians Gateway, and other data collection requirements per contract	☐	☐	☐	*Review written instructions, protocols for program staff used to document and check the accuracy of service documentation prior to entry into the electronic data entry system as evidence.*
3. System in place for monitoring and tracking attendance of the clients in your program to ensure non-duplication of clients	☐	☐		*Review written instructions, protocols for program staff on how to separate PEI funded participants from other programs as evidence.*
4. Submission of Annual PEI Data Report for the prior year in a timely manner *Note: For UELP Providers, this report is named "UELP Annual Report"*	☐	☐		*Confirm that Annual PEI Data Report (or UELP Annual Report) was submitted and uploaded by July 31 as evidence.*
5. Submission of PEI Evaluation report for the prior year in a timely manner *Note: This item does not apply for UELP Providers*	☐	☐	☐	*Confirm that Annual PEI Evaluation Report was submitted and uploaded by July 31 as evidence.*

6. **For UELP Providers only:** Submitting or entering the following data in a timely manner: a. Entering Clinicians Gateway data b. Completing and submitting MAA/ISLs c. Closing/Opening Insyst episodes d. Completing PEI Maintenance Screen in InSyst e. Completing and Submitting Client Satisfaction Surveys f. Completing and Submitting Pre/Post Health Assessment for Preventive Clients	☐	☐	☐	*Review internal agency protocols, instructions, etc. on timelines/deadlines regarding the submission and entering of the data listed as evidence.*

C. Compliance with staffing/personnel requirements	Yes	No	Action/Task for Provider (Add brief comments/notes below if needed)
1. Written job descriptions	☐	☐	*Review job descriptions as evidence.*
2. Written code of conduct	☐	☐	*Review code of conduct and/or personnel manual as evidence. Should include clauses re: use of alcohol/drugs; scope of services; confidentiality; cooperation w/investigations; conflict of interest; prohibition against discrimination, harassment & inappropriate sexual conduct.*

D. Compliance with confidentiality requirements	Yes	No	Action/Task for Provider (Add brief comments/notes below if needed)
1. Double-locked client charts and records, and no loose client charts	☐	☐	*Conduct visual inspection as evidence.*
2. Locked computers in non-secure areas	☐	☐	*Conduct visual inspection as evidence.*
3. Password changes every 90 days	☐	☐	*Review policy & procedure as evidence.*

D. Compliance with confidentiality requirements	Yes	No	Action/Task for Provider (Add brief comments/notes below if needed)
4. Secure/encrypted emails (that include a warning banner)	☐	☐	*Review a secure/encrypted email to ensure that warning banner is in place stating that: data is confidential, systems are logged, system use if for business purposes only by authorized users, and direction to users to log off the system if they do not agree with these requirements as evidence. (p. 26, Section J. of Privacy and Security Provisions).*
5. Participant Consent/Confidentiality Statement	☐	☐	*Review paperwork (which includes signatures) that explains consent to services, participant rights and grievances, and issues of confidentiality and safety as evidence.*

E. Documentation of program implementation (Note: For providers who have more than one PEI program, please provide evidence per each program)	Yes	No	N/A	Action/Task for Provider (Add brief comments/notes below if needed)
What PEI category is/are your program(s)? Mark all that apply.				☐Access and Linkage ☐Stigma and Discrimination Reduction ☐Outreach for Increasing Recognition ☐Prevention ☐Early Intervention ☐Suicide Prevention
1. Evidence-based practice standard, promising practice standard, community and/or practice-based evidence standard being implemented	☐	☐	☐	*Review documentation of the standard that program is implementing (i.e. curriculum or other lesson/activity plan and supporting documentation) as evidence.*
2. Program designed, implemented, and promoted in ways that: • Create access and linkage to treatment? • Improve timely access to mental health services for individuals,	☐	☐	☐	*Review any program guidelines, policy, etc. as evidence.*

families, and/or underserved populations? • Use non-stigmatizing and non-discriminatory language and activities?				
3. Process of referring participants to mental health treatment for clients that need such services	☐	☐	☐	*Review any program guidelines, policy, etc. as evidence.*

F. Compliance with additional requirements of program design	**Yes**	**No**	**N/A**	Action/Task for Provider **(Add brief comments/notes below if needed)**
1. Use of ACBH and Prop 63 logos on all promotions	☐	☐		*Review flyers, promotional materials, etc. as evidence.*
2. Ongoing program evaluation and improvement activities	☐	☐		*Review program guidelines, practices, policies, etc. that provider monitors their program, and identifies problems, challenges, and / or opportunities for improvement as evidence. Examples include documentation of staff productivity reports and monitoring, satisfaction surveys, staff training.*
3. **For UELP Providers only:** ACBH's PEI system is required under MHSA funding to serve 51% of clients who are under 26 years of age. Does your programming… a. include outreach and engagement of participants under 26 years of age? Do your data collection mechanisms accurately collect and input participants by age? b. serve at least 75% of participants that identify as part of your priority population	☐	☐	☐	*Review data reports from Clinician's Gateway and/or internal program tracking mechanism as evidence.*

Please use the space below to provide three program highlights that you would like to discuss at the site visit. **Optional: In addition, please share any additional comments. If referring to an item on this check list, please indicate the number of the item (i.e. C.2. Or F.1.) along with your comment.**
Program Highlights: 1) 2) 3) **(Optional) Additional comments:**

G. Other TA Resources and hyperlinks
☐ Information Systems Requirements, including Required Language for Secure/Encrypted Warning Banner ☐ ACBH Grievance Poster, at http://www.acbhcs.org/providers/Forms/SUD/Grievance_Appeal_Poster.pdf ☐ ACBH Training Calendar, at http://www.acbhcs.org/Training/default.htm ☐ Alameda County Training Registration Site, at http://alameda.netkeepers.com/TPOnline/TPOnline.dll/Home ☐ PEI Resources and Documents Drive and UELP Provider Resources Drive

For ACBH staff use only.

Additional comments or required follow up (post-virtual visit) for provider:

List of documents requested for review:

List of documents received:

List of documents unavailable or in process to submit and deadline (by when):

Documents Requested Submitted on:

Appendix F-1 | MHSA WET: Primary Care Integration Evaluation FY20/21

FY 2022/23 ACBH Training Unit, Listing of Trainings

The Trainings here reflect the WET training plan, which serves the department and our contracted Community Based Organizations, with primary focus on clinical learning and continuing education (CE) credits to support our licensed providers. The Training Unit sponsors CEs & works in collaboration with our ACBH units to meet more targeted training needs as well.

Date	Training Title	ACBH Sponsoring unit	Content Area	Audience	Training Format	Total Attendees	Behavioral Health Staff	#CE Certs	# Psych Certs	Psychologist CEs Offered	# CE's Offered (all)
July	**JUL '22**	**2022**									
July (ongoing)	Involuntary Psychiatric Holds 5150-5585 - Online Independent learning *(recorded training - recurs monthly)*	ACBH Crisis Support	Crisis support - Provider education, and resources	ACBH Staff and contracted CBOs/Providers	Online, recorded-Independent Study	8	0.0	4	2	3.5	3.5
August	**AUG '22**	**2022**									
August (ongoing)	Involuntary Psychiatric Holds 5150-5585 - Online Independent learning *(recorded training - recurs monthly)*	ACBH Crisis Support	Crisis support - Provider education, and resources	ACBH Staff and contracted CBOs/Providers	Online, recorded-Independent Study	18	5	9	0	3.5	3.5
September	**SEPT '22**	**2022**									
September (ongoing)	Involuntary Psychiatric Holds 5150-5585 - Online Independent learning *(recorded training - recurs monthly)*	ACBH Crisis Support	Crisis - Provider education, and resources	ACBH Staff and contracted CBOs/Providers	Online, recorded-Independent Study	11	0	9	1	3.5	3.5
9/13 & 22/22	Older Adult Training and Certification Program *(2-day training, 8 modules in all)*	ACBH Older Adult division	Older Adult services and support	ACBH Staff and contracted CBOs/Providers	Online, live training	46	14	28	0	0	9

Date	Training Title	ACBH Sponsoring unit	Content Area	Audience	Training Format	Total Attendees	Behavioral Health Staff	#CE Certs	# Psych Certs	Psychologist CEs Offered	# CE's Offered (all)
9/20/22	Neurobiology of Trauma and Co-regulation	Trg Unit/RFQ vendor	Trauma-Informed Care	ACBH Staff and contracted CBOs/Providers	Online, live training	28	11	0	0	0	0
9/23/22	Maternal Mental Health and Infant Disparities among African American Women	EthSvcs-Pathways to Wellness (AATA pgm)	Afr.Amer. Technical Assistance Program/CLAS	ACBH Staff and contracted CBOs/Providers	Online, live training	53	5	22	1	4	4
October	**OCT '22**	**2022**									
2022 October	Involuntary Psychiatric Holds 5150-5585 - Online Independent learning *(recorded training - recurs monthly)*	ACBH Crisis Support	Crisis support - Provider education, and resources	ACBH Staff and contracted CBOs/Providers	Online, recorded-Independent Study	1	0	1	0	3.5	3.5
10/5/22	MHFA- YOUTH	Trg Unit/CSS (vendor)	Introductory Mental Health community and lay-person training	ACBH Staff and contracted CBOs/Providers	Online, live training	22	0	0	0	0	0
10/10 & 11/22	Suicide Assessment & Intervention - YOUTH focus	Trg Unit/CSS (vendor)	Suicide Intervention	ACBH Staff and contracted CBOs/Providers	Online, live training	10	5	8	0	6	6
10/12/22	Preventing, De-Escalating, and Managing Aggressive Behavior in Behavioral Health Care Settings	Trg Unit/RFQ vendor	Behavior Management/De-Escalation	ACBH Staff and contracted CBOs/Providers	Online, live training	24	4	12	0	4.0	4.0

Date	Training Title	ACBH Sponsoring unit	Content Area	Audience	Training Format	Total Attendees	Behavioral Health Staff	#CE Certs	# Psych Certs	Psychologist CEs Offered	# CE's Offered (all)
10/18/22	Supporting Those Who Experience Grief During the Holidays	Trg Unit/RFQ vendor	Trauma-Informed Care/Grief	ACBH Staff and contracted CBOs/Providers	Online, live training	43	10	0	0	0	0
10/19/22	Law and Ethics for County Healthcare Providers	ACBH Trg Unit and HCSA collaboration	Law and Ethics	All Alameda County HCSA staff and CBOs	Online, live training	123	54	93	3	6	6
10/21/22	School Shootings, Neighborhood Violence, and Civil Unrest: The Impact of Community Violence on Black Youth Mental Health	EthSvcs-Pathways to Wellness (AATA pgm)	Afr.Amer. Technical Assistance Program/CLAS	ACBH Staff and contracted CBOs/Providers	Online, live training	96	7	25	1	4	4
10/28/22	Child and Family Teaming (CFT)	ACBH Children & Youth System of Care	Family Support and Collaboration	CYASOC staff & Interns by invitation	In person, live training	19	6	8	0	0.0	6.0
November	**NOV '22**	**2022**									
2022 November	Involuntary Psychiatric Holds 5150-5585 - Online Independent learning *(recorded training - recurs monthly)*	ACBH Crisis Support	Crisis support - Provider education, and resources	ACBH Staff and contracted CBOs/Providers	Online, recorded-Independent Study	8	4	5	1	3.5	3.5
11/1 & 3/22	Suicide Assessment & Intervention - ADULT focus	Trg Unit/CSS (vendor)	Suicide Intervention	ACBH Staff and contracted CBOs/Providers	Online, live training	44	3	9.0	0	6	6
11/7/22	MHFA - YOUTH focus	Trg Unit/CSS (vendor)	Introductory Mental Health community and lay-person training	ACBH Staff and contracted CBOs/Providers	Online, live training	13	0	0	0	0	0

Alameda County MHSA Annual Update, FY 2022-23_WET Training Unit Addendum

Date	Training Title	ACBH Sponsoring unit	Content Area	Audience	Training Format	Total Attendees	Behavioral Health Staff	#CE Certs	# Psych Certs	Psychologist CEs Offered	# CE's Offered (all)
December	**DEC '22**	**2022**									
2022 December	Involuntary Psychiatric Holds 5150-5585 - Online Independent learning *(recorded training - recurs monthly)*	ACBH Crisis Support	Crisis support - Provider education, and resources	ACBH Staff and contracted CBOs/Providers	Online, recorded-Independent Study	3	2	3	0	3.5	3.5
12/16/22	Provision of Mental Health Services with Latinx/Latiné Populations: An Intersectional and Inclusive Approach	EthSvcs/OnTrack vendor	CLAS	ACBH Staff and contracted CBOs/Providers	Online, live training	36	2	11	0	0.0	3.0
Quarter 4, Aug 27 - Dec 17 (Last semester. Program ends after 2022)	CSUEB Infant & Early Childhood Mental Health Postgraduate Certificate Program FALL SEMESTER (August-December 2022)	ACBH Children & Youth System of Care	Early Childhood Mental Health	Early Childhood Provider Staff enrolled in CSU program	Online, live training	11	1	11	0	0	15
January	**JAN '23**	**2023**									
01/23/23	Motivational Interviewing 101	Trg Unit/RFQ vendor (ABW did the CEs)	Motivational Interviewing	ACBH Staff and contracted CBOs/Providers	Online, live training	22	6.0	---	---	6	6
01/27/23	Trauma-informed and Trauma-focused Interventions using Telehealth for Adult Clients	Trg Unit/RFQ vendor	Trauma Informed Care/Telehealth	ACBH Staff and contracted CBOs/Providers	Online, live training	62	7	19	0	0.0	3.0

Date	Training Title	ACBH Sponsoring unit	Content Area	Audience	Training Format	Total Attendees	Behavioral Health Staff	#CE Certs	# Psych Certs	Psychologist CEs Offered	# CE's Offered (all)
01/27/23	Emergency Room: How it Impacts Healthcare Disparities in African Americans	EthSvcs-Pathways to Wellness (AATA pgm)	Afr.Amer. Technical Assistance Program/CLAS	ACBH Staff and contracted CBOs/Providers	Online, live training	56	9	53	0	0.0	3.5
February	**FEB '23**	**2023**									
2/6 & 2/8/23	Cognitive Processing Therapy for Post-Traumatic Stress Disorder	Trg Unit/RFQ vendor	Trauma Informed Care	ACBH Staff and contracted CBOs/Providers	Online, live training	32	29	27	0	0.0	8.0
02/24/23	Student and Faculty Mental Health: In the Setting of the Rise of School Shootings and School Violence	EthSvcs-Pathways to Wellness (AATA pgm)	Afr.Amer. Technical Assistance Program/CLAS/ TIC	ACBH Staff and contracted CBOs/Providers	Online, live training	90	2	22	0	0.0	3.5
02/24/23	Assembly Bill 541 –Treating Tobacco Dependence in Behavioral Health Settings	Linda Nguyen - Lifelong Medical Tobacco Pgm	Tobacco Cessation	ACBH Admin & Clinical Staff SUD and MH	Online, live training	9	1	0	0	0.0	0.0
March	**MAR '23**	**2023**									
03/09/23	DSM V Training: Applying Updated Information from DSM-5 Text Revision in Work with **Adults**	Trg Unit/RFQ vendor	DSM V	ACBH Staff and contracted CBOs/Providers	Online, live training	29	5	13	0	0.0	6.0

Alameda County MHSA Annual Update, FY 2022-23_WET Training Unit Addendum

Date	Training Title	ACBH Sponsoring unit	Content Area	Audience	Training Format	Total Attendees	Behavioral Health Staff	#CE Certs	# Psych Certs	Psychologist CEs Offered	# CE's Offered (all)
03/14/23	Defining Your "New Normal"; Strategizing for the Post-Pandemic in the Workplace and Beyond	ACBH Training Unit/HCSA Learning Center	Staff Development	Alameda County HCSA staff only	Online, live training	46	14	16	0	0.0	4.5
03/23/23	De-Escalating and Managing Aggressive Behavior in BH Settings	Trg Unit/RFQ vendor	Behavior Management/De-Escalation	ACBH Staff and contracted CBOs/Providers	Online, live training	33	8	8	0	0.0	4.0
03/24/23	Geriatric Mental Health Among African Americans	EthSvcs-Pathways to Wellness (AATA pgm)	Afr.Amer. Technical Assistance Program/CLAS	ACBH Staff and contracted CBOs/Providers	Online, live training	121	7	41	0	0.0	3.5
03/30/23	DSM V Training: Applying Updated Information from DSM-5 in Work with Children, Adolescents & Transition Age Youth	Trg Unit/RFQ vendor	DSM V	ACBH Staff and contracted CBOs/Providers	Online, live training	20	13	8	0	0.0	6.0
April	**APR '23**	**2023**									
4/7/23	Collaborative & Cultural Case Planning for Professionals Working w/ Spanish Speaking Families in Social Services & Foster Care **(IN SPANISH)**	Trg Unit/RFQ vendor	Family Support and Collaboration (SPANISH)	ACBH Staff and contracted CBOs/Providers	Online, live training	12	0		0	3.0	3.0
4/12/23	Child and Family Team (CFT) Facilitator Training	ACBH Children & Youth System of Care	Family Support and Collaboration	CYASOC staff & Interns by invitation	In person, live training	12	0	4	0	0.0	6.0

Date	Training Title	ACBH Sponsoring unit	Content Area	Audience	Training Format	Total Attendees	Behavioral Health Staff	#CE Certs	# Psych Certs	Psychologist CEs Offered	# CE's Offered (all)
4/18/23	De-Escalating and Managing Aggressive Behavior in BH Settings	Trg Unit/RFQ vendor	Behavior Management/De-Escalation	ACBH Staff and contracted CBOs/Providers	Online, live training	22	1	3	0	0.0	4.0
4/20/23	MHFA ADULT	Trg Unit/Crisis Support of Alameda County(CBO vendor)	Introductory Mental Health community and lay-person training	Peralta system - Laney College staff and secuity guards	Live, in person	17	0	0	0	0.0	0.0
4/21/23	Black Youth and Substance Use Issues in Mental Health	EthSvcs-Pathways to Wellness (AATA pgm)	Afr.Amer. Technical Assistance Program/CLAS	ACBH Staff and contracted CBOs/Providers	Online, live training	47	7	44	0	0.0	3.5
4/ 26 & 27/23	Suicide Assessment and Intervention - ADULT	Trg Unit/Crisis Support of Alameda County(CBO vendor)	Suicide Intervention	ACBH Staff and contracted CBOs/Providers	Online, live training	44	9	12	1	6.0	6.0
May	**MAY '23**	**2023**									
5/4/23	Bright Young Minds High School Behavioral Health and Career Pathways Conference	Training Unit and Cypress Resilience Project	Youth Education and Career Pipeline	High School Students (Eden Voc. HS and Alameda High, Juniors and Seniors)	Live, in person	93	24	0	0	0.0	0.0

Alameda County MHSA Annual Update, FY 2022-23_WET Training Unit Addendum

Date	Training Title	ACBH Sponsoring unit	Content Area	Audience	Training Format	Total Attendees	Behavioral Health Staff	#CE Certs	# Psych Certs	Psychologist CEs Offered	# CE's Offered (all)
5/16/23	Suicide Assessment - Adult **(Private training** for Santa Rita staff in the jail)	Trg Unit/Santa Rita Jail/CSS vendor	Suicide Intervention	ACBH Santa Rita Jail Clinical Staff	Live, in person	14	14	5	0	0.0	2.0
5/18/23	Suicide Assessment - Adult **(Private training** for Santa Rita staff in the jail)	Trg Unit/Santa Rita Jail/Crisis Support of Alameda County	Suicide Intervention	ACBH Santa Rita Jail Clinical Staff	Live, in person	14	14	8	0	0.0	2.0
5/18/23	Connecting the Dots; Historical Trauma, Toxic Stress and Indigenous Community	Ethnic Services and vendor, OnTrack	CLAS/Trauma-Informed Care	ACBH Staff and contracted CBOs/Providers	Online, live training	86	8	36	0	0.0	3.0
5/19/23	Deconstructing Gang Culture in African American Adolescents: Communal Insights and Interventions	EthSvcs-Pathways to Wellness (AATA pgm)	Afr.Amer. Technical Assistance Program/CLAS	ACBH Staff and contracted CBOs/Providers	Online, live training	110	6	30	0	0.0	3.5
5/25/23	MHFA ADULT (*Berkely Library Staff*)	Trg Unit/Crisis Support of Alameda County(CBO vendor)	Introductory Mental Health community and lay-person training	Community Trg - Berkeley Library Staff	Live, in person	25	0	0	0	0.0	0.0
5/24 - 7/12	Family Based Eating Disorder Treatment 2023 (8-part series)	ACBH Children & Youth System of Care	Eating Disorders	ACBH Staff and contracted CBOs/Providers	Online, live training	23	15	16	0	0.0	12.0
June	**JUNE '23**	**2023**									

Date	Training Title	ACBH Sponsoring unit	Content Area	Audience	Training Format	Total Attendees	Behavioral Health Staff	#CE Certs	# Psych Certs	Psychologist CEs Offered	# CE's Offered (all)
6/2/23	Knowing the Traumatized Afghan Refugee - Part I	Ethnic Services	Trauma-Informed Care/CLAS	ACBH Staff and contracted CBOs/Providers	Online, live training	5	3	3	0	0	3.5
6/8/23	What's Going On?! How to Help Black Racial Stress, Healing, and Trauma	Ethnic Services/OnTrack vendor	CLAS/Afr.Amer/ Trauma Informed	ACBH Staff and contracted CBOs/Providers	Online, live training	57	5	12	0	0	3
6/22/23	LGBTQIA+ Health Equity & Cultural Humility	Ethnic Services/OnTrack vendor	CLAS/SOGI	ACBH Staff and contracted CBOs/Providers	Online, live training	89	5	30	0	0	3
6/23/23	Law and Ethics Updates for Healthcare Providers	Trg Unit/RFQ vendor	Law & Ethics	ACBH Staff and contracted CBOs/Providers	Online, live training	43	29	38	1	6	6
6/23/23	When One Plus One Equals Three: The Illusion of Co-Occurring Disorders", presented by Lester Love, MD.	EthSvcs-Pathways to Wellness (AATA pgm)	Afr.Amer. Technical Assistance Program/CLAS	ACBH Staff and contracted CBOs/Providers	Online, live training	67	8	30	0	0	3.5
6/28/23	Knowing the Traumatized Afghan Refugee - Part II	Ethnic Services	Trauma-Informed Care/CLAS	ACBH Staff and contracted CBOs/Providers	Online, live training	15	3	3	0	0	3.5
					TOTALS:	**1932**	**385**	**739**	**11**	**68.5**	**196.0**

alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

INTERNSHIP OPPORTUNITIES

Alameda County Behavioral Health (ACBH) has Trainee intern opportunities to provide counseling, crisis intervention, case management, co-occurring disorder (mental health & substance abuse), and integrated health care services in Child & Young Adult, Transitional Age Youth, Adult & Older Adult community based programs.

Alameda County Behavioral Health (ACBH) offers a competitive Graduate Intern Stipend Program for eligible interns in county-operated programs and contracted community-based behavioral health organizations.

For additional *information* about available internship opportunities and the Graduate Intern Stipend Program, please visit: http://www.acbhcs.org/intern-and-trainee-programs/

For questions about the internship program at Alameda County Behavioral Healthcare please contact: acbhinternshipprogram@acgov.org – Oakland, CA 94606

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

-MEMORANDUM-

TO: ACBH Staff and Community Partners

CC: Karyn L. Tribble, PsyD, LCSW - Director
Cheryl Narváez, Workforce, Education & Training Manager
Robert Farrow, Training Officer

FROM: Ebony Jacob, ACBH Internship Coordinator

SUBJECT: **ACBH 2023-24 GRADUATE INTERN STIPEND PROGRAM (GISP) APPLICATION AVAILABLE**

Alameda County Behavioral Health (ACBH) is pleased to announce that the FY2023-24 application cycle for the **Graduate Intern Stipend Program (GISP) is now open**!

The application, instructions, and eligibility requirements are posted HERE.

PLEASE INSTRUCT STUDENTS TO COMPLETE AND SUBMIT THE APPLICATION ONLINE ON OR BEFORE THE DEADLINE OF **MONDAY, OCTOBER 16, 2023.**

We are looking for student applicants who meet eligibility requirements and are from diverse backgrounds to help increase the cultural responsiveness of our system, bridge gaps in skill sets, and improve language capacity. Please inform your 2023-24 school year students about this great opportunity to enhance their internship experience.

Each stipend is worth up to $6,000 for a maximum of 720 internship hours. The stipend amount will be pro-rated if the student works less than the maximum 720 hours.

For questions, please contact the ACBH Internship Program at **ACBHInternshipProgram@acgov.org** or the ACBH Internship Coordinator at **ebony.jacob@acgov.org**.

Alameda County Behavioral Health Care Services
A Department of Alameda County
Health Care Services Agency

Alameda County Behavioral Health (ACBH)
Workforce, Education & Training Unit
Graduate Intern Stipend Program

Rev 10.5.23

Responsibilities/ Processes

Student Responsibilities

- Complete first three boxes on Intern Stipend Claim/Invoice. Original signatures required. Mail in the form to WET unit.
    - Stipend Claim/Invoice due dates: First (1st) claim due to WET by end of Dec/early Jan. Finance to process by third week of January. Second (2nd) claim due to WET by end of May/early June. Finance to process by third week of June.
- Keep log of hours worked (requirements are 20 hours/week). If total maximum amount of hours not reached the stipend amount will be pro-rated. (Rate of pay = $8.33/hr.)
- Complete ACBH Alcolink Supplier Form and IRS W-9 Form.
- Notify WET of any address changes immediately. A new W-9 form will need to be completed/updated.

Intern Supervisor Responsibilities

- Track with intern and verify work hours.
- Sign off on Stipend invoice claim form (original signature required).

WET Internship Coordinator Responsibilities

- Send acceptance letter, Graduate Intern Stipend Claim Invoice Form, and IRS W-9 form to students, and outline their responsibilities. (W-9 form is required by finance to set up Supplier ID number for each student and to process stipend checks).
- Send formal letter to Supervisors with acceptance information and outline their responsibilities.
- Inform each intern of their Supplier ID when Finance sends it to WET.
- Send students Stipend invoice claim form. WET internship coordinator to populate intern's name and vendor ID prior to sending the claim form.
- When signed claim form returned, WET internship coordinator to assign amount to be paid and WET manager confirms and sign off.
- Track the stipend amounts distributed for each intern **(it is up to WET to ensure that proper payment is given and that student does not exceed amount of stipend – max is $6000.00. 720 hours of work required to fulfill agreement; rate of pay = $8.33/hr.)**
- WET Internship Coordinator to send Claim/Invoice to Finance unit for processing.
- Finance to process final checks with approval from the Auditor's Office, and
- Finance will be send final checks to internship coordinator.
- Internship Coordinator to mail out checks to each awardee.
- Internship Coordinator sends a reminder to awardees about the Stipend Claim form submission due date – one week prior to actual due date (mid December for the first payment).
- Internship Coordinator sends a letter to the awardees notifying the due date for the second payment. *The Internship Coordinator will set up the dates.*

Pay Schedule

Stipends paid out two times per year for students on semester schedule (Three times for those on a quarterly schedule).
Stipend Claim due dates:

- First (1st) claim due to WET by Dec 31st. Finance to process by January/February.
- Second (2nd) claim due to WET by May 31st. Finance to process by June/July.

For Internship hours covering period:	**Submit Stipend Claim/Invoice to Finance by:**
August to December	January
January to May	June

alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

INTERNSHIP ONBOARDING GUIDELINES/PROTOCOL

A successful internship program should include the following: an application, screening and interview, recruitment, onboarding process, structured orientation, a motivated supervisor and an evaluation and assessment protocol.

The goal of the internship program is to provide leadership and training opportunities for students as they prepare for careers in the behavioral healthcare field.

Please review the following guidelines when requesting an intern:

1. **INTERVIEW/SELECTION**
   Department/unit should schedule in-person and/or phone interviews. Once a decision is made, the supervisor will complete the ***"Intern Request Form."***
2. **VOLUNTEER JOB DESCRIPTION**
   Once department/unit interviews and selects a student to offer a potential internship, the intern supervisor will need to work with the student to complete the ***"Volunteer Job Application"*** and other required forms (listed below). These forms are then submitted to the Internship Coordinator.
3. **ONBOARDING PAPERWORK**
   The onboarding paperwork includes the ***"Volunteer Job Application, Alcolink Supplier Form, IRS W-9 Form, and Student Intern Information Form***." While the Volunteer Job Application and Student Intern Information Forms are required, the Alcolink Supplier and IRS W-9 are required only if student will be driving for internship assignment and may request travel reimbursements and/or is a recipient of the ACBH graduate intern stipend.
4. **NOTIFICATION**
   Once HR receives and reviews paperwork, HR will contact student for background, fingerprint checks and medical clearance process. Once the process is completed, HR will notify supervisor and internship coordinator of clearance.
   All internship assignments are contingent upon background/fingerprint/medical clearance
5. **CONFIRM START DATE**
   Once Intern Supervisor receives confirmation of clearance from Human Resources; supervisor may confirm start date with intern.
6. **PREPARE WORK SPACE**
   Prepare temporary space, computer, email, request ID (if necessary) and order office supplies for new intern.
7. **MID AND END OF YEAR EVALUATIONS**
   Students should complete a mid-year and end of year internship evaluation. An evaluation is important to best meet the needs of the internship program.
8. **END OF INTERNSHIP ASSIGNMENT**
   Once the internship assignment ends please complete the ***"Alameda County Behavioral Health Notice of Internship Separation Form."***

ACBH-ej

INTERNSHIP ONBOARDING GUIDELINES/PROTOCOL

Some of the benefits of utilizing the internship program include the following:

- **Internships will serve to develop a pipeline for future employees.**
- **It is a way to recruit potential future employees for ACBH by offering them an internal view of the organization which may encourage students to stay and work in the community.**
- **It provides new and innovative ideas and perspectives.**
- **It provides and can infuse a culture of diversity and creativity.**
- **It provides a way for current intern supervisors to pay it forward and educate students on what to expect in the workplace.**
- **It also provides potential new skills, knowledge, and increased management expertise.**
- **Internship opportunities deliver beneficial ROI for the employer by remaining competitive in the behavioral healthcare industry.**
- **An opportunity to receive the Alameda County Behavioral Health (ACBH) Graduate Intern Stipend Award, if qualified for up to $6,000 a year.**

ACBH-ej

Alameda County Community Assessment and Transport Team (CATT)

Fiscal Analysis, Client Journey Map and Final Report

December 2022

Prepared for

Alameda County Health Care Services Agency

by

Public Consulting Group LLC
www.publicconsultinggroup.com

PUBLIC CONSULTING GROUP

Table of Contents

Introduction

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 a coordinated in-community response that includes 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 issue at a county level. They have enhanced partnerships with multiple partners and stakeholder groups (Table 1) to create a client-centered, evidence-based approach through the **Alameda County Community Assessment and Transport Team (CATT) Program.**

Table 1. CATT Program Implementation Partners

Organization	Description
Alameda County Behavioral Health (ACBH)	Bonita House contract oversight and cost reimbursements for behavioral health services
Emergency Medical Services (EMS)	FALCK contract and CATT Program budget oversight
Bonita House	Contracted CATT Program clinician provider
FALCK	Contracted CATT Program EMT provider

Public Consulting Group, LLC (PCG) was contracted by HCSA in January 2020 to conduct a three-year evaluation of the CATT Program pilot. This evaluation has included evaluating strategies, processes, and outcomes and supporting the implementation team to make rapid improvements to develop a responsive crisis system that is both efficient and effective. The evaluation has also examined the interprofessional collaboration model (ICM), the transportation system for behavioral health crisis response and the potential systems changes as a result of CATT program implementation. Process and outcomes have been examined at the system, community, program, and individual levels.

CATT Program Overview

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, making it more effective and efficient to care for individuals who are experiencing a behavioral health crisis and connect them to the right services, at the right place and the right time.

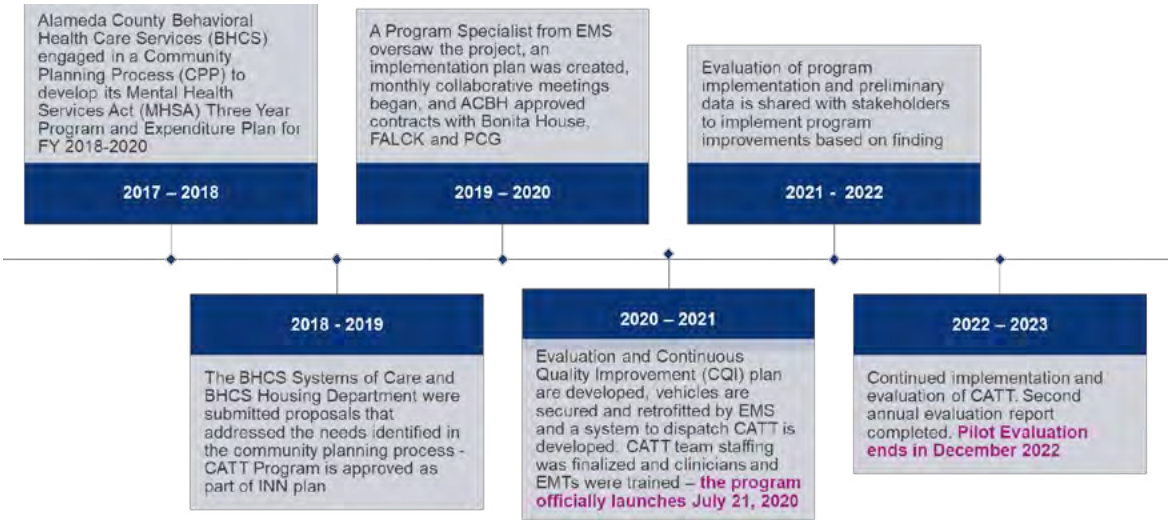
HCSA's two primary learning goals are:

1. Determine if and how collaboration among agencies responding to mental health crises 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.

CATT Program Timeline

The development of the CATT Program began in 2017 as a Community Planning Process for an innovative behavioral health crisis response program. Figure 1 illustrates a timeline of the CATT Program from the planning phase through the pilot period.

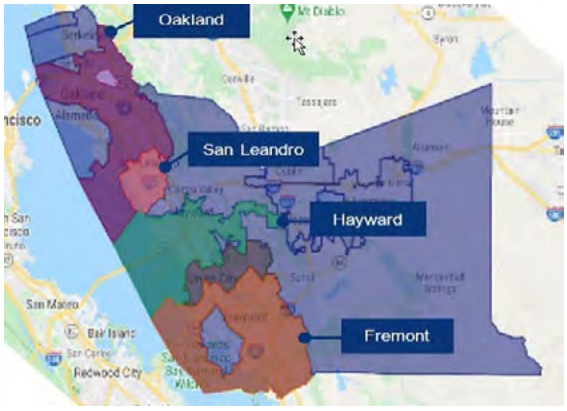
Figure 1. Timeline of CATT Program Development and Implementation



Program Overview and Goals

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**, but provide service throughout the entire county.

Figure 2. Map of CATT Team Dispatch Locations



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 has been assessed as safe by a law enforcement personnel; and
- the individual is able to be ambulated by a basic or Advanced EMT and not require emergency room medical care.

The CATT Program is intended to improve upon the current behavioral health crisis response system, making it more effective and efficient to care for individuals who are experiencing a behavioral health crisis and connect them to the right services, at the right place and the right time. 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.

CATT Program Evaluation Methodology

A process, outcome and fiscal impact evaluation was conducted utilizing a mixed-methods strategy drawing from multiple sources: 1) qualitative techniques, such as interviews, focus groups and open-ended questions in surveys with key collaborators, as well as the clients served by the CATT program and their families; 2) documentation review, such as advisory council reports, meeting minutes, QIC reports and policies and procedures governing the crisis response system; and 3) quantitative techniques, such as analysis of CATT program data, EMS data, ACBH behavioral health data, law enforcement data, and locally produced surveys.

The overarching evaluation questions were:

1. Does the CATT Program promote an effective system in which clients get to the services they need? and,
2. Does the CATT Program promote an efficient system which reduces law enforcement and ambulatory involvement in behavioral health crises?

For a list of summative evaluation questions answered in this report see Appendix A. The logic model of the CATT Program which guided summative evaluation questions is included in Appendix B.

PCG utilized an Action Research Model,[1] which required PCG to be actively engaged in the project implementation process by providing technical assistance and guidance on an ongoing basis. As evaluators, PCG attended ongoing CATT project team meetings and provide regular feedback to ensure continuous quality improvement. PCG worked with key program collaborators to identify key administrative and program data sources such as EMS and electronic health records (EHR) currently used to measure and evaluate the behavioral health crisis system and client outcomes. These data were used to develop a baseline to compare CATT Program outcomes.

The goal of the fiscal analysis was to assess the fiscal impact of the CATT Program on Alameda County, measuring the rate of success and calculating potential monies saved. PCG reviewed data sources available to inform the analysis (*e.g.,* ACBH contract payments, service cost), compiling the costs which were incurred annually. The costs were then compared to the costs which likely would have resulted had the program *not* been initiated, (*e.g.,* costs of transporting via ambulance *vs.* CATT teams, costs of delivering services to remediate the crisis outside a hospital setting *vs.* costs for emergency department visit). PCG used Medicaid claims data when available to monetize the average cost of each occurrence and multiply by the number of occurrences, comparing pre- and post-CATT crisis response costs. The methodology which was used to evaluate the fiscal impact to the county was carefully reviewed with ACBH prior to it being undertaken.

For the purposes of this final report, outcomes data is included through December 11, 2022 and fiscal data is included through December 31, 2022. For a full list of all data elements collected throughout the evaluation of the pilot see Appendix C.

[1] Patton, M. Q. (2003). *Utilization-focused evaluation*. Springer Netherlands.

CATT Program Implementation

Many changes have been made throughout the pilot period of the CATT Program to enhance services and improve outcomes. The CATT Program launched at the height of the COVID-19 pandemic in the midst of civil unrest and yet managed to persist against novel barriers to evolve into a successful mobile crisis response program. Changes related to staff hiring and retention, employee training and professional development; program policies and procedures; interprofessional collaboration; community engagement and outreach, and client outreach and follow-up are discussed in the following sections.

Staff Hiring and Retention, Employee Training and Professional Development

Several process improvements have been made to the hiring and retention of CATT field employees. Bonita House and FALCK have both updated the job descriptions for respective 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.**

CATT Program leadership created a CATT Program Field Employee Training Academy Committee, led by Bonita House. Bonita House is working with the California Association of Marriage and Family Therapist's (CAMFT), *Continuing Education Provider Approval (CEPA)* program to have training academy courses become certified for continuing education (CE) credits.

One major enhancement in onboarding training is the modality of all trainings are now in person in a college seminar style. **This gives new employees the opportunity to meet each other face-to-face and get to know each other better before starting field deployments, an approach that has ultimately led to stronger partnerships amongst CATT teams.**

Bonita House now offers stipends for CATT Clinicians to attend conferences and trainings. Clinicians have used this incentive and stated in the focus group they appreciate the opportunity to have professional development opportunities. **CATT EMTs stated they would like the opportunity to participate in additional trainings as well.** Bonita House also offers clinicians two paid professional development days and a 1,200-dollar training stipend annually.

Program Policies and Procedures and Interprofessional Collaboration

At the onset of the program, policies, procedures and workflows were established to implement and integrate the CATT Program into Alameda's crisis response system. As a component of ongoing rapid cycle evaluation, some policies and procedures did not contribute to program success and were thus adapted to determine if the changes would improve implementation and outcomes. These included:

1. Increasing CATT team response time from dispatch to arrival on scene from 15 minutes to 30 minutes;
2. Changing hiring requirements for clinicians to allow for hiring associate clinicians working towards licensing under clinical supervision; and
3. Allowing CATT EMTs to restrain clients who become a danger to themselves or others.

Additional policies were also developed throughout the pilot to improve the program. These included:

1. Requesting a specific CATT team be assigned to a call or having another responding team cancelled so a specific team can be dispatched to respond;
2. Updating CATT Clinician documentation system and reporting requirements and working with ACBH to align clinician documentation with the countywide Behavioral Health system; and,
3. Aligning CATT program training academy courses with CEPA standards for CE credits.

Community Engagement and Outreach and Client Outreach and Follow-Up

Community engagement and outreach to garner awareness are fundamental for the success of any new program. Marketing a pilot program, such as the CATT Program, and ensuring the community is aware of the availability of new services is an important component of building community awareness. The CATT Program is intended to operate throughout different cities in Alameda County, serving various communities, which all have intricacies related to the populations they serve.

CATT Program leadership has made a concerted effort throughout the pilot to conduct more outreach with CBOs, law enforcement and other first responders, and schools. They have conducted more than 30 briefings with law enforcement departments, including the County Sheriff's Office, and Bay Area Rapid Transit Authorities. They have also delivered presentations for Amber House and Eden Community Support Center. In addition, they facilitated meet-and-greets with CATT teams and ACBH Countywide MCT and MET teams. Finally, they are facilitating the field employee trainings for both Alameda City Community Assessment Response & Engagement (CARE) and Hayward Evaluation and Response Team (HEART) teams.

CATT Program Sustainability

There has been overwhelming support for the CATT Program across the County by program collaborators including ACBH, EMS, FALCK, Bonita House, law enforcement and the countywide behavioral health board of directors. Of those surveyed, all respondents agreed or strongly agreed they support the continuation of the CATT Program past the pilot period. All members of the CATT Program leadership team and field employees agree the CATT Program should continue past the pilot period, ending in June 2023. Moreover, they stated **the CATT Program is a vital countywide behavioral health service that is necessary for the ongoing care and support of the community and behavioral health system.**

In addition, they would like to see a CATT team operating in every city throughout the county to assist law enforcement and other first responders currently overburdened by large numbers of behavioral health calls. Multiple factors which position the CATT Program to be a premier behavioral health mobile crisis response model include providing medical and mental health assessments; serving youth and adolescents; transporting clients to alternative disposition sites; and ensuring scene safety while building positive partnerships with law enforcement.

CATT Program Outcomes

CATT Program outcomes focused on the effects the CATT Program has had on clients served and within the context of the greater behavioral health system in Alameda County. PCG collected data elements from a multitude of sources. These were analyzed and triangulated to assess CATT Program short-term and intermediate outcomes for the pilot implementation. Baseline data from 2018 through 2020 were included and changes in acute crisis responses were calculated.

Client Demographics

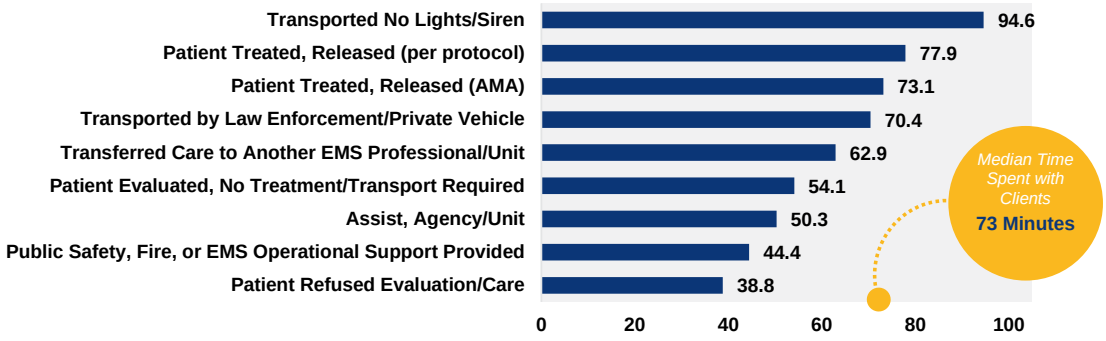
35	50%	34%	66%	29%
•Median age of clients •15.2% are aged 10 to 17 •7.6% are aged 66 or older	•Percent of clients who were male	•Percent of clients who were Black or African American •32% are of clients were White	•Percent of clients not in the labor force or unemployed	•Percent of clients who indicated they were homeless or housing insecure

Program Response and Transport Dispositions

The CATT Program received a total of 2,942 calls for service from July 21, 2020 through December 11, 2022, and responded to 2,564 (90.2%). On average, CATT teams responded to 89 calls per month, or three calls a day. Nearly three-quarters (71.9%) of all calls CATT teams respond to are in just three cities: Oakland (24.4%%), San Leandro (24%%) and Hayward (23.5%%). Individuals experiencing a behavioral health crisis are often in need of an expedited response and care to ensure their crisis does not escalate; CATT teams have a median response time of 20 minutes.

A major objective of the CATT Program is to reduce usage of traditional ambulatory responses since many behavioral health or psychotic episodes do not require such a high level of response. The time spent on scene with clients includes assessing the level of behavioral health care they need, along with linking individuals to behavioral health services, discussing additional needs the client has (such as housing/shelter, food, clothing and other basic needs), working to connect clients with family members or loved ones, and developing safety plans to avoid future crises. The median amount of time CATT teams spent with clients is 73 minutes (Figure 3).

Figure 3. Median Time Spent With Clients by Response Disposition



Service Outcomes

The primary goals of the CATT Program are to provide effective and appropriate behavioral health crisis response services for individuals in Alameda County and connect individuals to needed services. In addition, the CATT Program is intended to assist in freeing up ambulance and police transport and the time law enforcement, EMS and fire departments spend responding to behavioral health calls.

CATT teams received 2,564 calls and responded to 2,200 calls (85.8%) which were not cancelled throughout the pilot of the program. Close to one-third of non-cancelled calls resulted in treatment without transportation. Nearly one-half also resulted in a client transport with no lights/sirens by a CATT team (Table 2). Of CATT clients who were transported with no lights/sirens, more than two-thirds (68.7%) were transported to a hospital or medical center or John George PES. Nearly one-fifth were transported to a community-based organization (CBO) (Table 3). Over three-quarters (80.4%) of all clients transported to a CBO were transported to Amber House.

Table 2. CATT Client Outcome Dispositions

Disposition	Count	%
Patient Evaluated – No Transport Required	707	32.1%
Patient Treated – Transferred Care to EMS	325	14.8%
Patient Refused Evaluation	102	4.6%
Patient Treated, Released (Per Protocol)	69	3.1%
Patient Treated, Released (AMA)	27	1.2%
Patient Treated – Transported by Private Vehicle or Law Enforcement	26	1.2%
Assist – Agency/Unit	7	0.3%
Standby for Public Safety	3	0.1%
Patient Dead on Scene	1	0.0%
Transported No Lights/Sirens	**933**	**42.4%**
TOTAL	**2200**	**100.0%**

Table 3. CATT Client Transport Dispositions

Transport Outcome	Count	%
Hospital/Medical Center	494	52.9%
John George PES	147	15.8%
CBO	162	17.4%
Residence	35	3.8%
Shelter/Independent Living/Transitional Housing	23	2.5%
Other	21	2.3%
Business	17	1.8%
Willow Rock	14	1.5%
Transportation Center/BART	13	1.4%
Hotel/Motel	4	0.4%
Veteran Services	3	0.3%
TOTAL	**933**	**100.0%**

CATT teams respond to an average of 89 calls per month; approximately 30 of these calls per month result in a hospital transportation (33.1%). However, these hospital episodes would likely occur whether a CATT team or a traditional EMS Unit responded because nearly three-quarters (74.2%) of all CATT client hospital transports were medically necessary. Nearly one-quarter (22.4) of all hospital transports were to John George PES and nearly one-fifth (17.8) were to a Kaiser Facility.

About **60** CATT calls a month avoid what would likely be a 5150 involuntary hold and hospital transportation. **These avoid traditional responses of sending the client to the hospital.**

CATT Client Recidivism

CATT Program recidivism is defined as the number of individuals who utilize a CATT team or another behavioral health entity to provide services to them again. Nearly all (84.8%) of all CATT clients were only served once and only five percent were served three or more times by a CATT team. CATT client subsequent acute, sub-acute, and other crisis stabilization recidivation episodes have been significantly reduced throughout the pilot of the program. Post CATT services 7-day behavioral health crisis recidivism has reduced 45.2 percent and 30-day crisis recidivism has reduced 48.3 percent.

CATT clinicians develops safety plans with individuals who are experiencing a behavioral health crisis and links them to ongoing services to prevent future crisis events. Nearly all CATT clients served did not have another **crisis episode** occur within seven days (99.1%) or 30 days (98.7%) after receiving CATT services. 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; and nearly two-thirds (65.7%) did not have a mental health episode within 30 days of receiving services.

CATT clients were half as likely to have a subsequent crisis event following CATT Program services compared to clients served by John George PES within seven days (41.7%) and 30 days (47.3%). Only one percent of CATT clients had two or more CATT recidivation episodes within 30 days compared to 13 percent who had two or more subsequent crisis stabilization recidivation episodes from John George PES within 30 days. Only three percent of CATT clients receive CATT services again within 30 days of their initial CATT Program service provision.

Providing compassionate care to consumers and families in moments of crisis and supporting clients, sometimes advocating for them, during transfer to facilities has been one of the greatest successes of the CATT Program. While implementation of the pilot has not been without its challenges, many of those cited exist as part of the greater behavioral health crisis system and are not limited to the CATT Program.

Support of the program has been overwhelmingly positive from both community stakeholders and clients. Moreover, the data shows the CATT Program has been successful in achieving the goals set out for the program pilot, including: providing effective and appropriate behavioral health crisis response services for individuals in Alameda County; connecting individuals to needed ongoing supports and services to mitigate future behavioral health crises; reducing the number of individuals being placed on an unnecessary involuntary hold; creating a more efficient behavioral health crisis response system; and freeing up the resources and time law enforcement, EMS and fire departments spend responding to behavioral health calls.

Fiscal Analysis

The CATT Program pilot was approved for implementation and funding in 2017 under the Alameda County Behavioral Health Care Services (BHCS) Mental Health Services Act (MHSA) Three-Year Program and Expenditure Innovation Plan for FY2018–2020 (INN Plan). The CATT Program INN Plan was implemented in partnership with Alameda County Emergency Medical Services (EMS), who had already secured Measure A funds through a competitive process to support the start-up of the project. **Measure A was approved by voters in 2004 to support an array of services for low-income residents of Alameda County.** A total of $15,478,640.65 was allocated to fund the pilot from FY2018–2019 (9 months) through FY2022–2023 (*27 months total)* (Table 4). The CATT Program also received additional funding through MediCal reimbursements for behavioral health services.

Table 4. CATT Program Expenditures by Funding Source

Funding Source	Cost Allocation
Innovative MHSA Funding	$9,878,082.00
Federal Funding	$3,450,000.00
Measure A Funding	$2,150,558.65
TOTAL	**$15,478,640.65**

About two-thirds of all costs incurred to fund the CATT Program are allocated to staffing CATT teams. Additional ongoing programmatic costs include salaries for the CATT management team, vehicle maintenance, administrative fees, and operational costs (*e.g.,* service equipment, communications, training).

One-tenth of CATT Program expenditures was allocated to administrative planning in FY2018–2019. The CATT Program began providing services in July 2020 after 15 months of planning. Start-up costs included vehicle procurement, service equipment, insurance, uniforms and administrative overheard.

PCG received fiscal data spanning from January 2020 through December 2022 to assess the cost of operating the CATT Program. Total costs incurred through the 2.5-year span were $10,883,110.20 (Table 5). Start-up and administrative costs for FALCK and EMS are combined because EMS oversees all FALCK funding for the CATT Program. This figure includes the nonrecurring cost of $858,325.00 for the procurement and refurbishment of 15 vehicles. The projected cost of the pilot through June 2023 is $13,059,732.24, with an annual ongoing operational cost (excluding start-up costs) of $4,353,244.08.

Table 5. CATT Program Pilot Costs (January 2020–December 2022)

	Start-Up Costs	Administrative Costs	Operational Costs	Staffing Costs	Total Costs
Bonita House	$384,686.00	$693,459.29	$689,424.15	$3,141,142.65	**$4,908,712.09**
FALCK	$1,325,422.57	$300,000.00	$276,296.67	$3,722,003.04	**$5,623,722.28**
EMS			$23,175.83	$327,500.00	**$350,675.83**
TOTAL	**$1,710,108.57**	**$993,459.29**	**$988,896.65**	**$7,190,645.69**	**$10,883,110.20**

Fiscal Efficiency

PCG assessed whether the CATT Program was a more fiscally efficient model to respond to behavioral health crises in comparison to traditional law enforcement (LE) and EMS response. The total average monthly cost to operate the CATT Program—not including insurance reimbursements—has been $272,433.39. On average, there are 716 EMS 5150 transports and 2,170 behavioral health calls on a monthly basis in Alameda County. This totals $337,806.80 every month for LE and EMS response to behavioral health crises (Table 6).

Table 6. Average Monthly EMS and Law Enforcement Costs for Behavioral Health Responses and 5150 Transports

Type of Response	Hourly Rate	Average Number of BH/5150 Transport Annual Calls	Projected Total Monthly Cost
EMS	$48.00	716	$103,104.00
Law Enforcement	$36.06	2170	$234,702.80
		TOTAL	**$337,806.80**

The CATT Program has responded to 2,207 behavioral health crises between July 2020 and December 2022. Not including start-up costs, the monthly average cost for the CATT Program by call volume is $305,766.72. Comparatively, **the CATT Program costs 32k fewer dollars monthly than traditional LE responses to behavioral health crises and EMS 5150 transports as a measure of time spent on each call.**

Cost Reimbursements

Approximately eight percent of CATT Program services have been reimbursed by MediCal/ Medicaid billing ($588,652.96/per yr.). CATT Program services are only reimbursable through MediCal/Medicaid. However, fewer than two-thirds (63.6%) of CATT Program clients have or are eligible for MediCal/Medicaid. A third of all CATT clients have private insurance which the CATT Program cannot bill services to; Nearly a quarter (22.5%) of CATT clients have Kaiser Insurance. If the CATT Program was approved to bill private insurance for services an additional $140,508.00 could be generated annually. **This would account for a projected 15 percent of revenue in insurance reimbursements to fund the CATT Program post-pilot.**

Financial Sustainability

PCG projects that post-pilot the CATT Program will cost an estimated $7,087,129.46 annually. Additional costs include fully staffing all 12 CATT teams and a 15 percent increase in administrative and operational costs. PCG also projects once the CATT Program is fully staffed call volume will increase by 50 percent for a total estimated 3,120 calls per year.

Since the beginning of the CATT Program pilot there has been average annual reduction of 2,237 behavioral health calls responded by law enforcement and 750 EMS 5150 transports since baseline. This has accounted for a total estimated annual cost reduction of $4,053,659.55 for behavioral health responses countywide. **The CATT Program has accounted for approximately 10 percent of reductions in behavioral health calls responded to by law enforcement and EMS.**

PCG projects 30.6 percent of CATT Program costs will be reimbursable through insurance claims and law enforcement and EMS costs savings for reductions in behavioral health calls. **The projected annual county costs to operate the CATT Program post pilot are estimated to be $4,916,999.83** (Table 7).

Table 7. Projected Annual Costs and Reimbursements to Operate the CATT Program Post-Pilot

Projected Annual Cost of CATT Program	Projected Annual Insurance Reimbursements	Average Annual EMS Savings	Average Annual Law Enforcement Savings	Projected Annual Reimbursable Costs	Projected Annual County Costs
$7,087,129.46	$782,908.43	$449,280.00	$337,500.00	**$2,170,129.63**	**$4,916,999.83**

Client Journey Mapping

PCG has worked with CATT Program leadership throughout the evaluation of the pilot to gain a better understanding about CATT client experiences and satisfaction with the program and services. **Nearly all CATT clients who were surveyed throughout the pilot stated they felt respected by the CATT team even though they were experiencing some mental health challenges (87%). Most clients indicated the CATT team met their needs (85.7%) and would use CATT Program services again (78.3%).** When an individual is experiencing a behavioral health crisis, the more quickly services can be provided the greater the likelihood of avoiding an involuntary hold.

PCG conducted a client journey mapping exercise in focus groups with individuals who have received CATT Program services. Understanding the client experience is essential to understanding how an organization and system can better respond to customer needs. Too often, initiatives aimed at improving service are based on conjecture.

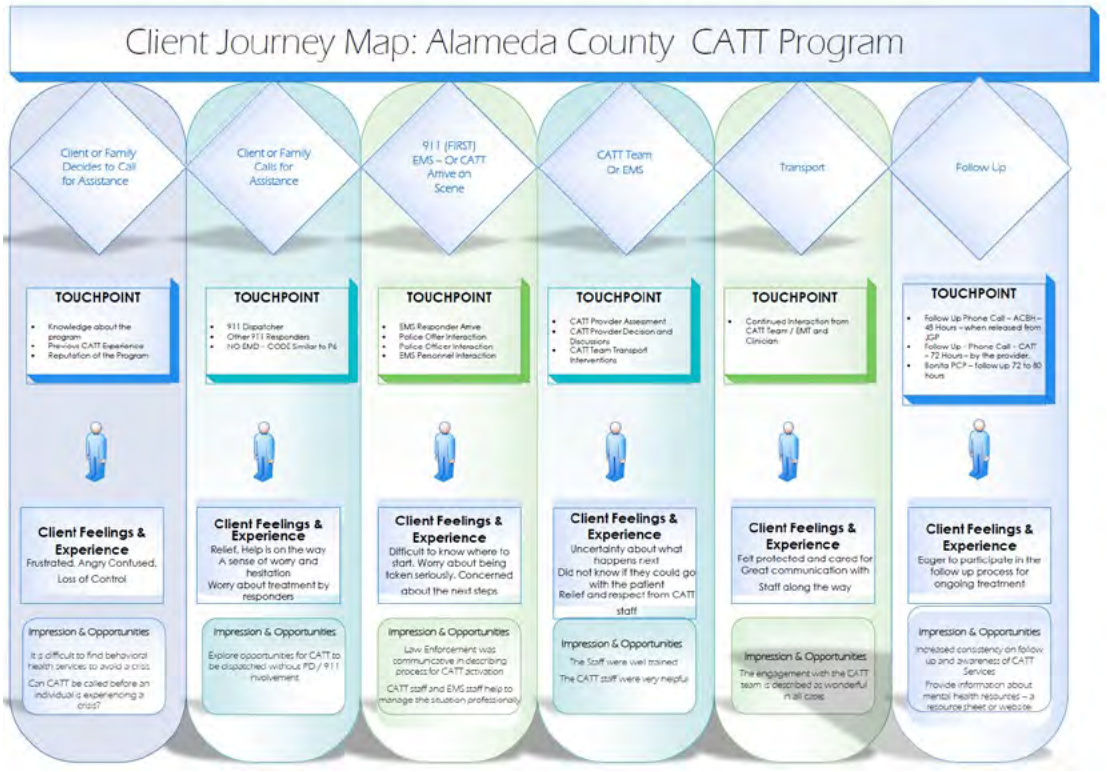
Client journey mapping captures key touchpoints and considers both explicit customer concerns – what are they saying and doing? – and implicit ones – what are they thinking and feeling? – throughout the experience. Seeing the system and its processes from CATT clients perspective provided a strong framework for identifying improvement opportunities. Understanding the end-to-end experience of CATT clients helped identify pain points and key areas for improvement of the program.

Major themes uncovered in the focus groups conducted included:

1. CATT clients had overwhelmingly positive experiences working with the CATT teams and would utilize CATT services again if needed;
2. Many CATT clients have a history utilizing different behavioral health crisis response services provided in Alameda County and prefer the CATT Program;
3. **Most members of the community are not aware the CATT Program exists and would like more information on the types of services CATT teams can provide and how to utilize them;**
4. Many CATT clients felt uncomfortable in the presence of law enforcement officers and expressed they would prefer CATT be dispatched directly;
5. CATT clients stated the CATT team treated them with respect, understood their situation, and helped resolve their behavioral health concerns; and
6. **CATT clients stated the CATT program is lacking a follow-up care component and clinicians did not follow-up with them after services were provided.**

A full description of the client experience can be found in the Journey Map below.

Figure 4. Client Journey Map



Lessons Learned

Launching a pilot program that requires a collaborative and unified implementation among many stakeholder groups and tests a new staffing model is a challenge in and of itself, let alone amidst a global pandemic and social justice unrest. The CATT Program has set out to accomplish several lofty goals to not only improve outcomes for the clients it serves, but also to increase the effectiveness and efficiency of the crisis response system. The evaluation findings below, highlight successes, challenges that have been overcome and those which remain, as well as lessons learned.

Lessons Learned

- Bonita House is working with the California Association of Marriage and Family Therapist's (CAMFT), Continuing Education Provider Approval (CEPA) Program to have training academy courses become certified for continuing education (CE) credits.
- The entire CATT Program leadership team and field employees agree the CATT Program should continue past the pilot period, ending in June 2023. Moreover, they stated the CATT Program is a vital countywide behavioral health service that is necessary for the ongoing care and support of the community and behavioral health system.
- 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.
- 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.
- The monthly average cost for the CATT Program by call volume is $305,766.72. Comparatively, the CATT Program costs 32k less than traditional LE responses to behavioral health crises and EMS 5150 transports as a measure of time spent on each call.
- PCG projects 30.6 percent of CATT Program costs will be reimbursable through insurance claims and law enforcement and EMS costs savings for reductions in behavioral health calls. The projected annual county costs to operate the CATT Program post pilot are estimated to be $4,916,999.83
- Nearly all CATT clients who were surveyed throughout the pilot stated they felt respected by the CATT team even though they were experiencing some mental health challenges. Most clients indicated the CATT team met their needs and would use CATT Program services again.
- Most members of the community are not aware the CATT Program exists and would like more information on the types of services CATT teams can provide and how to utilize them. In addition, CATT clients stated the CATT program is lacking a follow-up care component and clinicians did not follow-up with them after services were provided.

Recommendations

The following summative recommendations are offered to implementors to support the continuation and sustainability of the CATT Program post pilot, ending in June 2023.

Develop a Formal Client Outreach and Follow-Up Plan

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. Suggestions to improve prevention efforts included doing wellness check-ins with high utilizers; providing care packages including clothes, perishable food items, first aid kits and toiletries; and doing needle exchanges at homeless encampments. 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

Modify CATT Program Policy to Allow Billing Private Insurance for Service Reimbursement

Currently, the CATT Program can only bill Medicaid/Medical eligible clients for program services. However, fewer than two-thirds (63.6%) of CATT Program clients have or are eligible for MediCal/Medicaid. A third of all CATT clients have private insurance which the CATT Program cannot bill services to; Nearly a quarter (22.5%) of CATT clients have Kaiser Insurance. If the CATT Program was approved to bill private insurance for services an additional $140,508.00 could be generated annually. This would account for a projected 15 percent of revenue in insurance reimbursements to fund the CATT Program post-pilot.

Timeline	Within the next 6 months

Assess the Feasibility of Modifying the Policies and Procedures for Dispatching CATT teams

Many collaborators suggested the CATT Program offer a direct line for dispatching calls for specific types of calls, like behavioral health crises at schools or nursing homes. Additionally, to reduce the amount of time between onset of a crisis and a CATT team deployment, some suggested training ACRECC dispatchers to recognize behavioral health calls, allowing them to dispatch CATT teams at the same time law enforcement is dispatched.

Multiple collaborators also stated the CATT Program should expand their availability to operate 24/7 and suggested the program have one CATT team operating overnight shifts. In addition, some proposed expanding response time requirements to 45 minutes to increase the location radius CATT teams can respond to. Finally, some advanced the idea of creating CATT team deployment hubs in every city throughout Alameda County. At the end of the pilot period of the CATT Program these suggestions should be taken into consideration when assessing the expansion and sustainability of the program.

Timeline	Within the next year

Appendix A. Summative Evaluation Questions

A critical component when implementing a change to an existing system is to understand how the current system is structured and operating along with strengths and opportunities for improvement. PCG assessed both the intended and actual outcomes produced as a result of the collaborative model and CATT program. Summative evaluation questions PCG sought to answer were:

1. How many clients were served by the program?
    a. What were the demographic characteristics of clients served by the program?
2. Was there a reduction in 5150 designations and transports?
    a. How many 5150 transports to the ED for medical clearance were avoided?
    b. How many clients were diverted to appropriate services?
3. Was time spent on psychiatric crisis by ambulance and law enforcement decreased due to CATT services?
4. Is CATT a more efficient option for the outlined services than previous methods of ambulance and law enforcement transport?
5. Have clients seen an improvement in outcomes?

Fiscal Analysis Questions

1. Is the CATT Program a more efficient option for the outlined services than previous methods of ambulance and law enforcement transport?
2. Did the CATT program reduce costs incurred by EMS and law enforcement to respond to behavioral health calls and administer 5150 involuntary holds?

Appendix B. CATT Program Logic Model

To illustrate conceptual linkages between the training and the CATT program and measurable outcomes, HCSA created the following logic model which encompasses inputs, outputs, and outcomes at three levels—short-term, intermediate-term and long-term. This model describes how the CATT program proposes to impact the crisis response system using specific, measurable interventions and outputs. Short-term measures outcomes in the first year, intermediate measures second year and long-term measures third year and beyond.

Inputs	Outputs		Outcomes – Impact		
	Activities	Participation	Short	Intermediate	Long
Collaboration (INN) Personnel Time: • Program Specialist • Clinical Supervisor • Behavioral health clinician/EMT teams (INN) Technology: shared records, ReddiNet (INN) Modified vans, technology hardware Training Evaluator with Peer/Family	Monthly meetings Mental & physical assessments, de-escalation, pre-transport services Transport clients to range of services (5150 holds/non-5150) Training in CATT approach and technology Evaluation: CQI, process, numbers served, outcome, client satisfaction	BHCS, EMS, Whole Person Care, 911 dispatch, law enforcement, others CATT (BH clinician and EMT; with law enforcement) CATT (BH clinician and EMT; with receiving entities) CATT staff, collaborative partner staff Evaluator, Peer/Family, Collaborative partners	Collaborative partners design and implement policies and practices that improve crisis response (protocols, up to date records, ReddiNet expanded, etc.) Collaborative quickly identifies and addresses areas for improvement Clients served by CATT are connected to wide range of services at time of need (5150 and non-5150)	Clients transported to most appropriate service (5150, non-5150) due to: • Up-to-date client and service availability records • expanded assessment and pre-transport services Clients engage in planned services *Goal – 900* Clients satisfied with services, including reduced perceptions of stigma *Goal – 60%*	CATT service is more efficient than other options *Goal – 25%* Reduction in 5150 transports to ED for medical clearance *Goal – 25%* Reduction in 5150s *Goal – 30% of those served by CATT* Reduced time spent on psychiatric crises: • Law enforcement *Goal – 30%* • Ambulances *Goal – 50%*
Assumptions: BH clinician and EMT team, supported by technology, will increase transport to most appropriate and non-emergency services. Transport at time of need to non-emergency services will increase engagement in planned services. Engagement in planned services will reduce use of emergency services.					
External Factors: Level of law enforcement partnering with CATT regarding assessments and transport.					

Appendix C. List of Data Elements Collected

Table 8. Qualitative Data Elements Collected

Data Source	Description
Interviews	Interviews were conducted with CATT Program leadership. Protocols were developed to dig deeper into survey results regarding IPC, updates to policies and procedures, effectiveness of CATT Program services, and suggestions for improvements to the CATT Program. The interviews were used to better understand how CATT is moving from a well-thought-out plan to operationalization in the field.
Field Employee Focus Groups	Focus groups were conducted with CATT Program Field Employees. Focus group protocols were developed to gather information regarding the functionality, strengths and challenges of the program model, IPC among EMTs and clinicians, community outreach, training and effectiveness of CATT Program services, and suggestions for improvements to the CATT Program.
Client and Family Surveys	Consumer surveys with clients and family members of clients who received CATT Program services was conducted via phone. The surveys with individuals interfacing directly with the crisis system (clients) were used to gain insight into their individual needs and any deficiencies they believe to exist in the mental health crisis response system and ongoing care. Family members of clients also participated so PCG could gain their perspective of the system and how it is meeting their needs.
CATT Program Collaborator and Key Stakeholder Survey	Survey protocols were developed to gather information regarding individuals' roles in the implementation, functionality and strengths, challenges, IPC (using key components of established tools), community outreach and engagement, and success of the CATT Program
CATT Program Field Employee Survey	
Key Collaborator Meetings	PCG participates in several stakeholder engagement meetings. CATT Program Collaborators have multiple standing meetings in place to ensure the CATT Program is implemented successfully.

Table 9. Quantitative Data Elements Collected

Data Source	Description
Bonita House CATT Program Data*	Field Clinician Reporting of Clients Served by CATT Program from 7/21/2020–12/11/2022.
FALCK CATT Calls Data*	EMS ESO Dispatch Calls for CATT Program from 7/21/2020–12/11/2022.
Bonita House CATT Program Financial Data*	Administrative Costs, Operational Costs, and Staffing Costs incurred by Bonita House throughout the pilot.
FALCK CATT Program Financial Data*	Administrative Costs, Operational Costs, and Staffing Costs incurred by FALCK throughout the pilot.
ACBH Cost-Reimbursement Data*	Cost Reimbursements of CATT Program Services provided by Bonita House CATT clinicians
EMS CATT Program Financial Data*	Operating budget of the CATT program overseen by EMS and CATT Program director
ACBH Countywide MCT & MET Data	Call Disposition and Demographic Information of Behavioral Health Calls Responded to by MCT and MET Programs Overseen by ACBH for FY20/21 and FY21/22.
ACBH Post-Crisis Follow-up Data	ACBH post-crisis follow-up data of CATT clients served from July 21, 2020 through July 20, 2022.
ACBH Acute/Sub-Acute Behavioral Health Crisis/Involuntary Hold Data	ACBH acute and sub-acute behavioral health and involuntary hold data of CATT clients served from July 21, 2020 through July 20, 2022.
Countywide Quarterly Involuntary Hold Data	Countywide Quarterly Reports on All Involuntary Detentions in Alameda County from July 2019 through June 2022.
EMS 5150 Data	Involuntary hold data for EMS in Alameda County from 2018 through June 2022.
Hayward PD CAD Data	Hayward Police Department Behavioral Health Law Enforcement Responses from July 21, 2020–July 20, 2022.
San Leandro PD CAD Data	San Leandro Police Department Behavioral Health Law Enforcement Responses from July 21, 2020–July 20, 2022.
Fremont PD MET Data	Fremont Police Department Behavioral Health Law Enforcement and MET Responses from July 21, 2020–July 20, 2022.

* Data were collected for Final Report

Alameda County Community Assessment Transport Team (CATT) Metric... Jan 10, 2024 1:20:43 PM EMS

Filter statement

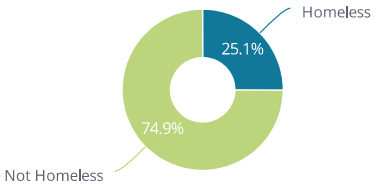
Filters **Years in Dispatched** 2023 | **Is Locked** true | **Is Active** true

Alameda County Community Assessment Transport Team (CATT)

2023 Response Metrics

Responses	On Scene	Transports	5150s
Total Responses 1,802	Total Responses Arriving on Scene 1,439	Total Transports 630	% of CATT Transports that are 5150s 9.0%

CATT Incidents Resident Status %



CATT Incidents Resident Status Counts

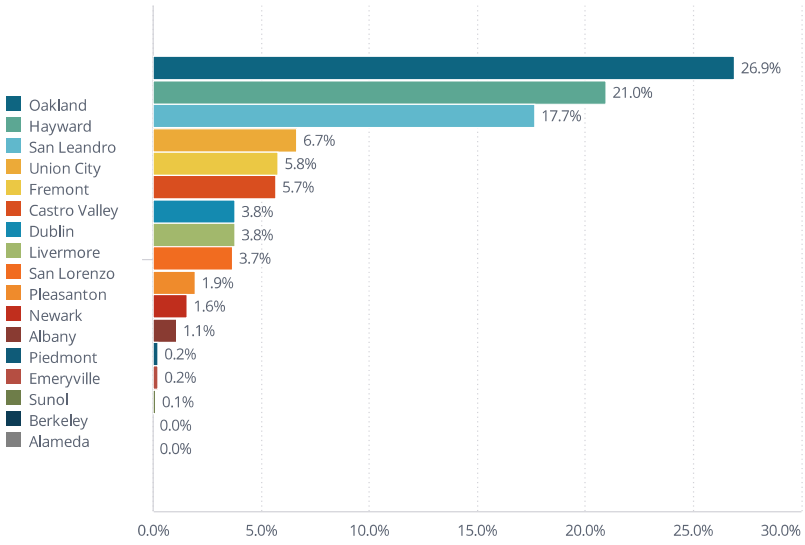
Patient Resident Status	Count of Incidents
Homeless	333
Not Homeless	994

Alameda County Community Assessment Transport Team (CATT) Metric... Jan 10, 2024 1:20:43 PM EMS

Filter statement

Filters **Years in Dispatched** 2023 | **Is Locked** true | **Is Active** true

% of CATT Responses by City



#of CATT Responses by City

Scene City	# of CATT Responses
	2023
Albany	19
Castro Valley	102
Dublin	68
Emeryville	4
Fremont	104
Hayward	378
Livermore	68
Newark	28
Oakland	485
Piedmont	4
Pleasanton	35
San Leandro	319
San Lorenzo	66
Sunol	2
Union City	120
Grand Total	1,802

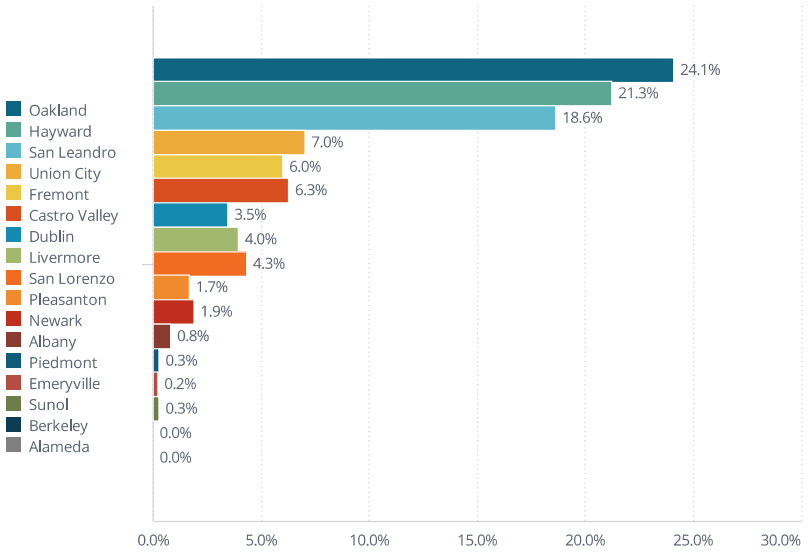
Alameda County Community Assessment Transport Team (CATT) Metric...

Jan 10, 2024 1:20:43 PM EMS

Filter statement

Filters **Years in Dispatched** 2023 | **Is Locked** true | **Is Active** true

% of CATT Responses Arriving On Scene (City)



#of CATT Responses Arriving On Scene (City)

Scene City	# of CATT On Scene
	2023
Albany	12
Castro Valley	90
Dublin	50
Emeryville	3
Fremont	86
Hayward	306
Livermore	57
Newark	27
Oakland	347
Piedmont	4
Pleasanton	24
San Leandro	268
San Lorenzo	62
Sunol	2
Union City	101
Grand Total	1,439

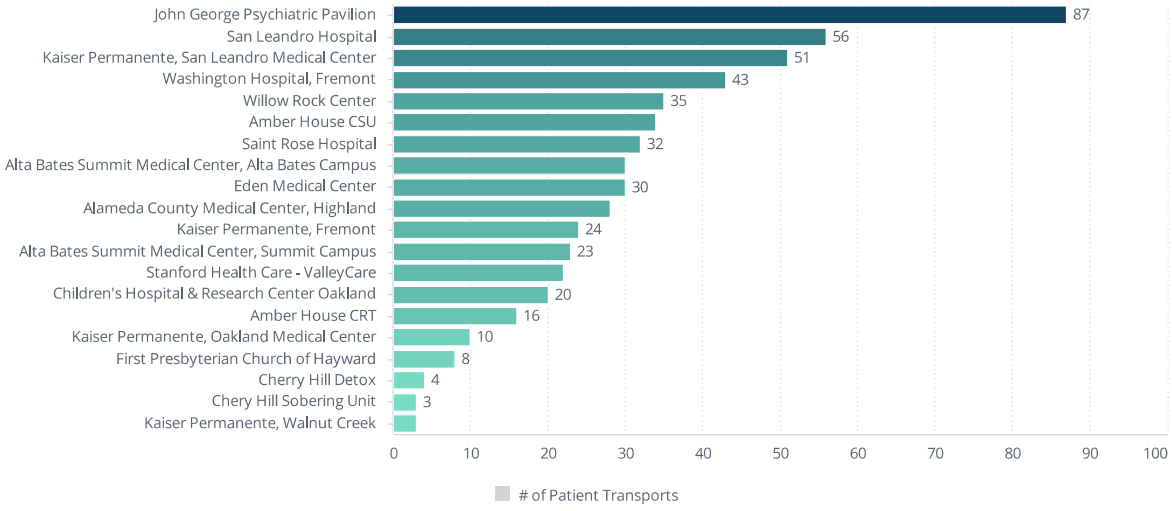
Alameda County Community Assessment Transport Team (CATT) Metric...

Jan 10, 2024 1:20:43 PM EMS

Filter statement

Filters **Years in Dispatched** 2023 | **Is Locked** true | **Is Active** true

Top 20 Destinations



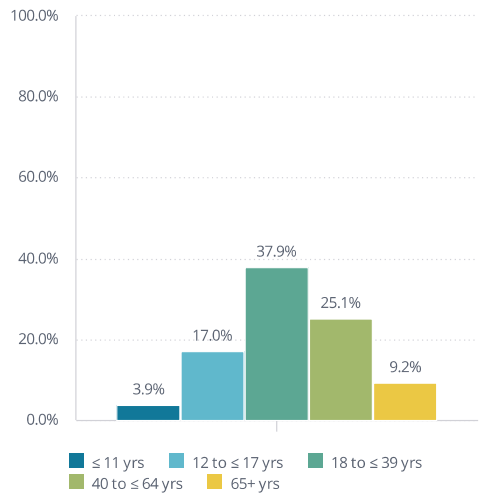
Alameda County Community Assessment Transport Team (CATT) Metric...

Jan 10, 2024 1:20:43 PM EMS

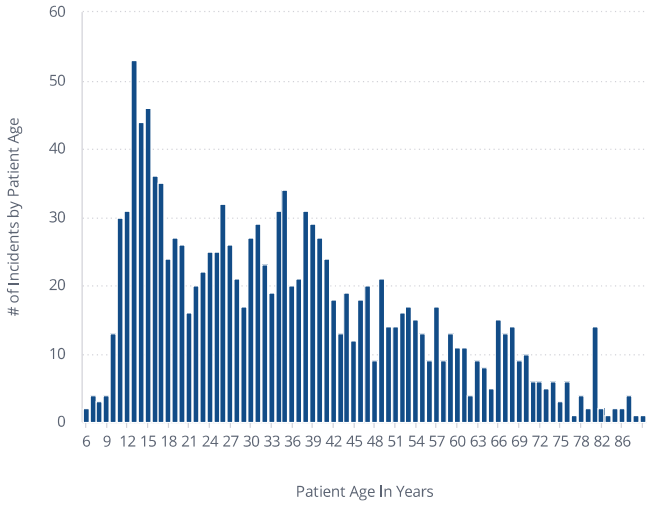
Filter statement

Filters **Years in Dispatched** 2023 | **Is Locked** true | **Is Active** true

Age Brackets for CATT Incidents



Age Range for CATT Inicdents



Alameda County Community Assessment Transport Team (CATT) Metric...

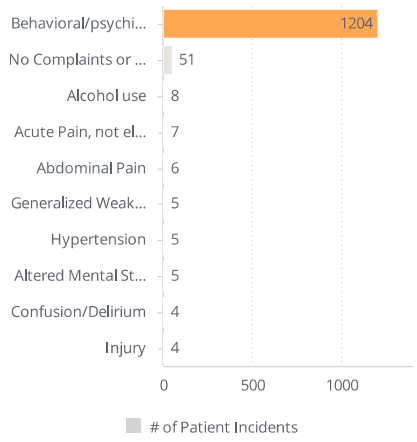
Jan 10, 2024 1:20:43 PM EMS

Filter statement

Filters **Years in Dispatched** 2023 | **Is Locked** true | **Is Active** true

90th Percentile Times (min)

Top 10 Primary Impressions



Alameda County Community Assessment Transport Team (CATT) Metric... Jan 10, 2024 1:20:43 PM EMS

Filter statement

Filters **Years in Dispatched** 2023 | **Is Locked** true | **Is Active** true

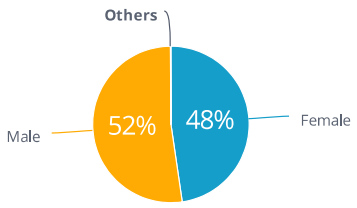
Race Documention - CATT OS

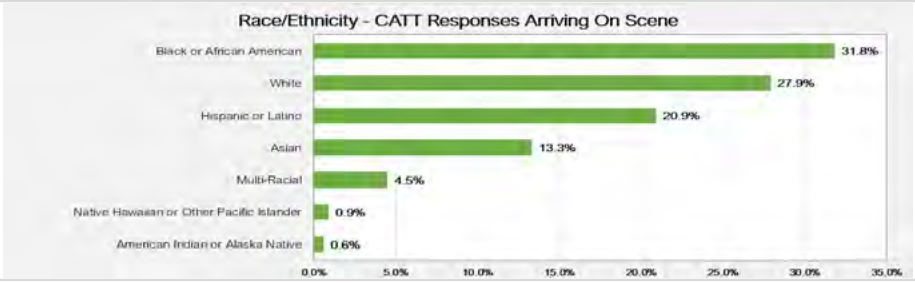
Race Documented for CATT On Scene
92.5%

Race Documention - CATTTrp

Race Documented for CATT Transp...
100.0%

CATT Incidents by Gender





Alameda County Community Assessment Transport Team (CATT) Metric... Jan 10, 2024 1:20:43 PM EMS

Filter statement

Filters **Years in Dispatched** 2023 | **Is Locked** true | **Is Active** true

Pediatric CATT Metrics

2023 Destination for 5150's

5150 Destination ≤ 11 yrs

Age ≤ 11 yrs 5150 Patients Transported to CHO: **33.3%**

Destination Table

Destination Location Name	# of Transports
Children's Hospital & Research Center Oakland	1
Kaiser Permanente, Fremont	1
Kaiser Permanente, San Leandro Medical Center	1

5150 Destination 12-17 yrs

Age 12-17 yrs 5150 Patients Transported to Willow Rock: **0.0%**

Destination Table

Destination Location Name	Formula
Alameda County Medical Center, Highland	3
Alta Bates Summit Medical Center, Alta Bates Campus	1
Alta Bates Summit Medical Center, Summit Campus	2
Children's Hospital & Research Center Oakland	1
Kaiser Permanente, Fremont	1
Kaiser Permanente, San Leandro Medical Center	2
Saint Rose Hospital	2
Stanford Health Care - ValleyCare	1
Washington Hospital, Fremont	3

Behavioral Health Responses Definition:
"Primary Impression = Mental Disorder or Behavioral/Psychiatric Episode," **OR** "Patient is on a 5150 Hold"

All Behavioral Health Related Incidents

# of Behavioral Health Incidents
16,332

8/8

Children's Mental Health Outreach via School-Home Communications Provider

Introduction

Alameda County Behavioral Health (ACBH) is seeking interest of collaboration with a school-home communications provider to be the medium that sends push notifications to help parents become more educated with their child's mental health development, milestones, possible warning signs for learning disabilities, autism, or other mental health challenges. These push notifications would be to educate parents about a child's mental health according to the child's age during the child's school years from elementary to high school. This type of passive campaign would bring information to parents who may not actively seek it out due to stigma, lack of resources, or most likely, do not know the signs of developing problems in their child's mental health[1].

This pilot project is a one of kind opportunity with funding, if approved, from Mental Health Services Act (MHSA) in the form of an innovation project[2]. The MHSA Innovation component helps create and oversee pilot projects that apply never before used methods of outreach, prevention, intervention, and education to mental health services and information. These types of pilot projects, if successful, will hopefully be adapted by the county where it's being tested.

Why the Need

The median age of onset for phobias/separation anxiety, autism disorders, ADHD, and social anxiety disorder is 8-13 years old. Most parents do not know this or as mentioned, know the signs. It's important to know that the onset of many mental disorders occur before age 14. This importance has increased due to the effects of the pandemic on children and teens' mental health. The lack of access to these support systems and mental health services during the recent pandemic-related closures has led to decreased mental health screenings, diminished ability to identify learning disabilities, and less child-protective and mental health referrals[3].

Although children's mental health tops the list of parents' worries[4], there is no focused passive outreach of mental health information for parents that is available over the span of a school age child to teenager. As mental health issues among children and adolescents have skyrocketed in recent years, parents feel helpless because they don't feel equipped to offer support in this area[5]. Alameda County's vision is to bring more age applicable information to parents because timing and resource allocation allows early intervention and preventive approaches just like when public health "campaigns" bring awareness to the general public of

[1] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3387881/
[2] https://mhsoac.ca.gov/the-act-mhsa/.
[3] https://jamanetwork.com/journals/jamapediatrics/article-abstract/2788069
[4] https://www.cnn.com/2023/01/31/health/mental-health-parenting-survey/index.html
[5] Ibid.

overall larger public health issues such as diabetes, cancer, and heart attack or stroke symptoms to the public's attention.

There are active avenues regarding children's physical health such as pediatricians and health centers with thrive charts and growth milestones; parents using internet for information; or asking other parents for guidance, to name a few. Most mental health for children and teens is accomplished by searching for answers after an incident or more likely, several incidents at school have occurred. Parents and caregivers often rely on input from schools, day cares, and other caregivers to help them be aware of potentially problematic shifts and changes in their child's behavior[6]. These reports beg many questions such as:

- Is the child acting out due to stressors at home such as a divorce; new baby or is it indicative of something more serious that if addressed quickly, will resolve with treatment?
- Not paying attention at school because their diet is poor or are they ADHD?
- Withdrawal or avoiding social interactions
- Outbursts or extreme irritability

These examples are very general because there are many reasons why a child may be behaving in a manner that causes an adult to take notice. However, many parents do not recognize signs of a larger mental health issue because they simply don't know. Therefore, it is likely that a parent may not even bring up concerns to their child's pediatrician.

The Plan

ACBH is seeking to provide passive mental health informational outreach to parents via a school-home communications provider. ACBH will collaborate with a school-home communications provider; other bay area counties and Alameda County's school district elementary, middle, and high schools currently participating with the same school-home communications provider; children's behavioral health experts, peers, and other consultants to ensure accuracy and health equity. Most school district websites currently contain web pages dedicated to mental health for children and youth. However, a parent must seek it out, whereas here, the information will be provided directly to the parent using the school's designated school-home communications app.

The school-home communications app would send push notifications to users that will do the following, but is not limited to:

- Be available to the parent/caregiver user only through an opt-in;
- Educate parents about (this list is not exhaustive):
    - Indicators of what a child's mental health progress should be according to the child's age;
    - Include active signs their child may need more support because they are struggling;

[6] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9390832/

- What mental health conditions are most common for teens;
- What role may social media be playing;
- How substance use may be used as a coping mechanism signaling a deep emotional pain that needs to be addressed;
- Tips on how to have open conversations with their child;
- How the child's pediatrician can provide support; and
- How to proactively promote mental health.

- Passive notifications would bring information to parents who may not actively seek it out due to:
  - stigma,
  - lack of resources, or most likely,
  - do not know the signs of developing problems in their child's mental health; and
- Videos that are evidence-based that can be used to help teach parents and children critical mental health and coping skills.

Children's physical and behavioral health needs are distinct from those of adults, as they are heavily influenced by stages of development, as well as by family, social, and educational environments. Untreated or poorly managed childhood mental health disorders not only affect individual children and families but also have significant consequences for a range of systems, including health care, child welfare, juvenile justice, and public education.[7]

Timely and adequate treatment can promote lifelong health and development, whereas a lack of appropriate treatment could lead to worsening and compounding of the child's difficulties in home, academic, and community settings.[8] Providing information early to parents and caregivers provides a potential for identifying and effectively seeking out treatment for a child's mental health concern.

Budget

The funding for this project would be provided, upon approval, from Mental Health Services Act (MHSA) Innovation funding[9] for five years. However, any in-kind funding from the school-home communications provider or the participating school district, will be accepted.

ACBH has previously supported the development of mental health apps which has provided the County some working knowledge of costs. However, ACBH strongly believes that a budget without consultation of the school-home communications provider would not be prudent. Nevertheless, ACBH understands adding to an already developed app costs much less than building one.

[7] https://www.milbank.org/wp-content/uploads/2017/03/MMF_BHI_REPORT_FINAL.pdf
[8] Ibid.
[9] https://mhsoac.ca.gov/the-act-mhsa/

Outcomes

ACBH is committed to adding more support to its Child and Young Adult System of Care (CYASOC) especially as recent research continues to show that mental health challenges in children and young adults have risen dramatically.[10]

The outcomes to be tracked for CYASOC will include, but not limited to:

- Accessing children mental health services for supportive services increases;
- Parents and caregivers feel less stigmatized to reach out for children's mental services;
- Parents and caregivers feel more informed about their child's mental health and well-being; and
- Parents and caregivers feel as though they're better able to manage their child's mental health.

Conclusion

A passive campaign, such as public service announcements (e.g., "This is Your Brain on Drugs"[11] or "What if bears killed 1 in 5 People?"[12]), to provide parents information about children's mental health will be groundbreaking. An Ipsos poll performed for National Alliance on Mental Illness (NAMI) in 2021, found that most parents support mental health being taught in schools[13]. As stated above, there are no passive campaigns educating parents about children's mental health. There is plenty of online information, including pages in school district websites, though an active search by a concerned parent or caregiver must be done.

Currently, there are no public campaigns to educate parents about their child's mental health. The closest is the Center for Disease Control's (CDC) own app of Milestone Tracker[14]. However, this app is most likely not only unknown to most parents, it only covers birth to age 5 of a child's development.

It has become increasingly necessary to find a non-stigmatizing manner to bring information to parents and caregivers regarding their children's mental health without having to actively search, sometimes in vain, for relevant information. There is no better place to begin a moment of needed change than with parents, caregivers, and schools. Using technology already being utilized by schools and parents will promote conversations that should already be happening.

The Surgeon General's report says it best:

> *"…everyone has a role to play in combating this mental health pandemic. Without individual engagement, no amount of energy or resources can overcome the biggest barrier to mental health care: the stigma associated with seeking help. For too long,*

[10] https://www.hhs.gov/sites/default/files/surgeon-general-youth-mental-health-advisory.pdf
[11] https://collections.nlm.nih.gov/catalog/nlm:nlmuid-101437932-img
[12] https://www.sbnation.com/2015/11/5/9677428/college-humor-its-on-us-bear-video
[13] https://www.ipsos.com/en-us/9-10-parents-want-mental-health-education-taught-school
[14] https://www.cdc.gov/ncbddd/actearly/milestones-app.html

mental and emotional health has been considered, at best, the absence of disease, and at worst, a shame to be hidden and ignored.

Only when we do will we be able to protect, strengthen, and support the health and safety of all children, adolescents, and young adults – and ensure everyone has a platform to thrive."[15]

[15] https://www.hhs.gov/sites/default/files/surgeon-general-youth-mental-health-advisory.pdf

Alameda County Supportive Housing Community Land Alliance

Year One Evaluation Report

December 2023

Prepared for

Alameda County Health Care Services Agency

Alameda County
Health Care Services Agency

by

Public Consulting Group LLC
www.publicconsultinggroup.com

PUBLIC CONSULTING GROUP

Table of Contents

Executive Summary

In Alameda County and across the Bay Area, there are not enough affordable housing units available in comparison to the number of low-income households. An inadequate supply of housing inventory has contributed to rising home prices and rental rates, and insufficient affordable housing has led to evictions, displacement, and homelessness. Households living on fixed incomes such as seniors, people with disabilities, and individuals with severe mental illness (SMI), face the most significant challenges in maintaining a residence in this environment. The County is in the midst of a homelessness crisis, and on September 19th, 2023, the Alameda County Board of Supervisors declared a State of Emergency related to Homelessness in Alameda County to address the critical situation.[1]

Alameda County is dedicated to creating a stable housing system that is more responsive to individuals with SMI. In 2019, Alameda County Health Care Services Agency (HCSA) put forth and was awarded a Mental Health Services Act (MHSA) Innovation grant, to utilize a community land trust (CLT) model paired with a supportive housing model as a pathway for permanent and sustainable affordability and increased community control to address the housing crisis for individuals with SMI. The Supportive Housing Community Land Alliance (SHCLA) has been contracted to fulfill this role and bring the innovation plan to life.

SHCLA has four **Learning Goals**:

1. Can Alameda County, within two years of using the Community Land Trust (CLT) model, create an equitable representation on a well-run/effective Board of Directors that includes one-third (1/3) consumers, one-third (1/3) family members, and one-third (1/3) community housing experts?
2. Can a CLT model, targeting the SMI population, facilitate a successful financing model that results in adequate resources to sustain operation of a community land trust to provide permanent supportive housing for individuals with an SMI?
3. Can the use of a CLT model for supportive, affordable housing targeted to the SMI population have an impact on reducing Board and Care closure rates in Alameda County?
4. Can the CLT model provide an opportunity to build personal wealth balanced with community wealth using the private sector for public good?

Alameda County Behavioral Health (ACBH) contracted Public Consulting Group LLC (PCG) to conduct an evaluation of SHCLA. The purpose of this report is to present the evaluation findings from Year One (January 1, 2023 – December 31, 2023), including accomplishments, successes, and challenges of implementing SHCLA, and the initial impacts of Board and Care home/facility closures in Alameda County. PCG conducted a process and outcome evaluation, utilizing a mixed methods strategy drawing from multiple qualitative and quantitative sources. Key evaluation questions were derived from the program's implementation goals and outlined in the theory of change and logic model to guide the evaluation. Results from the evaluation are important to inform what actions are recommended to improve implementation and enable the program to achieve the best outcomes.

[1] Homelessness Solutions in Alameda County. (2023) Office of Homeless Care and Coordination. Retrieved from https://homelessness.acgov.org/.

Key Findings

As a start-up nonprofit, SHCLA had many accomplishments, challenges, and areas of opportunity, highlighted throughout the evaluation findings. Key findings are described below.

Key Findings

Achievements

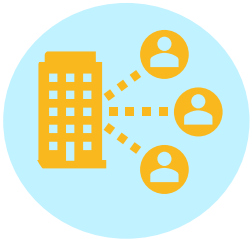
- One of SHCLA's earliest accomplishments thus far has been receiving non-profit (501c3) status, submitting the 1023 application, and getting approval from the IRS. This completes one of SHCLA's short term outcomes.
- SHCLA successfully hired an Executive Director in November 2021.
- In 2021, the SHCLA recruited an Advisory Committee, which is comprised of a diverse membership including, but not limited to, the project management team, MHSA stakeholders, interested community members, National Alliance on Mental Illness (NAMI) members, individuals who utilize behavioral health and/or housing services, and family members.
- A primary objective and short-term outcome of the SHCLA was the establishment of a Board of Directors which is comprised of nine to 12 individuals represented by one-third consumers, one-third family members, and one-third community housing experts. There are currently four members on the Board of Directors.
- All Board of Directors governing documents have been created including bylaws and decision-making policies.
- SHCLA has established essential operational components such as a financial infrastructure, including a bank account, payroll processing, as well as health benefits for staff. To facilitate the onboarding processes, they have developed an onboarding guide, personnel handbook, and training plan for prospective new hires.
- The SHCLA is actively working towards securing larger sources of capital within the next year. This has included applications for Bay Area Housing Finance Authority (BAHFA), state and local Homekey, Community Care Expansion, and Homeless Housing, Assistance and Prevention (HHAP) Grant Program opportunities.
- The Executive Director meets with ACBH staff to discuss needs and opportunities for connections and funding for acquisitions.
- Over the past year, SHCLA has facilitated communication with Board and Care operators about opportunities that exist, challenges that they face, and interest in property rental or ownership.
- SHCLA's Executive Director meets with the HSP team once every other month to foster open communication and develop relationships with Board and Care operators across the County.
- SHCLA created social media platforms and conducted training sessions to optimize community and donor engagement in early 2023.
- They also launched the website's donation page, which provides information about various ways donors can contribute to the organization. As of April 2023, SHCLA received more than $2,000 in donations.
- On May 20, 2023, SHCLA hosted their second-anniversary community event at the Oakley Museum of California. Ultimately 98 individuals registered for the event, which served as a community engagement and fundraising opportunity for the organization.

Key Findings

Challenges	• Initial SHCLA staffing was postponed by approximately four months due to delays in contract execution. The contract was executed in March 2023 and SHCLA received its first funds in May 2023. • There is a lack of understanding by stakeholders of what the innovation, model and value SHCLA brings to Alameda County. • SHCLA identified that Board and Care operators have a lack of trust related to public entities. • The County initially identified MHSA Capital Facilities and Technological Needs (CFTN) funding to purchase initial property for the project. However, SHCLA has not yet received CFTN funding, which has inhibited land and property acquirement. • Various funding sources require an organization to have at least three years of experience with audited financials and three projects that are similar in size or community served. Therefore, SHCLA is ineligible to receive these specific funds. • Overcoming biases and institutional complexity across the system is necessary.
Opportunities	• In light of implementation to date, SHCLA has identified staff positions that would be better suited for their current needs and would allow them to identify new opportunities for land and projects and manage them in a sustainable way. • Recruit new Board of Director members with critical lived or living experience. • Continue to search for ways to collaborate with community organizations such as BACS, and the Peer Wellness Collective. • Develop a shared understanding of what it means to innovate with this model. • SHCLA has made many presentations to stakeholders throughout the County. To further make their presence in the community known, SHCLA should continue and bolster presentations and outreach to educate community members and partners to garner support and buy-in. • Development of community and public sector champions from OHCC, HCD and other offices addressing housing and development. • Continue to seek funding opportunities to obtain its first property.

Recommendations

Based on process and outcome evaluation findings, the following recommendations are offered to expand on existing developments, improve implementation, and meet intended outcomes.



Expand Partnerships with Housing Development Entities and Real Estate Consultancy Firms

SHCLA should engage subject matter experts or consultants in housing development and real estate to create a plan for prioritized acquisitions for the next year. SHCLA would benefit from a synergy of financial expertise, regulatory insight, community engagement strategies, and risk management practices. These collaborations can strengthen SHCLA's ability to provide affordable housing, promote community resilience, and foster sustainable development.

This work could expand to evaluate family member and client mixed affordable and market rate developments. SHCLA can work with development organizations to finance and redevelop land and structures on behalf of three residential facility operators who currently lease and wish to purchase a 15-bed home for expanded operations.

SHCLA should also prioritize organizations who lead with environmentally sustainable practices, such as energy efficiency, renewable energy, and green building designs. This contributes to reducing the environmental impact of housing and creating more sustainable communities.

Explore Additional Funding Streams and Grant Opportunities to Finance Land Acquisition and Support Program Sustainability

Generating additional funding is linked to acquisition and sustainability. SHCLA should continue to seek funding opportunities through sources such as CCEP funding and grant and philanthropic opportunities. SHCLA could also explore how to utilize publicly funded rental subsidies in creative ways to expand opportunities for those with rental subsidies, to create opportunities for tenant ownership, and/or reinvestment of subsidy funds into expanding supportive housing unit availability.

Develop a Service Network Collaborative Model to Support Board and Care Homes/Facilities

SHCLA should continue to engage with Board and Care homes/facilities to develop a robust service model which utilizes community resources and networks in support of community integration, program delivery, and neighborhood cohesion. Services included in the logic model are sustainability and beautification initiatives like developing community gardens, food systems, and habitat restoration. In addition, community resources promote creativity and provide wellness activities utilizing living and performing arts, murals, free little libraries, and media donations.

SHCLA should continue to partner with Federally Qualified Healthcare Center (FQHC) service partners to support improving the health outcomes of individuals residing in ARF and RCFE facilities. Evidence-based practices should be implemented to improve health, promote resident stability, and support member facilities. SHCLA should connect advocacy partners, such as Cardea Health with HSP members and other licensed facilities to educate members on the needs of high acuity residents requiring additional care and provide updates on behavioral health, housing, and advocacy efforts.

Background

In Alameda County and across the Bay Area, there are not enough affordable housing units available in comparison to the number of low-income households. An inadequate supply of housing inventory has contributed to rising home prices and rental rates, and insufficient affordable housing has led to evictions, displacement, and homelessness. Households living on fixed incomes such as seniors, people with disabilities, and individuals with severe mental illness (SMI), face the most significant challenges in maintaining a residence in this environment.

Stable housing provides the foundation upon which people build their lives. Without a safe, affordable place to live, it is almost impossible to achieve good health or to achieve one's full potential. For people living with a SMI, stable and supportive housing not only has the potential to improve mental health, but also physical health, both of which help to increase overall quality of life and wellbeing.

As Alameda County receives federal funding to support homeless services, they are required to report the findings of their local Point-in-Time (PIT) Count to the U.S. Department of Housing and Urban Development (HUD).[2] The PIT Count data is used for fundraising, planning, funding allocation, and expanding housing and services to address needs and implement changes. Notably, the Alameda PIT Census and Survey in 2022 is the sole comprehensive count of sheltered and unsheltered individuals since 2019. In February 2022, the count revealed a total of 9,747 individuals experiencing homelessness, an increase of 1,725 individuals since 2019. Additionally, 40 percent of PIT Count participants reported having at least one disabling condition such as psychiatric or emotional conditions, PTSD, chronic health condition, physical disability, drug or alcohol abuse, traumatic brain injury, or HIV/AIDS related illness. The PIT Count also found that marginalized groups, such as African Americans, multi-racial, and LGBTQ+ individuals, are disproportionately represented in the homeless population, facing a significantly higher likelihood of homelessness compared to the general population.

The County is in the midst of a homelessness crisis, and on September 19th, 2023, the Alameda County Board of Supervisors declared a State of Emergency related to Homelessness in Alameda County to address the critical situation.[3] This emergency declaration is crucial to accelerate and focus resources on implementation and expansion of the response.

Alameda County has made impactful efforts to address homelessness and housing insecurity for its residents, through a community-based, equity driven approach, which is outlined in the Home Together 2026 Community Plan. In 2019, Alameda County Health Care Services Agency (HCSA) established the Office of Homelessness and Care Coordination (OHCC). OHCC and multiple County and community partners work together to implement a number of programs and initiatives to "ensure the availability of diverse and affordable housing for all residents. Their collective goal is to eliminate homelessness in Alameda County."[4]

Alameda County is dedicated to creating a stable housing system that is more responsive to individuals with SMI. In 2019, Alameda County Health Care Services Agency (HCSA) put forth and was awarded an Mental Health Services Act (MHSA) Innovation grant, to utilize a community land trust (CLT) model paired with a supportive housing model as a pathway for permanent and sustainable affordability and increased community control to address the housing crisis for individuals with SMI. The Supportive Housing Community Land Alliance (SHCLA) has been contracted to fulfill this role and bring the innovation plan to life.

[2] Applied Survey Research. (2022). 2022 Alameda County Homeless Count and Survey Comprehensive Report. Retrieved from https://everyonehome.org/wp-content/uploads/2022/12/2022-Alameda-County-PIT-Report_9.22.22-FINAL-3.pdf.
[3] Homelessness Solutions in Alameda County. (2023) Office of Homeless Care and Coordination. Retrieved from https://homelessness.acgov.org/.
[4] Home Together 2026 Community Plan. (2022). Retrieved from https://homelessness.acgov.org/homelessness-assets/docs/reports/Home-Together-2026_Report_051022.pdf.

Community Land Trust Model

CLTs are nonprofit organizations specifically designed to uphold the long-term availability of land for affordable housing, catering primarily to families with lower incomes. Governed by a Board of Directors with representation from the community, the CLT model is reinforced by the concept that residents, as part of the land trust, share a common interest in the organization that owns the land they inhabit. This model facilitates a sustained balance, ensuring residents maintain a degree of control over the organization while striving for long-term sustainable community outcomes. The CLT operationalizes its mission through several key strategies:

- Retains ownership of the land and provides a long-term lease, generally a ground lease, of the structure(s) to homebuyers.
- Maintains an interest in maintenance of the structures and property while the tenant/co-owner makes improvements to the property.
- Retains a long-term option to repurchase the home at an agreed-upon formula-driven price, giving the homeowner partial equity with the remaining equity staying with the community land trust.
- Resells the structure at a below-market rate, and the cost of the land is retained in perpetuity within the trust.

A primary objective of CLTs is to sustain the affordability of housing, ensuring that households with lower incomes can maintain access to safe and reasonably priced residences, even as neighborhood housing costs escalate. Beyond affordability, CLT models offer broader support to residents and the community. CLT homeowners exhibit lower rates of delinquency and foreclosure compared to those engaging with the traditional housing market. This is attributed to the CLT's proactive assistance for homeowners facing mortgage challenges and its inherent ability to add community value irrespective of the housing market's rapid cost increases. Furthermore, CLTs prioritize community voices in decision-making and land use, fostering a more inclusive and participatory approach.

Crucially, CLTs contribute to advancing racial equity in homeownership by increasing opportunities for minorities to engage in first-time homeownership.[5] This multifaceted approach aligns with the overarching mission of CLTs, transcending the conventional housing paradigm to create sustainable, affordable, and equitable communities. This model also fosters the opportunity for individuals with lower incomes to build wealth through equity of home ownership which in turn ensures residents are not displaced due to gentrification or land speculation.

SHCLA Overview and Goals

Following the initial plan set forth in the Alameda County MHSA Innovation Grant, the SHCLA will apply the CLT model by bringing permanent affordability and community control to help ease the housing crisis for SMI consumers whose income is 200 percent below the federal poverty level. SHCLA will acquire land and maintain ownership of what it acquires permanently. In turn, developing long-term, renewable leases with residents., If the owner chooses to sell, the owner 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. To achieve this lofty aim within the five-year time frame of the innovation funding, the SHCLA will need to create initial infrastructure, staffing, establish agreements between community partners, develop policies and procedures, acquire properties and residents.

Establishment as a nonprofit [501(c)(3)] structure is critical for the use of the land to be preserved and support the development of financial and operational models which will be sustainable. A staffing plan was also developed and will need to be executed in addition to creating operating policies and procedures that govern the organization and staff, as well as the acquisition of funding and land.

[5] Shelterforce. (2021). Understanding Community Land Trusts. Retrieved from https://shelterforce.org/2021/07/12/understanding-community-land-trusts/.

The SHCLA will also be governed by of a Board of Directors who are comprised of nine to 12 individuals with one-third representing consumers and family members, one-third representing the public sector, and one-third representing community partners with specific areas of expertise and a commitment to expanding and improving supportive housing. This is designed to balance the interest of individual land trust homeowners with the interests of the community.

SHCLA engages and promotes interagency and community collaboration among a wide range of partners (County Agencies and Offices, housing, real estate legal and financial experts, consumer/client representatives, family member representatives, and existing nonprofit affordable housing developers) developing informal and formal agreements. These partnerships will aid SHCLA in the establishment of a CTL focusing on supportive housing that incorporates unique aspects to address local conditions. In summation:

- SHCLA will create and steward permanently affordable housing through the community land trust model by maintaining ownership of the land.
- SHCLA will create a sustainable secure housing initiative is by leveraging public and private investments and building a diverse network utilizing a diverse Board of Directors with supportive housing property management skills and the best interest for the general public in mind.
- The community-driven membership will ensure that the homes on this land will provide safe, secure, and supportive housing for residents whose income is 30 percent or less of the Alameda County Area Median Income (AMI).
- SCHLA will provide residents with stable and affordable housing that is integrated with compassionate and caring supportive services to ultimately provide opportunities for individuals with SMI to have affordable home ownership while building personal and community equity.

Figure 1 depicts the timeline for SHCLA operations from 2019 to 2024. Primary activities in 2023 included ongoing exploration of funding opportunities, working toward the establishment of a collaborative network of Board and Care homes/facilities, and facilitation of community outreach events. As this is the first evaluation report for the SHCLA, notable activities and outcomes are reported, although they occurred in previous years.

ACBH contracted Public Consulting Group LLC (PCG) to conduct a Baseline Board and Care Assessment (October 1, 2022 - June 30,2023) and evaluation of the SHCLA pilot. The Year One Evaluation covers January 1, 2023 through December 31, 2023, while the Year Two evaluation will be conducted from January 1, 2024, through September 30, 2024.

Figure 1. Timeline

Report Purpose and Structure

The purpose of this report is to present the evaluation findings from Year One (January 1,2023 – December 31, 2023), including achievements, challenges and opportunities for SHCLA operations, and initial impacts on Board and Care home/facility closures in Alameda County. The

The report is comprised of the following sections:

- Evaluation Methodology;
- Findings;
- Summary; and
- Recommendations.

Evaluation Methodology

PCG conducted a process and outcome evaluation utilizing a mixed methods strategy drawing from multiple qualitative and quantitative sources. Key evaluation questions were derived from the program's implementation goals. Additionally, they were outlined in the theory of change and logic model to guide the evaluation. Results from the evaluation are important to inform what adjustments need to take place to improve implementation and enable the program to achieve the best outcomes. Results Based Accountability (RBA) is also employed to center the intended results and measures needed to achieve them (How much did we do? How well did we do it? Is anyone better off?).[6]

To enhance the evaluation, PCG utilized an Action Research Model[7] which requires the evaluator to be actively engaged in the project implementation process by providing technical assistance and guidance on an ongoing basis. As the evaluator, PCG attended ongoing SCHLA project meetings and provided regular feedback to ensure continuous quality improvement.

The overarching evaluation questions are:

1. Can Alameda County, within two years of using the Community Land Trust (CLT) model, create an equitable representation on a well-run/effective Board of Directors that includes one-third (1/3) consumers, one-third (1/3) family members, and one-third (1/3) community housing experts?
2. Can a community land trust model, targeting the SMI population, facilitate a successful, financing model that results in adequate resources to sustain operation of a community land trust?
3. Can the use of a CLT model for supportive, affordable housing targeted to the SMI population have an impact on reducing Board and Care closure rates in Alameda County?
4. Can the CLT model provide an opportunity to build personal wealth balanced with community wealth using the private sector for public good?

Process Evaluation

The process evaluation aims to provide insight and documentation of the first year of SHLCA implementation, measuring whether the CLT model is on track to create, within two years, an equitable representation of an effective Board of Directors that includes an even distribution of consumers, family members and community housing experts. Additionally, the process evaluation examines if a CLT model specifically targeting the SMI population can facilitate a successful financing model that results in building adequate resources to sustain the program over time. Lastly, the process evaluation considers the potential effect on Board and Care closure rates in Alameda County resulting from the use of a CLT model for supportive, affordable housing targeted to the SMI population. The process evaluation questions examined in Year One are included in Table 1.

TABLE 2. PROCESS EVALUATION QUESTIONS

1.	How were members of the Board recruited and has the composition goal been achieved?
2.	Are members satisfied with the governance, discussions, decisions, and bylaws?
3.	Has an Executive Director been appointed, and other staff positions filled?
4.	Has the CLA secured approval for incorporation as a non-profit 501(c)(3) entity?
5.	What public and private investments have been identified and/or secured?

[6] Clear Impact. (2016). What is Results-Based Accountability? Retrieved from https://clearimpact.com/results-based-accountability/.
[7] Patton, M. Q. (2003). Utilization-focused evaluation. Springer Netherlands.

Outcome Evaluation

The outcome evaluation focuses on the broader effects directly impacting individuals served through SHCLA by examining if the CLT model provides an opportunity to build personal wealth balanced with community wealth using the private sector for the public good. Given the nature of this final overarching evaluation question, it must be assessed as a long-term outcome. Table 2 illustrates the outcome questions PCG will seek to answer as part of the SHCLA Program evaluation Year Two Report.

TABLE 3. OUTCOME EVALUATION QUESTIONS

1. What investments from family members have been made in specific land trust projects?
2. Have clients and families purchased units?
3. Have outcomes improved for housed clients?

Data Collection and Analysis

Using a mixed-methods evaluation strategy involving both qualitative and quantitative data sources, PCG worked with ACBH to develop data collection instruments and collect data from key stakeholders for Year One.

Qualitative data elements consisted of eight interviews with key informants, including the Project Management Team, Board of Directors, Office of Homeless Care and Coordination staff, Housing Support Services liaisons, and service providers; and eight interviews with Board and Care operators (Appendix A). Interviews were conducted in October through November 2023 via Microsoft Teams, although a limited number of stakeholder interviews were conducted during a site visit in October 2023.

Quantitative data included surveys with Board and Care operators, as well as facility listings and closure and licensing data reported within Alameda County from the Community Care Licensing Division (CCLD) from December 2023. The Board and Care survey was developed by SHCLA and updated by PCG to gain insights into residents, staff, training, service fees and cost-saving strategies, as well as long-term planning and sustainability for facilities. The survey was developed in JotForm and consisted of multiple choice, short- and long-answer questions. The survey was distributed to all unduplicated email addresses from the CCLD data, and remained open from October 23, 2023, through November 17,2023. In an attempt to increase the survey response rate, PCG pulled a sample of 200 ARF/RCFEs to call. Ultimately, there were 14 responses to the survey from Board and Care operators.

Limitations

There are several limitations to note, primarily related to the engagement of stakeholders, that has impacted data collected. Due to small sample sizes, reliable reporting on the significance of the findings is limited to the perspectives of those included in the data. It is also important to acknowledge the myriad of responsibilities that Board and Care administrators and staff have as they operate their facilities 24/7, which may have led to limited participation. PCG is also unknown to many stakeholders, and despite every effort made to use warm handoffs, limited connections were made via phone or email.

In PCG's proposed evaluation plan, focus groups were intended to be conducted with Peer Support representatives from the Pool of Consumer Champions (POCC) and the Peer Wellness Collective. The aim of these focus groups was to discuss how peer organizations support individuals with behavioral health disorders who are experiencing housing insecurity in the County. PCG also arranged to conduct interviews and facility tours with several Board and Care operators during the site visit in October 2023; however, was unable to connect with everyone that had confirmed. Furthermore, there was a low response to the Board and Care survey; thus, operator feedback was more limited than anticipated. PCG will work with the Project Management Team to establish a revised stakeholder engagement plan to gain a more comprehensive understanding of how SHCLA can work toward providing and advocating for solutions that would benefit facilities, providers, and residents.

Findings

The first two years of implementation were intended to create initial infrastructure, staffing, establish agreements between community partners, and develop policies and procedures. In subsequent years, the SHCLA will have tested the innovation to determine if a CTL, targeting individuals with SMI can be sustained and if their Family and Supportive Housing Models have an impact on Board and Care closure rates, and most importantly for residents to have an opportunity to build personal wealth and improve behavioral and physical health outcomes. This section discussed the evaluation findings across SHCLA start-up operations, collaboration and impact on Board and Care homes/facilities.

SHCLA Start-Up Operations

As the SHCLA has moved from a well-documented plan to implementation, there have been many accomplishments and lessons learned, particularly with operations. Key short-term outcomes discussed in this section were to ensure the incorporation of the SHCLA as a non-profit 501C(3) and form a diverse Board of Directors and internal staffing structure which allows for equitable participation by SMI consumers and family members.

Staffing

The vision and direction of SHCLA is a collaborative effort informed and governed by SHCLA staff, a Board of Directors, and an Advisory Committee. Table 3 presents the original SHCLA Staffing Plan Proposal.

TABLE 3. INITIAL SHCLA STAFFING PLAN PROPOSAL

Title	Responsibilities	FTE
Executive Director	Provides primary oversight of SHCLA, consultants, and staff, in addition to oversight of the Board of Directors, financing models, the family investment model, and sustainability model	1.00
Director of Property Management	Integrates supportive housing property management and policies, existing best practices and the unique requirements created by mixed funding sources	1.00
Director of Workforce Development and Training	Ensures that staff involved with specific housing projects have the support and tools necessary to maximize the success of housing projects	1.00
Administrative Assistant	Provides support to the Executive Director and other SHCLA staff, assists in daily office needs, and manages the agency's general administrative activities	1.00
Real Estate Development Intern	Researches and assists in the identification of future development sites; assists in land use administrative tasks; reports to Executive Director; prepares reports	0.5
Real Estate Marketing Intern	Develops content for social media and website distribution; works closely with the Administrative Assistant	0.5

The organization successfully hired an Executive Director in November 2021. Initial SHCLA staffing was postponed by approximately four months due to delays in contract execution. The Administrative Assistant position was filled in June 2023 but became vacant once again in August 2023. In light of implementation to date, SHCLA has identified positions that would be better suited for their current needs. Proposed changes included adding a Director of Real Estate Development (replacing the Director of Property Management), as the program has not yet acquired land and adding an Operations Manager (replacing the Administrative Assistant) and a Project Manager (replacing the Director of Workforce Development and Training). Additionally, SHCLA plans to add a new staffing position, Director of Resident Services, to oversee service planning and program design for the target population. These positions would allow SHCLA

to identify new opportunities for land and projects and manage them in a sustainable way. SHCLA conducted interviews for all four of the new roles in December 2023; however, the request for these changes is still pending approval from the County.

SHCLA's Executive Director also met with staff from the UC Berkeley Work Study Program in early 2023 to coordinate the future involvement of interns. The UC Berkley Work Study Program posted the positions of Real Estate Marketing Intern and Real Estate Development Intern and received 14 resumes in the spring of 2023. SHCLA plans to extend offers by the end of 2023 and will engage UC students once other staff positions have been filled.

Advisory Committee

In 2021, the SHCLA recruited an Advisory Committee, which is comprised of a diverse membership including, but not limited to, the project management team, MHSA stakeholders, interested community members, National Alliance on Mental Illness (NAMI) members, individuals who utilize behavioral health and/or housing services, and family members. There are multiple members of the Advisory Committee with living and lived experience who represent various areas of expertise. The Advisory Committee meets monthly to provide feedback on items and documents related to operations.

One of the early key accomplishments of the Advisory Committee was electing the founding Board of Directors. There were five initial Board members elected; however, two of those individuals are no longer members, due to varying reasons. The process for filling Board positions involved the creation of a list of 20 potential Board members, outreach to ten potential Board members, and several interviews. SHCLA secured a new member, bringing the total to four. Current recruitment includes elevating current Advisory Committee members to the Board.

Board of Directors

A primary objective and short-term outcome of the SHCLA was the establishment of a Board of Directors which is comprised of nine to 12 individuals represented by one-third consumers, one-third family members, and one-third community housing experts.

The current Board of Directors is comprised of four members (2 founding members) including a President, Treasurer, and Secretary. Each Board member works on various tasks commensurate with their positions as well as Board recruitment. According to one member, "there is a division of labor, and this truly is a labor of love among us". All governing documents have been created including bylaws and decision-making policies. Currently all four Board members have combined experiences and are striving to meet the proposed composition. Figure 2 showcases achievements, challenges and opportunities highlighted by the Board.

FIGURE 2. SHCLA ACHIEVEMENTS, CHALLENGES AND OPPORTUNITIES

Establish Non-Profit (501c3) Operational Infrastructure

One of SHCLA's greatest accomplishments thus far has been receiving non-profit (501c3) status, submitting the 1023 application, and getting approval from the IRS. The application required a significant investment of time to complete from the Board of Directors and it took almost one year to hear back from the IRS. SHCLA received this status, just in time to continue its operations. This completes one of SHCLA's short term outcomes.

Administrative Operations, Policies and Procedures

SHCLA has established essential operational components such as a financial infrastructure, including a bank account, payroll processing, as well as health benefits for staff. To facilitate the onboarding processes, they have developed an onboarding guide, personnel handbook, and training plan for prospective new hires. SHCLA partnered with an accounting firm to handle bookkeeping and accounting services. The scope of their services includes establishing SHCLA's chart of accounts, generating invoices, processing payroll, and providing financial statements.

The Executive Director and Board of Directors reviews the Standards of Excellence checklist as an ongoing risk management and performance tracking tool. This tool helps SHCLA adhere to best practices concerning its board, mission, governance, financial management, development and fundraising, volunteer management, safety, project protocol, community impact, hiring, training, record retention, IT, collaboration, marketing, and communications.

Funding Operations, Acquisitions and Projects

Funding to obtain acquisitions and sustain operations has been a top priority for SHCLA. They have considered multiple project-based funding sources to support its acquisition strategy including Capital Facilities and Technology Needs (CFTN), Community Care Expansion Preservation (CCEP), Community Development Block Grant (CDBG), Permanent Local Housing Allocation Program (PLHA), Kresge Foundation, San Francisco Foundation, and State Homekey. In addition, SHCLA contacted Kataly Foundation to explore collaboration to enhance sustainability planning through restorative economics consultation. Additional contact was made with the Oakland-based ICA to discuss organization funding and

fundraising initiatives to support Board and Care operators. This funding will support two models – the Family Partnership Model and the Board and Care Model.

Over the next year, SHCLA is required to have two project types, the Family Partnership Model and the Board and Care Model, that serve at least 10 residents in total. SHCLA ambitiously plans to secure more than the two projects, likely taking smaller operators, and increasing the size of their facilities. SHCLA continues to develop the logic model for its Family Partnership and is preparing the logic model for Board and Care homes/facilities.

With the Family Partnership, SHCLA plans to utilize permanent supportive housing in neighborhoods of opportunity. SHCLA aims to protect and preserve land particularly in areas where land prices are rapidly escalating. By acquiring land and taking it off the market, SHCLA can safeguard the land for affordable housing and other community uses. SHCLA has further refined its financial model for the Family Partnership Model in anticipation of securing debt and equity sources. SHCLA staff met with residents and families in July 2023 to discuss the feasibility of a lifetime lease contribution of $100,000 and propose adjusting rents from the current market rates to the $500-$700 range. There have been conversations to ensure the project aligns with the original intent of the MHSA proposal and community interests, particularly emphasizing a diverse mix of residents within the property. SHCLA aims to have at least 25 percent of residents with SMI in the Family Partnership model to help reduce stigma related to mental health.

Staff continue to work with families at Vernon Street, an apartment building in Oakland, to refine the financial terms, program description, and creation of a Resident Council with family participation. The current financial terms for the $2M property indicate that a $100K initial investment and a $1K monthly contribution are required to generate sufficient cash flow over the next 30 years. Programming for the property includes expanding the existing nine-unit property to accommodate a total of ten units, with one unit designated for a part-time, live-in Resident Assistant. Among the ten units, five units would be designated for families and the other four for formerly homeless seniors. Families have expressed concern regarding referral sources in the non-lifetime lease units from coordinated entry, as the established sense of community could be compromised. In response, SHCLA has engaged in conversation with St. Mary's Center about executing an agreement to accept formerly homeless seniors in the nonfamily units. SHCLA has identified a consultant and plans to submit a Section 4 grant to the Local Initiatives Support Corporation.

SHCLA received an invitation from the Community Development Resource Group (CDRG) to secure a $150,000 grant for each of the two projects (Family Partnership Model and Board and Care Model). They agreed to submit a letter documenting the partnership to provide an Anti-Displacement Program (PGM) for the Amador West Dublin project and the San Leandro Bayfair project.

SHCLA will provide subsidy retention to counties by ensuring all subsidies paid to a land trust are only required once, upfront, with the long-term guarantee that the property is used as permanent supportive housing. The SHCLA is actively working towards securing larger sources of capital within the next year. This has included applications for Bay Area Housing Finance Authority (BAHFA) and Homeless Housing, Assistance and Prevention (HHAP) Grant Program opportunities.

SHCLA is also in the process of applying for a Capital Catholic Campaign for Human Development, which is a grant for operating, and an application to the San Francisco Foundation. One goal for implementation over the next year is to use unspent funds as capital for land acquisition, which would allow SHCLA to implement pre-development activities necessary for larger sources of capital such as BAHFA and HHAP.SHCLA intends to request a budget amendment that anticipates using approximately $1.5M in unspent MHSA funds from FY2023 towards predevelopment activities in 2024. Unfortunately, it is unlikely that the $3-5M in CFTN funding from the County will be available as previously anticipated,

Despite the many achievements of SHCLA, the organization has encountered numerous obstacles related to funding and acquisition of land and property. Various funding sources require an organization to have at least three years of experience with audited financials and three projects that are similar in size or community served. Therefore, SHCLA is ineligible to receive these specific funds. In addition, while SHCLA finalized their contract in January of 2022, they did not receive finances until mid-April, which delayed predevelopment activities and prohibited them from applying for grants until the beginning of May 2022.

SHCLA has yet to secure its first acquisition; however, program staff are strategizing to meet this goal over the next year.

Sustainability Planning

SHCLA facilitated sustainability planning throughout 2023. SCHLA's Executive Director collaborated with OHCC staff and provided updates to the Board of Directors and Advisory Committee to align the availability of funds and explore measures for gap funding. The organization maintains an updated list of capital and operating funding sources, revising it during weekly staff fundraising meetings and as new opportunities or information becomes available. Ultimately, their goal is to achieve sustainability beyond 2024.

Partnership and Collaboration

Addressing homelessness and housing for individuals with SMI requires a multi-faceted, collaborative, and person-centered approach. As discussed in the background, Alameda County has made many strides and is testing innovative ways to address this critical issue.

Partnerships and collaboration are essential components of community development and sustainable urban planning, with the CLT model as an innovative and equitable approach to land ownership and management. The development of a collaborative framework ensures that decision-making processes are inclusive, transparent, and reflective of the community's needs and aspirations.

Additionally, it is imperative that everyone is on the same page and moving forward with the shared vision. Introducing a new innovative approach to partners and the community requires a thoughtful and strategic communication strategy to ensure understanding and acceptance. Messaging needs to resonate with the community's values, needs, and aspirations. Leveraging trusted community leaders and influencers across public sector and community partners can also enhance the credibility of the new approach.

SHCLA partners with local government, community-based organizations, including Peer Support organizations, hospitals, and other community stakeholders to leverage resources, secure funding, and effectively address community needs. Collaboration with these organizations helps to facilitate alignment on sustainability and achievement of goals and outcomes. Additionally, it allows SHCLA to build relationships within the community, tap into a range of experiences, and develop together with partners. This next section explores SHCLA's partnerships and collaborations.

Alameda County Behavioral Health (ACBH), within HCSA

ACBH offers an extensive network of integrated programs and services for individuals with psychiatric disabilities, regardless of age, ethnicity, language, or geographic location. The mission of ACBH is to support and empower individuals experiencing mental health and substance use conditions along their path towards wellness, recovery, and resiliency.

Staff from ACBH meet with SHCLA's Executive Director to discuss needs and opportunities for connections and funding for acquisitions. Key stakeholders for connection over the past year included real estate consultants, developers, and Board and Care operators.

Community Care Expansion Preservation Program (CCEP) and SHCLA Outreach

The CCEP Program was created under Assembly Bill 172 (Chapter 696, Statutes of 2021) to provide financial support and to promote the sustainability of residential adult and senior care facilities and to address longstanding gaps in the long-term care continuum. The CCEP Program aims to preserve and prevent the closure of licensed residential adult and senior care facilities that serve applicants and recipients of Supplemental Security Income/State Supplementary Payment (SSI/SSP) and Cash Assistance Program for Immigrants (CAPI) recipients, with a priority for individuals at risk of or experiencing homelessness.[10]

The CCEP Program Capital Projects Request for Proposal (RFP) was released on September 18, 2023, and responses were originally due on October 31, 2023. However, the RFP was postponed due to

confusion around Small, Local and Emerging Business (SLEB) Program requirements. The Office of Homeless Care and Coordination (OHCC) revised the original RFP regarding SLEB and deed restriction processes and re-released the RFP on November 21, 2023. The contract is expected to start on March 1, 2024. SHCLA facilitated outreach and engagement with Board and Care homes/facilities to promote this funding source.

Office of Homeless Care and Coordination (OHCC), within HCSA

OHCC strives to establish a robust, integrated, and well-coordinated system for housing and homelessness services. It serves as the County's focal point for strategic planning and program development related to homelessness. OHCC is dedicated to enhancing health and housing outcomes for individuals experiencing homelessness, collaborating within HCSA and alongside other County agencies, departments, cities, and community-based organizations. Additionally, OHCC is responsible for overseeing Coordinated Entry and Housing Services within the County's homelessness response system.[8] A key program partner within this office has been Housing Support Program that oversees and supports licensed Board and Care programs, among other housing solutions.

OHCC is responsible for the oversight and management of SHCLA's contract. They are an integral partner of the project management team. OHCC staff increased the number of meetings in the past year, and regularly introduced SHCLA staff to key personnel in housing development and other parts of the system of care. Meeting topics included project updates, program evaluation, contract review, community event planning, and funding opportunities.

Housing Support Program (HSP)

SHCLA also collaborates with the Housing Support Program (HSP), which has provided funding and support for the non-clinical care of individuals with SMI living in licensed Board and Care/residential homes and facilities since 1987. These supports include maintaining their housing and helping to prevent homelessness. HSP is a critical component of the housing continuum, also supporting ACBH in meeting residents' goals related to treatment plans and serving populations not reached by HCD and other partners and programs. Services can include financial assistance and housing-related wraparound supportive services, such as rental assistance, housing navigation, case management, security deposits, utility payments, moving costs, legal services, and credit repair. Referrals to the HSP program come from ACBH sub-acute mental health facilities and are approved by OHCC. Each facility has a dedicated HSP Liaison to support residents and in-turn operators. SHCLA's Executive Director meets with the HSP team once every other month.

Many residents are individuals that are stepping down from sub-acute treatment facilities. There are currently 17 homes in the HSP Network. These homes provide a significant service to the county as they are licensed and support individuals with SMI, who often only have Supplemental Security Income / State Supplementary Payment (SSI/SSP) to rely on for living expenses.

Bay Area Community Services (BACS)

BACS is a leading organization in homelessness prevention initiatives that actively engages in rapid re-housing, targeted outreach for individuals experiencing homelessness, and assistance in navigation of available resources. Additionally, they purchase housing throughout the Bay Area to provide shelter for those who would otherwise be homeless. BACS is committed to delivering recovery-oriented behavioral health services that cover a spectrum of needs. Their mission is to uplift underserved individuals and their families by doing whatever it takes. Each year, BACS serves more than 14,500 individuals in the Bay Area, including teens, adults, older adults, and their families.[9]

[8] Homelessness Solutions in Alameda County. (2023). Office of Homeless Care and Coordination. Retrieved from https://homelessness.acgov.org/.
[9] Bay Area Community Services. (2023). Who We Are. Retrieved from https://www.bayareacs.org/who-we-are/.

One of the barriers that BACS case managers reported was finding enough bed availability for the level of acuity that their clients need. There is a gap in terms of the quality and number of beds available for transfer of care to a less restrictive setting. Some clients are housed in licensed Board and Care homes/facilities, some of which are part of the HSP network. BACS case managers collaborate with HSP liaisons when they have clients who need a Board and Care housing placement.

The process of referring and providing critical care services for individuals with SUDs/SMIs varies by the type of housing they need. If a client requires a tiered level of care in a licensed Board and Care home/facility case managers will submit a referral to the HSP team which includes all of the client's mental health information, past records, and assessments. However, there are often delays in the timeline of this process because clients are required to have a current physician's report and a tuberculosis test completed. Scheduling an appointment with a physician can sometimes take several months and the paperwork process is also lengthy and complicated.

Because of these factors, some BACS clients are housed in unlicensed facilities. In addition, licensed facilities are often too expensive for individuals with SSI to afford. However, these facilities do not have the same level of oversight and the quality of living conditions varies. SHCLA should continue to search for ways to collaborate with BACS.

Housing and Community Development Partners

Another primary agency working to address homelessness is the Alameda County Department of Housing and Community Development (HCD). They have more than 25 years of experience in provision and oversight of homeless housing and programs, along with community leadership through collaborative partnerships to serve people who are currently homeless while working to end homelessness across Alameda County. HCD receives HUD CoC funding allocated through HCSA and plays a lead role in the development of housing and programs serving low- and moderate-income households, homeless, and disabled populations.

This past year SHCLA shared one of their proposed projects with HCD staff which included county representation. Additionally, SHCLA has made connections with multiple real estate staff at HCD. SHCLA views this as a continued opportunity for greater collaboration and knowledge-sharing. Ideally, the real estate consultants can support SHCLA and potentially assist in the development and execution of a funding plan. OHCC staff introduced SHCLA to the HCD Director and staff, and SHCLA shared information about their organization. SHCLA was invited to join their Emerging Developers Cohort.

HCD is the grant recipient for the Community Development Block Grant (CDBG) program which is funded by the U.S. Department of Housing and Urban Development. The CDBG grant funds provide local governments with resources to implement programs and services that support individuals and neighborhoods with low incomes, remove blight, and address the needs of community development. HCD contracts with the cities of Albany, Emeryville, Piedmont, Newark, and Dublin for sharing of CDBG funds. Additionally, HCD administers the portion of grant funds to the Unincorporated County.[10] SHCLA would like to build their relationship with HCD and explore opportunities related to access to capital and development opportunities. Support and championship from HCD will be important for viability of this partnership.

Peer Support Programs

POCC is a peer-centered program that aims to enhance the quality of life for Alameda County residents living with mental health or mental health and substance use challenges and to provide the consumer perspective in transforming ACBH to a consumer-driven, culturally responsive, and holistic recovery vision. The vision of the POCC is that people with lived experience have a voice and role in the development, implementation, and evaluation of mental health programs in the County. The POCC has 16 committees including a Steering Committee that oversees the work of the program, a Healing Trauma Committee that

[10] Alameda Community Development Agency. (2023). Community Development Block Grant (CDBG). Retrieved from https://www.acgov.org/cda/hcd/cdp/index.htm.

raises awareness and educates about mental health and trauma, and a Consumer Employment Advisory Taskforce that advocates and collaborates to establish consumer employment, leadership, and consumer-led programs.

SHCLA has created pathways for activities or events in which they could collaborate with POCC, including their second-anniversary community event at the Oakland Museum of California. At the event, POCC welcomed guests and had a table to showcase their services at SHCLA's gathering. Additionally, four members of SHCLA's Advisory Committee are from POCC.

Another key peer support organization in Alameda County is the Peer Wellness Collective. The Peer Wellness Collective is a peer-run community support organization that provides self-help service for individuals with behavioral health challenges in Alameda County. The organization currently operates six programs led by BIPOC peers with lived experience in the mental health community. These programs focus on community support, crisis support, and peer support training.[11] SHCLA can further seek opportunities to collaborate with the Peer Wellness Collective to seek guidance and discuss organizational strategies.

Community Partners and Enagement

SHCLA created social media platforms and conducted training sessions to optimize community and donor engagement in early 2023. Additionally, they developed a pitch deck for presentations to potential funders, and they plan to streamline branding across social media and SHCLA's website. SHCLA also launched the website's donation page, which provides information about various ways donors can contribute to the organization, such as monetary donations, real estate, planned giving bequests, retirement assets, life insurance, stocks, and securities. As of December 2023, SHCLA received more than $2,000 in donations. They continue to communicate with the web designer and developers to update their website to provide a more engaging experience for users.

On May 20, 2023, SHCLA hosted their second-anniversary community event at the Oakland Museum of California. The event served as a community engagement and fundraising opportunity for the organization. The event included a gathering of donors, a panel discussion titled "Out of the Shadows" that focused on highlighting Board and Care operators and the residents they serve, and an outdoor reception. SHCLA sent invitations to the broader community to publicize the event within the County departments such as HCSA and ACBH, BACS and OHCC. Additionally, SHCLA invited 281 ARF/RCFE owners and operators, 242 potential independent donors, 175 community members 48 potential sponsors, 44 members of the media, and 32 government officials. A newsletter was also distributed to their mailing list prior to the event. Ultimately 98 individuals registered for the event, which was a twelve percent registration rate of sent invitations. Following the gathering, SHCLA sent an email of appreciation to attendees that included a request for feedback. This feedback provided SHCLA with valuable input from attendees and offered opportunities for further discussion and improvements. Furthermore, a videographer filmed the community event, and the video product will be used for continued outreach, marketing, and fundraising opportunities. SHCLA plans to hold more community events and opportunities in the coming year.

Impact on Board and Care Homes/Facilities

Board and Care homes/facilities are one housing option for individuals with SMI in Alameda County that are a critical component of the County's housing continuum. In the context of this program and evaluation, Board and Care homes/facilities encompass Adult Residential Facilities (ARFs) and Residential Care Facilities for the Elderly (RCFE). ARFs offer 24-hour non-medical care and oversight to individuals between the ages of 18 and 59. The residents of these facilities primarily consist of individuals with developmental disabilities. RCFEs provide 24-hour non-medical care to support elderly individuals, typically aged 60 or older who may require assistance with daily activities.

ARF and RCFE residents receive support with daily activities such as bathing, dressing and grooming, and many facilities are designed to offer social activities and avenues for residents to engage in meaningful engagement. This supportive environment plays a vital role for seniors and individuals with developmental

[11] Peer Wellness Collective. (2023). Community Services in the Bay Area. Retrieved from https://peerwellnesscollective.org/community-services.

disabilities who may not have access to similar services outside of these care facilities.[12] Both housing types represent an opportunity to prevent homelessness and health deterioration and provide vulnerable populations with a safe residence when other housing options are not possible or appropriate.

PCG pulled data extracts from CCLD from December 2023 to assess the most recent facility listings and closure and licensing data within Alameda County. In December 2023, there were 213 licensed ARF facilities comprising a total capacity of 1,451 beds: with the majority (186) of ARFs having a capacity of one to six beds. There were also a small number of ARFs that were pending (n=4) and one on probation. Additionally, there were 65 ARFs that had been documented as closed since 2018, comprising a total capacity of 522 beds lost (Table 4).

There were 227 licensed RCFE facilities comprising a total capacity of 6,093 beds; with the majority (145) of RCFEs having a capacity of one to six beds. Also of note is the number of RCFEs that have 51 or more beds (n=37) that comprise a capacity of 4,212 beds. There are a small number of RCFEs that are pending (n=9) and none on probation. There were 119 RCFEs that have been documented as closed since 2018, comprising a total capacity of 2,496 beds lost (Table 4). RCFEs have a significantly higher closure compared to ARFs.

TABLE 4. ALAMEDA COUNTY ARF AND RCFE FACILITIES CAPACITY AS OF DECEMBER 2023[13]

ARF and RCFE Facilities and Capacity		Adult Residential Facilities (ARF) Alameda County		Residential Care Facilities for the Elderly (RCFE) Alameda County	
Facility Status	**No. of beds**	**Total Facilities**	**Total Bed Capacity**	**Total Facilities**	**Total Bed Capacity**
Licensed	1–6	186	996	145	837
	7–50	27	455	45	1044
	51+	-	-	37	4,212
Licensed Total		**213**	**1451**	**227**	**6093**
Pending	1–6	4	15	3	18
	7–50	—	—	4	67
	51+	—	—	2	203
Pending Total		**4**	**15**	**9**	**288**
On Probation	1–6	1	6	—	—
	7–50	—	—	—	—
	51+	—	—	—	—
On Probation Total		**1**	**6**	**0**	**0**
TOTAL		**218**	**1472**	**236**	**6381**
Closed	1–6	55	296	84	497
	7–50	10	226	20	390
	51+	—	—	15	1,609

[12] Ca Care Association. (December 2021). Selecting Residential Care: Top Considerations. Retrieved from https://www.cacareassociation.org/news-and-resources/news/2021-12-21/rcfe-arf-residential-care.
[13] California Department of Social Services, Community Care Licensing Division. (December 2023). Care Facility Search. Retrieved from https://www.ccld.dss.ca.gov/carefacilitysearch/.

CLOSED TOTAL		**65**	**522**	**119**	**2496**

In December 2023, HSP provided direct support to ten ARFs (200 beds) and seven RCFEs (216 beds) who provide housing for individuals with SMIs throughout the County (Table 5). The majority of HSP ARFs and RCFEs had between 10 and 32 beds; however 90 was the maximum number of beds. There were gaps in the South County area and Livermore area.

TABLE 5. ALAMEDA COUNTY HSP ARF AND RCFE FACILITIES AND CAPACITY – RETRIEVED IN DECEMBER 2023

HSP - ARF and RCFE Facilities and Capacity		Adult Residential Facilities (ARF) Alameda County		Residential Care Facilities for the Elderly (RCFE) Alameda County	
Facility Status	**No. of beds**	**Total Facilities**	**Total Bed Capacity**	**Total Facilities**	**Total Bed Capacity**
Licensed	1–6	1	6	1	6
	7–50	9	194	5	120
	51+	—	—	1	90
Licensed Total		**10**	**200**	**7**	**216**

There were 14 responses to the Board and Care operator survey. Half of all survey respondents were a part of the HSP Network. Additionally, 57 percent of respondents were ARF administrators and 43 percent were RCFE administrators. Of note, nearly one-third (29%) of survey respondents were interviewed for Year One Evaluation data collection; limiting the findings to the perspectives of just a few.

At the time of survey completion, half of the ARF survey respondents were at capacity, while the other half had at least one bed available. Similarly, half of RCFE survey respondents reported that they did not currently have beds available, while the other half had at least one open bed.

The majority of survey respondents (69%) indicated that they do not plan to increase or decrease the number of residents it serves this year or next year, while 23 percent indicated that they plan to increase, and eight percent plan to decrease the number of residents it serves. However, approximately half of survey respondents reported that they have considered purchasing a new building or property to operate a new Board and Care home/facility. Those who have considered expansion have considered purchasing a new facility in Hayward, San Leandro, Fremont, Union City, and Oakland. Most survey respondents (71%) do not anticipate closing their facility this year or next year. All Board and Care operators interviewed reported that they are interested in expanding their business and developing additional facilities to serve individuals with SMI. However, cost was the most reported barrier of sustainability.

CCLD's mission is to promote the health, safety, and quality of life for each individual in community care by implementing an effective and collaborative regulatory enforcement system.[14] They provide oversight to Board and Care facilities in the County. Several interviewed Board and Care operators indicated that licensing is one of the greatest challenges to expanding their business because securing licensing and completing the necessary paperwork is a time-consuming process. One interviewee reported that it can take four to five months from property purchase to fulfill the licensing requirements. According to CCLD, operators must complete an application and demonstrate that they are financially viable, pass various background checks, meet training qualifications, and receive a recommendation from the Centralized Applications Bureau before the local regional office conducts their review. Then, CCLD would conduct a pre-licensing visit to ensure the facility meets various requirements under law and statute. If CCLD concludes that the facility adequately meets the needs of their residents, then they will recommend a license be issued.

[14] California Department of Social Services. (2023). Community Care Licensing Division. Retrieved from https://www.cdss.ca.gov/inforesources/community-care-licensing.

Despite the lengthy licensing process, multiple operators expressed satisfaction with communication with CCLD, highlighting that they feel comfortable reaching out whenever issues arise and receive helpful suggestions. Additionally, CCLD conducts annual visits to homes/facilities with residents with SMI. CCLD indicated a willingness to collaborate with SHCLA and invite them to Board and Care site visits to identify areas where facilities may require assistance.

A significant characteristic of Board and Care homes/facilities is whether or not they accept residents with SMI and/or SSI. Nearly two-thirds (63%) of ARFs who completed the survey have residents with an SUD, and most ARFs (88%) reported that they have at least one resident with a severe mental health impairment. In addition, 75 percent of ARFs reported that they currently serve at least one resident with a designated SMI tiered level of care need. Almost two-thirds (63%) of ARF facilities also indicated that they have at least one resident with a physical disability.

On the other hand, the majority (83%) of RCFEs reported that they do not have any residents with an SUD, and two-thirds reported that they do not currently serve any residents with severe mental health impairment. Additionally, half of RCFE survey respondents indicated that they do not currently serve any residents with a designated SMI tiered level of care. However, two-thirds of RCFEs reported that they currently serve at least one resident with a physical disability.

All survey respondents reported that they have residents who receive SSI, and most (92%) indicated that they receive patch/supplementary payments as well. However, survey respondents and Board and Care operators interviewed reported that **SSI and patch/supplementary payments have not increased to reflect the rising costs of living. This has hindered some operators' ability to pay staff at a comparable rate and has raised concerns regarding long-term viability.**

SHCLA continues to gather insights from ARF/RCFE operators and residents to ensure that its workforce development and training plan align with the skills, interests, and opportunities within the community. The training plan will incorporate a Board and Care career ladder, leveraging the Individual Placement and Support evidence-based framework and including elements from modified therapeutic communities. Among survey respondents, more than half (64%) of operators reported that they would or maybe need or would like support with training their staff on Board and Care best practices. When Board and Care operators interviewed were asked about areas of training that would be most helpful for them and their staff to receive related to ARF/RCFE best practices, operators indicated a desire for additional training on how to approach mental health challenges, and wholistic approaches for operating a Board and Care home/facility.

One of SHCLA's priorities is environmentally sustainable practices, such as energy efficiency, renewable energy, and green building designs. This contributes to reducing the environmental impact of housing and creating more sustainable communities. Additionally, SHCLA is conducting research around the benefits of biophilic design, a concept within the building industry that focuses on the use of direct nature to increase connection to the natural environment. This allows individuals with severe mental health challenges to connect and express themselves through the therapeutic nature of their environment.

SHCLA hopes to expand the number of Board and Care homes/facilities in the County by creating new ownership opportunities for operators. One way to do that is to move smaller operators to larger facilities and to move from rental to homeownership. Among survey respondents who currently rent their property, two-thirds indicated that they are interested in owning it. Operators who cannot afford homeownership could potentially master lease a property from SHCLA and continue to rent, but at a reduced rental rate.

SHCLA has also facilitated conversations with smaller operators to increase their capacity and move from smaller facilities to address financial sustainability concerns. SHCLA considers Board and Care homes/facilities a more appropriate setting for individuals with high needs that are often placed in traditional permanent supportive housing and larger affordable housing developments. They also aim to highlight the importance of Board and Care homes/facilities and their role in the housing continuum. They will continue to advocate for the important role they serve in the community and why they need to be supported.

Additionally, SCHLA seeks to create pathways out of Board and Care homes/facilities to permanent housing in home-like settings. Through its Family Partnership, SHCLA hopes to provide step-down housing for Board and Care residents who are ready to live in more independent settings. In turn, this would allow individuals from higher levels of care in hospitals and Institutes of Mental Disease the opportunity to fill open Board and Care units.

SHCLA also works to secure funding for the maintenance of Board and Care homes/facilities. The majority of survey respondents reported that their property has deferred maintenance. The estimated cost of needed repairs ranged from $500 to $375,000. Most Board and Care operators interviewed also indicated that their facilities have deferred maintenance such as bathrooms, kitchens, flooring, and bedroom updates. One interviewee reported that they have applied for maintenance and repair grants, but they are ineligible to apply for the CCEP grant because they do not own their facility.

Over the past year, SHCLA has facilitated communication with Board and Care operators about opportunities that exist, challenges that they face, and interest in property rental or ownership. SHCLA's Executive Director facilitates weekly calls with multiple HSP operators to discuss opportunities for acquiring property. One challenge identified by SHCLA is the operator's lack of trust related to public entities. SHCLA recognizes the importance of building trust over time and made a commitment to attend the HSP monthly meetings to foster open communication and develop relationships with Board and Care operators across the County. They will continue to emphasize community control, as SHCLA empowers residents to have direct control and decision-making power over the land and housing within the trust. The Board and Care Advisory Committee is designed to allow residents to have a say in how the trust is managed, ensuring the consideration of community needs and priorities.

There was some limited familiarity with SHCLA; however, Non-HSP operators did not share an understanding of SHCLA but reported they were excited to learn more about it. The HSP operators learned about SHCLA through introductions to the Executive Director and presentations at monthly HSP meetings. Among survey respondents, a little over half (57%) of operators reported that they would consider partnering with SHCLA to reduce the purchase price of a new facility. Board and Care operators interviewed hope that SHCLA can support them to prevent facility closures and serve individuals in their communities. One operator stated, "I hope that SHCLA will somehow ease the process and help with the stability of the Board and Care industry. This industry is crumbling and that leaves people without housing. I hope it can help alleviate homelessness."

Community Impact

Interagency and community collaboration among County and community partners, individuals with SMIs and their family members, affordable housing developers and other external stakeholders is key to achieving the broader goals of SHCLA. The organization hopes to go beyond providing stable and supportive housing to assist in creating an enhanced community partnership that works to improve the quality of life and well-being of all supportive housing residents.

Interviews with service providers highlighted some common challenges in providing quality supportive services to individuals with SMIs, and areas where SHCLA has the potential to assist.

- Insufficient funding and financial instability were identified as the greatest challenge by all Board and Care operators providing care for individuals reliant on public benefits. There is a large gap between monthly costs and SSI/SSP reimbursement rates which impacts all areas of operation. As a result, the quality of meals, activities and even staffing in each facility varies widely. Several operators also mentioned being financially unable to keep up with routine property maintenance due to rising costs. It was noted by service providers that the facilities with higher standards of living typically accept only high-functioning individuals.
- There is a need for training and education for staff, many of whom work with residents receiving behavioral health services. Training in crisis de-escalation, building trust and rapport with residents

and education on mental health diagnoses and how they present would be beneficial, and may prevent eviction. The costs associated with employing experienced, skilled staff are a big hurdle for many operators, and staff retention is a challenge.

- Access to behavioral health support and other systems of care was also seen as a challenge by operators and service providers. Approval from ACBH is required for an individual to receive supportive housing services, but primary diagnoses such as intellectual disabilities or traumatic brain injury are often not considered behavioral health despite the exhibited behaviors. The need for expanded partnerships with community-based organizations willing to work with individuals with behavioral health and/or substance use disorders was identified, along with training in behavioral health for staff.
- A renewed focus on coordinating care and services to move individuals to the next level of the continuum is needed. It is difficult to connect individuals with vocational, financial, and living skills needed to transition to independent living across the different placement types. It was also noted that coordination of care between the mental health and housing systems is challenging. Services are somewhat siloed and consistent and coordinated case management would be beneficial to improve quality of life.

Many of these identified challenges align with SHCLA goals to increase access to mental health and other services through the use of permanent support housing. The intention of SHCLA to promote greater collaboration among community-based organizations will also assist in addressing noted barriers. This past year, SHCLA has worked hard to build relationships within the community, vocalize their mission and continue to build new relationships.

Summary

As a start-up nonprofit, SHCLA had many accomplishments, challenges, and areas of opportunity, highlighted throughout the evaluation findings. Key findings are described below.

Key Findings

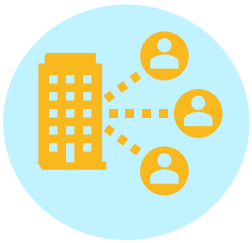
Achievements

- One of SHCLA's earliest accomplishments thus far has been receiving non-profit (501c3) status, submitting the 1023 application, and getting approval from the IRS. This completes one of SHCLA's short term outcomes.
- SHCLA successfully hired an Executive Director in November 2021.
- In 2021, the SHCLA recruited an Advisory Committee, which is comprised of a diverse membership including, but not limited to, the project management team, MHSA stakeholders, interested community members, National Alliance on Mental Illness (NAMI) members, individuals who utilize behavioral health and/or housing services, and family members.
- A primary objective and short-term outcome of the SHCLA was the establishment of a Board of Directors which is comprised of nine to 12 individuals represented by one-third consumers, one-third family members, and one-third community housing experts. There are currently four members on the Board of Directors.
- All Board of Directors governing documents have been created including bylaws and decision-making policies.
- SHCLA has established essential operational components such as a financial infrastructure, including a bank account, payroll processing, as well as health benefits for staff. To facilitate the onboarding processes, they have developed an onboarding guide, personnel handbook, and training plan for prospective new hires.
- The SHCLA is actively working towards securing larger sources of capital within the next year. This has included applications for Bay Area Housing Finance Authority (BAHFA), state and local Homekey, Community Care Expansion, and Homeless Housing, Assistance and Prevention (HHAP) Grant Program opportunities.
- The Executive Director meets with ACBH staff to discuss needs and opportunities for connections and funding for acquisitions.
- Over the past year, SHCLA has facilitated communication with Board and Care operators about opportunities that exist, challenges that they face, and interest in property rental or ownership.
- SHCLA's Executive Director meets with the HSP team once every other month to foster open communication and develop relationships with Board and Care operators across the County.
- SHCLA created social media platforms and conducted training sessions to optimize community and donor engagement in early 2023.
- They also launched the website's donation page, which provides information about various ways donors can contribute to the organization. As of April 2023, SHCLA received more than $2,000 in donations.
- On May 20, 2023, SHCLA hosted their second-anniversary community event at the Oakley Museum of California. Ultimately 98 individuals registered for the event, which served as a community engagement and fundraising opportunity for the organization.

Key Findings	
Challenges	• Initial SHCLA staffing was postponed by approximately four months due to delays in contract execution. The contract was executed in March 2023 and SHCLA received its first funds in May 2023. • There is a lack of understanding by stakeholders of what the innovation, model and value SHCLA brings to Alameda County. • SHCLA identified that Board and Care operators have a lack of trust related to public entities. • The County initially identified MHSA Capital Facilities and Technological Needs (CFTN) funding to purchase initial property for the project. However, SHCLA has not yet received CFTN funding, which has inhibited land and property acquirement. • Various funding sources require an organization to have at least three years of experience with audited financials and three projects that are similar in size or community served. Therefore, SHCLA is ineligible to receive these specific funds. • Overcoming biases and institutional complexity across the system is necessary.
Opportunities	• In light of implementation to date, SHCLA has identified staff positions that would be better suited for their current needs and would allow them to identify new opportunities for land and projects and manage them in a sustainable way. • Recruit new Board of Director members with critical lived or living experience. • Continue to search for ways to collaborate with community organizations such as BACS, and the Peer Wellness Collective. • Develop a shared understanding of what it means to innovate with this model. • SHCLA has made many presentations to stakeholders throughout the County. To further make their presence in the community known, SHCLA should continue and bolster presentations and outreach to educate community members and partners to garner support and buy-in. • Development of community and public sector champions from OHCC, HCD and other offices addressing housing and development. • Continue to seek funding opportunities to obtain its first property.

Recommendations

Based on process and outcome evaluation findings, the following recommendations are offered to expand on existing developments, improve implementation, and meet intended outcomes.



Expand Partnerships with Housing Development Entities and Real Estate Consultancy Firms

SHCLA should engage subject matter experts or consultants in housing development and real estate to create a plan for prioritized acquisitions for the next year. SHCLA would benefit from a synergy of financial expertise, regulatory insight, community engagement strategies, and risk management practices. These collaborations can strengthen SHCLA's ability to provide affordable housing, promote community resilience, and foster sustainable development.

This work could expand to evaluate family member and client mixed affordable and market rate developments. SHCLA can work with development organizations to finance and redevelop land and structures on behalf of three residential facility operators who currently lease and wish to purchase a 15-bed home for expanded operations.

SHCLA should also prioritize organizations who lead with environmentally sustainable practices, such as energy efficiency, renewable energy, and green building designs. This contributes to reducing the environmental impact of housing and creating more sustainable communities.

Explore Additional Funding Streams and Grant Opportunities to Finance Land Acquisition and Support Program Sustainability

Generating additional funding is linked to acquisition and sustainability. SHCLA should continue to seek funding opportunities through sources such as CCEP funding and grant and philanthropic opportunities. SHCLA could also explore how to utilize publicly funded rental subsidies in creative ways to expand opportunities for those with rental subsidies, to create opportunities for tenant ownership, and/or reinvestment of subsidy funds into expanding supportive housing unit availability.

Develop a Service Network Collaborative Model to Support Board and Care Homes/Facilities

SHCLA should continue to engage with Board and Care homes/facilities to develop a robust service model which utilizes community resources and networks in support of community integration, program delivery, and neighborhood cohesion. Services included in the logic model are sustainability and beautification initiatives like developing community gardens, food systems, and habitat restoration. In addition, community resources promote creativity and provide wellness activities utilizing living and performing arts, murals, free little libraries, and media donations.

SHCLA should continue to partner with Federally Qualified Healthcare Center (FQHC) service partners to support improving the health outcomes of individuals residing in ARF and RCFE facilities. Evidence-based practices should be implemented to improve health, promote resident stability, and support member facilities. SHCLA should connect advocacy partners, such as Cardea Health with HSP members and other licensed facilities to educate members on the needs of high acuity residents requiring additional care and provide updates on behavioral health, housing, and advocacy efforts.

Appendix A. Data Collection Summary

Method	Source	Purpose	Sample Questions
Program Documentation	• MHSA 2023 – 2026 Plan • Home Together 2026 Report • CCE Meeting Notes • SHCLA Quarterly Reports • Board of Directors (BOD) Meeting Minutes	• Component of the process evaluation • Assess how the SHCLA aligns and supports the goals of the MHSA 2023 – 2026 Plan • Assess potential funding opportunities for the SHCLA • Assess progress being made in the implementation of the SHCLA • Assess ongoing decision making and potential changes to SHCLA operations • Assess findings from recommendations and lessons learned from similar studies and their application to Alameda County	• What funding types can this model attract and secure? (Funding from foundations, healthcare, local/state revenue, MHSA, reinvestment of rental income, etc.) • What stakeholders serve on the BOD? • How often does the BOD meet? • What discussions and decisions are made and by whom provides guidance to the project?
Project Management Team Interviews	• Amy Faulstich • Teslim Ikharo	These interviews are aimed at understanding the implementation of the SHCLA pilot program including: • Alignment to work plan – intended activities compared to implemented activities • Staffing, • Filling Board of Director positions, • Engaging with various other government entities and housing development organizations, • Developing future funding opportunities and sustainability plans, • Hosting/Participating in community engagement activities.	• What has been the process of staffing the SHCLA and filling BOD positions? • What government entities and/or housing development organizations have you networked and/or partnered with? • Is there a network of County offices who work in coordination with one another to support housing needs and care coordination for individuals with SMI? • What can be done to strengthen partnerships between County agencies to support individuals with SMIs struggling with stable housing placement?

Method	Source	Purpose	Sample Questions
Collaboration OHCC Staff and HSP Liaison Interviews	• 1 – 2 with OHCC staff • 1 – 2 with HSP Liaisons	These interviews are aimed at understanding different OHCC partners' roles in improving the housing continuum and delivery of services to and by Board and Care homes/facilities.	• What are the greatest challenges of supporting ARF/RCFE facilities? • What services and support do ARF/RCFEs receive from OHCC and other entities in the County? ○ How do these services help to support Board and Care operations? • What is needed to meaningfully improve the sustainability and quality of ARF/RCFE facilities?

Collaboration Additional Key Informant Interviews	• 1 – 2 with Peer Support Groups - POCC
	• Community Care Licensing
	  ○ Issac Taggart
	• BHCS Critical Care
	  ○ Ann Elliot
	• Cardea Health Services
	  ○ Alexis Chettiar
	• Service Providers
	  ○ BACS
		• The POCC interviews are aimed at understanding the role peers play in supporting individuals with SMIs/SUDs who reside in Board and Care homes/facilities.
		• The CCL interview is aimed at understanding ARF/RCFE operations including certification, licensing, and staffing, risk of and reason for ARF/RCFE closures, how closures impact the housing continuum, and financial sustainability of ARF/RCFEs. PCG will also discuss the Board and Care quantitative data collected by CCLD.
		• The BHCS Critical Care interview is aimed at understanding the process of referring and providing critical care services for individuals with SUDs/SMIs who reside in Board and Care homes/facilities.
		• The Cardea Health Services interview is aimed at understanding how non-profit public health programs can coordinate with SHCLA to improve the coordination of care and outcomes for individuals
			• How often do you coordinate with Alameda County Behavioral Health Services (ACBH) and OHCC, among others?
			• What services and support do ARF/RCFEs receive from other entities in the County?
			• How do ARFs/RCFEs ensure high standards and quality of life for their residents.
			  ○ Peer support networks?
			  ○ On-site professional supportive services to increase resident engagement with case managers and mental health professionals?
			  ○ Community-based resources available to offer on-site enrichment activities to improve resident quality of life?
			  ○ What organizations/resources exist to support ARF/RCFE residents with SMIs?
			• Can you describe the coordination of care between your organization and the ARF/RCFE facilities your clients reside at?
			• What can be done to foster better coordination of care among service providers/care coordinators and ARF/RCFE facilities?

Method	Source	Purpose	Sample Questions
		who reside in Board and Care homes/facilities. • The service provider interviews are aimed at understanding how case managers coordinate services for their clients who reside in Board and Care homes/facilities and how SHCLA can help improve quality of life of residents.	• What can be done to strengthen partnerships between County agencies to support individuals with SMIs struggling with stable housing placement? ○ How can you partner with SHCLA?
Board of Directors Meeting	• Current Supportive Housing Community Land Alliance Board Members	These meetings are aimed at understanding BOD's perception of the effectiveness of the land trust, including what contributed to or impeded success. "Effectiveness" will be operationalized as: • well facilitated/structured meetings, • opportunities for all voices to be heard, • concrete decision-making structure, terms of service for the BOD, • clear/structured application process to become a BOD member, etc.	• How often do you communicate as a group between regularly scheduled meetings? • What is the application and selection process for new board members? • What have been your greatest achievements this year? • What are the greatest opportunities for the SHCLA?
HSP & Non-HSP ARF and Board and Care Director Site Visit/ Interviews	• HSP - Will be conducted during site visits ○ 2 – 3 ARF interviews ○ 2 – 3 RFCE interviews • Non-HSP Will be conducted during site visits ○ 2 – 3 ARF interviews ○ 2 – 3 RFCE interviews	Meet Board and Care Operators where they are to better understand: • operations including certification, licensing, and staffing, • satisfaction coordinating with ACBH, • satisfaction with the work they do, • excitement about future opportunities and programs to continue their work. We also use site visits to assess: • best practices, • challenges operators are facing,	• Are you familiar with OHCC or the SHCLA? • What are the greatest challenges of operating and maintaining an ARF/RCFE facility? • What is needed to meaningfully improve the sustainability and quality of ARF/RCFE facilities? • What have been the top three challenges hiring and retaining qualified and reliable staff members? • Are you interested in expanding your business and developing additional facilities to serve individuals with SMI? What assistance would you need to expand your organization?

Method	Source	Purpose	Sample Questions
		• needs to mitigate challenges. Finally, we discuss with operators how the SHCLA can support them if they are at risk of closure or have a desire to expand operations.	• What training and/or support would be helpful to receive related to ARF/RCFE best practices? What are the greatest training and professional development needs for you and your staff? • Do you partner with other organizations (community care licensing; ARF/RCFE facilities; County Department of Housing and Homelessness) to identify and mitigate challenges your facility is experiencing?
Board and Care Facility Survey	• Current licensed CCL facilities in Alameda County who accept SSI/SSP	The purpose of the Board and Care Operator survey is to gain a broader sense of operations and needs (staff, training, capital), cost of operations and cost-saving strategies, as well as long-term planning and sustainability for facilities.	• How many beds/units do you have? • What is the amount of patch per resident? • Does your property have any deferred maintenance? This could include electrical, roof, bathrooms, kitchens, landscaping, community room, etc. • What are the leading factors contributing to risk of closure or sale of your facility? • Please describe common behavioral or health challenges of your residents.
Peer Support Focus Groups	• 2 Focus Groups ○ 10 participant goal	The purpose of the focus group is to better understand peer experiences and how they could support residents and the SHCLA.	• Have any of you ever lived or currently live in an ARF/RCFE? What was your experience living in these facilities? ○ How well maintained were the grounds? ○ Were food options healthy and nutritious? ○ Were you allowed a comfortable degree of privacy? • What do ARF/RCFEs do to meet the needs of residents who have SMIs/SUDs? • What can be done to improve the quality of life of ARF/RCFE residents with SMIs/SUDs?

Appendix B. Key Informant Interview Data Collected

Data Source	Description	Number of Participants
Program Management Interviews	Interviews were conducted with several members of the Project Management Team. These interviews were aimed at understanding the implementation of SHCLA Pilot Program.	2
OHCC Staff Interviews	Interviews were conducted with OHCC staff persons and both HSP and non-HSP liaisons. These interviews were aimed at understanding different OHCC partners' roles in improving the housing continuum and delivery of services to and by Board and Care homes/facilities.	2
CCLD Interview	An interview was conducted with a CCL staff person, with the aim of understanding ARF/RCFE operations, including licensing, staffing, financial sustainability and risk and reason of ACF/RCFE closures.	1
BHCS Critical Care Interview	An interview was conducted with a staff person with Alameda Behavioral Health Care Services (BHCS) Critical Care. This interview was aimed at understanding the process of referring and providing services for individuals with SMIs who reside in Board and Care homes/facilities.	1
Bay Area Community Services Focus Group	A focus group was conducted with service providers with the aim of understanding how case managers coordinate services for their clients who reside in Board and Care homes/facilities and how SHCLA can help improve quality of life for residents.	6
SHCLA Board of Directors Meeting	This meeting was aimed at understanding Board of Director's perception of the effectiveness of the land trust, including what contributed to or impeded success.	4
Board and Care Operators	Interviews were conducted on site and virtually with Board and Care Operators from the HSP Network and broader community.	8

Appendix H-1 | MHSA Update (FY24/25) Public Comments (English)

Name or Contact	Comments:	Date Submitted
1. N/A	I know to some extent this is unavoidable, however I feel it's important to say that an 800+ page plan with an hour long "how to read this plan" webinar is pretty inaccessible for most people. I'm not saying this should be a tiktok video, but it seems like there is room for some middle ground. ACBH/MHSA Response: Thank you for your public comment. Each county is required by the State of California to include certain program information, fiscal details and planning information in the Annual Plan Update. The MHSA team has taken steps this year to create an Annual Plan Update where the information is easy to find, easy to use, easy to understand. It's been designed to have hyperlinks, color coordination and succinct language that can help the reader decipher the information they want to read. We will also continue to work to improve this report and its length.	**4/10/24**
2. Santi Munoz	To extend services in the further east bay. First time I've hear of mental health services as a community endeavor. Send info out to Hayward Public Libraries ACBH/MHSA Response: Thank you for your public comment. Alameda County MHSA funds mental health programs with a fluctuating multi-million dollar annual budget. To learn more about the programs funded through Alameda County please read the MHSA Annual Plan Update FY24/25 located at https://acmhsa.org/reports-data/#mhsa-plans. We will also work to provide more outreach to the library system.	**4/22/24**
3. Jaime	We are happy to see that the Alameda County MHSA plan draft proposes a number of support services for the youth LGBTQIA+ population! As you know, LGBTQIA+ communities have had quite traumatic experiences associated with social discrimination and legal persecution, with same-sex sexual orientation at one time being categorized as a mental illness under the diagnostic and statistical manual of mental disorders (DSM) prior to 1973! The research shows that as a group, the LGBTQIA+ population consumes more alcohol, with lesbian and bisexual women at higher risk for alcohol use disorder and transgender men and women also being at higher risk. In particular, LGBTQIA+ youth are more likely to consume nicotine through cigarettes and vaping while struggling with a higher prevalence of mental health conditions this day and age. A large body of research also shows that early initiation of substance use is associated with higher levels of use later in life, increased risk of addiction and negative outcomes including violent and maladaptive behavior, poor physical health and mental health problems. It is so important then to engage our LGBTQIA+ population sooner, and to offer the support services that they need which may mitigate a number of risk factors. Alameda County's thoughtful approach of adding a youth and young adult LGBTQIA+ drop-in center is so important for our at-risk youth and we hope to see this service utilized by communities which they are intending to serve! These drop-in centers will serve as a safe space where many services will be provided such as a projected 75+ hours of therapy monthly, outreach and other support! In the face of impending payment reform which will likely impact ACBH and the system of care, it is important to keep these services for the underserved LGBTQIA+ population intact!	**4/22/24**

	ACBH/MHSA Response: Thank you for your comment. Alameda County will continue to fund programs that help LGBTQIA+ mental health.	
4. July	yes: Re the HEAT team- you able to hire and plan with existing homelessness outreach teams as part of the engagement strategy? Wood St Outreach Team, Food not Bombs, Community Kitchens... there are so many mutual aid and CBO groups that already to a large part of this work that just need to know what resources to connect people with. ACBH/MHSA Response: Thank you for your comment and recommendations. Two additional resources for you are the Alameda County Public Health Nutrition team (https://acphd.org/nutrition-services/) and the Alameda County Office of Homeless Care and Coordination (https://homelessness.acgov.org/index.page).	**4/24/24**
5. Mimi Michael	Due to the recent suicide rates in the Almeda County among the youth, we need prevention programs for the youth. We need early intervention programs for the youth. ACBH/MHSA Response: Thank you for your comment. MHSA funding does support suicide and crisis prevention work. For additional resources please go to Crisis Support Services of Alameda County. To learn more about the programs funded through Alameda County please read the MHSA Annual Plan Update FY24/25 located at https://acmhsa.org/reports-data/#mhsa-plans.	**4/25/24**
6. Anne Moe	Don't know what the annual plan is, but will try to read about it in the next few days. ACBH/MHSA Response: Thank you for your comment. To learn more about the programs funded through Alameda County please read the MHSA Annual Plan Update FY24/25 located at https://acmhsa.org/reports-data/#mhsa-plans.	**4/26/24**
7. Alma Esparza	Yo pienso que se necesita más fondos para la salud mental *I think that more funds are needed for mental health.* ACBH/MHSA Response: Gracias por su comentario público. Para obtener mas información sobre los programas financiados a través del Condado de Alameda, por favor lea la Actualización Anual del Plan MHSA FY24/25 ubicada en https://acmhsa.org/reports-data/#mhsa-plans. Thank you for your public comment. To learn more about the programs funded through Alameda County please read the MHSA Annual Plan Update FY24/25 located at https://acmhsa.org/reports-data/#mhsa-plans.	**5/8/24**
8. María Hilda Ramírez	Hola pues yo quiero pedir por favor empatía para personas que hemos pasado por traumas o situaciones de abuso sexual familiar los sicólogos o doctores que no refieren a especialista no toman en serio alas victimas nos dicen que nos vallan a llamar y nunca se comunican con nosotros más seriedad por favor *I want to ask for empathy for people who have gone through traumas or situations of family sexual abuse. Psychologists or doctors who do not refer us to specialists do not take victims seriously. They tell us they will call us back and never get in touch with us. Please more seriousness.* ACBH/MHSA Response:	**5/8/24**

	Gracias por su comentario público. El Programa ACCESS es el punto de contacto de todo el sistema para información, evaluación y referencias para servicios y tratamientos de salud mental y uso de sustancias para los residentes del Condado de Alameda. ACCESS es un servicio telefónico atendido de 8:30am a 5:00pm de lunes a viernes por clínicos de salud mental licenciados y apoyo administrativo para una variedad de servicios ambulatorios. Fuera de este horario, las llamadas son atendidas por los Servicios de Apoyo en Crisis del Condado de Alameda. Para hablar con alguien por teléfono, puede comunicarse con nuestro equipo de ACCESS 1-800-491-9099. La otra opción es el número de crisis: 988 Thank you for your public comment. The ACCESS Program is the system wide point of contact for information, screening and referrals for mental health and substance use services and treatment for Alameda County residents. ACCESS is a telephone service staffed from 8:30am-5:00pm Monday-Friday by licensed mental health clinicians and administrative support for both general behavioral questions and determining eligibility for a range of outpatient services. After hours are answered by Crisis Support Services of Alameda County. To speak with someone on the phone you can reach our ACCESS team: 1-800-491-9099. The other option is the crisis number: 988.	
9. Paula	Es muy importante , Para las personas tener acceso a la salud mental, para mejorar. La calidad de vida dela población *It is very important for people to have access to mental health services in order to improve the quality of life for the population.* ACBH/MHSA Response: Gracias por su comentario público. Para obtener mas información sobre los programas financiados a través del Condado de Alameda, por favor lea la Actualización Anual del Plan MHSA FY24/25 ubicada en https://acmhsa.org/reports-data/#mhsa-plans. Thank you for your public comment. To learn more about the programs funded through Alameda County please read the MHSA Annual Plan Update FY24/25 located at https://acmhsa.org/reports-data/#mhsa-plans.	**5/8/24**
10. Yolanda urioste	Aún no conozco este plan solo se que tomo medicamentos para depresión y salud mental severa no en un año no e podido encontrar un siquiatra o grupos de locos como yo *I still don't know about this plan, only that I take medication for depression and severe mental health. In a year, I haven't been able to find a psychiatrist, or groups of crazy people like me.* ACBH/MHSA Response: Gracias por su comentario público. El Programa ACCESS es el punto de contacto de todo el sistema para información, evaluación y referencias para servicios y tratamientos de salud mental y uso de sustancias para los residentes del Condado de Alameda. ACCESS es un servicio telefónico atendido de 8:30am a 5:00pm de lunes a viernes por clínicos de salud mental licenciados y apoyo administrativo para una variedad de servicios ambulatorios. Fuera de este horario, las llamadas son atendidas por los Servicios de Apoyo en Crisis del Condado de Alameda. Para hablar con alguien por teléfono, puede comunicarse con nuestro equipo de ACCESS 1-800-491-9099. La otra opción es el número de crisis: 988	**5/9/24**

	Thank you for your public comment. The ACCESS Program is the system wide point of contact for information, screening and referrals for mental health and substance use services and treatment for Alameda County residents. ACCESS is a telephone service staffed from 8:30am-5:00pm Monday-Friday by licensed mental health clinicians and administrative support for both general behavioral questions and determining eligibility for a range of outpatient services. After hours are answered by Crisis Support Services of Alameda County. To speak with someone on the phone you can reach our ACCESS team: 1-800-491-9099. The other option is the crisis number: 988.	
11. Jaleah Winn	The 24/25 annual plan is nicely organized. It is detailed yet succinct. Many kudos to the team who composed the report. I have some questions: How are MHSA program successes measured? What support is available to MHSA programs that do not meet program goals? How is MHSA funding determined for its programs? Thank you, very much. ACBH/MHSA Response: Thank you for your public comment. Alameda County enters into agreements with programs and sets forth attainable benchmarks in connection with the contracted provider. Programs agree on these community serving benchmarks per their contract. Alameda County conducts program monitoring and provides technical assistance in accordance with contractual agreements. Program funding is determined by the contractual agreement and approval by the Board of Supervisors.	**5/13/24**
12. Eleni Spiru	The common misconception that the VA provides care to all veterans has become a persistent barrier to adequate resources in Alameda County. Our political leaders and state and local agencies must understand that while the VA brings significant federal funds to California, the VA is not a replacement for state and local resources, and VA services do not provide for all veterans or all veteran needs. Like any other population group, as citizens of California veterans need and deserve state and local options for care. We are grateful for the Governors and the Legislature's efforts to update and improve the MHSA/BHSA reforms, including additional venues for substance use treatment and housing options for veterans with mental health needs. However, it appears that the overall plan provides no improvements in funding for veteran services, and therefore supportive service dollars will be even more difficult to secure. We are concerned that veterans continue to be extremely underfunded in county MHSA plans and will not be adequately addressed in the Alameda County mental health BHSA funding formula. As the stakeholder listening sessions identified, veterans are a vulnerable population and require specialized support. We recommend that a guaranteed percentage of BHSA funds be directed to veterans in Alameda County. 1. In implementing the FSP requirements, the FSP allocation should include a requirement for subcontracting funds to veteran organizations. Generally, community-based veteran serving agencies do not have the capacity to be FSPs, as they do not have the administrative capacity to deal with medical billing and serve a specific cohort of the county population in need. Subcontracting with FSPs will allow veteran organizations to be included in these coordinated services. 2. The Behavioral Health Services and Supports allocation could also include veteran services since veterans can experience behavioral health, substance use, and or co-occurring mental health, behavioral health, and substance use issues. 3. Further, Alameda County must report annually on the amount of funding provided to veteran-specific programs/organizations. Transparency and accountability are important; veterans need their fair share of county resources.	**5/13/24**

	ACBH/MHSA Response: Thank you for your public comment. The concerns regarding the capacity of veteran FSPs are noted and will be shared with ACBHD Leadership and discussed internally as we prepare for BHSA program planning later in the year.	
13. Reece Huff	The common misconception that the VA provides care to all veterans has become a persistent barrier to adequate resources in Alameda County. Our political leaders and state and local agencies must understand that while the VA brings significant federal funds to California, the VA is not a replacement for state and local resources, and VA services do not provide for all veterans or all veteran needs. Like any other population group, as citizens of California veterans need and deserve state and local options for care. We are grateful for the Governors and the Legislature's efforts to update and improve the MHSA/BHSA reforms, including additional venues for substance use treatment and housing options for veterans with mental health needs. However, it appears that the overall plan provides no improvements in funding for veteran services, and therefore supportive service dollars will be even more difficult to secure. We are concerned that veterans continue to be extremely underfunded in county MHSA plans and will not be adequately addressed in the Alameda County mental health BHSA funding formula. As the stakeholder listening sessions identified, veterans are a vulnerable population and require specialized support. We recommend that a guaranteed percentage of BHSA funds be directed to veterans in Alameda County. 1. In implementing the FSP requirements, the FSP allocation should include a requirement for subcontracting funds to veteran organizations. Generally, community-based veteran serving agencies do not have the capacity to be FSPs, as they do not have the administrative capacity to deal with medical billing and serve a specific cohort of the county population in need. Subcontracting with FSPs will allow veteran organizations to be included in these coordinated services. 2. The Behavioral Health Services and Supports allocation could also include veteran services since veterans can experience behavioral health, substance use, and or co-occurring mental health, behavioral health, and substance use issues. 3. Further, Alameda County must report annually on the amount of funding provided to veteran-specific programs/organizations. Transparency and accountability are important; veterans need their fair share of county resources. ACBH/MHSA Response: Thank you for your public comment. The concerns regarding the capacity of veteran FSPs are noted and will be shared with ACBHD Leadership and discussed internally as we prepare for BHSA program planning later in the year.	**5/14/24**
14. Elliot Ki	The common misconception that the VA provides care to all veterans has become a persistent barrier to adequate resources in Alameda County. Our political leaders and state and local agencies must understand that while the VA brings significant federal funds to California, the VA is not a replacement for state and local resources, and VA services do not provide for all veterans or all veteran needs. Like any other population group, as citizens of California veterans need and deserve state and local options for care. We are grateful for the Governors and the Legislature's efforts to update and improve the MHSA/BHSA reforms, including additional venues for substance use treatment and housing options for veterans with mental health needs. However, it appears that the overall plan provides no improvements in funding for veteran services, and therefore supportive service dollars will be even more difficult to secure. We are concerned that veterans continue to be extremely underfunded in county MHSA plans and will not be adequately addressed in the Alameda County mental health BHSA funding formula. As the stakeholder listening sessions identified, veterans are a vulnerable population and require specialized support. We	**5/14/24**

	recommend that a guaranteed percentage of BHSA funds be directed to veterans in Alameda County. 1. In implementing the FSP requirements, the FSP allocation should include a requirement for subcontracting funds to veteran organizations. Generally, community-based veteran serving agencies do not have the capacity to be FSPs, as they do not have the administrative capacity to deal with medical billing and serve a specific cohort of the county population in need. Subcontracting with FSPs will allow veteran organizations to be included in these coordinated services. 2. The Behavioral Health Services and Supports allocation could also include veteran services since veterans can experience behavioral health, substance use, and or co-occurring mental health, behavioral health, and substance use issues. 3. Further, Alameda County must report annually on the amount of funding provided to veteran-specific programs/organizations. Transparency and accountability are important; veterans need their fair share of county resources. Q2 ACBH/MHSA Response: Thank you for your public comment. The concerns regarding the capacity of veteran FSPs are noted and will be shared with ACBHD Leadership and discussed internally as we prepare for BHSA program planning later in the year.	
15. Yvette Fee	What is this about? ACBH/MHSA Response: Thank you for your public comment. Alameda County MHSA funds mental health programs with a fluctuating multi-million annual budget. Funded mental health programs fall into several categories: Community Services & Supports, Full Service Partnerships, Prevention & Early Intervention, Innovation, Workforce Education and Training, Capital Facilities and Technology Needs. To learn more about the programs funded through Alameda County please read the MHSA Annual Plan Update FY24/25 located at https://acmhsa.org/reports-data/#mhsa-plans.	**5/14/24**
16. Alameda Health Consortium	May 15, 2024 Dr. Karyn L. Tribble, PsyD, LCSW, Director Alameda County Behavioral Health Mental Health Services Act Division 2000 Embarcadero Cove, Suite 400 RE: Mental Health Services Act; FY24-25 Annual Plan Update Dear Dr. Tribble, The Alameda Health Consortium (AHC) appreciates the opportunity to comment on Alameda County Behavioral Health Care Services (ACBH) Department's Fiscal Year (FY) 2024 - 2025 Mental Health Services Act (MHSA) Program and Expenditure Plan. AHC supports the FY 24-25 spending plan and encourages inclusion of our network of health centers in the County process to develop and improve BH services, including the spend plan under the new spending authorizations of the Behavioral Health Services Act. The Alameda Health Consortium is the regional association of eight community health centers that work together and support the involvement of our communities in achieving comprehensive, accessible health care and improved outcomes for everyone in Alameda County, California. Collectively, our health centers provide primary medical, behavioral health, dental care and supportive services to more than 286,000 patients at over 110 clinic sites and 21 mobile units throughout the East Bay.[i] Together, we advocate for high-quality healthcare for the underserved in the East Bay; share best practices to sustain, expand and diversify our community's safety-net healthcare workforce; and collaborate as thought partners with policymakers to inform, shape, and implement health policy changes. We appreciate ACBH's continued investments in the historic partnerships that we developed over many years. These investments have supported the integration of behavioral health services into our primary care health centers and our culturally tailored behavioral health programs, which are the backbone of the behavioral health work at our health centers. These programs include: -Integrated	**5/15/24**

	Behavioral Health Care Coordinator and Pediatric Care Coordinator (PCC) In FY 2022 – 2023, PCCs made 6,330 linkages to care to resources like WIC, Help Me Grow, regional centers, school-based services and supported 1300+ patients with positive Adverse Childhood Experiences screeners. A preliminary analysis showed that with every additional care coordinator touch, (on average) the total cost of care per patient decreases by $266. CC's have become the backbone of our health center's integrated BH programming. -Prevention and Early Intervention programs at Native American Health Center, Bay Area Community Health, Asian Health Services, La Clinica de la Raza, and Tiburcio Vasquez Health Center An example of a PEI program is Cultura y Bienestar (CyB), a partnership between two of our member health centers, La Clinica, Tiburcio Vasquez, and a partner CBO - La Familia. CyB annually serves an average of 720 individuals through outreach, 320 individuals through community events, 330 individuals through workshops and leadership training, and 2,800 individuals through prevention and early intervention. -ACCESS Language Line at Asian Health Services This crucial intake and referral phone line serves as a gateway to specialty mental health services through ACBH ACCESS in over 9 Asian Pacific Islander languages; providing 376 unduplicated intake clients with 1,476 service contacts in FY22-23. -Axis Bridge – Mental Health Urgent Care at Axis Community Health Axis Bridge, Axis Community Health's innovative mental health urgent care service, served 809 unduplicated patients in 2023 with 1,611 referrals into the program. This resulted in 2,522 total program therapy and psychiatry visits and 2,160 total program stabilization service visits. AHC supports ACBH's FY 24-25 MHSA Plan Update to strengthen access to behavioral health services in Alameda County to better serve our patients. Alameda County' s investment in these services offsets structural challenges of the federally qualified health center (FQHC) prospective payment system (PPS). These challenges include not recognizing care coordinators as billable providers and the State of California not allowing FQHCs to bill for mental health services on the same day as medical services. We appreciate ACBH's efforts to address the need for equitable and community focused behavioral health services. Alameda Health Consortium is concerned about Proposition 1's impact on programs historically funded through MHSA. We look forward to working with our county partners to plan for the sustainability of these crucial programs. AHC urges ACBH to take an intentional approach to proactively include federally qualified health centers (FQHCs) as the MHSA transforms into "Behavioral Health Services Act" (BHSA) with the passing of Proposition 1. Sincerely, Toni Panetta, Chief Impact Officer [i] While all 8 FQHCs have multiple sites in Alameda County, the following FQHCs also serve neighboring counties: Bay Area Community Health (Santa Clara County), La Clinica de la Raza (Contra Costa and Solano counties), Native American Health Center (San Francisco County), and LifeLong Medical Care (Contra Costa County). The types of clinic sites operated by health centers in Alameda County include: comprehensive primary preventive care (medical, dental, and mental/behavioral health services); supportive housing; Women's, Infant & Children (WIC) locations; health education and wellness centers; stand-alone behavioral health services; and school-based clinics. Additionally, health centers operate 21 mobile units; 3 FQHCs contract with Alameda County Health Care for the Homeless to provide Street Health teams to serve individuals experiencing homelessness in Oakland, Hayward, Castro Valley, and Fremont (https://www.achch.org/street-health.html); and our FQHCs are lead operating agencies for 28 of the County's 32 school-based clinics across 8 school districts through contracts with Alameda County Center for Healthy Schools and Communities (https://achealthyschools.org/wp-content/uploads/2020/04/125_School_Heath_Centers_Model-1.pdf). Q2	

	ACBH/MHSA Response: Thank you for your public comment. Alameda County thanks the Alameda Health Consortium (AHC) and the 8 participating health centers in the multitude of health care and behavioral health services they provide to Alameda County residents. The concerns of your public comment are noted and will be shared with ACBHD Leadership and discussed internally as we prepare for BHSA program planning later in the year.	
17. Aaron Ortiz	I am pleased to announce a significant development in our ongoing efforts to address mental health disparities within the Latino community in Alameda County. As part of our commitment to inclusivity and community-driven initiatives, La Familia acknowledges the establishment of the Latinx Steering Committee in 2023. This committee represents a pivotal step forward in our collective mission to ensure that the mental health needs of the Latino community are effectively addressed and supported. The Latinx Steering Committee has undertaken the crucial task of compiling a Utilization Report, which aims to provide a comprehensive understanding of the challenges and opportunities within our community. Through extensive outreach efforts, hundreds of community members across the county have been surveyed to gather valuable insights into the specific needs and concerns regarding mental health services among Latinos. This initiative is particularly timely and relevant given the unique challenges facing the Latino community in Alameda County. According to recent data, Latinos continue to experience disparities in access to mental health services, with higher rates of unmet needs and lower utilization of available resources compared to other demographic groups. These disparities are often compounded by factors such as language barriers, cultural stigmatization, and limited access to culturally competent care. By harnessing the collective wisdom and lived experiences of our community members, we are better equipped to design and implement targeted interventions that address the root causes of mental health disparities. Through the Utilization Report, we aim to identify gaps in service delivery, advocate for equitable resource allocation, and foster partnerships with key stakeholders to promote culturally responsive care for Latinos in Alameda County. As CEO of La Familia, I am proud to support the efforts of the Latinx Steering Committee and reaffirm our organization's commitment to advancing health equity for all members of our community. Together, we will continue to work tirelessly to ensure that every individual receives the support and care they need to thrive. ACBH/MHSA Response: Thank you for your public comment. The concerns of your public comment are noted and will be shared with ACBHD Leadership and discussed internally as we prepare for BHSA program planning later in the year.	**5/15/24**
18. Juliet Leftwich	I am a member of the Alameda County Mental Health Advisory Board (MHAB) and we commented on the Annual Plan today at our May 20 monthly meeting. The MHAB will also be writing a letter to the Board of Supervisors with our comments. The comments I made today are that: 1) the County needs to conduct a quantitative, evidence-based needs assessment before it can determine how to best utilize MHSA funds (the MHAB made this recommendation to the Board of Supervisors in our letter dated June 21, 2023, regarding the Three-Year Plan and has made the recommendation repeatedly over the last several years); 2) the FY 24/25 Plan should contain more background information about the Safe Landing Project at Santa Rita Jail and describe how MHSA funds will be used to expand the Project; and 3) there is a typographical error on p. 19 of the Plan - the second sentence of the description of Overnight Mobile Crisis Services should say they hope to staff the second half of the week by the end of "January 2025," not "January 2024."	**5/20/24**

	ACBH/MHSA Response: Thank you for your public comment. The MHSA team will make the identified corrections and edits to the Draft MHSA Plan Update FY 24/245. The additional request for the needs assessment process is noted and will be shared with ACBHD Leadership.	
19. Alice Feller	See attached document on early psychosis program. Thank you for your public comment.	**5/20/24**

Proposal for early intervention in psychosis

Alameda needs another early intervention in psychosis program (aka Coordinated Specialty Care) program. We understand that Felton Institute in the city of Alameda does provide such a service, but they are limited in several ways that preclude service to the entire county.

First, they are limited to clients who are either on Medi-Cal or Medi-Cal eligible, which leaves out the majority of young people suffering a first break. Second, while they are increasing their staff so as to be able to serve up to 100 clients, but as of 3/13/24 they have a census of 50. Meanwhile, the need for this service in the county is in the hundreds. Third, they are located in the city of Alameda, which is inaccessible to many residents outside that city. Accessibility is important, as this program requires frequent visits for both patient and family members. Finally, some individuals do not begin to show the first signs of illness before their early twenties, and Felton's age cutoff at 24 excludes some who could otherwise meet the criteria. We recommend that the age cutoff be 30, not 24. This will also allow the program to be funded through Adult Services as well as TAY.

As we envision it, the program would provide **four basic services to each patient throughout the two-years of their participation**:

1) Long-term **psychotherapy** to provide emotional support, establish a therapeutic alliance and help the young person cope with this calamity and move ahead with their life.

2) **Medication** management with a psychiatrist experienced in the treatment of serious mental illness, to meet regularly with the young person and together work to find the most effective medication with the least side effects at the lowest dose. The psychiatrist needs to be located with the rest of the team for essential collaboration.

3) **Family involvement** from the beginning, to provide much-needed support and education, to collaborate on care and to form a working alliance with the family.

4) **Vocational rehabilitation** to help the young person return to school or work at the earliest opportunity.

Staffing the program: we will need well-trained clinicians with relevant expertise to provide psychiatric care and long-term therapy. A person experienced with family work would be ideal to be the lead on family involvement, although families should meet with the clinicians treating their loved ones as well. A peer advocate might be a good fit for the vocational rehabilitation work.

A **receptionist** to greet patients and family members, answer phones and provide clerical services as needed. Receptionists can be wonderful, and good ones provide the welcoming presence essential to these clients.

Location: the service will need a dedicated clinic space, with a waiting room, small offices for individual meetings and a large room for group meetings and staff meetings. Because this approach to treatment relies heavily on **collaboration** between all the staff members including the receptionist, it is important that the program be housed in one location, with ample opportunity for all the staff to collaborate closely. Such collaboration is important to treatment outcome, formally in meetings as well as informally. (Studies show that medical care is

significantly more effective in clinic settings where the team members have frequent face-to-face contact with one another. Frequent email contact has no beneficial effect.) (Mundt et al, 2015) Also collaboration among staff is crucial for maintaining morale in this work.

Financing: We believe that the new MHSA funds available for early intervention and prevention should be used to fund this program. Although we can't prevent schizophrenia we can significantly change its course with proper early intervention, and help the young person to resume his or her former life. Studies on early intervention in schizophrenia bear this out. (Dixon et al, 2018).

In order to use staff time wisely and to provide useful medical records, the EMR should be dedicated to patient care and EMR records should not be used for billing. It is important for this program to be funded directly, as with IHOT in Alameda County. Rather than fee for service, the program should be supported directly through funds available for early intervention and prevention, which is desperately needed in Alameda County. An additional funding stream could be provided on a per person per month basis, rather than fee for service, again to preserve medical records and free staff time for patient care.

Alice Feller, M.D.
alicefeller967@gmail.com
alicefellermd.com

References

Dixon, L, Goldman, H, Srihari, V. and Kane, J. 2018. "Transforming the Treatment of Schizophrenia in the United States: The RAISE Initiative" Annu Rev Clin Psychol. 2018 May 7; 14: 237–258. doi: 10.1146/annurev-clinpsy-050817-084934

Mundt, Marlon, Gilchrist, Valerie, Fleming, Michael, Zakletskaia, Larissa, Tuan, Wen-Jan and Beasley, John. 2015. "Effects of Primary Care Team Social Networks on Quality of Care and Costs for Patients With Cardiovascular Disease." *The Annals of Family Medicine* March 13 (2) 139-148.

Feller, A. *American Madness: Fighting to Help Patients in a Broken Mental Health System* (2024) Rowman & Littlefield.

Enclosure 1

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION[1]

County/City: ALAMEDA

☐ Three-Year Program and Expenditure Plan
X Annual Update
☐ Annual Revenue and Expenditure Report

Local Mental Health Director	County Auditor-Controller / City Financial Officer
Name: Karyn Tribble, ACBH Director	Name: Melissa Wilk
Telephone Number: (510) 567-8100	Telephone Number: (510) 272-6565
E-mail: Karyn.Tribble@acgov.org	E-mail: melissa.wilk@acgov.org
Local Mental Health Mailing Address: 2000 EMBARCADERO COVE, SUITE 400 OAKLAND, CA 94606	

I hereby certify that the Five-Year Program and Expenditure Plan, Annual Update or Annual Revenue and Expenditure Report is true and correct and that the County has complied with all fiscal accountability requirements as required by law or as directed by the State Department of Health Care Services and the Mental Health Services Oversight and Accountability Commission, and that all expenditures are consistent with the requirements of the Mental Health Services Act (MHSA), including Welfare and Institutions Code (WIC) sections 5813.5, 5830, 5840, 5847, 5891, and 5892; and Title 9 of the California Code of Regulations sections 3400 and 3410. I further certify that all expenditures are consistent with an approved plan or update and that MHSA funds will only be used for programs specified in the Mental Health Services Act. Other than funds placed in a reserve in accordance with an approved plan, any funds allocated to a county which are not spent for their authorized purpose within the time period specified in WIC section 5892(h), shall revert to the state to be deposited into the fund and available for counties in future years.

I declare under penalty of perjury under the laws of this state that the foregoing and the attached update/revenue and expenditure report is true and correct to the best of my knowledge.

KARYN TRIBBLE, ACBH DIRECTOR
Local Mental Health Director (PRINT)

DocuSigned by:
BA167CA0C0D444A...
Signature

8/21/2024
Date

I hereby certify that for the fiscal year ended June 30, 2024, the County/City has maintained an interest-bearing local Mental Health Services (MHS) Fund (WIC 5892(f)); and that the County's/City's financial statements are audited annually by an independent auditor and the most recent audit report is dated December 22, 2023 for the fiscal year ended June 30, 2023. I further certify that for the fiscal year ended June 30, 2024, the State MHSA distributions were recorded as revenues in the local MHS Fund; that County/City MHSA expenditures and transfers out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that the County/City has complied with WIC section 5891(a). in that local MHS funds may not be loaned to a county general fund or any other county fund.

I declare under penalty of perjury under the laws of this state that the foregoing, and if there is a revenue and expenditure report attached, is true and correct to the best of my knowledge.

MELISSA WILK, AUDITOR-CONTROLLER
County Auditor Controller / City Financial Officer (PRINT)

Melissa Wilk
Signature

8/29/24
Date

Alameda County Health

Colleen Chawla
Director

AGENDA _____ September 17, 2024

August 20, 2024

The Honorable Board of Supervisors
County of Alameda
1221 Oak Street
Oakland, CA 94612

SUBJECT: ADOPT THE FISCAL YEAR 2024-25 MENTAL HEALTH SERVICES ACT ANNUAL PLAN UPDATE FOR ALAMEDA COUNTY HEALTH, BEHAVIORAL HEALTH DEPARTMENT

Dear Board Members:

RECOMMENDATION:

Adopt the Mental Health Services Act Annual Plan Update for Fiscal Year 2024-25, which has been certified by the Alameda County Health, Behavioral Health Department Director and the Auditor-Controller to meet specified requirements in accordance with the California Welfare & Institutions Code Section 5847.

DISCUSSION/SUMMARY:

Alameda County Health, Behavioral Health Department (ACBHD) is requesting your Board to adopt the Fiscal Year (FY) 2024-25 Mental Health Services Act Annual Plan Update (MHSA Plan). Following your approval, ACBHD will submit the MHSA Plan to the Mental Health Services Oversight & Accountability Commission (MHSOAC) within 30 days after the Board of Supervisors' adoption.

The MHSA Plan must be certified by the designated Mental Health Director and the Auditor-Controller of Alameda County, to meet specified Mental Health Services Act (MHSA) requirements in accordance with the California Welfare & Institutions Code Section 5847, attesting that ACBHD has complied with fiscal accountability requirements as directed by the State Department of Health Care Services (DHCS); ensured expenditures are consistent with the MHSA requirements; and prepared and circulated a draft plan for review and comment for 45 days (increased from 30 days), to representatives of stakeholder interests or interested parties. The FY 2024-25 MHSA Plan meets those requirements and provides an overview of the various MHSA funded programs being implemented in the County as well as a fiscal overview of MHSA funds the County has received.

On June 27, 2012, Assembly Bill 1467, the Omnibus Health Trailer Bill, chaptered into law requires each county mental health program to prepare and submit a Board-adopted three-year program and expenditure plan, and annual plan updates, to the MHSOAC.

On December 19, 2023 (Item No. 3), your Board approved the adoption of the MHSA Three-Year Program and Expenditure Plan (MHSA 3-year Plan) for FY 2023-24 through 2025-26. On January 4, 2024, ACBHD submitted the MHSA 3-year Plan to MHSOAC and DHCS.

On April 1, 2024, ACBHD posted the FY 2024-25 Annual Plan Update, which is the second year of the MHSA 3-year Plan on its website for a 45-day public comment period. The Mental Health Advisory Board hosted a public hearing on May 20, 2024, at which time ACBHD addressed public questions and concerns. ACBHD presented the MHSA Plan to the Alameda County Board of Supervisors Health Committee at its public meeting on June 10, 2024, and the Health Committee recommended the MHSA Plan go to the full Board for adoption.

The MHSA Plan continues with the implementation of over 220 ongoing and short-term programs and projects in treatment, prevention, workforce development, innovation and capital facilities/technology. The main changes from the previous years include:

I. COMMUNITY SERVICES AND SUPPORTS (CSS)

a) Full Service Partnerships (FSP)
- Continued analysis and transition of Service Team Case Management Model to FSP Model
- Transition Age Youth (TAY) Forensic Focused FSP Implementation

b) Outreach, Education and System Development (OESD) Programs
- Early Childhood Mental Health Services and Consultation Program Implementation
- Washington Hospital: Full Implementation of Pilot FY 23/24 - FY 24/25
- Asian American & Pacific Islander Older Adult pilot with City of Fremont Update
- Safe Landing Re-entry Project funding type change
- Assessment and Mapping

II. PREVENTION AND EARLY INTERVENTION (PEI)

- New PEI/CSS blended program for Lesbian, Gay, Bi-sexual, Transgender, Gender Non-binary, Gender Non-conforming, Queer or Questioning, Intersex, Asexual, and more on the gender and sexuality spectrum (LGBTQIA+) youth/TAY implementation

III. INNOVATION (INN)

- New INN Program: Integrating Psychiatric Advance Directives (PADs)

IV. WORKFORCE EDUCATION DEVELOPMENT AND TRAINING (WET) AND CAPITAL FACILITIES AND TECHNOLOGICAL NEEDS (CFTN)

a) WET Program

- No changes to the WET Component

b) CFTN Projects

- African American Wellness Hub Update
- Electronic Health Record System Update

SELECTION CRITERIA/PROCESS:

Not applicable.

FINANCING:

Appropriations outlined in the Plan Update are offset by MHSA revenue already included in the ACBH FY 2024-25 Approved Budget. There will be no increase in net County cost as a result of your approval.

VISION 2026 GOAL:

The FY 2024-25 MHSA Plan Update meets the 10X goal pathway of **Healthcare for All** in support of our shared vision of a **Thriving and Resilient Population**.

Sincerely,

DocuSigned by:
CB284AE84C50405...

Colleen Chawla, Director
Alameda County Health

Attachment: Plan with Certification

CC/TH/bn

ALAMEDA COUNTY BOARD OF SUPERVISORS
MINUTE ORDER

The following action was taken by the Alameda County Board of Supervisors on 10/01/2024

Approved as Recommended ☑ **Other** ☐

Unanimous ☐ **Tam:** ☐ **Haubert:** ☐ **Miley:** ☐ **Márquez:** ☐ **Carson:** ☐ - 5
Vote Key: N=No; A=Abstain; X=Excused

Documents accompanying this matter:

Documents to be signed by Agency/Purchasing Agent:

File No. _____
Item No. 3

Copies sent to:

Notified: Brenda.Ng@acgov.org; Cecilia.Serrano@acgov.org; Jill.Louie@acgov.org; Maricruz.Melero@acgov.org; Tracy.Hazelton@acgov.org

Special Notes:

I certify that the foregoing is a correct copy of a Minute Order adopted by the Board of Supervisors, Alameda County, State of California.

ATTEST:
Clerk of the Board
Board of Supervisors

By: Nancy French
Deputy

State of California
Health and Human Services Agency

Department of Health Care Services

MENTAL HEALTH SERVICES ACT
PRUDENT RESERVE ASSESSMENT/REASSESSMENT

County/City: Alameda County

Fiscal Year: FY 2023-24

Local Mental Health Director

Name: Karyn Tribble, ACBHD Director

Telephone: 567-8100

Email: Karyn.Tribble@acgov.org

I hereby certify[1] under penalty of perjury, under the laws of the State of California, that the Prudent Reserve assessment/reassessment is accurate to the best of my knowledge and was completed in accordance with California Code of Regulations, Title 9, section 3420.20 (b).

Karyn Tribble, ACBHD Director	DocuSigned by: BA167CA0C0D444A...	9/10/2024
Local Mental Health Director (PRINT NAME)	Signature	Date

[1] Welfare and Institutions Code section 5892 (b)(2)

DHCS 1819 (02/19)

APPENDIX J: J-1: Community Services and Supports: Clients Served by Age Group

Program Number	Name of Program	Funding Category	Age/Population Served	TOTAL Number of Clients Served	Budget	Cost per Client
OESD 4A	City of Fremont - Mobile Teams	CSS - OESD	66 Adults, 5 Older Adults	71	$1,173,998	$16,535
OESD 5A	Alameda County Behavioral Health Crisis	CSS - OESD	27 Youth 203 Transitional Age Youth, 2,135 Adults, 51 Older	2,416	$9,755,626	$4,038
OESD 7	Behavioral Health Court (BHC)	CSS - OESD	259 Adults	259	$463,212	$3,332
OESD 7	Court Advocacy Project (CAP)	CSS - OESD	82 Adults	82	$463,212	$3,332
OESD 9	Seneca Family of Agencies – MST	CSS - OESD	33 Youth	33	$1,035,030	$31,364
OESD 11	BACS Amber House – CSU / CRU	CSS - OESD	479 Adults CSU, 200 Adults CRT	479 (CSU), 200 (CRT)	$5,382,469 (CSU) / $2,540,813 (CRT)	$11,326 (CSU) / $12,704 (CRT)
OESD 11	STARS – Willow Rock	CSS - OESD	248 Youth	248	$5,762,755	$20,804
OESD 11	Telecare Alameda County Youth Crisis Stabilization Unit	CSS - OESD	250 Youth	250	$5,762,755	$20,804
OESD 14	Multi-Lingual Counseling Center – Staffing to Asian Population	CSS - OESD	23 Youth 15 Transitional Age Youth, 86 Adults	124	$175,750	$1,417
OESD 14	Asian Health Services - Language ACCESS	CSS - OESD	376 Adults	376	$1,741,027	$1,153
OESD 15	La Familia Counseling Center – ACCESS Staffing to Latinx Population	CSS - OESD	55 Adults	55	$975,499	$17,736
OESD 17	A&A Health Services – Residential Treatment	CSS - OESD	7 Adults	7	$604,440	$86,348
OESD 17	Ever Well Health Systems – Residential Support Services	CSS - OESD	3 Adults	3	$652,795	$217,598
OESD 18	Wellness Centers (Fremont) / So. Co. Wellness	CSS - OESD	1,611 Adults	1,611	$687,955	$427
OESD 18	Wellness Centers (HEDCO)	CSS - OESD	2,355 Adults	2,355	$833,766	$354
OESD 18	Wellness Centers (Townhouse)	CSS - OESD	62 Transitional Age Youth, 4554 Adults	4,616	$1,113,609	$241
OESD 18	Wellness Centers (Valley)	CSS - OESD	100 Adults	100	$631,188	$6,311
OESD 18	Bonita House – Berkeley	CSS - OESD	53 Adults	53	$466,397	$8,799
OESD 18	Bonita House – Casa Ubuntu / East Oakland Wellness Center	CSS - OESD	126 Adults	126	$939,041	$7,452
OESD 18	NAMI MHAAC – Chinese Community	CSS - OESD	4,700 Adults	4,700	$20,000	Capacity Building Funds
OESD 18	NAMI MHAAC – East Bay	CSS - OESD	Adults	no data	$20,000	Capacity Building Funds
OESD 18	NAMI MHAAC – Tri-Valley	CSS - OESD	Adults	no data	$20,000	Capacity Building Funds
OESD 18	ACNMHC – Peer Wellness Collective	CSS - OESD	3,245 Adults	3,245	$1,095,423	$337
OESD 19	Hiawatha Harris	CSS - OESD	2,782 Adults	2,782	$2,344,999	$842
OESD 19	STEPS – Telecare	CSS - OESD	59 Adults	59	$753,353	$12,768
OESD 20	Bonita House – Individual Placements Services (IPS)	CSS - OESD	18 Adults	18	$2,181,163	$121,175
OESD 20	Center for Independent Living (CIL)	CSS - OESD	29 Adults	29	$72,941	$2,515
OESD 23	REFUGE	CSS - OESD	32 Transitional Age Youth	32	$1,734,121	$54,191
OESD 24	Schreiber Center	CSS - OESD	51 Adults, 4 Older Adults	55	$397,904	$7,234
OESD 25	Primary Care Integration – TRUST Clinic	CSS - OESD	1,657 Adults	1,657	$3,038,853	$1,833
OESD 25	Alameda Health Consortium (AHC) – IBHCS (Pediatric Care Coordination Pilot)	CSS - OESD	6,330 Youth	6,330	$2,040,434	$322
OESD 25	Alameda Health System (AHS) – IBHCS (Care Coordination)	CSS - OESD	900 Adults	900	$161,363	$179
OESD 25	Axis Community Health – Behavior Health Primary Care Integration Project	CSS - OESD	809 Adults	809	$2,388,695	$2,952
OESD 25 BH	Primary Care Integration – Care Coordination Bay Area Community Health (BACH)	CSS - OESD	2,600 Adults	2,600	$193,738	$75
OESD 25 BH	Fremont PATH/Bay Area Community Health	CSS - OESD	278 Adults	278	$141,908	$510
OESD 25 BH	Primary Care Integration – Native American Health Center	CSS - OESD	170 Adults	170	$97,020	$571
OESD 25 BH	Primary Care Integration – La Familia (Early Childhood Integration)	CSS - OESD	12 Youth	12	$101,187	$8,432
OESD 25 BH	Primary Care Integration Eastmont–Oakland-PATH (OACSC)	CSS - OESD	316 Adults	316	$127,227	$403
OESD 25 BH	Primary Care Integration Eden – Oakland-PATH	CSS - OESD	307 Adults	307	$187,357	$610
OESD 25 BH	Primary Care Integration – La Clinica de la Raza	CSS - OESD	1279 Adults	1,279	$193,738	$151

Program Number	Name of Program	Funding Category	Age/Population Served	TOTAL Number of Clients Served	Budget	Cost per Client
OESD 25 BH	Primary Care Integration – Tiburcio Vasquez Health	CSS - OESD	3,976 Adults	3,976	$161,363	$41
OESD 25 BH	Primary Care Integration – West Oakland Health Center	CSS - OESD	399 Adults	399	$97,020	$243
OESD 26A	Hiawatha Harris – Pathways	CSS - OESD	943 Adults	943	$381,647	$405
OESD 26B	ROOTS – AfiyaCare	CSS - OESD	54 Adults	54	$425,940	$7,888
OESD 27	Adobe Services (IHOT)	CSS - OESD	124 Adults	124	$655,264	$5,284
OESD 27	Bonita House (IHOT)	CSS - OESD	127 Adults	127	$655,264	$5,160
OESD 27	La Familia (IHOT)	CSS - OESD	80 Adults	80	$655,264	$8,191
OESD 27	STARS (IHOT)	CSS - OESD	54 Adults	54	$567,627	$10,512
OESD 27	Telecare – AdROC	CSS - OESD	112 Adults	112	$477,292	$4,262
OESD 27	Telecare – TAYROC	CSS - OESD	115 Transitional Age Youth	115	$273,160	$2,375
OESD 28	BACS – SAGE	CSS - OESD	170 Adults,	170	$3,569,040	$20,994
OESD 30	La Familia – Sally Place Peer Respite	CSS - OESD	93 Adults	93	$1,204,953	$12,956
OESD 31	Felton Institute – Early Psychosis Program	CSS - OESD	100 Transitional Age Youth	100	$1,528,122	$16,257
OESD 32	Crisis Support Services – Suicide Prevention Crisis Line	CSS - OESD	All ages, data not disaggregated*	39,476	$689,402	$17
OESD 32	Crisis Support Services – Zero Suicide Program	CSS - OESD	707 Adults	707	$275,165	$389
OESD 33	Felton Institute – Deaf Community Counseling (Adult & Child)	CSS - OESD	33 Adults	33	$328,153	$9,944
OESD 34	School-Based Behavior Health – Alameda Family Services	CSS - OESD	1,557 Youth	1,557	$145,441	$93
OESD 34	EBAC (East Bay Agency for Children) – program closed	CSS - OESD	2,063 Youth	2,063	$138,250	$67
OESD 34	Fred Finch Youth & Family Svc. – program closed	CSS - OESD	27 Youth	27	$273,000	$3,739
OESD 34	Lincoln Child Center – program closed	CSS - OESD	27 Youth	27	$94,500	$3,500
OESD 34	School-Based Behavior Health – Seneca ASCEND	CSS - OESD	1,383 Youth	1,383	$309,590	$224
OESD 34	School-Based Behavior Health – STARS	CSS - OESD	221 Youth	221	$96,474	$437
OESD 35	East Bay Agency for Children (EBAC) – Fremont	CSS - OESD	1,855 Adults	1,855	$91,974	$50
OESD 35	MHAAC – Family Education and Resource Center (FERC)	CSS - OESD	2,331 Adults	2,331	$2,094,840	$899
OESD 36	CalMHSA Presumptive Transfer	CSS - OESD	183 Youth	183	$762,973	$6,521
OESD 37	Bay Area Community Services (BACS) – Re-entry Treatment Teams (RTT)	CSS - OESD	257 Adults	257	$1,826,672	$7,108
OESD 37	La Familia Counseling Center – Re-entry Treatment Teams (RTT)	CSS - OESD	48 Adults	48	$491,281	$10,235
OESD 38	Bay Area Legal Aid	CSS - OESD	333 Adults	333	$466,409	$1,401
OESD 38	Alameda County Homeless Action Center (HAC)	CSS - OESD	368 Adults	368	$932,817	$2,535

*For OESD 32 Crisis Line, age is not aggregated due to the primary focus for crisis support and deescalation.

APPENDIX J:J-2: Prevention and Early Intervention: Clients Served by Age Group

Program Number	Provider Name	Program Name	Age/Population Served	TOTAL Number of Clients Served	Budget	Cost per Client
PEI 1A	Blue Skies Mental Wellness Team	School-Based Mental Health Consultation in Preschools	180 Youth	180	$677,347	$3,763.04
PEI 1D	La Familia Counseling Services	Outreach, Education & Consultation for Unaccompanied Immigrant Youth	65 Youth 69 Transitional Age Youth 6,879 is outreach data with no disaggregated age grouping	7,013	$826,466	$117.85
PEI 5	Cultura y Bienestar (La Clinica De La Raza)	Outreach, Education & Consultation for Unaccompanied Latino Community	73 Youth 34 Transitional Age Youth 150 Adults, 19 Older Adults 1,611 is outreach data with no disaggregated age grouping	1,887	$1,886,931	$999.96
PEI 6	Asian Health Services (AHS)	Outreach, Education & Consultation for Asian Community	12 Youth 20 Transitional Age Youth 19 Adults, 15 Older Adults 340 is outreach data with no disaggregated age grouping	406	$353,464	$870.60
PEI 6	Bay Area Community Health (BACH)	Outreach, Education & Consultation for East Asian Community	12 Youth, 21 Older Adults, no outreach data provided	33	$353,500	$11,665
PEI 6	Center for Empowering Refugees and Immigrants CERI	ROYA	11 Youth 19 Transitional Age Youth 67 Adults, 48 Older Adults 1,611 is outreach data with no disaggregated age grouping	145	$707,000	$4,875
PEI 6	Korean Community Center of the East Bay (KCCEB)	Outreach, Education & Consultation for East Asian Community	39 Youth 41 Transitional Age Youth 15 Adults, 10 Older Adults 165 is outreach data with no disaggregated age grouping	270	$353,464	$1,309.13
PEI 6	Richmond Area Multi-Services, Inc. (RAMS)	Outreach, Education & Consultation for Pacific Islander Community	6 Youth 17 Transitional Age Youth 37 Adults, 6 Older Adults 182 is outreach data with no disaggregated age grouping	248	$612,250	$2,468.75
PEI 7	Afghan Coalition	Outreach, Education & Consultation for South Asian/Afghan Community	6 Youth, 10 Transitional Age Youth, 94 Adults, 17 Older Adults 1,155 is outreach data with no disaggregated age grouping	1,282	$560,500	$437.21
PEI 7	Afghan Path Toward Wellness - International Rescue Committee (IRC)	Outreach, Education & Consultation for Afghan Community	2 Youth, 13 Transitional Age Youth, 56 Adults, 5 Older Adults 36 is outreach data with no disaggregated age grouping	109	$353,500	$3,243.12
PEI 7	Filipino Advocates for Justice	Outreach, Education & Consultation for Filipino Community	7 Youth 23 Transitional Age Youth 5 Adults, 35 is outreach data with no disaggregated age grouping	70	$353,500	$5,050
PEI 7	The Hume Center	Outreach, Education & Consultation for South Asian/Afghan Community - South Community Health Promotion Services Program	18 Youth 28 Transitional Age Youth 35 Adults, 5 Older Adults is outreach data with no disaggregated age grouping	868	$707,000	$741.09
PEI 8	Native American Health Center (NAHC)	Outreach, Education & Consultation for Native American Community	4 Youth, 20 Transitional Age Youth, 95 Adults, 22 Older Adults 79 is outreach data with no disaggregated age grouping	220	$353,500	$1,606.82
PEI 10	Partnership for Trauma Recovery (PTR)	Outreach, Education & Consultation for African Community	1 Youth, 10 Transitional Age Youth, 19 Adults, 147 is outreach data with no disaggregated age grouping	177	$353,381	$1,996.50
PEI 19	Diversity in Health Training Institute (DHTI)	Outreach, Education & Consultation for Middle Eastern Community	5 Youth, 17 Transitional Age Youth, 15 Adults, 2 Older Adults 29 is outreach data with no disaggregated age grouping	68	$750,444	$11,035.94
PEI 1B	Center for Healthy Schools and Communities (CHSC)	School-Based Mental Health Access and Linkage	10,562 Youth	10,562	$649,338	$61.48
PEI 1C	Jewish Family and Community Services East Bay	Early Childhood Mental Health Outreach and Consultation	15 Youth	15	$178,239	$11,882.60
PEI 3	Alameda County Behavioral Health - GART	Geriatric Assessment and Response Team	133 Older Adults	133	$1,336,629	$10,049.84
PEI 4	Peers Envisioning and Engaging in Recovery Services (PEERS)	Everyone Counts Campaign (EEC)	295 Youth, 17 TAY, 21 Adults, 16 Older Adults	349	$1,405,806	$4,028.10
PEI 12	Crisis Support Services of Alameda County (CSS) – Text Line	Text Line	267 Youth, TAY 429, 342 Adult, 25 Older Adult,	1,464	$661,359	$451.75
PEI 12	Crisis Support Services of Alameda County (CSS) – Community Education Prog.	Community Education Program (CEP)	1,703 Youth, 51 TAY, 38 Adult, 5 Older Adult	14,563	$661,359	$45.41
PEI 12	Crisis Support Services of Alameda County (CSS) – Clinical Program	Clinical Program	184 youth	184	$922,875	$5,015.63
PEI 17A	YOUTH UPRISING	Early Intervention	137 Transition Age Youth	137	$447,943	$3,269.66
PEI 17B	REACH	Early Intervention	222 Youth	222	$535,233	$2,410.96
PEI 20A	Beats, Rhymes, and Life (BRL)	Beats, Rhymes, and Life (BRL)	234 Youth	234	$870,713	$3,712
PEI 20B	Black Men Speak MHAAC	Culturally Responsive Programs for African Americans - Black Men Speak	51 Adults	51	$361,937	$7,096
PEI 20C	MHAAC	Culturally Responsive Programs for African Americans - Family Outreach Program	51 Adults	51	$329,604	$6,462.82
PEI 20E	Tri Cities Community Development Center	Culturally Responsive Programs for African Americans - Faith Based	480 Adults	480	$304,192	$633.73
PEI 20E	PEERS	Culturally Responsive Programs for African Americans - Hope & Faith	167 TAY	167	$304,741	$1,824.80
PEI 20F	RJOY	Culturally Responsive Programs for African Americans - Africentric Healing Circles	72 Youth	72	$583,834	$8,108.81
PEI 22	Pacific Center for Human Growth – Older and Out	Older and Out	46 Older Adults	46	$267,361	$5,812.20
PEI 22	Pacific Center for Human Growth – Peer Mentorship	Peer Mentorship Project	261 Older Adults	261	$134,810	$516.51
PEI 22	Pacific Center for Human Growth – Training Assistant	Technical Assistant	105 Older Adults	105	$239,452	$2,281.35
PEI 24	Roots Community Health Center	Sobrante Park	27 Youth	27	$350,000	$12,962.96
PEI 26	HHREC – 10X10 Wellness Campaign	10 X 10 Wellness Campaign	23 TAY	23	$208,224	$9,053.22
PEI 27	HHREC – Health Through Art & Black Women’s Media Project	Health Through Art & Black Women's Media Project	303 Adults	303	$268,637	$886.59
PEI 28	HHREC – Downtown TAY	Downtown TAY	287 TAY	287	$418,666	$1,458.77

For questions or additional information regarding this report, please contact the report developer:

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